

Building a Recovery-Oriented System of Care:

A Report of the NCIOM Task Force on Substance Abuse Services

January 2009

North Carolina Institute of Medicine
A report requested by the North Carolina General Assembly





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Acknowledgements

The North Carolina Institute of Medicine's (NCIOM) Task Force on Substance Abuse Services was created at the request of the North Carolina General Assembly in 2007. The North Carolina General Assembly directed the NCIOM to study the substance abuse services system in North Carolina and to present an interim report and recommendations to the 2008 General Assembly and a final report to the 2009 General Assembly. The work of the Task Force was led by 3 co-chairs, including Dewayne Book, MD, Medical Director, Fellowship Hall; Representative Verla Insko, North Carolina House of Representatives; and Senator Martin Nesbitt, Jr., JD, North Carolina Senate. There were 51 additional Task Force members, including legislators, state and local agency officials, substance abuse providers and other healthcare professionals, and consumers and other interested people, who dedicated approximately one day a month between October 2007 and January 2009 to study this important issue. Another 12 people participated in the Task Force's work as Steering Committee members. The Steering Committee members helped shape the meeting agendas and identify speakers and gave important input into the interim report and recommendations. The accomplishments of this Task Force would have not been possible without the combined effort of the Task Force and Steering Committee members. For a complete list of Task Force members and Steering Committee members, please see pages 9-12 of this report.



The NCIOM Task Force on Substance Abuse Services heard presentations from state and national experts on substance abuse and the substance abuse system. Their presentations helped to inform the work of the Task Force. We want to thank the following people for sharing their expertise with the Task Force: Patrice Alexander, SPHR, Director of Human Resources, Greenville Utilities; David Ames, MD, DLFAPA, Chair, North Carolina Psychiatric Association Addictions Committee; Thomas Babor, PhD, MPH, Professor, Physicians Health Services Chair in Community Medicine and Public Health, University of Connecticut Health Center; Dewayne Book, MD, Medical Director, Fellowship Hall; Bill Bronson, Manager, Drug Control Unit, North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS), North Carolina Department of Health and Human Services (NC DHHS); Becky Brownlee, President, Power Steering, Inc., Contractor, Governor's Institute on Alcohol and Substance Abuse; Mady Chalk, PhD, Director, Center for Policy Analysis and Research, Treatment Research Institute; Spencer Clark, MSW, Community Policy Management Section, DMHDDSAS, NC DHHS; Chris Collins, MSW, Acting Assistant Director for Managed Care, NC Division of Medical Assistance (DMA), Deputy Director, Office of Rural Health and Community Care (ORHCC), NC DHHS; Ashley Cox, Coordinator of Resource Development, Alcohol/Drug Council of North Carolina; Kelly Crowley, LCSW, System of Care Coordinator, Community Policy Management, Prevention and Early Intervention Team, DMHDDSAS, NC DHHS; Steve Day, Executive

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The North Carolina Institute of Medicine served as staff for the Task Force. Pam Silberman, JD, DrPH, President and CEO of the North Carolina Institute of Medicine, and Mark Holmes, PhD, Vice President of the North Carolina Institute of Medicine, helped lead the staff effort and assisted in writing sections of the report. In addition to their work, Berkeley Yorkery, MPP, Project Director, Jennifer Hastings, MS, MPH, Project Director and Director of Communications, and Daniel Shive, MSPH, Research Assistant, helped write sections of the report. Kimberly Alexander-Bratcher, MPH, Project Director, assisted in writing the accompanying fact sheet and made community presentations about the Task Force's work. Christine Nielson, MPH, Managing Editor of the *North Carolina Medical Journal*, and Phyllis Blackwell, Assistant Managing Editor, took the lead on editing the report and in editing the January/February 2009 issue of the *North Carolina Medical Journal* devoted to the North Carolina substance abuse system. Kimberly Alexander-Bratcher, Berkeley Yorkery, and Jesse Lichstein served as Project Directors for the Task Force's work and made presentations to the community about the Task Force. They were assisted by Thalia Fuller, Administrative Assistant, who helped with meeting logistics.

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Executive Summary

Dependence on alcohol, tobacco, and other drugs is a complex and costly *chronic illness*. Drug addiction is a brain disorder.¹ Although this disorder is triggered by the use of substances, there are predisposing genetic and environmental factors that can make some people more susceptible to addiction.

Addiction disorders are remarkably similar to other chronic diseases, although there is a widespread perception that substance abuse and addiction represent a failure of an individual's morals. People with addiction disorders have similar adherence and relapse rates as do people who have asthma, type 2 diabetes, or hypertension. Chronic diseases, including substance abuse disorders, are generally lifelong conditions. They are not "cured" in the acute care sense. Instead, the goal of treatment is to *manage* them so that the burden on the individual—and to the healthcare system, the workplace, and society in general—is minimized as much as possible.

In North Carolina, there are more than 250,000 people aged 12 years or older who report illicit drug dependence and more than twice as many (550,000) who report alcohol dependence or abuse.² Yet fewer than 10% of those with dependence on illicit drugs and fewer than 5% of those with alcohol dependence or abuse received treatment in North Carolina (SFY 2007) from providers funded through the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS), the lead agency charged with coordinating prevention, treatment, and recovery supports. Many individuals with substance abuse problems either do not recognize they have a problem or do not seek treatment. Even those who do seek treatment are not always able to get the services they need when they need them or with the intensity needed to successfully address their problem. Further, people with substance abuse problems need ongoing recovery supports to help prevent relapse.

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services has primary responsibility for the coordination of substance abuse services throughout the state. Most of the direct provision of publicly-funded substance abuse services is managed by Local Management Entities (LMEs). Services are also offered through, or in collaboration with, many other agencies throughout the state. Overall, North Carolina spent \$138 million in 2006 to fund the public substance abuse service system in the state, a sum that left North Carolina substance abuse services underfunded in relation to other states.³ A report presented to the North Carolina General Assembly in 2007 estimated it would take an additional \$35 million in appropriations to achieve parity with national per capita funding for substance abuse services.⁴

Substance abuse carries both direct and indirect costs to society. In addition to the direct costs of prevention, treatment, and recovery supports, there are indirect costs associated with motor vehicle accidents, premature death, comorbid health



Dependence on alcohol, tobacco, and other drugs is a complex and costly chronic illness.

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conditions, disability, lost productivity, crime, unemployment, poverty, homelessness, and a host of other social problems. Alcohol and drug abuse cost the North Carolina economy over \$12.4 billion in direct and indirect costs in 2004.⁵ Nationally, alcohol or drug abuse is a contributing factor in more than 75% of the cases when children are removed from the home and placed in foster care.⁶ Substance abuse is also an underlying problem for many youth involved in the juvenile justice system. In North Carolina, 43% of North Carolina juveniles involved in the juvenile justice system were determined to need further assessment or treatment for substance use.

Substance use is also one of the major causes of motor vehicle deaths in the state. In 2005, more than 5% of all traffic accidents in the state were alcohol-related, and these accidents accounted for 26.8% of all crash-related fatalities.⁷ Alcohol and drug-related crimes also consume a large amount of criminal justice resources. Almost 90% of the people entering the North Carolina prison system needed substance abuse treatment, with 63% of new prisoners needing residential treatment.⁸

The North Carolina General Assembly asked the North Carolina Institute of Medicine (NCIOM) to convene a Task Force to study substance abuse services in the state (SL-2007-323 §10.53A) and to present an interim report with recommendations to the 2008 North Carolina General Assembly and the final report and recommendations to the 2009 North Carolina General Assembly. The Task Force was co-chaired by Dwayne Book, MD, Medical Director, Fellowship Hall; Representative Verla Insko, Representative District 56, North Carolina House of Representatives; and Senator Martin L. Nesbitt Jr., JD, Senator District 49, North Carolina Senate. It included 51 other members including other legislators, state and local agency officials, substance abuse providers, other health professionals, consumers, educators, and other knowledgeable and interested individuals. In addition, the work of the Task Force was guided by a 12-member Steering Committee. The Task Force met 14 times between October 2007 and December 2008 working to develop the final report to the North Carolina General Assembly.

Prevention: Most of the Task Force's work focused on developing a comprehensive system of care to provide evidence-based interventions based on a person's need. This comprehensive system begins with a strong prevention effort, targeted at adolescents and young adults. Targeting youth and young adults will help reduce the number of people who later become addicted, as evidence shows that people who initiate substance use in childhood or adolescence are more likely to later become addicted. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), communities can save four to five dollars for every one dollar they spend on substance abuse prevention.⁹ The following is a summary of the Task Force's prevention recommendations.

Recommendation 4.1 (PRIORITY RECOMMENDATION)

The North Carolina General Assembly should appropriate \$1,945,000 in SFY 2010 and \$3,722,000 in SFY 2011 in recurring funds to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to develop comprehensive state and local substance abuse prevention plans. Of these funds, \$1,770,000/\$3,547,000 would be used to fund six comprehensive prevention pilot projects at local level. Eligible Local Management Entities must develop a comprehensive plan that includes a mix of evidence-based strategies, and should include a wide array of community partners. The North Carolina General Assembly should appropriate \$250,000 to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to evaluate these pilots and, if successful, to recommend roll-out to other parts of the state.

Recommendation 4.2

The North Carolina General Assembly should direct the State Board of Education, Office of Non-Public Education; NC Community College system; and University of North Carolina system to review their existing substance abuse prevention, early intervention, and treatment services, plans, and policies and report on these plans to the North Carolina General Assembly.

Recommendation 4.3

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; Division of Public Health; Division of Alcohol Law Enforcement; and Department of Public Instruction should develop a plan to further reduce tobacco and alcohol sales to minors.

Recommendation 4.4 (PRIORITY RECOMMENDATION)

The North Carolina General Assembly should further increase the tobacco tax to meet the national average, with the increased revenues used to support evidence-based prevention and treatment efforts.

Recommendation 4.5

The North Carolina General Assembly should appropriate \$1.5 million in recurring funds to the Division of Public Health to support Quitline NC.

Recommendation 4.6 (PRIORITY RECOMMENDATION)

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

Recommendation 4.7 (PRIORITY RECOMMENDATION)

In order to reduce underage drinking, the North Carolina General Assembly should increase the excise tax on malt beverages (including beer). In addition, the excise taxes on malt beverages and wine should be indexed to the consumer price index so they can keep pace with inflation. Funds raised should be used to support evidence-based prevention and treatment efforts.

Recommendation 4.8

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

Recommendation 4.9 (PRIORITY RECOMMENDATION)

The North Carolina General Assembly should appropriate \$610,000 in recurring funds in SFY 2010 to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services over three years to support efforts to reduce high-risk drinking on college campuses.

Recommendation 4.10

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; Division of Public Health; Division of Social Services; and other providers should develop a prevention plan to prevent alcohol spectrum disorders and report the plan to the Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services no later than July 1, 2009.

Recommendation 4.11

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services should work with the Controlled Substances Reporting System (CSRS), Attorney General's Office and other appropriate health professional organizations to explore options to allow the exchange of prescription information obtained through the CSRS between health care practitioners.

Early Screening and Intervention: Early screening and intervention strategies are needed for people who start to engage in risky behaviors but who have not yet become addicted. Without early intervention services, these individuals are likely to progress to worse stages of abuse and/or dependence. The Substance Abuse and Mental Health Services Administration (SAMHSA) has developed an evidence-based screening, brief intervention, and referral into treatment (SBIRT) program for individuals who are at risk for substance abuse problems. Although SBIRT has been shown to be effective in helping at-risk individuals reduce their use of alcohol, tobacco, or other drugs, providers do not routinely use these strategies.¹⁰ The Task Force's recommendations focus on educating primary care and other providers about the SBIRT model or other strategies to encourage providers to identify and treat people with substance abuse disorders. A summary of the Task Force's recommendations in this area are as follows:

Recommendation 4.12

North Carolina health professional schools, the Governor’s Institute on Alcohol and Substance Abuse, the North Carolina Area Health Education Centers program, residency programs, health professional associations, and other appropriate organizations should expand training for primary care providers and other health professionals in academic and clinical settings, residency programs, or other continuing education programs on screening, brief treatment, and referral (SBIRT) for people who have or are at risk of tobacco, alcohol, or substance abuse or dependency.

Recommendation 4.13 (PRIORITY RECOMMENDATION)

The North Carolina General Assembly should appropriate \$1.5 million in recurring funds to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to work with the Office of Rural Health and Community Care, Governors Institute on Alcohol and Substance Abuse, and Area Health Education Centers program to expand use of SBIRT in Community Care of North Carolina (CCNC) networks and other primary care and outpatient settings.

Recommendation 4.14

The North Carolina General Assembly should appropriate \$750,000 in recurring funds to the Office of Rural Health and Community Care. Funding can be used to help support co-location of licensed substance abuse professionals in primary care practices, or to support continuing education of mental health professionals who are already co-located in an existing primary care practice in order to help them obtain substance abuse credentials to provide substance abuse services to Medicaid and uninsured patients. The goal is to offer evidence-based screening, counseling, brief intervention, and referral to treatment to help patients prevent, reduce, or eliminate the use of or dependency on tobacco, alcohol, and other drugs.

Recommendation 4.15 (PRIORITY RECOMMENDATION)

The North Carolina General Assembly should mandate that insurers offer the same coverage for treatment of addiction diseases as for other physical illnesses. Insurers should reimburse for substance abuse screening, intervention, and treatment services whether offered through primary care providers or specialized substance abuse providers. Insurers should also reimburse for telephone consultations by psychiatrists, as well as for mental and behavioral health services provided on the same day as medical services are provided.

Specialized Substance Abuse Services and Recovery Supports: Individuals with more severe problems need different levels of treatment offered through the specialized substance abuse system. Substance abuse services are generally provided through private providers under contract with Local Management Entities (LMEs). Local Management Entities screen people to determine eligibility and need for services and then help these individuals access appropriate services. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services has established performance standards to ensure that people with substance abuse problems can obtain timely services with the frequency needed to address their problems. Local Management Entities do not currently serve the majority of people who have substance abuse disorders. In fact, the LMEs that are serving the highest percentage of people who need services are only reaching 11% of the estimated number of children or adults who need services; the LMEs reaching the lowest percentage of people in need are only serving 4% of the estimated number of children and 5% of the adults who need services. Local Management Entities also vary in their ability to meet the state's performance standards for timely initiation of treatment and ongoing engagement in the substance abuse system. Further, even when services are offered, they may not be provided with the level of intensity needed to help a person achieve sobriety.

The Task Force recognizes that individuals with substance abuse problems should have access to a full continuum of services including screening and assessment, brief intervention, outpatient services, medication management, intensive outpatient and partial hospitalization, clinically managed low-intensity residential services, clinically managed medium-intensity residential treatment, inpatient services, and crisis services including detoxification. In addition, individuals also need access to recovery supports in order to help them live without use of alcohol, tobacco, and other drugs. To achieve this goal, the Task Force recommends:

Recommendation 4.16 (PRIORITY RECOMMENDATION)

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) should develop a plan for a recovery oriented system of care for adults and adolescents, ensure that services are available and accessible across the state, and are coordinated among different providers. DMHDDSAS should develop plans for performance based incentive contracts to ensure that services are provided to a significant portion of those in need, that the services are provided in a timely fashion, that people are provided the intensity of services appropriate to their needs and engaged for appropriate lengths of time, and that people are provided appropriate recovery supports. In addition, DMHDDSAS should identify barriers and strategies to increase the quality and quantity of substance abuse providers in the state including, but not limited to, electronic health records, reduced paperwork, streamlined administrative processes, expanded service definitions, and adequacy of reimbursement rates. DMHDDSAS should also immediately begin expanding the capacity of adolescent treatment services across the state.

Recommendation 4.17

The North Carolina General Assembly should appropriate \$17.2 million in SFY 2010 and \$34.4 million in recurring funds in SFY 2011 to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS). DMHDDSAS should make funding available on a competitive basis to Local Management Entities (LMEs) to support six pilot programs to implement county or multi-county comprehensive recovery oriented system of care. The North Carolina General Assembly should appropriate \$750,000 to DMHDDSAS to independently evaluate these projects and, if successful, build a plan to expand systems across the state.

Recommendation 4.18 (PRIORITY RECOMMENDATION)

The North Carolina General Assembly should appropriate recurring funding for additional staff in the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (\$650,000); Office of Rural Health and Community Care (\$130,000); Division of Medical Assistance (\$81,000); and Department of Public Instruction (\$100,000) to provide substance abuse services in support of the Task Force recommendations.

In addition to prevention, early intervention, and treatment services provided to the general population with substance abuse problems, there are other services available for specific subpopulations. Many of these services are tailored to specific groups of individuals involved with the juvenile justice or criminal justice system. Other services are available to employees in the workplace, families involved in Work First and/or Child Protective Services, or active and retired military personnel. A summary of the Task Force's recommendations for these subpopulations is listed below. The full text is included in Chapter 5.

Juvenile Justice: The Department of Juvenile Justice and Delinquency Prevention (DJJDP) is responsible for providing prevention and intervention services to reduce delinquency as well as treatment services and sanctions for juvenile offenders. By necessity, DJJDP helps link juveniles to available substance abuse services, as 43% of juveniles in the juvenile justice system need further assessment or treatment for substance abuse.¹¹ Most of the substance abuse services for youth involved in the juvenile justice system are provided through the Managing Access for Juvenile Offender Resources and Services (MAJORS) program. MAJORS is funded through DMHDDSAS and administered by DMHDDSAS in collaboration with DJJDP. MAJORS provides substance abuse screening and assessment, therapy, life skills training, and ongoing monitoring, but additional work is needed to coordinate care between the juvenile, substance abuse providers, and juvenile courts. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and DJJDP are piloting a Cross Area Service program to provide better coordination and to enhance the quality of services offered through MAJORS. However, this pilot needs to be tested in additional sites before expanding statewide. To achieve this goal, the Task Force recommended:

Recommendation 5.1

The North Carolina General Assembly should appropriate \$500,000 in recurring funds to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to expand the Cross Area Service Program model in two additional Department of Juvenile Justice and Delinquency Prevention regions. If successful, the program should be rolled out statewide.

Employees: Employees with substance abuse problems often have performance and/or conduct problems that adversely affect their job performance. Loss of productivity, depression, and alcohol and drug addiction cost businesses \$287 billion each year.¹² Many companies turn to employee assistance programs (EAPs) to help them identify and resolve employee productivity problems, including employees' substance abuse problems. However, finding affordable worksite model EAPs can be difficult, particularly for small firms. In addition, employers need to ensure that providers offering EAP services have the necessary training and skills to address workplace problems. To address these concerns, the Task Force recommends:

Recommendation 5.2

Local Management Entities (LMEs) should assess the availability and need for Employee Assistance Program (EAP) services in their catchment area. If there are insufficient providers to address this need, the LMEs should work with the local Chambers of Commerce or other business organizations to develop a strategy to expand the availability of EAP services.

Recommendation 5.3

The North Carolina General Assembly should ensure that all individuals advertising and promoting themselves as providing EAP services must be licensed or have EAP specific training and work under the supervision of licensed EAP professionals, no later than 2014. All organizations that promote themselves as providing EAP services should be able to offer all the statutorily defined core services.

Families Involved in Work First or the Child Protective Services System: The goal of the Work First program is to move families with dependent children into employment and self-sufficiency. However, substance abuse and mental health issues are significant barriers to self-sufficiency. In addition, substance abuse is one of the major contributors to child abuse and neglect. Nationally, the Child Welfare League of America estimates that alcohol and/or drug abuse was an underlying factor in at least 75% of children entering foster care.⁶ The North Carolina Division of Social Services and DMHDDAS have developed a number of programs to serve these adults. One of these initiatives involves outstationing

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substance abuse professionals in local departments of social services to help parents with substance abuse problems engage in appropriate treatment. However, there are insufficient numbers of outstationed substance abuse professionals to work with all of the parents in need of services.

Recommendation 5.4

The North Carolina General Assembly should appropriate \$475,000 in recurring funds to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to hire seven additional Licensed Clinical Addiction Specialists to work with parents involved with the Work First or Child Protective Services System.

Adults Involved in the Criminal Justice System: Most of the people arrested for criminal activities have underlying addiction disorders. Approximately 90% of the criminals who enter the prison system have a substance abuse problem requiring treatment.⁸ Driving while impaired is a criminal offense; more than one-quarter of motor vehicle fatalities involved the use of alcohol. In response to these problems, North Carolina agencies have developed special substance abuse assessment, treatment, and monitoring programs for people convicted of driving while impaired, for those who have been convicted and are serving their sentences or probation in the community (community services) as well as for those serving active prison sentences (institutional services). However, there are severe shortages in the availability of services—both for people who are on probation or community corrections and for people who are currently incarcerated. For example, DMHDDSAS provides care management to people with substance abuse disorders who are on probation or in community corrections through the Treatment Accountability for Safer Communities (TASC) program. TASC counselors link individuals with substance abuse disorders to services provided through the Criminal Justice Partnership Program (CJPP). A North Carolina Sentencing and Policy Advisory Commission recidivism study found that adult offenders who received TASC services and completed their treatment were less likely to be rearrested over the next two years.¹³ Despite its strong track record, only a fraction of people who need TASC services receive it. In SFY 2008, the Division of Community Corrections supervised 24,773 offenders convicted of non-trafficking drug offenses; however, more than 75,000 people may need these services.

Drug courts have also been shown to be successful in engaging people with substance abuse disorders into active treatment. North Carolina currently operates three specialized courts that involve people with substance abuse disorders: family drug treatment courts (for adults who are having their children removed), juvenile drug treatment courts, and adult drug treatment courts. Typically, these courts begin with a federal grant, but ongoing state funding is needed to sustain the work and treatment resources after the initial federal funding is exhausted.

Treatment services are also needed for people who enter the prison system. Of the 23,111 offenders screened in SFY 2007, 63% needed residential substance abuse treatment, and another 23% needed some other substance abuse intervention.⁸ The Division of Alcoholism and Chemical Dependency (DACDP) provides different levels of substance abuse services depending on the needs of the prisoners. However, the availability of treatment resources has not kept pace with the need. Between SFY 2001-2007, the prison population grew by 20% (from 31,899 to 38,423), but the treatment beds declined by 21% (from 1,898 to 1,490).¹⁴ Because of limited resources, only about one-third of the prisoners who need services receive them.

To address these outstanding needs for substance abuse screening, care management, and treatment services, the Task Force recommends:

Recommendation 5.5

The North Carolina General Assembly should appropriate \$2.8 million in recurring funds in SFY 2010 and an additional \$2.8 million in SFY 2011 to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to expand the availability of Treatment Accountability for Safer Communities (TASC) program services.

Recommendation 5.6

The North Carolina General Assembly should appropriate \$500,000 in recurring funds in SFY 2010 to the Division of Community Corrections to expand the availability of Criminal Justice Partnership Program (CJPP)-funded substance abuse services.

Recommendation 5.7 (PRIORITY RECOMMENDATION)

The North Carolina General Assembly should appropriate \$500,000 in recurring funds in SFY 2010 to the Administrative Office of the Courts to support four new adult treatment courts, and \$500,000 in recurring funds in SFY 2011 to the Administrative Office of the Courts for an additional four adult treatment courts. In addition, the North Carolina General Assembly should increase appropriations to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services by \$570,000 in recurring funds in SFY 2010 and \$570,000 in recurring funds in SFY 2011 to support treatment services for people involved in the drug treatment courts. The North Carolina General Assembly should also appropriate \$269,940 in recurring funds in SFY 2010 and an additional \$269,940 in SFY 2011 to the Department of Corrections, Division of Community Corrections to fund probation officers to support the drug treatment courts.

Recommendation 5.8

The North Carolina General Assembly should appropriate \$4.5 million in recurring funds to the Department of Corrections to expand the availability of substance abuse services to adults within the prison system, as well as residential services for those on probation or parole.

Military Personnel: There are currently 107,000 active duty personnel based at North Carolina's seven military bases or deployed overseas and another 11,500 soldiers, marines, and airmen who live in North Carolina and serve in the National Guard or reserves.¹⁵ In addition to these men and women actively serving in our armed forces, we have another 773,630 veterans who live in North Carolina. Alcohol and other drug use is a serious problem for many in the military. Almost one-fourth (24%) of active duty military personnel and returning National Guard have reported alcohol dependence problems.^{16,17} Further, many of the returning veterans report post-traumatic stress disorder, depression, and substance abuse disorders. A study of more than 88,000 soldiers who returned from active duty in Iraq showed that 20.3% of active duty soldiers and 42.4% of the National Guard and reserve component were identified as needing mental health or substance abuse treatment post deployment.¹⁸ While some veterans services are available to active and returning military personnel and their families, these services are not sufficient to address all of the needs of the returning veterans. Many returning veterans receive their health care services through civilian health professionals rather than from health professionals who serve in the military or from the Veterans Administration (VA) system. Civilian health professionals may not recognize or may fail to screen returning veterans for common problems, including post traumatic stress disorder, depression, or substance abuse disorders. The VA has offered trainings, in conjunction with the Area Health Education Centers (AHEC) program and other organizations, to increase the skills and awareness of community mental health, substance abuse, and medical practitioners on the medical and behavioral health needs of returning veterans and their families.^{3,19} However, more work is needed to disseminate this information. In addition, returning veterans and their families need help with other nonrelated health services. To address these problems, the Task Force recommends:

a AHEC provides 6-hour trainings for different health professionals, and one-hour webinars are available to primary care providers through I-CARE.

Recommendation 5.9

The Veterans Administration should continue to work with appropriate partners to provide training for mental health and substance abuse professionals; Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and Local Management Entity agency staff; primary care providers; psychiatrists; school personnel; and other appropriate organizations about the medical and behavioral health needs of returning veterans and their families. In addition, the North Carolina General Assembly should appropriate \$200,000 in SFY 2010 to pay the 35% match for the Veterans Administration Homeless Providers Grant and Per Diem Program for transitional housing for homeless veterans with substance abuse or mental health disorders.

The Task Force recognized that the state will be unable to address any of these issues without an adequate supply of qualified substance abuse professionals. North Carolina has begun to build a cadre of qualified substance abuse professionals, but more people are needed to expand the supply of licensed and certified substance abuse providers as well as physicians and other health care professionals and counselors with addiction training. The North Carolina Substance Abuse Professional Practice Board (NCSAPPB) offers seven different types of substance abuse credentials.^b The number of qualified substance abuse professionals varies considerably across the state. Although all LMEs have some substance abuse clinicians who can provide services directly to people with addiction disorders, the availability of these professionals varies considerably across the state. In September 2008, there were eight counties that had no qualified substance abuse clinicians and another 33 counties with five or fewer clinicians. Other health professionals—such as physicians, nurse practitioners, physician assistants, licensed clinical social workers, psychologists, licensed marriage or family therapists, or licensed professional counselors—are authorized under their licensure laws to provide substance abuse services. These professionals can provide substance abuse services directly under their own licensure laws. However, available data suggest that there are few health professionals who are providing substance abuse services. There are no health professionals with addiction specialties in the eight counties that lack licensed, credentialed, or certified substance abuse professionals. Further, there continues to be a large discrepancy in the availability of all substance abuse clinicians even when including licensed health professionals. Polk County has the highest proportion of licensed, credentialed, or certified substance abuse clinicians (including both substance abuse and health professionals) to estimated population in need of substance abuse services, with one clinician to every 48 people with a

^b Licensed Clinical Addiction Specialists (LCAS), LCAS-Provisional (LCAS-Provisional), Certified Clinical Supervisor (CCS), Certified Substance Abuse Counselor (CSAC), Certified Substance Abuse Prevention Consultant (CSAPC), Certified Substance Abuse Residential Facility Director (CSARFD), and Certified Criminal Justice Addictions Professional Credential (CCJP).

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substance abuse disorder.^c Aside from the eight counties with no clinicians, Pasquotank has the fewest clinicians, with one clinician for every 3,092 people estimated to be in need of substance abuse services. State and local agencies have particular problems attracting qualified substance abuse professionals because of the low state pay grades assigned to people with these credentials.

Although data are not available about the total number of licensed health and counseling professionals who provide substance abuse services, anecdotal information presented to the Task Force from organizations that hire qualified substance abuse professionals to provide counseling and other substance abuse services all point to the serious workforce shortage.²⁰⁻²² The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services commissioned a workforce study to examine the adequacy of the behavioral health workforce and found a significant behavioral health workforce shortage in the state.²³ North Carolina has several scholarship or loan forgiveness programs targeted to produce certain types of professionals who are in short-supply in the state. The Task Force recommended that North Carolina adopt a similar approach to encourage more individuals to be trained as substance abuse providers. A summary of the Task Force's recommendations are listed here. The full text is included in Chapter 6.

Recommendation 6.1 (PRIORITY RECOMMENDATION)

The North Carolina General Assembly should appropriate \$750,000 in recurring funds in SFY 2010, \$1.5 million in recurring funds in SFY 2011, increasing to \$2.0 million in SFY 2013 to the Governor's Institute on Alcohol and Substance Abuse to create a scholarship program to increase the number of qualified professionals in the field of substance abuse treatment. Funding should be provided to help support people seeking training through the community colleges, undergraduate education, master's degrees, or those who are seeking to pay for their hours of supervised training needed for their license. Individuals who receive state funds must agree to work for one year in a public or private not-for-profit substance abuse treatment program for every \$4,000 in scholarship funds. In addition, the North Carolina General Assembly should appropriate \$200,000 in recurring funds to the Area Health Education Centers program to establish clinical training sites for people seeking their substance abuse professional credentials.

^c This ratio examines the number of substance abuse or health professionals to population estimated to be in need of substance abuse services. The population figure includes all people who are estimated to have substance abuse disorders, not just those expected to seek services through the public substance abuse system. The clinicians include CSAC, LCAS-P, LCAS, Certified Substance Abuse Peer Specialists, physicians, physician assistants, nurse practitioners, registered nurses, and licensed practical nurses.

Recommendation 6.2

The North Carolina General Assembly should appropriate \$200,000 in recurring funds in SFY 2010 to the Area Health Education Centers program to develop and support new residency training rotations for psychiatrists, family physicians, emergency medicine, or other physicians likely to enter the addiction field.

Recommendation 6.3

The North Carolina State Personnel Commission should reevaluate and increase the pay grades for substance abuse professionals with appropriate credentials recognized by the North Carolina Substance Abuse Professional Practice Board.

The Task Force also examined the data needs of the state. North Carolina needs good data to make informed policy choices. Not only does the state need to enhance its data collection capacity, it also needs to enhance its analytic capability to better identify needed changes in the existing substance abuse service system. A summary of the Task Force's recommendations regarding data is listed below. The full text of these recommendations is found in Chapter 7 of the report.

Recommendation 7.1

The North Carolina General Assembly should appropriate \$1.2 million in recurring funds to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to enhance and expand current data systems. Funding should be used to develop an information technology plan, including adoption of electronic health records, and to develop additional analytic capacity and undertake studies to understand systemic patterns and barriers to identification, referral, and engagement of consumers in treatment.

Recommendation 7.2

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services should work with other agencies, including the Departments of Juvenile Justice and Delinquency Prevention, Corrections, and other Health and Human Services agencies to collect comprehensive data on substance abuse prevention and treatment services and people served with public funds. Further, the North Carolina General Assembly should adopt an equalization formula to ensure that Local Management Entities receive comparable funding to achieve equity in access to care and services.

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The importance of a comprehensive substance abuse delivery system cannot be overstated. Our failure to adequately prevent, treat, and provide recovery supports to people with addiction problems has huge implications to our state. We can no longer afford to stigmatize and ignore people with addiction problems. Rather, we need to work together to ensure that appropriate evidence-based education, prevention, treatment, and recovery resources are available and accessible throughout the state. This will take the involvement of many different agencies, providers, and treatment professionals.

This report provides a roadmap that can be used to ensure that comprehensive publicly-funded substance abuse services are available throughout the state. In total, if all of the Task Force recommendations were implemented it would cost \$38,943,440 in SFY 2010 and \$62,060,380 in SFY 2011, with an additional \$1,050,000 in non-recurring funds. Implementing the priority recommendations alone would cost the state \$9,105,940 in SFY 2010 and \$12,222,880 in SFY 2011, with an additional \$300,000 in non-recurring funds. However, the recommended increase in the cigarette tax alone would generate approximately \$297 million per year, much more than the new funding needed to fully implement the Task Force recommendations.

Some may argue that we cannot afford to implement the Task Force recommendations in our current economic crisis. In reality, we cannot afford to wait. We are already paying far more for our failure to appropriately address addiction disorders. We pay for our failure through increased crime, broken households, children in the foster care system, lost worker productivity, and preventable motor vehicle deaths. Funding evidence-based prevention, early intervention, treatment, and recovery supports will lead to longer-term cost savings, with savings of four to five dollars for every one dollar spent on substance abuse prevention,⁹ and up to \$12 for every dollar spent on substance abuse treatment (after factoring in reduced costs of crime, criminal justice costs and treatment of other health-related expenses).²⁴ North Carolina can make significant progress in reducing the burden of substance abuse on individuals, their families and society by implementing the Task Force recommendations.

Some may argue that we cannot afford to implement the Task Force recommendations in our current economic crisis. In reality, we cannot afford to wait.

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Overview of Substance Abuse Problems in North Carolina

Substance abuse carries huge direct and indirect costs to society. In addition to the direct costs of prevention, treatment, and recovery supports, there are indirect costs associated with motor vehicle accidents, premature death, comorbid health conditions, disability, lost productivity, crime, unemployment, poverty, homelessness, unwanted pregnancies, and a host of other social problems. Alcohol and drug abuse cost the North Carolina economy over \$12.4 billion in direct and indirect costs in 2004.¹ In 2005, more than 5% of all traffic accidents in the state were alcohol-related, and these accidents accounted for 26.8% of all crash-related fatalities.² Alcohol and drug-related crimes also consume a large amount of criminal justice resources. There were over 70,000 DWI cases adjudicated in the state court system in SFY 2005,³ and the rate of drug possession arrests has hovered over 400 per 100,000 population for the past 10 years.⁴ Nationwide, half of all state prison inmates were under the influence of drugs or alcohol at the time of their offense, and nearly one in six state inmates committed a crime to support a drug habit.⁵ In North Carolina, 63% of the offenders who enter the prison system and 43% of juveniles in the juvenile justice system need further assessment or treatment for substance use.^{6,7}

According to 2005–2006 National Survey on Drug Use and Health (NSDUH) data, 7.7% of North Carolinians 12 years of age and older reported illicit drug use in the past month, and 19.5% reported past month alcohol binge drinking.⁸ Using 2008 population projections, this translates into approximately 642,000 individuals 12 years or older reporting illicit drug use, and 1.63 million individuals reporting alcohol binge drinking. A substantial number of people also reported dependence or abuse problems. Three percent of the state’s population aged 12 years or older reported illicit drug dependence or abuse in the past year (approximately 250,000 people), and 6.6% reported alcohol dependence or abuse (approximately 550,000 people). The same survey reports that the treatment gap (those individuals needing, but not receiving, treatment during the past year) for illicit drug users 12 years and older was approximately 225,000 and for alcohol binge drinkers was 526,000 (in 2008 population numbers). In total, only about 10% of those who needed treatment for illicit drug use received it, and less than 5% of those who needed treatment for alcohol dependence or abuse received it. Prescription drug abuse is a significant problem in North Carolina as well as nationally. Between 2002 and 2004, 5.8% of North Carolinians 12 years and older (approximately 450,000 in 2008 population numbers) reported non-medical use of prescription psychotherapeutic drugs in the past year, 4.6% (approximately 350,000 people) reported non-medical use of pain relievers, and 2.2% (approximately 170,000 people) reported non-medical use of tranquilizers.⁹



Substance abuse carries huge direct and indirect costs to society.

**Approximately
250,000 North
Carolinians aged
12 years or older
reported illicit drug
dependence or
abuse in the past
year and 550,000
reported alcohol
dependence or
abuse.**

Alcohol and drug use varies by age and typically peaks between the ages of 18 and 25. Approximately 37.7% of high school students in North Carolina reported past month alcohol use, and 19% reported current marijuana use. Over 20% of high school students report first using alcohol before the age of 13.¹⁰ These statistics are especially troubling because it has been shown that brain development and maturation is incomplete during this period and that exposure to substances can cause long-term changes in brain function and a greater likelihood of developing an addiction disorder.

The prevention, diagnosis, and treatment of substance abuse is difficult for several reasons. A large percentage of individuals with substance abuse problems do not recognize that they have a problem. Similarly, many of those who know they have a problem do not seek treatment. In fact, national estimates suggest that nearly 90% of people who abuse or are dependent on alcohol or illicit drugs never seek treatment.¹¹ The few who do seek treatment often encounter problems accessing it due to service availability or cost. The primary care setting has not played a large role in the substance abuse treatment system despite the fact that, if identified early and treated appropriately, substance use disorders often can be successfully managed without further progression.

Only 6% (\$66.8 million) of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) expenditures in 2005 were for substance abuse services for 42,000 people.¹² Overall, North Carolina spent \$138 million in 2006 to fund the public substance abuse service system in the state, a sum that left North Carolina substance abuse services underfunded in relation to other states.¹³ A report presented to the North Carolina General Assembly in 2007 estimated it would take an additional \$35 million in appropriations to achieve parity with national per capita funding for substance abuse services.¹⁴

The importance of a comprehensive substance abuse delivery system cannot be overstated. State efforts that ensure appropriate and evidence-based education, prevention, treatment, and recovery resources can minimize the myriad problems associated with substance abuse and dependence and improve the quality of life for communities statewide.

Task Force on Substance Abuse Services

The North Carolina General Assembly asked the North Carolina Institute of Medicine (NCIOM) to convene a Task Force to study substance abuse services in the state (SL-2007-323 §10.53A). The Task Force was co-chaired by Dwayne Book, MD, Medical Director, Fellowship Hall; Representative Verla Insko, Representative District 56, North Carolina House of Representatives; and Senator Martin L. Nesbitt Jr., JD, Senator District 49, North Carolina Senate. It included 63 other Task Force and Steering Committee members. (See pages 9-12 for a complete listing of Task Force and Steering Committee members.) The North Carolina General Assembly charged the Task Force with nine goals, specifically:

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

The Task Force was directed to develop an interim report for the 2008 session with the final report due before the convening of the 2009 North Carolina General Assembly (Section 10.53A of Session Law 207-323).

Work of The Task Force

The Task Force met a total of 14 times between October 2007 and December 2008. A complete list of topics and Task Force meeting agendas is included in Appendix A.

The report includes eight chapters, the first being this brief introduction. Chapter 2 describes how substance abuse and dependency is a chronic illness, similar to other chronic illnesses such as diabetes or asthma. Chapter 2 also describes how the use of alcohol and drugs as a child or adolescent impacts brain development. Finally, Chapter 2 examines the influence of risk and protective factors on addictive behavior. Chapter 3 describes the current public substance abuse prevention and treatment system in North Carolina, focusing on services provided by the Division

of Mental Health, Developmental Disabilities, and Substance Abuse Services and by Local Management Entities. Unlike general medical care, which is primarily financed through private insurance, substance abuse services are predominantly financed through governmental programs.^a Nationally, in 2003, more than three-quarters of funding for substance abuse services was through the public system.¹⁵ Chapter 4 describes the array of services needed to address alcohol and substance abuse problems as well as the gaps in the current delivery system. Chapter 4 also focuses on prevention and some early intervention services. Chapter 5 describes substance abuse services available to subpopulations, including students (kindergarten through college), juveniles involved in the juvenile justice system, adults in the workplace, families involved in Work First or Child Protective Services, adults involved in the criminal justice system, or active or retired military personnel. Chapter 6 provides an overview of the substance abuse workforce and identifies strategies to increase the number of qualified substance abuse professionals and to expand the distribution of these professionals across the state. Most of the Task Force's recommendations will be impossible to implement without an adequate supply of qualified substance abuse professionals. In addition, creating sound public policies without solid data is difficult. Chapter 7 provides an overview of existing substance abuse data as well as the identifiable data gaps. Chapter 8 summarizes the Task Force's recommendations, and identifies those priority recommendations that will have the greatest impact on preventing initiation, reducing use, or helping people with addiction problems remain in recovery.

a Historically, substance abuse services have not been covered by private insurers in parity with coverage of other medical problems. If offered, coverage of substance abuse services was generally more limited than that for other physical illnesses. However, Congress recently passed legislation to require insurers to offer mental health and substance abuse coverage in parity with coverage of other physical illnesses. This is discussed more fully in Chapter 4.

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Historically, addiction or dependence on alcohol, tobacco, or other drugs has been viewed as a sign of moral failure, not an illness that can be treated. In reality, addiction is a chronic illness that can be managed successfully. Before considering the current state of the North Carolina substance abuse system and how it might be improved, it is important to understand what scientists currently know about addiction and substance abuse, including its causes, risk factors, physiologic effects, and—most critically—how to treat it successfully.

Substance Abuse Disorders

Although some substances are patently illegal, others are illegal only for certain age groups (e.g. alcohol and tobacco), while others are legal *per se* but are misused (e.g. prescription drugs, prescription cough syrup, aerosol cans used for huffing).^a Some are drugs while others are best considered substances. For the purposes of this report, “substances” will be the generic term used to describe drugs, alcohol, and other substances.

Modest use of some of these substances may not pose a public health problem. For example, some studies suggest that very moderate use of alcohol not only has few adverse health effects but may, in some circumstances, improve health (e.g. occasional consumption of a glass of red wine).¹⁻³ It is important to differentiate between *abuse* and *dependence*. *Abuse* refers to misuse of a substance (usually in terms of quantity/frequency) which puts the individual at risk of a variety of harms (e.g. injury, job loss, family disruption, sexual assault, and a host of medical conditions). One example would be binge drinking. *Dependence*, however, entails an emotional and physiological dependence on the substance in which the individual loses control over alcohol use or drug-taking behavior despite the adverse, and often very dramatic, consequences in his or her life.⁴ This is commonly called addiction.

In the past, many people have blamed individuals for their addiction disorders. A 1998 editorial in the *American Journal of Psychiatry* acknowledged this history and pointed out how much remains to be done:

American psychiatry has made remarkable progress in recategorizing the addictive disorders from moral failures to brain diseases, but the need for community education continues. The concept of moral failure is by no means gone from the discussion of addictive disorders, as evidenced by our country’s investment in criminal justice rather than treatment, including the denial of health insurance parity for addictive disorders and the court ruling that alcoholism among military personnel was “willful misconduct,” not a disease.⁵



Addiction is a chronic illness that can be managed successfully.

^a Huffing is defined as the intentional inhalation of toxic chemicals or substances with the purpose of becoming intoxicated.

Despite this widespread perception that substance abuse and addiction represent a failure of an individual's morals, scientists now know that drug addiction is, in fact, a brain disorder.

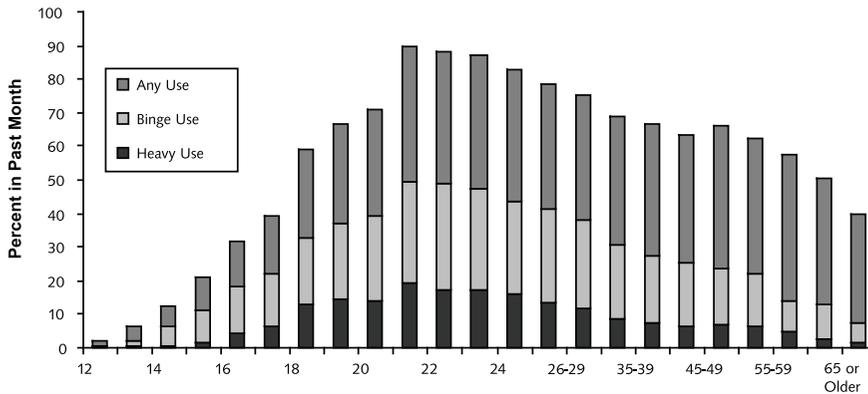
Despite this widespread perception that substance abuse and addiction represent a failure of an individual's morals, scientists now know that drug addiction is, in fact, a brain disorder.⁴ Although this disorder is triggered by the use of substances, there are predisposing genetic and environmental factors that can make some people more susceptible to addiction. Genetics accounts for approximately one-half of the likelihood that an individual becomes an addict, a finding similar to other chronic illnesses (See Table 2.1).^{b,6} Use of addictive substances brings satisfaction to the user while creating physical changes in a specific brain circuit. Over time, most substances yield ever lower levels of satisfaction as they alter the physiology of the brain. Physiologic effects from substance abuse may endure for long periods after the substance use is curtailed. For example, the brain activity of a monkey that is cocaine-abstinent for 227 days is more like one that is abstinent for 3 days than of one that has never been exposed to cocaine.⁴ That is, changes induced by long-term drug use far outlast drug use. This highlights the importance of avoiding exposure to these substances in the first place as well as interventions that take the brain physiology of addiction into account by trying to curtail drug use as soon as possible after it starts.

The late development of the prefrontal cortex region of the brain is an additional physiologic consideration that is important in the development of drug use in adolescents. This is the section of the brain that controls long-term decision making such as the trade-off between a small reward now (e.g. getting high) and a large reward in the future (e.g. going to college). This region of the brain typically does not fully develop until around age 25, so adolescents are particularly vulnerable to the allure of drug use. In addition, substance abuse can actually alter the normal maturation of the brain. Thus, the brains of young people respond differently to drugs than the brains of adults. The younger drug use starts, the greater the likelihood of addiction.

Recent findings about how the adolescent brain develops make it clear that adolescents and young adults are at highest risk for addiction if they begin abusing drugs. Young adults have the highest rates of alcohol use while adolescents and young adults have the highest rates of current drug use (i.e. drug use in the previous month). (See Charts 2.1 and 2.2.)

^b Scientists ascertain the degree to which a disease is genetically determined by comparing outcomes among identical twins. These twins studies conclude that genetics plays a similar role for substance abuse addiction disorders, asthma, type 2 diabetes, and hypertension, leading to between roughly one-third and one-half of the total causes of the disease.

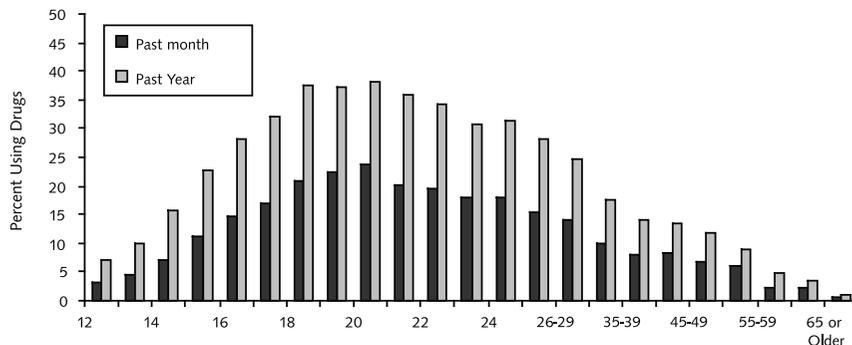
Chart 2.1
Use of Alcohol is Highest Among Young Adults



Source: Substance Abuse and Mental Health Services Administration. *Results From the 2006 National Survey on Drug Use and Health: National Findings*. Rockville, MD: Department of Health and Human Services; 2007. DHHS publication SMA 07-4293.

Young adults have the highest rates of alcohol use while adolescents and young adults have the highest rates of current drug use.

Chart 2.2
Use of Drugs is Highest Among Adolescents and Young Adults

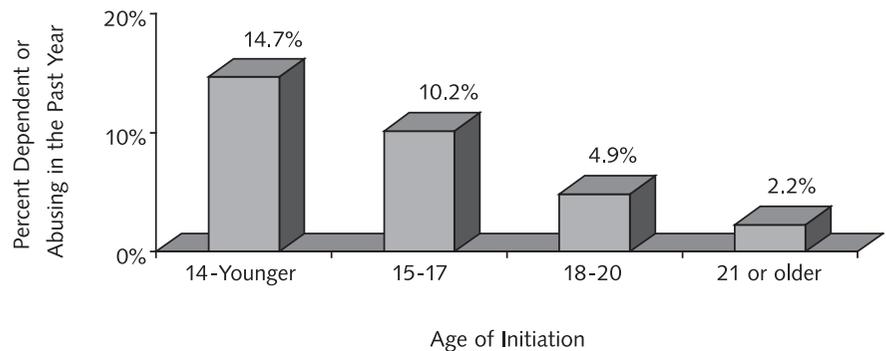


Source: Substance Abuse and Mental Health Services Administration. *Results From the 2006 National Survey on Drug Use and Health: National Findings*. Rockville, MD: Department of Health and Human Services; 2007. DHHS publication SMA 07-4293.

More disturbing is the effect early use has on long-term addiction. As an example, the age at first use of alcohol or drugs is closely associated with the likelihood of abuse or drug dependence later in life. (See Chart 2.3) Approximately one-sixth (14.7%) of adults age 21 or older who reported alcohol abuse or dependence in the past year (2007) first began using alcohol at age 14 whereas less than 3% first began using alcohol after age 21. Similarly, adults who first smoked marijuana at age 14 or younger were more likely to report being addicted to illicit drugs than were those

The age at first use of alcohol or drugs is closely associated with the likelihood of abuse or drug dependence later in life.

Chart 2.3
Early Initial Use of Alcohol is Associated with Higher Risk of Abuse or Dependence



Source: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Results from the 2007 National Survey on Drug Use and Health: National Findings. <http://www.oas.samhsa.gov/nsduh/2k7nsduh/2k7Results.pdf>.⁷

who first smoked marijuana after age 18. The combination of high prevalence of use and abuse and the inherent vulnerability of the adolescent brain suggests that targeting prevention efforts specifically at adolescents may be the most effective use of scarce prevention dollars.

Treating Substance Abuse as a Chronic Illness

There is a common misconception that treatment for substance use disorders does not work. This is because individuals with substance use disorders are generally not permanently “recovered” even after undergoing an episode of treatment. Many individuals with addiction disorders experience periods of decreased use and/or sobriety during treatment, followed by relapse into use or abuse. It may take an average of 5-7 serious attempts for sobriety to persist. The percentage of those who are able to maintain abstinence drops from 100% to 70% within the first month and to 40% by the end of the third month post-treatment. People seeking treatment may experience a number of periods of relapse before they gain the motivation and build the skills needed to resist substance use and to replace substance-using activities with constructive behaviors. They may need to establish new relationships before being able to live for long periods of time in recovery. If viewed from the perspective of the acute care model—where health problems are treated and cured (e.g. penicillin for strep infection)—this pattern of addiction, treatment, recovery, relapse, and later treatment would rightly be categorized as a failure. However, this chronic relapsing pattern is not surprising or unexpected if we view addiction disorders as we do other chronic illnesses.

Scientists and healthcare professionals who study brain chemistry and addiction disorders have now recognized that addiction is a *chronic, relapsing disease with no complete cure*.⁸ These chronic diseases can not be cured in the acute care sense. Instead, the goal of treatment is to *manage* them so that the burden on the individual—and to the healthcare system, the workplace, and society in general—is minimized.

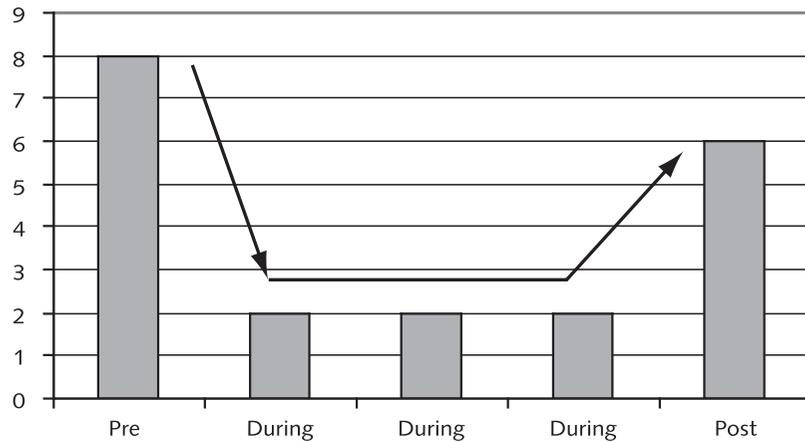
Addiction is like other chronic diseases such as diabetes, high blood pressure, and asthma. While the ultimate goal is to help the people live without alcohol, tobacco, or other substances, the more immediate goal is to decrease use per episode or increase the length of time between episodes of use. This will, in turn, have positive impacts on a person's health status and help improve functioning (including avoiding legal problems, keeping a job, and improving family dynamics). This approach is similar to the approach used to treat people with other chronic diseases such as diabetes. There is no cure for diabetes. Instead, the immediate goal is to help people manage their diabetes so they minimize the negative impact of their disease on their body to avoid complications such as heart disease, blindness, kidney failure, or amputation of feet and legs. The goal of any chronic disease system of care is to help people manage their chronic condition, prevent the acute symptoms of their disease, and reduce longer term complications. However, unlike other chronic illnesses which primarily affect the individual and his or her family, addiction also causes significant harm to the public (i.e. motor vehicle fatalities, increased criminal activities, incidents of child abuse, and lost worker productivity). Thus, it is all the more important to help people effectively manage their addiction disorders.

Understanding that addiction is a chronic illness is important when evaluating the effectiveness of individual treatment or the substance abuse treatment system as a whole. For example, assume that a person was being treated for any other chronic illness. Prior to the treatment, this individual had a high level of symptoms. During treatment, the symptoms were diminished as shown in Chart 2.4. This suggests that treatment is effective and is the kind of evidence the Federal Drug Administration (FDA) looks for when evaluating new drugs and other therapies. For most therapies, the increase in symptoms after the treatment is stopped (post) is further evidence that treatment is effective. Unfortunately, this is not how we have viewed substance abuse treatments. Even though drug use diminishes during treatment, if it reoccurs after treatment, we take that as evidence that treatment has failed. This curious dichotomy between how we view most treatments and how we view substance abuse treatment has led us to believe that substance abuse treatment is ineffective even though it is just as effective, or even more effective, than treatments for diabetes, hypertension, and asthma.

Addiction is like other chronic diseases such as diabetes, high blood pressure, and asthma...The goal of any chronic disease system of care is to help people manage their chronic condition, prevent the acute symptoms of their disease, and reduce long term complications.

People with substance abuse disorders have similar adherence and relapse rates as those with asthma, type 2 diabetes, or hypertension

Chart 2.4
Chronic Care Treatment Outcomes



Source: McLellan T. Reconsidering addiction treatment: have we been thinking correctly? Presentation to the North Carolina Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse; October 31, 2007; Raleigh, NC.

Treatment for any chronic illness, including substance abuse disorders, is much more effective if the patient adheres to the treatment protocol, prescribed medications, and recommended follow-up care. Many think that people with substance abuse disorders are less likely to adhere to their treatment regimens and more likely to relapse than people with other chronic illnesses. However data do not support this conclusion. People with substance abuse disorders have similar adherence and relapse rates as those with asthma, type 2 diabetes, or hypertension (See Table 2.1). Adherence rates may vary widely across specific types of treatments (e.g. adherence to medication is generally higher than adherence to treatments like diet and/or exercise), but adherence is generally similar across all types of chronic illnesses. Furthermore, factors decreasing adherence to treatment—such as poverty, lack of family support, and co-occurring psychiatric conditions—are similar across all four diseases.

Table 2.1
Substance Abuse Similarity to Other Chronic Diseases in Adherence to Treatment, Relapse, and Genetic Heritability

Chronic Disease	Substance Abuse	Asthma	Diabetes	Hypertension
Adherence	~60%	60%	<40%	<40%
Relapse/Recurrence	40% - 60%	50% - 70%	30% - 50%	50% - 70%
Genetic Inheritability	0.34 - 0.61	0.36 - 0.70	0.30 - .55	0.25 - 0.50
Controllable Risk Factors?	Yes	Yes	Yes	Yes
Uncontrollable Risk Factors?	Yes	Yes	Yes	Yes
Cure?	No	No	No	No
Clear Diagnostic Criteria?	Yes	Yes	Yes	Yes
Research-based Treatment Guidelines and Protocols?	Yes	Yes	Yes	Yes
Effective Patient and Family Education?	Yes	Yes	Yes	Yes
Parity With Other Medical Conditions?	No	Yes	Yes	Yes

Sources: McLellan AT, Lewis DC, O'Brien CP, Kleber HD. Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation. *JAMA*. 2000;284(13):1689-1695. Gilmore JD, Lash SJ, Foster MA, Blosser SL. Adherence to substance abuse treatment: clinical utility of two MMPI-2 scales. *J Pers Assess*. 2001;77(3):524-540. Comparisons among alcohol-related problems, including alcoholism, and other chronic diseases. Ensuring Solutions to Alcohol Problems, George Washington University Medical Center Web site. http://www.ensuringsolutions.org/usr_doc/Chronic_Disease_Comparison_Chart.pdf. Accessed September 28, 2007.

Creating successful treatment systems for people with addiction disorders will require a paradigm shift, one that recognizes and treats addicts the same as any other person with a chronic illness.

The fact that addicts are treated differently, despite the similar adherence and relapse rates, is evidence that addicts have not been dealt with fairly. A treatment failure for any other chronic condition would be a reason to change treatment options or increase the intensity of treatment. No one would tell someone with a second heart attack that he could not have any more treatment because he didn't change his eating or exercise habits. However, recovering addicts who lapse or relapse back into drug use are routinely excluded from treatment programs. Creating successful treatment systems for people with addiction disorders will require a paradigm shift, one that recognizes and treats addicts the same as any other person with a chronic illness.

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Publicly-Funded Substance Abuse Services

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

Chapter 3



Many public agencies provide services aimed at preventing, reducing, or treating people with substance abuse problems. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS), within the NC Department of Health and Human Services, is the lead agency charged with coordinating prevention, treatment, and recovery supports. Services are also offered through or in collaboration with the Division of Social Services and Division of Public Health within the NC Department of Health and Human Services, the Department of Juvenile Justice and Delinquency Prevention, Administrative Office of the Courts, Division of Motor Vehicles, Department of Correction, Department of Public Instruction, North Carolina Community College System, and the University of North Carolina System.

The federal and state governments help subsidize the costs of prevention and treatment services to certain target populations who do not have another source of coverage. Medicaid pays for substance abuse services for some low-income people who otherwise meet the Medicaid eligibility rules. However, many people with substance abuse disorders are not eligible for Medicaid. These individuals often rely on the publicly-funded system of care or pay for services out of pocket, as historically most third-party insurers offer limited coverage of substance abuse services.^{a,1}

This chapter provides an overview of the structure of the publicly-funded substance abuse system offered to the general public with substance abuse disorders. The chapter focuses on services offered through DMHDDSAS, Local Management Entities (LMEs), and contracted providers. In addition to the services offered to the general public with substance abuse problems, state and local agencies also provide services to targeted groups of individuals (such as families on welfare or people in the prison system). Chapter 5 describes targeted substance abuse prevention and treatment programs offered or funded through other agencies, often under contract with or in collaboration with DMHDDSAS.

Federal Funding for a Single State Agency

The primary source of federal funding for substance abuse services comes from the Substance Abuse Prevention and Treatment (SAPT) block grant provided by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). North Carolina received approximately \$46.2 million in SAPT funds in SFY 2008. In addition, the North Carolina General Assembly appropriated \$26.1 million in state funds for the three Alcohol and Drug Abuse Treatment Centers (ADATCs) and \$28.1 million to DMHDDSAS to provide substance abuse services across the state.

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, within the NC Department of Health and Human Services, is the lead agency charged with coordinating prevention, treatment, and recovery supports.

a Nationally, most insured employees (88%) had some coverage for substance abuse treatment services in 2006. However, coverage of substance abuse treatment services is typically much more limited than for other medical-surgical benefits, and cost sharing is much higher.

**According to
Substance Abuse
and Mental
Health Services
Administration
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709,000 North
Carolinians (8.5% of
the population age
12 and older) who
had illicit drug or
alcohol dependence
or abuse or both in
2005-2006.**

In order to get federal SAPT funds, states must designate a “single state authority.” The single state authority is responsible for planning, administering, and overseeing the SAPT funds, under guidelines established by SAMHSA. The North Carolina General Assembly designated the North Carolina Department of Health and Human Services as the single state authority. Day-to-day management of substance abuse services was placed in the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS). As its name suggests, DMHDDSAS oversees publicly-funded care provided to people with mental health, developmental disabilities, and substance abuse problems. The North Carolina General Assembly established the structure of DMHDDSAS, along with the target populations and services offered. In the past, DMHDDSAS employees focused on one of these three disability areas. With mental health system reform in 2001, employees were reorganized into sections that cut across all three disability areas.^b The Community Policy Management (CPM) section of DMHDDSAS is charged with overseeing substance abuse services as well as mental health and developmental disability services.^c DMHDDSAS now has very few employees that focus exclusively on any of the three specific areas.

DMHDDSAS establishes policies regarding the target populations to be served, structure of the delivery system, covered services, and data collection. These policies are in compliance with broad guidelines established by SAMHSA, the Centers for Medicare and Medicaid Services (CMS), and the North Carolina General Assembly.

Target Populations

According to SAMHSA estimates, there were approximately 709,000 North Carolinians (8.5% of the population age 12 and older) who had illicit drug or alcohol dependence or abuse or both in 2005-2006.^{d,2} Of these, 250,000 (3.0% of the population age 12 and older) were estimated to have illicit drug dependence or abuse, and 551,000 (6.6%) were estimated to have alcohol dependence or abuse. However, SAMHSA data show that 10% or fewer of North Carolinians with alcohol or substance abuse addictions received treatment. According to SAMHSA, approximately 225,000 people with illicit drug dependence or abuse (90%) needed but did not receive treatment for illicit drug use, and 526,000 people with alcohol dependence or abuse (95%) needed but did not receive treatment for their alcohol problems.^e

b The five cross-disability sections include State Operated Services (SOS), Community Policy Management (CPM), Resource Regulatory Management (RRM), Advocacy and Customer Services (ACS), and Operations Support (OS).

c CPM staff members work in one of five cross-disability teams, including: Best Practice and Community Innovations, Local Management Entities (LMEs) Systems, Justice Systems Innovations, Quality Management, and Early Intervention and Prevention.

d Illicit drugs include marijuana, hashish, cocaine, heroin, hallucinogens, inhalants, and prescription drugs that are used non-medically.

e SAMHSA defines needing but not receiving treatment as people who were classified as needing treatment for either illegal drugs or alcohol but who did not receive treatment from a specialty facility (including drug or alcohol rehabilitation facility, hospital, or mental health center).

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

Under state law, DMHDDSAS is required to target services to those most in need.^{f,3} The targeted adult population includes individuals who have a primary diagnosis of a substance abuse disorder who are or have been:

- Injecting drug users or individuals with communicable diseases
- Pregnant women or women with dependent children under age 18
- Criminal justice offenders
- Parents of children in the Division of Social Services (DSS) Child Protective Services System or parents who are receiving Work First payments
- All other adults with an abuse or dependence diagnosis

Individuals who are part of a target population can receive publicly-funded substance abuse services that are appropriate to their level of severity.

Children and adolescents who are in the targeted population include youth (under age 18) with a primary diagnosis of a substance-abuse related disorder who are or have been:

- Adjudicated as delinquent and enrolled in the MAJORS Substance Abuse/Juvenile Justice Program
- All other children with an abuse or dependence diagnosis

In addition, other groups of youth are eligible for preventive services. These include adolescents who are at-risk of substance abuse or who are currently using alcohol or other drugs at a level that does not meet the definition of substance abuse or dependence.

Structure of the Delivery System

With certain limited exceptions, DMHDDSAS does not provide services directly to individuals. Substance abuse services are generally provided through private providers under contract with Local Management Entities (LMEs). The only substance abuse services provided directly through DMHDDSAS include services offered through the four state psychiatric hospitals or the three Alcohol and Drug Treatment Centers (ADATCs).^{g,h} The state psychiatric hospitals provide inpatient mental health services

Under state law, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services is required to target services to those most in need.

^f DMHDDSAS has further defined priority populations within these broad categories of targeted adult and child populations based on federally-established priorities. These include adult and adolescent pregnant injecting drug users, adult and adolescent pregnant substance abusers, and adult and adolescent injecting drug users.

^g The four state psychiatric hospitals are Broughton Hospital (Morganton), Cherry Hospital (Goldsboro), Dorothea Dix Hospital (Raleigh), and John Umstead Hospital (Butner).

^h The ADATCs are Julian F. Keith ADATC (Black Mountain), Walter B. Jones ADATC (Greenville), and R. J. Blackley ADATC (Butner).

**Most of the
direct provision of
publicly-funded
substance abuse
services is
managed by the
Local Management
Entities.**

for people with mental illness, and include services for individuals dually-diagnosed with mental health and substance abuse problems. The ADATCs provide a comprehensive array of detoxification services, including but not limited to: behavioral health crisis stabilization and acute and intensive inpatient treatment.

Most of the direct provision of publicly-funded substance abuse services is managed by the LMEs. There are 24 LMEs that oversee and manage care provided to individuals at the community level. LMEs must cover a population of at least 200,000 residents or a 5-county area. Most LMEs cover multiple counties, but some of the larger counties have single-county LMEs.

LMEs are responsible for providing or assuring 24-hour, 7-day a week access to the DMHDDSAS system. LMEs have qualified substance abuse professionals who, either through telephone or in-person contact, screen individuals to determine eligibility and need for services. Individuals who have an emergency are referred immediately into crisis services. Others are screened further to determine if they are a member of a target population or whether they are Medicaid-eligible. The LMEs authorize state-funded services for non-Medicaid-eligible individuals, and Value Options authorizes services for Medicaid-eligible individuals.ⁱ In addition to the initial screening, LMEs must recruit providers, establish contracts with local or regional substance abuse providers, approve the Person-Centered Plans for individual clients, and establish local Consumer and Family Advisory Committees.

In general, LMEs do not provide direct services (aside from the initial screening and some crisis services). However, if private providers are not adequately available in the community, the LME can receive approval from DMHDDSAS to provide one or more of the following core services: community support, social setting and non-hospital medical detoxification, residential day treatment, and day treatment in homeless shelters.⁴

Services

DMHDDSAS has established policies for what substance abuse services can be covered and reimbursed. DMHDDSAS, in collaboration with the Division of Medical Assistance, authorizes a comprehensive array of services needed for people with or at risk of addiction disorders.^j The DMHDDSAS allowable services include a range of services to meet all the levels of need, as recommended by the American Society of Addiction Medicine (ASAM).^k

i Menon N. Quality Management Team, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. Written communication regarding LME services. April 22, 2008.

j These service definitions were developed in collaboration with the Division of Medical Assistance to ensure that Medicaid will also pay for the same services to the maximum extent possible under federal Medicaid laws.

k The American Society of Addiction Medicine (ASAM) is an international organization of physicians with a mission to increase access and improve the quality of addiction treatment. ASAM developed widely recognized guidelines for placement, continued stay, and discharge of patients with alcohol and other drug problems. ASAM also developed a continuum of services for adults and children.

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

DMHDDSAS and the LMEs are required to provide preventive services aimed at youth and adolescents in order to prevent or reduce the use of tobacco, alcohol, and other drugs. Prevention activities are designed to prevent or reduce the use of tobacco, alcohol, and other drugs. They may be targeted to the whole community (“universal”), to people who have risk factors that make them more likely to engage in these unhealthy behaviors (“selective”), or to individuals who have started using these substances but who have not yet become dependent or addicted (“indicated”). Evidence-based prevention programs are discussed more fully in Chapter 4. In addition, the Division of Public Health is actively involved in prevention activities to reduce tobacco use and exposure to secondhand smoke.¹

An individual in a target population who seeks treatment will be assessed to develop a Person-Centered Plan. The Plan is based on the person’s general health, behavioral health history, and presenting problems, and the individual’s strengths and weaknesses across a variety of biological, psychological, familial, social, developmental, and environmental dimensions. The type of services authorized for individuals as part of their Person-Centered Plan varies, depending on a person’s level of need and individual preferences for treatment choices. Some of the specific services that can be provided as part of the Person-Centered Plan include outpatient services, medication assisted treatment, intensive outpatient and partial hospitalization, clinically managed low-intensity residential services, clinically managed medium- and high-intensity residential treatment, medically monitored high-intensity inpatient treatment, detox, crisis services, and recovery supports:

- **Outpatient treatment:** Includes therapy, medication management, and supportive services needed to help consumers manage their substance abuse problems. Outpatient treatment is limited to people who do not need more intensive levels of care (such as residential or detoxification services). Some outpatient services include evaluation, community support services, methadone administration, psychosocial rehabilitation, supported employment, and in-home services (for children and adolescents).
- **Medication assisted treatment:** Includes the use of a wide variety of medications for treating people diagnosed with substance use disorders.^m Appropriately prescribed medications can improve treatment outcomes

The types of substance abuse services that an individual may receive may vary, depending on a person’s level of need and individual preferences for treatment choices.

¹ *Tobacco Control Branch:* The Tobacco Prevention and Control Branch works to improve the health of North Carolina residents by reducing tobacco use and exposure to secondhand smoke. The Branch helps prevent tobacco use initiation and promotes quitting among young people; assists adult tobacco users in quitting when they seek help; works to eliminate exposure to secondhand smoke by building support to make all NC schools, workplaces, and public places smoke free; and works to eliminate tobacco-related health disparities. The Branch contracts to offer a statewide tobacco quitline, 1-800-Quit-Now, and works collaboratively with worksites, schools, community groups, and healthcare systems to carry out effective policy, media, and program services.

^m Currently, there are several medications that are approved by the Food and Drug Administration (FDA) for treatment of addictive disorders. For example, methadone and buprenorphine have been shown to be effective in reducing illicit opioid use. Naltrexone and acamprosate can improve rates of abstinence and reduce the risk of relapse for heavy drinking. Varenicline, bupropion and nicotine replacement therapies have helped improve quit rates and abstinence for nicotine addictions.

as well as the patient's quality of life. Medications may be used in detoxification, the treatment of co-morbid medical conditions, co-occurring psychiatric conditions, opioid addiction, alcohol or nicotine dependence, pain management, and management of sleep disorders.

- ***Intensive outpatient and partial hospitalization:*** Includes day treatment, intensive outpatient programs, and comprehensive outpatient programs.
- ***Clinically managed low-intensity residential treatment:*** Includes substance abuse services provided in a residential setting 24-hours a day, 7-days a week. Residential centers provide treatment for children, adolescents, and adults through a multi-disciplinary team of substance abuse professionals. These residential services are targeted to individuals with less severe addiction problems and may include halfway houses and supervised or group living arrangements.
- ***Clinically managed medium- and high-intensity residential treatment:*** Similar to clinically managed low-intensity residential treatment. However these services are geared to individuals with more severe addiction problems. These services include non-medical community residential treatment, medically monitored community residential treatment, and residential services for pregnant and parenting women and their children.ⁿ
- ***Inpatient, medically monitored high-intensity inpatient treatment:*** Includes care provided in a general hospital, psychiatric hospital, psychiatric residential treatment facility (adolescents), or intensive residential services for high-risk individuals provided in a hospital setting
- ***Crisis services (including detoxification):*** Crisis stabilization and support includes all supports, services, and treatment necessary to stabilize and manage the consumer's substance abuse problems. Crisis services are available on a 24-hour, 7-day a week basis and include immediate evaluation, triage, and access to acute and detoxification services, treatment, and other needed support services. Crisis services include mobile and facility-based crisis services, detoxification services offered in social settings, or non-hospital based.
- ***Recovery supports:*** Includes services that help people remain sober, such as telephone follow-up, sober housing, care management, employment coaching, and family services.

ⁿ The Perinatal and Maternal Substance Abuse Initiative is administered by the Division of DMHDDSAS and includes specialized residential programs for substance abusing pregnant and parenting women and their children. These programs provide comprehensive gender-specific substance abuse services that include, but are not limited to, the following: screening, assessment, case management, intensive out-patient substance abuse and mental health services, parenting skills, residential care, referrals for primary and preventative healthcare, and referrals for appropriate interventions for the children. The children in these families benefit from the services provided by the local health departments (pediatric care), early intervention programs, and child services coordination services.

Managed ByThe Division of Mental Health,
Developmental Disabilities, and Substance Abuse Services

Data

DMHDDSAS collects a wide variety of data from different data sources to monitor the state's substance abuse system. These data include numbers of people who seek care and the timeliness of services provided; numbers of people served and services provided through DMHDDSAS payments or Medicaid funds; and visits to the community hospital emergency department due to mental illness, developmental disabilities, or substance abuse disorders. More information about the data collected, as well as gaps in the current data system, is described in Chapter 7.

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Substance Abuse Comprehensive System of Care

Chapter 4



Many North Carolinians engage in risky alcohol, tobacco, and/or drug use behavior. Some are physically or psychologically addicted to these substances, while others have engaged in risky or abusive behaviors that may later turn into an addiction. Reducing substance use, abuse, and dependence requires a comprehensive system of care that starts with prevention, offers early intervention services before people become dependent, provides various levels of treatment services to meet the needs of people with more severe substance abuse problems, and offers continual recovery supports to help people in recovery remain sober.

The Task Force envisioned a system of care that would provide evidence-based interventions based on a person's need.^a At one end of the spectrum, the state would target prevention efforts to youth and adolescents to enhance their knowledge and skills, reduce risk factors, and enhance protective factors so that they are less likely to engage in risky behaviors. Implementing evidence-based prevention programs, policies, and practices should help reduce or delay the use of alcohol, tobacco, and other drugs among adolescents. As discussed in Chapter 2, people who initiate substance use in childhood or adolescence are more likely to later become addicted. Thus, if the state implements evidence-based prevention programs that reduce or delay use among adolescents, the result will be fewer people with addiction problems.

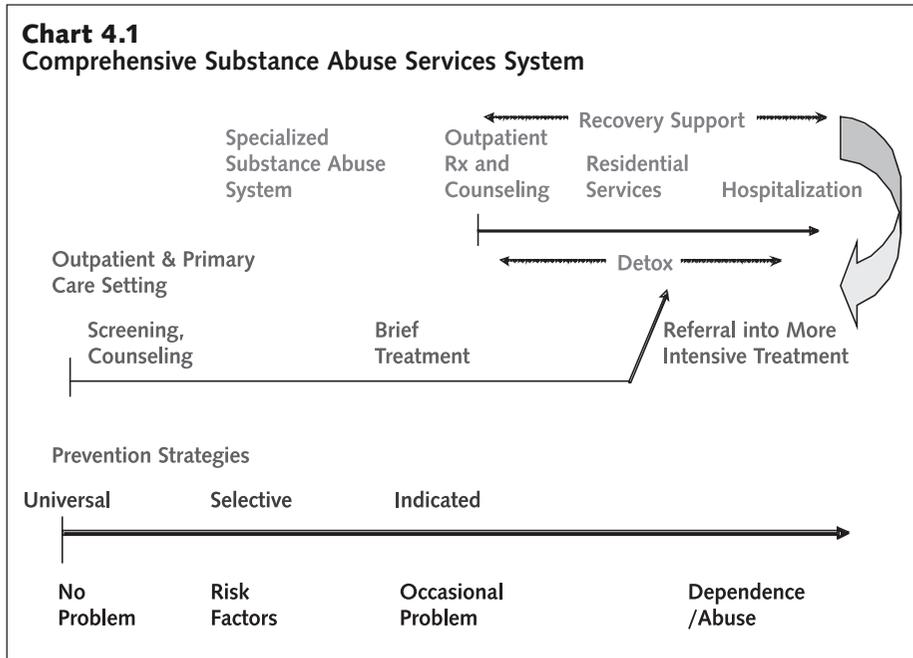
A different strategy is needed for people who are starting to engage in risky behaviors but who have not yet become addicted. These individuals would benefit greatly from a primary care-based brief intervention to help prevent them from engaging in more destructive behaviors. Without these early intervention services, these individuals are likely to progress to worse stages of abuse and/or dependence.

At the far end of the spectrum, individuals with more severe problems need different levels of treatment offered through the specialized substance abuse system. Even after they have been treated and have become sober, they will likely need recovery supports to prevent relapse. Chart 4.1 shows the services needed to fully address substance abuse problems in the state.

Reducing substance use, abuse, and dependence requires a comprehensive system of care that starts with prevention, offers early intervention services before people become dependent, provides various levels of treatment services to meet the needs of people with more severe substance abuse problems, and offers continual recovery supports to help people in recovery remain sober.

^a The National Registry of Evidence-based Programs and Practices (NREPP), a part of Substance Abuse and Mental Health Services Administration, maintains a searchable database of interventions for the prevention and treatment of mental and substance use disorders. Information is available online at www.nrepp.samhsa.gov. The Promising Practices Network maintains a list of evidence-based programs and practices for prevention efforts targeted to children and youth. Available online at <http://www.promisingpractices.net>.

Implementing evidence-based prevention programs and policies can help to reduce the burden of substance abuse in North Carolina and on North Carolinians.



PREVENTION

Comprehensive Community Prevention Efforts

Substance abuse severely impacts the lives of individuals and the quality of life for individuals, families, and communities. In addition, as discussed more fully in Chapter 1, alcohol and drug abuse cost the North Carolina economy over \$12.4 billion in direct and indirect costs in 2004.¹ In 2005, alcohol use contributed to 26.8% of crash-related fatalities.² Further, people with alcohol or drug abuse problems are more likely to commit crimes or have their children removed due to abuse or neglect than people without these addiction disorders.³ Implementing evidence-based prevention programs and policies can help to reduce the burden of substance abuse in North Carolina and on North Carolinians. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), communities can save four to five dollars for every one dollar they spend on substance abuse prevention.⁴ Research has shown that prevention and intervention are among the most appropriate strategies to respond to student problematic behaviors such as violence, substance abuse, school failure, and delinquency.⁵⁻⁷ Research also supports the development of comprehensive strategies involving multiple systems that target youth during critical developmental stages.^{8,9}

Addiction is a disease that often begins in childhood and adolescence.¹⁰ The adolescent developmental period is the critical time to intervene to prevent substance abuse.¹⁰ If we can prevent youth from using alcohol, tobacco, or other drugs, or if we catch youth who are abusing substances early, we can prevent people from becoming dependent on these substances.¹¹ Surveys of North Carolina youth show that almost 40% of high school students had at least one drink in the last 30 days.¹² Almost 40%

of high school students in North Carolina have used marijuana, and while the use of tobacco is declining among youth, still more than 22% of high school students smoked cigarettes in the last 30 days. Further, a substantial proportion of children in middle school have also used these substances.¹³

For optimal results, a comprehensive community prevention plan for the state should consider the risk status of all members of the population and should incorporate various strategies to effectively reach members with varying degrees of risk. Some individuals have risk factors which make them more likely to engage in risky behaviors; others have protective factors which protect the individual even if he or she is exposed to risk factors. For example, risk factors for adolescent substance abuse include parents with substance abuse problems, lack of parental supervision, and negative peer influences. Protective factors include increased parental involvement and a strong attachment to the community. Evidence-based prevention strategies can help reduce risk factors and strengthen protective factors.¹⁴

A mixture of different evidence-based prevention models are appropriate, depending on whether a prevention effort is targeted at the general population (“universal” population), a subset of the population at increased risk (“selective” population), or aimed at individuals who have already begun to use or misuse substances (“indicated” population). This maximizes the opportunity for all individuals in the population to receive an intervention but tailors interventions to the appropriate risk level. This classification system, developed by the Institute of Medicine of the National Academies of Science, has been adopted by the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS).¹⁵

- **Universal:** Interventions are aimed at the general population with the assumption that every individual in the population is at some level of risk for substance abuse. The goal of universal prevention is to deter onset of use.
- **Selective:** Interventions are tailored to reach a subset of the general population—those individuals who are believed to be at some level of risk for substance abuse simply due to their inclusion within a particular subset of the population. Children with a parent with a substance abuse problem or children who are displaying poor academic performance are subgroups that warrant selective prevention interventions. Biological, psychological, social, or environmental risk factors that are associated with substance abuse can also be used to identify at-risk segments of the population.
- **Indicated:** Interventions target those persons at high risk for substance abuse problems, such as those who are using alcohol, tobacco, or other drugs but not at a level that is diagnosable as addiction. Teachers, youth workers, parents, and other community members can refer individuals to indicated prevention programs.¹⁶

Risk factors for adolescent substance abuse include parents with substance abuse problems, lack of parental supervision, and negative peer influences.

Implementing prevention programs that reflect specific community needs is critical to the success and sustainability of programs.

In addition to targeting prevention interventions to subsets within the population, using multilevel interventions to improve population health has been shown to be effective in a variety of areas including substance abuse.¹⁷ This multilevel approach relies on interventions aimed at the personal, interpersonal, institutional, community, and/or public policy levels.^{b,18} Designing and implementing prevention efforts in this way allows for various interventions to build on and support one another. Evidence suggests that a multilevel approach may be essential to create change in a broad population.¹⁷ Substance abuse prevention efforts should incorporate strategies at each of the above-mentioned levels. For example, a successful substance abuse prevention initiative might include individual level interventions (i.e. increasing knowledge and skills to resist peer pressure to use drugs), interpersonal interventions (i.e. strengthening family connections and positive peer networks), institutional interventions (i.e. evidence-based programs in schools, universities, or worksites), community factors (i.e. community anti-drug coalitions that involve various community groups and agencies in drug prevention efforts), and public policy interventions (including smoking bans and taxation on alcohol).

Implementing prevention programs that reflect specific community needs is critical to the success and sustainability of programs. Currently, DMHDDSAS works with Local Management Entities (LMEs) to conduct needs assessments and to implement evidence-based prevention programs, practices, and policies.^{c,15} Funds are allocated to LMEs through the Substance Abuse Prevention Treatment (SAPT) block grant. On a semiannual basis, communities report the use of evidence-based prevention programs, practices, and policies to the state. This information is then provided to the federal government. However, while LMEs are required to engage in community-based needs assessments and implement evidence-based prevention programs, these community-based prevention programs reach very few people. In 2007, there were 731,632 children aged 12-17 years in North Carolina. Of those, DMHDDSAS estimates that nearly all were in need of a universal substance abuse prevention program, and 275,826 were in need of selective or indicated prevention programs. However, DMHDDSAS estimates that only 42,000 were served through substance abuse block grants and the Safe and Drug-Free Schools and Communities Act (SDFSC) grants (SFY 2006-2007).¹¹

The North Carolina General Assembly provided funding in 2007 to begin to expand community-based prevention strategies. DMHDDSAS created the North Carolina Coalition Initiative (NCCI), a substance abuse prevention initiative that engages community coalitions in substance abuse prevention. DMHDDSAS provides funding to Centerpoint LME and Wake Forest University School of Medicine to serve as the

b This intervention approach is based upon the socioecological model of health behavior theory.

c Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices (NREPP) provides a searchable database of evidence-based prevention programs for use in communities at <http://www.nrepp.samhsa.gov>. The Promising Practices Network maintains a list of evidence-based programs and practices for prevention efforts targeted to children and youth. Available online at <http://www.promisingpractices.net>.

NCCI Coordinating Center and provide technical assistance to sustain local efforts. To date, \$35,000 in one-time funding has been provided to eight emerging and three established coalitions that are geographically dispersed across the state. The funding will be used primarily to support a community needs assessment and the development of a strategic action plan to build community coalitions to prevent substance use and abuse in a community, but the funding is insufficient to support comprehensive prevention strategies.

North Carolina should develop and implement a comprehensive statewide substance abuse prevention plan for use at the state and local levels. The plan should be consistent with the Center for Substance Abuse Prevention (CSAP) Strategic Prevention Framework and include multilevel evidence-based interventions targeted to the individual, interpersonal, institutional, community, and policy levels.^d The Task Force recommends pilot testing the plan in six local communities and evaluating it to determine its effectiveness before expanding implementation statewide. Because LMEs are the local entities charged with overseeing substance abuse prevention and treatment activities in the state, the Task Force recommended that LMEs serve as fiscal and management agencies for these pilots. However, the Task Force also heard concerns that some of the LMEs were not actively interested and engaged in managing prevention or treatment services. In these instances, local community agencies could work directly with DMHDDSAS to identify potential cross-area programs or regional LMEs that could serve as fiscal agents.

To develop and pilot comprehensive substance abuse prevention plans, the Task Force recommends:

Recommendation 4.1 (PRIORITY RECOMMENDATION)

- a) **The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) should develop a comprehensive substance abuse prevention plan for use at the state and local levels. The plan should increase the capacity at the state level and within local communities to implement a comprehensive substance abuse prevention system, prioritizing efforts to reach children, adolescents, young adults, and their parents. The goal of the prevention plan is to prevent or delay the onset of use of alcohol, tobacco, or other drugs, reduce the use of addictive substances among users, identify those who need treatment, and help them obtain services earlier in the disease process.**

^d The Strategic Prevention Framework (SPF) is Substance Abuse and Mental Health Services Administration's approach to substance abuse prevention from a systemic perspective. The five steps operate as the guiding foundation with sustainability and cultural competence as embedded principles. There are several required components to the SPF including:

- Needs Assessment
- Capacity Building
- Planning
- Implementation
- Evaluation

Information taken from: <http://www.samhsa.gov/csap>.

- 1) DMHDDSAS should work with appropriate stakeholders to develop, implement, and monitor the prevention plan at the state and local level. Stakeholders should include, but not be limited to, other public agencies that are part of the Cooperative Agreement Advisory Board, consumer groups, provider groups, and Local Management Entities (LMEs).
 - 2) DMHDDSAS should direct LMEs to involve similar stakeholders to develop local prevention plans that are consistent with the statewide comprehensive substance abuse prevention plan.
- b) The North Carolina General Assembly should appropriate \$1,945,000 in SFY 2010 and \$3,722,000 in SFY 2011 in recurring funds to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) to develop this comprehensive substance abuse prevention.
- c) Of the recurring funds appropriated by the North Carolina General Assembly, \$1,770,000 in SFY 2010 and \$3,547,000 in SFY 2011 should be used to fund six pilot projects to implement county or multi-county comprehensive prevention plans consistent with the statewide comprehensive substance abuse prevention plan. DMHDDSAS should make funding available on a competitive basis, selecting one rural pilot and one urban pilot in the three DMHDDSAS regions across the state. Technical assistance should be provided to the selected communities by the regional Centers for Prevention Resources. LMEs should serve as fiscal and management agencies for these pilots. The six pilot projects should:
- 1) Involve community agencies, including but not limited to the following: Local Management Entities, local substance abuse providers, primary care providers, health departments, social services departments, local education agencies, local universities and community colleges, Healthy Carolinians, local tobacco prevention and anti-drug/alcohol coalitions, juvenile justice organizations, and representatives from criminal justice, consumer, and family advisory committees.
 - 2) Be comprehensive, culturally appropriate, and based on evidence-based programs, policies, and practices.
 - 3) Be based on a needs assessment of the local community that prioritizes the substance abuse prevention goals.
 - 4) Include a mix of strategies designed for universal, selective, and indicated populations.
 - 5) Include multiple points of contact to the target population (i.e. prevention efforts should reach children, adolescents, and young adults in schools, community colleges and universities, and community settings).
 - 6) Be continually evaluated for effectiveness and undergo continuous quality improvement.
 - 7) Be consistent with the systems of care principles.
 - 8) Be integrated into the continuum of care.

- d) The North Carolina General Assembly should appropriate \$250,000 of the Mental Health Trust Fund or from general funds to the DMHDDSAS to arrange for an independent evaluation of these pilot projects and for implementation of the state plan. The evaluation should include, but not be limited to, quantifying the costs of the projects; identifying the populations reached by the prevention efforts; and assessing whether the community prevention efforts have been successful in delaying initiation and reducing the use of tobacco, alcohol, and other drugs among children, adolescents, and young adults. To determine effectiveness, the evaluation should include an analysis of the performance of the pilot communities with appropriate comparison groups. The evaluation should also include other community indicators that could determine whether the culture of acceptance of underage drinking or other inappropriate or illegal substance use has changed, including but not limited to arrests for driving under the influence, underage drinking, or use of illegal substances; alcohol and drug related traffic crashes; reduction in other problem indicators such as school failure; and incidence of juvenile crime and delinquency.
- e) The DMHDDSAS should use the findings from the independent evaluation of prevention services to develop a plan to implement the successful strategies statewide. The plan should be presented to the Legislative Oversight Committee on Mental Health within six months of when the evaluation is completed.

School-Based Prevention, Screening, and Treatment Efforts

Schools are an integral part of a multifaceted prevention strategy, as youth spend a considerable amount of time at school. A comprehensive substance abuse prevention plan would focus on preventing children, teens, and young adults from initiating or using alcohol, tobacco, or other drugs but should also include early intervention, brief treatment, and referrals to more intensive services for those who need it. Different strategies are needed, depending on whether the students are enrolled in elementary, middle, or secondary schools, or in post-secondary colleges and universities.

Elementary, Middle, and Secondary Students

North Carolina schools are responsible for providing substance abuse education to students. This curriculum is part of the *Healthful Living Standard Course of Study*, the state's health education requirements for children in kindergarten through eighth grade, with one unit of combined health and physical education in high school.¹⁹ The *Healthful Living Standard Course of Study* includes educational objectives for every grade, but does not require a specific curriculum. Students are required to receive information about the health risks of using alcohol, tobacco, and other drugs in each grade level, and are taught skills to help them decline offers to engage in these unhealthy behaviors. In 2004, Pankratz and Hallfors found that while some schools in North Carolina use evidence-based substance

Schools are an integral part of a multifaceted prevention strategy, as youth spend a considerable amount of time at school.

The Department of Public Instruction and Division of Mental Health, Developmental Disabilities, and Substance Abuse Services should work to establish evidence-based prevention, early intervention, and treatment programs for students in the school setting.

abuse prevention curricula, they are not the most commonly used.^{e,20} It is difficult to assess the effectiveness of any part of the Healthful Living Standard Course of Study as health education is not subject to end of course testing.

In addition to the substance abuse education provided as part of the Healthful Living Course of Study, schools also receive federal funds which can be used to provide substance abuse services. The US Department of Education provides states with funding for *Safe and Drug-Free Schools and Communities* (SDFSC).²¹ Eighty percent of the funding goes to the North Carolina Department of Public Instruction (DPI) to use directly in the school system, while 20% of the funding is allocated to the Governor. The funding to DPI is used to prevent violence in and around schools; prevent students from using alcohol, tobacco, or other drugs; involve parents and communities; and work with other federal, state, and community efforts to foster a positive learning environment that supports academic achievement. Local education agencies have a lot of flexibility in the use of the federal funds, as long as the funds are used to support the goals stated above. For example, schools can use these funds to expand and improve school-based mental health services including early identification of violence and illegal drug use; provide counseling, mentoring, and referral services for students at risk of violent behavior and illegal use of drugs; or test students for illegal drug use. However, schools can also use the funds for other purposes—such as purchasing security equipment—which are not as directly tied to preventing, identifying, referring, or treating students at risk of or using alcohol, tobacco, or other drugs.

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) manages the governor's portion of the Safe and Drug-Free Schools and Communities (SDFSC) funding from the US Department of Education. The governor's portion provides community-based services to special populations and high-risk youth who are not normally served by the state or local education agencies. These funds are coordinated through the LMEs which contract with community providers in over 30 counties.

DPI and DMHDDSAS should work to establish evidence-based prevention, early intervention, and treatment programs for students in the school setting. In the past, both agencies worked collaboratively to support student assistance programs, which provided a framework to deliver prevention, intervention, and support services to students with alcohol and drug problems.^f These programs were initially funded in

e The Drug Abuse Resistance Education (DARE) program is used in approximately three-fourths of schools across the nation. However, multiple studies have shown that this program produces no long-term effect on alcohol, tobacco, or drug use. (Office of the Surgeon General, United States Dept of Health and Human Services. The surgeon general's call to action to prevent and reduce underage drinking. <http://www.surgeongeneral.gov/topics/underagedrinking/calltoaction.pdf>. Published 2007. Accessed January 21, 2009. Lynam DR, Milich R, Zimmerman R, et al. Project DARE: No effects at 10-year follow-up. *J Consult Clin Psychol*. 1999;67(4):590-593. Ringwalt CL, Greene JM, Ennett ST, Iachan R, Clayton RR, Leukefeld CG; Research Triangle Institute and the University of Kentucky. Past and future directions of the D.A.R.E. program: An evaluation review. <http://www.ncjrs.gov/txtfiles/darerev.txt>. Published September 1994. Accessed December 29, 2008.)

f *Help is Down the Hall* is a handbook on student assistance from SAMSHA. This handbook provides a sample of selected student assistance models and selected national resources. It is available online at: <http://www.nacoa.net/pdfs/SAP%20HANDBOOK.pdf>.

1988 through state funds but lost state funding in years of tight budget constraints. Effective student assistance programs, like the one in Washington State, include developmentally appropriate services that target schools, classrooms, and individual students. The programs offer early alcohol and drug prevention services to students and their families, help with referrals to community treatment providers, and strengthen the transition back to school for students who have alcohol or drug abuse problems. When implemented appropriately, this model has been shown to be effective in reducing use of alcohol and drugs and also in reducing barriers to learning.²²

Every school district in North Carolina should implement *evidence-based* substance abuse prevention programs and have trained staff to ensure that children with substance abuse problems are identified early and referred into treatment with the appropriate family and school supports.

Community Colleges, Colleges, and Universities

Community colleges and universities should also have a comprehensive substance abuse prevention, early intervention and treatment plan. All institutions of higher education are required to provide information to students about unlawful use of alcohol and drugs, under the Drug-Free Schools and Communities Act and the Drug and Alcohol Abuse Prevention Regulations.^g As part of this requirement, all post-secondary institutions must implement a substance abuse prevention program to prevent unlawful use of illegal drugs or alcohol on campus. Schools must provide information to students and employees about the health risks associated with substance use, as well as the expected conduct standards and sanctions relating to inappropriate or illegal use of drugs and alcohol. Schools must also provide information on available counseling, treatment, and rehabilitation programs. Community colleges typically refer students with drug and alcohol issues to community agencies (such as LMEs), whereas many universities offer counseling and treatment services on campus. Each institution is required to review the effectiveness of its alcohol and drug abuse prevention program and sanctions enforcement on a biennial basis, and revise the plan as needed. In addition, to the requirements of the Safe and Drug Free Schools Act, all community colleges, colleges, and universities are required to prepare and release annual crime data, including information about the number of people who have been arrested or subjected to disciplinary actions involving illegal drugs or alcohol.^h

Some colleges and universities go beyond the minimum requirements of federal law. The University of North Carolina campuses provide substance abuse prevention

Community colleges and universities should also have a comprehensive substance abuse prevention, early intervention and treatment plan.

^g 20 USC §1145g and the Education Department General Administrative Regulations (EDGAR), 34 CFR Parts 74-99. A summary of the federal requirements are available at: <http://www.higheredcenter.org/mandates/dfsca>.

^h Community colleges, colleges, and universities are required to submit crime reports to the US Department of Education. This report, often referred to as the Clery Report, includes information about the number of people who have been arrested or subjected to disciplinary actions involving illegal drugs or alcohol. 20 USC § 1092(f). Postsecondary institutions are required to report illegal drug use, possession, or sale if it occurs on campus property. These institutions are also required to report on underage drinking and illegal purchase or transportation of alcohol, but they are not required to report driving under the influence or drunkenness. Institutions do not need to report on tobacco use by students or any student activities regarding drug or alcohol use that occurs off campus (even if leading to a disciplinary action).

and education programs, screening, counseling services, and referrals to treatment agencies for alcohol and drug addiction. In addition, many work together with their local communities through coalitions and partnerships and collaborate with each other through the Network Addressing Collegiate Alcohol and Other Drug Issues. Similar prevention services are offered at other colleges and campuses. For example, all incoming freshman are required to complete an on-line training course on alcohol education at Duke University.²³

Although each of the colleges and universities has some prevention activities in place, more work is clearly needed. As described in Chapter 2, youth and young adults have the highest use of alcohol and drugs. More work is needed on college campuses to prevent the use of alcohol, tobacco, and other drugs. Schools should be required to implement evidence-based prevention interventions, and have systems for early interventions and referral into treatment. The strategies might differ, depending on whether the students with substance abuse problems are enrolled in community colleges or universities. Further, North Carolina state policy makers should become more actively involved in monitoring the prevention, early intervention, and treatment options in our elementary, middle, and secondary schools and institutions of higher education. Thus, the Task Force recommended:

Recommendation 4.2

- a) **The North Carolina General Assembly should direct the State Board of Education, Office of Non-Public Education, North Carolina Community College System, and University of North Carolina System to review their existing substance abuse prevention plans, programs and/or policies, and availability of substance abuse screening and treatment services, in order to ensure that these educational institutions offer comprehensive substance abuse prevention, early intervention, and treatment services to students enrolled in their schools. These institutions should submit a description of their prevention plans, programs and/or policies, procedures for early identification of students with substance abuse problems, and information on screening, treatment, and referral services to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS), the Appropriations Subcommittee on Education, and Education Committees no later than the convening of the 2010 session. The description should include the following:**
 - 1) **Information about what evidence-based or promising prevention programs, policies, and practices have been or will be implemented to prevent or delay children, adolescents, and young adults from initiating the use of tobacco, alcohol, or other drugs, or reducing the use among those who have used these substances in public schools, community colleges, and the public universities.ⁱ**

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

- 2) Information from the State Board of Education on how local education agencies have implemented the substance abuse component of the Healthful Living Curriculum, including the educational curriculum or other services provided as part of the Safe and Drug Free Schools Act.
 - 3) A plan from the Office of Non-Public Education to incorporate similar prevention strategies into home school and private school settings.
 - 4) Information from the State Board of Education, North Carolina Community College System, and University of North Carolina System on the schools treatment referral plans, including linkages to the Local Management Entities and other substance abuse providers, the criteria used to determine when students need to be referred, and whether follow-up services and recovery supports are available on campus or in the community.
- b) The Department of Public Instruction, North Carolina Community College System, and University of North Carolina system should coordinate their prevention efforts with the other prevention activities led by the DMHDDSAS to ensure the development of consistent messages and optimization of prevention efforts. Prevention efforts should be based on evidence-based programs that focus on intervening early and at each stage of development with age appropriate strategies to reduce risk factors and strengthen protective factors before problems develop.

Prevention Efforts Targeting Tobacco, Alcohol, and Improper Use of Prescription Drugs

In addition to general prevention efforts, the Task Force also focused on prevention efforts that have been shown to be effective in reducing the use or misuse of tobacco, alcohol, prescription drugs, and illicit drugs.

Tobacco

Youth tobacco use: Tobacco is considered a gateway drug and is often one of the first substances that children use.²⁴ Tobacco use (as well as alcohol and marijuana use) is a precursor to other illicit drug use.²⁴ Studies show that children and adolescents who use tobacco are more likely than those who do not use tobacco to consume alcohol or use other illicit substances.²⁵ Tobacco is a highly addictive substance and targets the same pathway in the brain as alcohol and many other drugs.²⁶

North Carolina Youth Risk Behavior Survey data from 2007 show that 22.5% of high school students have smoked cigarettes on one or more of the past 30 days, while 11.7% of middle school students have.¹³ In general, as age increases, so does the probability that cigarettes have been smoked on one or more of the last 30 days.

Tobacco is a highly addictive substance and targets the same pathway in the brain as alcohol and many other drugs.

Congress enacted the Synar Amendment in 1992 to reduce youth access to tobacco products. The Synar Amendment requires states to have laws prohibiting the sale and distribution of tobacco to individuals under the age of 18 and to have effective enforcement mechanisms.^j Under this law, North Carolina must conduct random, unannounced inspections of retail outlets. In 2005, the state had an inspection failure rate of 16.9%, making it the state with the 5th highest failure rate in the country that year.^{k,27}

The North Carolina Department of Crime Control and Safety, Division of Alcohol Law Enforcement (ALE), is the lead state agency for the Tobacco Education and Compliance Check Program.^{l,28} Working in partnership with DMHDDSAS, ALE is responsible for reducing tobacco sales to minors. In 2007, the agency conducted 6,895 tobacco compliance checks across the state. Citations were given to 1,125 store clerks in 91 counties for selling tobacco or tobacco products to a minor.²⁹

Similarly, DMHDDSAS, through the Federal Office of Juvenile Justice and Delinquency Prevention Enforcing Underage Drinking Laws Program, administers the North Carolina Preventing Underage Drinking Initiative. The Initiative performs alcohol purchase surveys in five counties and cities in North Carolina.^m The survey involves a youthful appearing person, over the age of 21, attempting to purchase alcohol without identification.ⁿ If the alcohol establishment allows the purchase without checking for identification, the purchase is considered a sale to an underage person. In the fall of 2008, 554 surveys were conducted of which 158 (28%) of the alcohol establishments would have sold to the surveyor.ⁿ

To further reduce the opportunity for children to access tobacco or alcohol products, the Task Force recommends:

-
- j Promulgation of regulation and monitoring states' compliance with the requirements of Synar are the responsibility of the Substance Abuse and Mental Health Administration (SAMHSA). The SAMHSA regulation implementing the Synar Amendment requires the State to do the following:
 - a. Have in effect a law prohibiting any manufacturer, retailer, or distributor of tobacco products from selling or distributing such products to any individual under the age of 18.
 - b. Enforce such laws in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under the age of 18.
 - c. Conduct annual random, unannounced inspections to ensure compliance with the law. These inspections are to be conducted in such a way as to provide a valid sample of outlets accessible to youth.
 - d. Develop a strategy and timeframe for achieving an inspection failure rate of less than 20% of outlets accessible to youth.
 - k SAMHSA Web site. <http://prevention.samhsa.gov/tobacco/require.aspx>. Accessed February 24, 2008.
 - l Connecticut, Michigan, the District of Columbia, and Kansas had higher failure rates than North Carolina in 2005.
 - m Beginning in 2002, the North Carolina Health and Wellness Trust Fund began providing \$500,000 in grant funds/year to North Carolina Division of Mental Health Developmental Disabilities, and Substance Abuse Services to purchase services from Alcohol Law Enforcement. Continued funding is not guaranteed as the funds are awarded as part of a competitive grant process.
 - n The alcohol purchase survey was conducted in Alamance County, Chapel Hill, Carrboro, Dare County, Durham County, Forsyth County, Fuquay-Varina, Mecklenburg County, New Hanover County, and Robeson County.
 - n Eisen M. Community Policy Management Section, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, North Carolina Department of Health and Human Services. Written communication regarding the North Carolina preventing underage drinking initiative. December 12, 2008.

Recommendation 4.3

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; the North Carolina Division of Alcohol Law Enforcement; the Division of Public Health; and the Department of Public Instruction should develop a strategic plan to further reduce tobacco and alcohol sales to minors. The plan may include, but not be limited to additional compliance checks, outlet control, or server education.

In 2005-2006, North Carolina increased its cigarette tax by 30 cents, bringing the state cigarette tax up to its current rate of 35 cents. Increasing the unit price for tobacco products will help reduce the number of people who start smoking and help those who smoke quit.³⁰ Research shows that a 10% increase in the price of a pack of cigarettes results in a 3-5% drop in adult consumption.³¹ Further, research findings suggest children are more sensitive to an increase in price, and a 10% price increase results in a 6-7% decrease in the number of kids who smoke.³² The federal tax on cigarettes was increased to 61.66 cents with the February 2009 federal reauthorization of the State Children's Health Insurance Program.^{o,p} Increasing the cigarette tax to the national average would provide tremendous gain for the state in terms of reducing death and disability due to tobacco use. At the time this report was being written, the national cigarette tax average was \$1.19. The Campaign for Tobacco Free Kids estimates that raising North Carolina's cigarette tax by 84 cents to reach the national average would generate \$297 million in new state tax revenues annually.^q Furthermore, the organization reports that such an increase in North Carolina's cigarette tax would result in a 14.2% decrease in the youth smoking rate and that 75,100 children alive today would not become smokers.³³

Increasing North Carolina's tax on other tobacco products is also key to reducing youth tobacco use.^r A US Surgeon General's report states that youth who use smokeless tobacco are more likely to use cigarettes.³⁴ Currently, other tobacco products are taxed at 10% of wholesale price. A tax of 50% of wholesale price on other tobacco products would be comparable to a \$1.19 tax on cigarettes. Such a tax increase on other tobacco products would raise an additional \$60.8 million in new revenue and lead to a 26% decrease in consumption among youth.³⁵ The revenues generated from these increased taxes should be used to support substance abuse prevention efforts.

Increasing North Carolina's tax on cigarettes and other tobacco products is key to reducing youth tobacco use.

o Pub L No.111-003

p The new federal tax will go into effect April 1, 2009.

q The methodology that the Campaign for Tobacco-free Kids uses to calculate these estimates was recently modified to reflect new predictions for cigarette consumption. In response to these predictions, the Campaign has increased the background decline (decline in cigarette pack sales) used in its calculations from 1%-2% to 4.5%. The estimates in this report are preliminary. The final estimates will be released by the Campaign in January 2009.

r Taxable tobacco products include smoking tobacco, cigarettes, cigars, cigarillos, bidis, kreteks, snuff, chewing tobacco, snus, and also any other product expected or intended for consumption that contains tobacco or nicotine unless it has been approved by the United States Food and Drug Administration as a cessation-assistance product and is being distributed and sold exclusively for that approved cessation-assistance purpose.

In order to further reduce youth smoking, the Task Force recommends:

Recommendation 4.4 (PRIORITY RECOMMENDATION)

- a) The North Carolina General Assembly should increase the tax on a pack of cigarettes to meet the current national average. The cigarette tax should be regularly indexed to the national average whenever there is a difference of at least 10% between the national average cost of a pack of cigarettes (both product and taxes) and the North Carolina average cost of a pack of cigarettes.
- b) The North Carolina General Assembly should increase the tax on all other tobacco products to be comparable to the current national cigarette tax average, which would be 50% of the product wholesale price.
- c) The increased fees should be used to fund evidence-based prevention and treatment efforts for alcohol, tobacco, and other drugs.

One step to reduce adolescent smoking is to encourage cessation among parents.

Adult tobacco use: Parents play a key role in adolescent health behavior development. Children who have parents who smoke are more likely to smoke.^{36,37} One step to reduce adolescent smoking is to encourage cessation among parents.³⁷ Reducing the number of adults or parents who smoke may lead to reductions in the number of youth who initiate and/or continue to smoke.

The Centers for Disease Control and Prevention (CDC) recommends telephone counseling and support to assist individuals in quitting tobacco when included in a comprehensive tobacco cessation plan. All 50 states and the District of Columbia offer quitline services as evidence-based practice for smoking cessation.^s From November 2005 to November 2007, over 5,000 callers had reached the Quitline NC for cessation assistance.^{tu} Success rates for the Quitline NC program show an average 17% quit rate, which is comparable with other tobacco use cessation programs. Preliminary data show that 94% of callers are satisfied with their Quitline NC experience. On average, quitlines reach an average of 4% of all smokers; however, the current annual funding of North Carolina's Quitline only allows the Quitline to reach less than 1% of smokers in the state. The Centers for Disease Control and Prevention (CDC) recommends that state quitlines reach 6% of smokers.^v Funding

^s This recommendation was developed by the US Task Force on Community Preventive Services, which is a group of experts appointed and supported by the Centers for Disease Control and Prevention, US Department of Health and Human Services. The recommendations of the US Task Force on Community Preventive Services are compiled in the Guide to Community Preventive Services, which "serves as a premier source of high quality information on those public health interventions and policies (including law-based interventions) that have been proven to work in promoting health and preventing disease, injury, and impairment." Community Guide Web site. <http://www.thecommunityguide.org/about/> and <http://www.thecommunityguide.org/policymakers.html>. Accessed March 7, 2008.

^t Quitline NC was established in November 2005 and is administered by the Tobacco Prevention and Control Branch (TPCB), NC Department of Health and Human Services. Funding is provided by the NC Health and Wellness Trust Fund, Blue Cross and Blue Shield of North Carolina, and the Centers for Disease Control and Prevention (through the TPCB).

^u Free & Clear, Inc. is the current Quitline NC vendor. The vendor for SFY 2008-2009 will be determined in April 2008.

^v Information provided by the Tobacco Prevention and Control Branch, NC Department of Health and Human Services, on February 27, 2008.

maintain operation of the Quitline is needed to provide cessation assistance to all adults. Therefore the Task Force recommends:

Recommendation 4.5

The North Carolina General Assembly should appropriate \$1.5 million in recurring funds to the Division of Public Health to support Quitline NC. The Division of Public Health should use some of this funding to educate providers and the public about the availability of this service.

As of January 2008, 22 states and the District of Columbia have passed smoke-free laws that prohibit smoking in restaurants and bars.^w Four other states have smoke-free laws that cover restaurants but exempt stand-alone bars.^{x,38}

The CDC recommends smoking bans and restrictions to decrease exposure to secondhand smoke.^y A review of the evidence showed that smoking bans and restrictions help to increase the number of people who quit smoking and decrease the consumption among those who continue to smoke.³⁹

In 2007, the North Carolina General Assembly passed smoke-free legislation prohibiting smoking in buildings owned, leased, or occupied by state government.^z In order to further reduce exposure to secondhand smoke, reduce cigarette consumption and increase the number of people who quit smoking, the Task Force recommends:

Recommendation 4.6 (PRIORITY RECOMMENDATION)

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

Alcohol

Adolescent Alcohol Use: Adolescent alcohol use is a nationwide problem. According to the US Surgeon General's *Call to Action to Prevent and Reduce Underage Drinking*, which was released in 2007, some of the leading adverse outcomes associated with underage alcohol use include death from injury, risky sexual behavior, and increased risk of sexual and physical assault.^{aa} In addition, the report highlights that underage

Smoking bans and restrictions help to increase the number of people who quit smoking.

w States with smoke-free laws are Arizona, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland (Feb. 1, 2008), Massachusetts, Minnesota, Montana (extends to bars Sept. 1, 2009), New Hampshire, New Jersey, New Mexico, New York, Ohio, Oregon (Jan. 1, 2009), Rhode Island, Utah (extends to bars Jan. 7, 2009), Vermont, and Washington.

x States with smoke-free laws covering restaurants but exempting stand-alone bars are Florida, Idaho, Louisiana, and Nevada.

y US Task Force on Community Preventive Services.

z S.L.2007-193

aa Underage in the report refers to persons under the minimum drinking age of 21.

Alcohol is the most commonly used drug among youth and a large proportion of youth begin drinking alcohol prior to age 13.

drinking is associated with academic failure, illicit drug use, and tobacco use. Furthermore, since the brain continues to develop well into the 20s, alcohol can impact structure and function of the developing brain.⁴⁰

The US Surgeon General’s Report states that alcohol is the most commonly used drug among youth^{bb} and that a large proportion of youth begin drinking alcohol prior to age 13. When youth drink, they tend to drink larger quantities than adults, resulting in more frequent binge drinking.⁴⁰ Further, the quantity of alcohol that the youth consumes in one setting is associated with other negative outcomes. A study of community college students showed that binge drinkers were more likely to report school, relationship, job, and legal problems than were non-binge drinkers and nondrinkers.^{cc,41} The consequences of underage drinking include violence, traffic crashes, property damage, injury, and high-risk sexual behavior, all of which cost the state of North Carolina \$1.2 billion in 2005 (or \$1,705 per youth annually; see Table 4.1).⁴²

Table 4.1
The Costs of Underage Drinking in North Carolina (2005)

Problem	Total Costs in millions
Youth Violence	\$521.1
Youth Traffic Crashes	\$393.0
High-Risk Sex, Ages 14-20	\$120.2
Youth Property Crime	\$97.7
Youth Injury	\$43.8
Poisonings and Psychoses	\$8.5
Fetal Alcohol Syndrome among Mothers Age 15-20	\$22.0
Youth Alcohol Treatment	\$19.1
Total	\$1,225.3

Source: Underage drinking in North Carolina: the facts. Pacific Institute for Research and Evaluation Web site. <http://www.udetc.org/factsheets/NorthCarolina.pdf>. Published October 2006. Accessed February 10, 2008.

Early onset of drinking increases the risk of alcohol addiction.⁴³ Most people who die from alcohol begin drinking in their youth.⁴⁴ Delaying initiation of alcohol use is important because age of first use is a predictor of future alcohol abuse. An analysis of data from the 1992 National Longitudinal Alcohol Epidemiologic Survey revealed the percent of individuals with lifetime alcohol abuse to be higher among those individuals who started drinking at age 14 or younger compared to those who started drinking at age 20 or older (40% versus 10%). Further analysis

bb Youth refers to individuals under the age of 21.

cc In this study, binge drinkers were defined as men consuming five or more drinks on one occasion or women consuming four or more drinks on one occasion at least 2-3 times a month. Nonbinge drinkers were defined as those who consume alcohol but do not meet the definition of a binge drinker.

showed that delaying initiation was associated with reduced risk of later dependence.⁴⁵ According to a 2004 National Survey on Drug Use and Health report, individuals who first drank alcohol prior to age 15 were more than five times as likely to report alcohol dependence or abuse in the past year than were persons who first drank alcohol at age 21 or older.⁴⁶ Further, more than 90% of the 14 million adults who were classified as having alcohol abuse or dependence problems in 2003 had initiated their drinking before age 21.⁴⁷

Data from the 2007 North Carolina Youth Risk Behavior Survey (YRBS) show that 19.7% of high school students had their first drink of alcohol before age 13,^{dd} while 15.9% of middle school students reported their first drink before age 11.^{ee} Having at least one alcohol drink on one or more of the past 30 days was reported by 37.7% of high school students.^{ff,13} Results from a recent nationwide survey showed that 19% of college students ages 18-24 met Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) criteria for alcohol use or dependence.^{gg,48}

Prevention and Reducing Youth Alcohol Use and Abuse: Social norms education is the core of a majority of youth alcohol prevention programs. Research has shown that youth overestimate the amount their peers drink. Additionally, they misunderstand their peers' feelings toward alcohol use, believing them to be more positive than they are.⁴⁹ Counter-marketing tobacco media campaigns have been successful in changing social and cultural norms leading to reduced teen smoking. Similar media strategies should be used with alcohol, in an effort to change the cultural acceptance of underage drinking. Media campaigns to reduce underage drinking through changing social norms have been proven to be effective on college campuses.⁵⁰

In addition to media campaigns, tax increases have also been suggested as one method to prevent harmful drinking by youth. Several studies have shown that increasing the price of alcohol reduces youth consumption.⁵¹ Further, studies have shown that increasing beer or alcohol taxes leads to other positive health and social consequences.⁵² For example, a study by Grossman and Markowitz (2001)⁵² showed that a 10% increase in the price of beer led to a:

- 4.5% decrease in the rate at which students got into trouble with the police, residence hall, or other college authorities.
- 5.5% drop in the rate at which students damage property.
- 3.4% decline in the rate at which students get into arguments or fights.
- 3.6% decline in the rate at which students take advantage of another person sexually or are taken advantage of sexually.

More than 90% of the 14 million adults who were classified as having alcohol abuse or dependence problems in 2003 had initiated their drinking before age 21.

dd YRBS QN40: Percentage of students who had their first drink of alcohol other than a few sips before age 13 years.

ee YRBS QN25: Percentage of students who had their first drink of alcohol other than a few sips before age 11 years.

ff YRBS QN41: Percentage of students who had at least one drink of alcohol on one or more of the past 30 days.

gg National Epidemiologic Survey on Alcohol and Related Conditions, National Institute on Alcohol Abuse and Alcoholism. unfortified wine is 79 cents per gallon (or 21 cents per liter), while the rate for fortified wine is 91 cents per gallon (or 24 cents per liter).

**Tax increases,
particularly on beer,
can help reduce
youth drinking.**

In addition, another study by Hollingsworth (2006) suggests that increasing the cost of beer by \$1 per 6-pack could reduce premature alcohol-related deaths by 3.3%.⁴⁴

Malt beverages, including beer, are the alcoholic drinks of choice among youth.^{53,54} Therefore, it is especially important to examine the cost of beer and the beer excise taxes in the state. North Carolina has the 4th highest beer excise tax in the country; however, the last time the beer tax was raised in North Carolina was in 1969. The current beer tax of 53 cents per gallon equates to five cents per 12-ounce bottle.⁵⁵ The real dollar value of the beer tax has eroded by more than 82% since it was last raised.^{hh} Had the tax been adjusted for inflation, it would have equated to \$3.13 per gallon or 29 cents per 12-ounce bottle sold. Wine and spirits are taxed at a higher rate than is beer. The wine tax is currently 79 cents per gallon, which is the 18th highest state tax on wine.^{ii,56} The wine tax was last increased in 1979. The real dollar value of this tax has eroded by 65% by failing to keep pace with inflation. Had the wine tax been adjusted for inflation, it would now be \$2.36 per gallon. North Carolina has a 25% tax on distilled spirits, which was last raised in 1987. Unlike the other taxes, this is a percentage of the cost of distilled liquor; therefore it naturally increases as the cost of alcohol increases.⁵⁷

Tax increases, particularly on beer, can help reduce youth drinking. In addition, increases in excise taxes are also likely to reduce use among heavy drinkers, who have been shown to be responsive to tax increases.⁵⁸⁻⁶⁰ Furthermore, raising the tax on beer by only 22 cents would increase revenues by over \$40 million and raising the tax on unfortified wine by 21 cents would increase revenues by almost \$4 million. (See Table 4.2)

Preventing and Reducing Driving While Impaired: Driving under the influence of alcohol is a statewide concern with both young and adult drivers. For young drivers, driving under the influence amplifies the pre-existing risks facing young drivers such as inexperience, impulsiveness, and driving often at night and/or with multiple passengers.⁶¹ As shown in Table 4.3, approximately one in four fatal crashes in North Carolina were alcohol-related from 2001 to 2005, and approximately 5% of all crashes were alcohol-related during this period.

Aside from the risk of alcohol abuse, there is also concern regarding the percent of North Carolina youth reporting to be in situations where alcohol use overlaps with vehicles. One-fourth (24.5%) of high school students reported in 2007 that they rode in a vehicle with someone who had been drinking alcohol^{jj} while 26.9% of middle school students reported riding in a car being driven by someone who had

hh This is calculated using the Consumer Price Index Inflation Calculator, available at: http://www.bls.gov/data/inflation_calculator.htm (accessed December 7, 2008).

ii Wine projections are for unfortified wine only, as current consumption for unfortified wine is far higher than it is for fortified wine. (Fortified wine has a higher alcohol content. Some examples of fortified include port and sherry). Note that unfortified and fortified wines are taxed differently. The current excise tax rate for unfortified wine is 79 cents per gallon (or 21 cents per liter), while the rate for fortified wine is 91 cents per gallon (or 24 cents per liter).

jj YRBS QN10: Percentage of students who rode one or more times during the past 30 days in a car of other vehicle driven by someone who had been drinking alcohol.

Table 4.2
Projected Increased Revenues and Decreased Consumption Due to Tax
Increases in Beer and Wine^{kk}

Beer Tax		
<i>Current Tax Per Gallon</i>	<i>Current Revenues</i>	
\$0.53	\$100,533,960.71	
<i>Potential New Tax Per Gallon</i>	<i>Increased Revenue</i>	<i>Percent Decrease in Consumption</i>
\$0.75	\$41,300,454.96	0.96
\$1.00	\$86,502,261.96	2.04
\$1.50	\$173,791,378.62	4.22
\$2.50	\$335,911,622.60	8.57
\$3.13	\$429,518,636.79	11.31
Wine Tax (unfortified wine)		
<i>Current Tax Per Gallon</i>	<i>Current Revenues</i>	
\$0.79	\$14,320,319.55	
<i>Potential New Tax Per Gallon</i>	<i>Increased Revenue</i>	<i>Percent Decrease in Consumption</i>
\$1.00	\$3,737,327.95	0.38
\$1.50	\$12,518,514.19	1.29
\$2.00	\$21,134,608.76	2.2
\$2.36	\$27,235,972.09	2.86

Note: Calculations are based on 2007 NC consumption and revenues (NC Beer and Wine Wholesalers Association). Calculations were performed using the calculator available through the Alcohol Policies Project, Center for Science in the Public Interest. Accessed at <http://www.cspinet.org/booze/taxguide/TaxCalc.htm>. National average beer and wine retail prices per gallon were used (\$4.86 per gallon of beer, \$34.23 per gallon wine) as provided by the Alcohol Policies Project. The -0.35 price elasticity used for beer was obtained from Phillip J. Cook, PhD, Duke University.^{ll} The price elasticity used for wine was -0.58. Nelson, JP.C22 Economic and demographic factors in U.S. alcohol demand: A growth-accounting analysis. *Empirical Economics* 22(1):83-102, 1997.

been drinking alcohol.^{mm} Moreover, 9.6% of high school students reported driving while under the influence.^{nn,12}

The Centers for Disease Control and Prevention (CDC) recommends media campaigns to prevent impaired driving, provided that campaigns are “carefully planned and well executed, attain adequate audience exposure, and are implemented in conjunction with other ongoing alcohol-impaired driving prevention activities.”^{oo}

kk The predicted price increase (and implied consumption decrease) assumes that the price increases by 7.5% more than the excise tax increase, consistent with the findings by Young and Bielinska-Kwapisz who find that retail price increases by an amount greater than the increase in excise tax.

ll Cook PJ. Duke University. Written communication regarding the price elasticity for beer. January 12, 2009.

mm YRBS QN9: Percentage of students who ever rode in a car driven by someone who had been drinking alcohol.

nn YRBS QN10: Percentage of students who rode one or more times during the past 30 days in a car of other vehicle driven by someone who had been drinking alcohol.

oo US Task Force on Community Preventive Services.

Table 4.3
Crashes in North Carolina and the Percent of those Crashes that were Alcohol-Related Crashes, 2001-2005^{pp}

	2001	2002	2003	2004	2005
Non-fatal Crashes	83,043 (8.9)	82,558 (8.1)	83,525 (6.9)	83,211 (7.5)	78,313 (7.8)
Fatal Crashes	1,363 (24.5)	1,426 (24.5)	1,403 (24.5)	1,420 (25.6)	1,417 (26.8)
Total Crashes	217,923 (6.5)	222,164 (5.5)	231,588 (4.7)	230,931 (5.0)	222,298 (5.1)

Source: North Carolina alcohol facts. University of North Carolina Highway Safety Research Center Web site. <http://www.hsrrc.unc.edu/index.cfm>. Accessed February 28, 2008.

In a review of relevant literature, the US Task Force on Community Preventive Services found a 13% median decrease in total alcohol-related crashes associated with such campaigns.⁶²

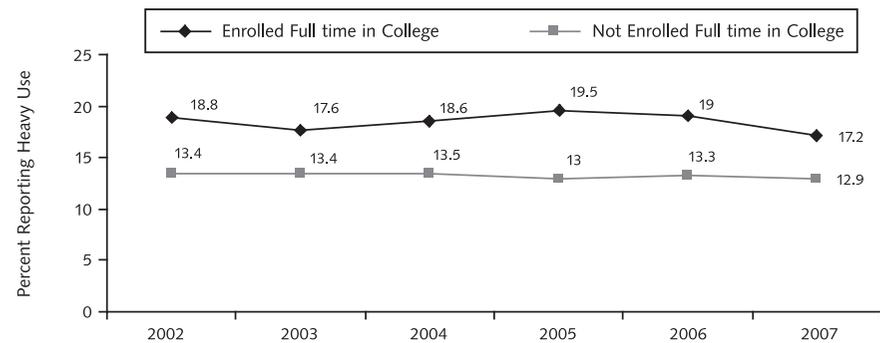
Given the need to reduce youth access to alcohol beverages, reduce underage alcohol consumption, and reduce the incidence of driving while impaired, the Task Force recommends:

Recommendation 4.7 (PRIORITY RECOMMENDATION)

- a) In order to reduce underage drinking, the North Carolina General Assembly should increase the excise tax on malt beverages (including beer). Malt beverages are the alcoholic beverages of choice among youth, and youth are sensitive to price increases.
- b) The excise taxes on malt beverages and wine should be indexed to the consumer price index so they can keep pace with inflation. The excise tax for beer was last increased in 1969, and wine was last increased in 1979. The increased fees should be used to support prevention and treatment efforts for alcohol, tobacco, and other drugs.
- c) The increased fees should be used to fund evidence-based prevention and treatment efforts for alcohol, tobacco, and other drugs.
- d) The North Carolina General Assembly should appropriate \$2.0 million in recurring funds in SFY 2010 to support a comprehensive alcohol awareness education and prevention campaign aimed at changing cultural norms to prevent initiation, reduce underage alcohol consumption, reduce alcohol abuse or dependence, and support recovery among adolescents and adults.

pp Property damage-only crashes were not included in the table; therefore nonfatal crashes and fatal crashes do not equal total number of crashes.

Chart 4.2
Heavy Alcohol Use among Adults Aged 18 to 22, by College Enrollment
(2002-2007)



Source: North Carolina alcohol facts. University of North Carolina Highway Safety Research Center Web site. <http://www.hsrb.unc.edu/index.cfm>. Accessed February 28, 2008.

Underage drinking on campuses: Alcohol use is particularly problematic on college campuses. Many college students are too young to drink *legally* because the minimum legal drinking age is 21.^{qq} Nonetheless, national research suggests that drinking among college-age (18-24 years) students is prevalent, with an estimated 51% of men and 40% of women being classified as binge drinkers (defined as five or more drinks on the same occasion for men and four or more drinks on the same occasion for women).³ Thirty-one percent of college students abuse alcohol, and 6% meet the clinical guidelines for alcohol dependence with few seeking treatment during college.⁶³ Drinking among college students has been estimated to contribute to 1,700 deaths, 559,000 injuries, and 97,000 cases of sexual assault or date rape nationally each year.⁶⁴

Perhaps surprisingly, students enrolled full-time in college are more likely to report heavy drinking than those of the same age who are not enrolled full-time in college.⁶⁵ (See Chart 4.2.) Heavy drinking is defined as having five or more drinks during one occasion on five or more of the past 30 days.

Many underage college students drink, but do so clandestinely to avoid being caught by campus authorities or law enforcement. Some college presidents and chancellors have argued that this makes it more difficult for them to intervene to teach students to drink responsibly. A group of 130 college presidents and chancellors, including the President of Duke University, have signed a statement to encourage broader-based discussion of the minimum legal drinking age.^{rr} This initiative, called the Amethyst Initiative, calls on Congress to unlink the minimum legal drinking age from federal highway funds.

qq Each state establishes its own minimum legal drinking age, however, states that establish a minimum drinking age that is less than 21 lose 10% of their federal highway funds. Thus, all 50 states have established age 21 as the minimum legal drinking age.

rr Statement of Amethyst Initiative available at: <http://www.amethystinitiative.org/statement/>.

Drinking among college students has been estimated to contribute to 1,700 deaths, 559,000 injuries, and 97,000 cases of sexual assault or date rape nationally each year.

The Task Force examined the health consequences of lowering the minimum drinking age. Studies have consistently shown an inverse relationship between the minimum legal drinking age and alcohol consumption and traffic crashes among youth.⁶⁶ Motor vehicle fatalities increased by 10% when the drinking age was lowered to 18. Conversely, fatalities declined by an average of 16% when the drinking age was increased to 21.⁶⁷ Drinking among 18 to 20-year-olds has also declined since 1985, about the time when all the states adopted 21 as the minimum drinking age. One study found that drinking among persons 18 to 20 declined from 59% in 1985 to 40% in 1991,⁶⁸ and another study found that drinking among college students declined from 82% in 1980 to 67% in 2000.⁶⁹

Although sympathetic to the desire to increase the dialogue about how to reduce underage drinking on college campuses, the Task Force strongly opposed lowering the minimum drinking age. Therefore the Task Force recommended:

Recommendation 4.8

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

**Some universities
have developed
more comprehensive
prevention activities
that are changing
the social norms
around college
drinking.**

Some universities have developed more comprehensive prevention activities that are changing the social norms around college drinking. Elon College recently piloted a 0-1-3 campaign: 0 drinks for underage students, no more than one standard size drink per hour and no more than three drinks on any day.⁷⁰ Initial evidence has suggested that drinking has declined since initiation of this campaign, with decreases in drinking among first-year students and increases in the number of students choosing not to drink. In addition, almost all students are aware of the 0-1-3 campaign and what it means.^{ss}

Wake Forest University School of Medicine is conducting a North Carolina-based Study to Prevent Alcohol-Related Consequences (SPARC) to identify successful interventions to change the culture of acceptance around high-risk drinking behaviors and to reduce alcohol-related consequences.^{tt} The study is being funded from the National Institutes of Health and the North Carolina Department of Health and Human Services. The study involves the creation of community-coalitions on five campuses. These SPARC coalitions have worked to reduce alcohol availability both on and off campus, implemented social marketing campaigns to change social norms, and enhanced enforcement activities. Preliminary results have been positive. For example, the SPARC intervention campuses have experienced a significant reduction in alcohol-related injuries caused by others, citations for underage alcohol use, students being sick or injured due to alcohol, and students suspected or seen drinking as compared to control campuses.^{tt}

ss Eisen M. Community Policy Management Section, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, NC Department of Health and Human Services Written communication regarding the Elon college 0-1-3 pilot. December 10, 2008.

tt Alvarez Martin B. Senior Research Associate, Division of Public Health Sciences, Wake Forest University School of Medicine. Written communication regarding the study to prevent alcohol-related consequences (SPARC). November 18, 2008.

To build on these successful efforts on college campuses, the Task Force recommended:

Recommendation 4.9 (PRIORITY RECOMMENDATION)

The North Carolina General Assembly should appropriate \$610,000 in recurring funds in SFY 2010 to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services over three years to support efforts to reduce high-risk drinking on college campuses.

- a) \$500,000 per year should be used to be used to replicate the Study to Prevent Alcohol Related Consequences (SPARC) intervention at six additional North Carolina public universities by establishing campus/community coalitions that use a community organizing approach to implement evidence-based, environmental strategies.
- b) \$110,000 per year should be allocated to provide coordination, monitoring and oversight, training and technical assistance, and evaluation of these campus initiatives.

Fetal Alcohol Spectrum Disorder: Fetal alcohol spectrum disorder (FASD) refers to the range of adverse outcomes caused by alcohol use during pregnancy. Fetal alcohol spectrum disorder in itself is not a diagnostic term but a term that broadly refers to several conditions related to alcohol use during pregnancy. These conditions include fetal alcohol syndrome (FAS), alcohol-related neurodevelopmental disorder, and alcohol-related birth defects.⁷¹ Approximately 1% of all births are children born with FASD.⁷² Individuals affected by FASD may have physical, mental, learning, and/or behavioral disabilities that will affect them throughout their lives.⁷³

Brain damage is the most serious effect of FASD.⁷³ In fact, brain imaging and autopsy studies have shown reductions and abnormalities in overall brain size and shape in children with heavy prenatal alcohol exposure.⁷¹ In addition to brain damage, FASD can result in low birth-weight babies with failure to thrive. Other adverse physical outcomes of FASD may include heart and skeletal defects, vision and hearing problems, kidney and liver defects, and dental abnormalities.⁷³ Heavy prenatal alcohol exposure can lead to overall impairments in intellectual performance, learning and memory, language, attention, reaction time, visual spatial abilities, executive functioning, fine and gross motor skills, and adaptive and social skills.^{71,74} Further, FASD can lead to other social problems. In one study of 400 adolescents and adults with FAS and fetal alcohol effects, 90% had mental health problems, 60% had trouble with the law, 50% had been in confinement (for inpatient treatment for mental health problems or alcohol/drug problems, or incarcerated for a crime), 50% showed inappropriate sexual behavior, and 30% had alcohol or drug problems.⁷⁴

Individuals affected by fetal alcohol spectrum disorder (FASD) may have physical, mental, learning, and/or behavioral disabilities that will affect them throughout their lives.

The occurrence of fetal alcohol-related disorders is, in theory, an entirely preventable public health problem.

The financial burden of FASD is great. In the US, it is estimated that FAS cost \$4 billion in 1998.⁷⁵ Another source has the estimate approaching \$5 billion.⁷⁴ Children with FAS may incur lifetime costs of as much as \$2 million.^{uu,75} North Carolina spent an estimated \$22 million on FAS among teen mothers alone in 2005.⁴² Klug and Burd analyzed data from the North Dakota Health Claims Database and found that the mean annual cost of healthcare for children (from birth through age 21) with FAS was \$2,842 versus an average of \$500 for children without FAS. The authors estimated that preventing one case of FAS alone would result in a savings of \$23,420 in 10 years.⁷⁶

The occurrence of fetal alcohol-related disorders is, in theory, an entirely preventable public health problem. Prevention interventions for FASD may include public service announcements and beverage warning labels (universal prevention), counseling pregnant women who positively screen for drinking alcohol (selective prevention), and long-term counseling for high-risk women, including those with an alcohol abuse history and/or a child with FASD (indicated prevention). Universal prevention interventions have increased the general public's knowledge about drinking alcohol and pregnancy. Furthermore, a reduction in alcohol consumption by pregnant women and improved outcomes for the child can result from selective and indicated prevention efforts.⁷⁷ For example, a recent study published in the *American Journal of Preventive Medicine* showed that a brief motivational intervention with pre-conceptual women can reduce the risk of an alcohol-exposed pregnancy in at-risk women.^{vv,78}

According to 2005 North Carolina Pregnancy Risk Monitoring System (NC PRAMS) data, 3.8% of pregnant women in North Carolina had five or more alcoholic drinks in one sitting at least twice during the last three months of their pregnancy, while 0.5% reported having done this one time during the last three months of their pregnancy.⁷⁹

To reduce the burden of FASD, the SAMHSA Fetal Alcohol Spectrum Disorders (FASD) Center for Excellence and the National Organization on Fetal Alcohol Syndrome have developed a curriculum for addiction professionals to prevent, recognize, and address FASD. Curriculum components have been designed for men, women, and children; however, the prevention component is aimed toward women.⁸⁰ More needs to be done to ensure that other health professionals are trained to recognize at-risk individuals, provide early intervention and education to women and adolescents at risk of giving birth to children with FASD, and provide help to caregivers of children born with FASD. The use of other types of drugs during pregnancy can also be harmful to the developing fetus.^{81,82} Thus, more also needs to be done to reduce the use of non-therapeutic medications or illegal substances during pregnancy. Given the burden and preventability of fetal alcohol spectrum disorders to society and to individuals born with FASD and the risk of drinking or use of other drugs during pregnancy, the Task Force recommends:

uu FAS is the only condition within FASD for which cost information exists.

vv The brief motivational intervention consisted of four counseling sessions and one contraception consultation and services visit.

Recommendation 4.10

- a) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; the Division of Public Health; the Division of Social Services; and appropriate provider associations should develop a prevention plan to prevent fetal alcohol spectrum disorders and use of other drugs during pregnancy and report this plan to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services no later than July 1, 2009. The plan should include baseline data and evidence-based strategies that have been shown to be effective in reducing use of alcohol or other drugs in pregnant women and adolescents as well as strategies for early screening and identification, intervention, and treatment for children who are born with fetal alcohol spectrum disorders or addicted to other drugs in utero. The plan should:
- 1) Focus on women and adolescents at most risk of giving birth to children with fetal alcohol spectrum disorders.
 - 2) Identify a standardized substance abuse screening tool that local health departments, primary care, and obstetrical providers can use for early identification and appropriate referral for services for pregnant women.
 - 3) Include strategies to educate, train, and support caregivers of children born with fetal alcohol spectrum disorders.
 - 4) Identify strategies to educate primary care providers about early identification of infants and young children born with fetal alcohol syndrome disorder or addiction to other drugs, available treatment, and community resources for the affected children and their families.

Most of the research on fetal alcohol spectrum disorders has focused on the impact of alcohol use on the developing fetus. However some of the Task Force members raised concerns that there has been insufficient research to understand the effect, if any, from the use of tobacco, alcohol, or other drugs on the ability of couples to conceive a healthy fetus or on the long-term health consequences of children born from parents who actively used tobacco, alcohol, or other drugs prior to conception. Therefore, the Task Force supports efforts from researchers to seek governmental or foundation research funds to research these issues.

Improper Use of Prescription Drugs

Prescription drug abuse is rising in North Carolina and across the nation. According to the Centers for Disease Control and Prevention, deaths due to accidental overdose increased by 62.5% from 1999 through 2004.⁸³ The State Medical Examiner's Office reported that unintentional deaths related to prescription drug use rose from 466 deaths in 2003 to 700 deaths in 2006 in North Carolina.⁸⁴ Misuse of prescription drugs has resulted in increased emergency room visits, drug related crime, and a rise in drug abuse and dependency.

Prescription drug abuse is rising in North Carolina and across the nation.

A key tool needed to prevent misuse, abuse, and diversion of prescription drugs is the availability of adequate prescription monitoring.

Access to prescription drugs for non-medical or improper use occurs almost entirely from diverted prescriptions, forged prescriptions, or prescriptions written on the basis of inaccurate or untruthful information. While laws regulating and controlling substances can cut down on theft and some diversion, a key tool needed to prevent misuse, abuse, and diversion is the availability of adequate prescription monitoring.

The North Carolina General Assembly established the North Carolina Controlled Substances Reporting System Act (CSRS) in 2005.^{ww} This law helps improve the State's ability to identify people who abuse or misuse controlled substances and refer them for treatment. The goal is to stop the misuse of prescription drugs without impeding the appropriate medical use of controlled substances.

People who dispense medications must submit information about each prescription for controlled substances (Schedule II through V) dispensed in North Carolina to CSRS. Physicians and other practitioners authorized to prescribe controlled substances, as well as dispensing pharmacists, can access information from CSRS about their patients. Providers can use this information to ensure that their patients are not receiving prescriptions elsewhere in quantities or types that contraindicate the current prescription being written. However, because of restrictions in state laws, information obtained from the CSRS about patients who are potentially misusing controlled substances cannot be shared with other practitioners without specific consent of the patient.

While the primary purpose of CSRS is to assist practitioners in identifying people who are misusing controlled substances so as to get them into treatment, the system can also be used, under limited situations, to help law enforcement when investigating cases of diversion and misuse. CSRS also helps identify unusual patterns of controlled substance use and can assist law enforcement in identifying forgeries.

Recommendation 4.11

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services should work with the North Carolina Medical Society, North Carolina Division of Public Health North Carolina Academy of Family Physicians, North Carolina Psychiatric Association, North Carolina Chapter of the American Society of Addiction Medicine, Governor's Institute on Alcohol & Substance Abuse, physician representation from the North Carolina Controlled Substance Reporting System (CSRS) Advisory Committee, and North Carolina Office of the Attorney General to explore options to allow for the exchange of information obtained from the CSRS between health care practitioners.

^{ww} NCGS §90-113.70 et. seq.

Early Intervention Services in Primary Care and Other Settings

The goal of North Carolina's prevention efforts is to reduce the numbers of people who use, abuse, or become dependent on alcohol, tobacco, or other drugs. However, we know that there are people who currently use these substances. Not everyone who uses tobacco products, drinks alcohol, or uses illicit drugs is already addicted. Early interventions may be helpful in reducing the number of occasional users who eventually become dependent.

Primary care providers are ideally situated to screen individuals to identify people who currently use alcohol, tobacco, or other drugs. Once identified, primary care providers can provide counseling and brief treatment about the health risks of using or abusing these substances. Research shows that people are more likely to quit smoking if they are advised to do so by their primary care provider, particularly if this is combined with other treatment and intervention strategies.⁸⁵ Similarly, research shows that counseling is an important element of a larger intervention for alcohol and drug use.⁸⁶

The Substance Abuse and Mental Health Services Agency (SAMHSA) has developed an evidence-based screening and brief intervention or treatment program for individuals who use and are at-risk for substance abuse problems. This program, Screening, Brief Intervention, and Referral to Treatment (SBIRT) has been successful in helping reduce consumption among people who use illegal substances or consume five or more alcoholic beverages in one setting.^{xx,87} The program has been tested in emergency departments, primary care providers' offices, hospitals, federally qualified health centers, health departments, and school-based clinics.⁸⁸⁻⁹⁰

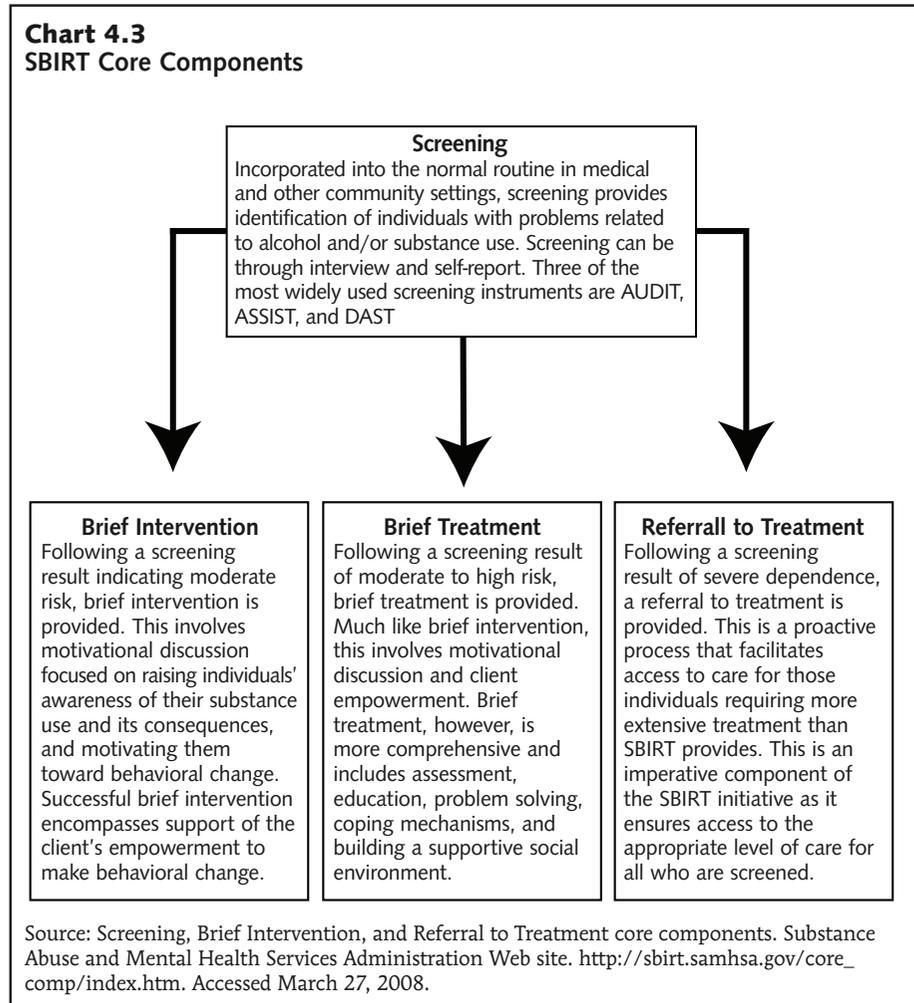
Under the SBIRT system, providers first screen patients to determine the severity of the person's substance abuse problems and identify appropriate levels of intervention.⁸⁸ Providers are trained to offer brief intervention or brief treatment for people who are not yet dependent on alcohol, tobacco, or other drugs. Treatment should include medication assisted therapies, when appropriate. As with other chronic diseases, research has shown that medication can assist in the addiction recovery process in combination with evidence-based behavioral therapies.⁹¹ Those who have more extensive needs are referred into the specialized substance abuse treatment system. Creating linkages and improving coordination of care between primary care providers and substance abuse specialists is critical to the effective treatment of people with substance abuse problems. The SBIRT Core Components are shown in Chart 4.3.

Although SBIRT has been shown to be effective in helping at-risk individuals reduce their use of alcohol, tobacco, or other drugs, providers do not routinely use these strategies.⁹² Many providers are unaware of this model and others are unfamiliar with the recommended screening and assessment tools. Others may need

Primary care providers are ideally situated to screen individuals to identify people who currently use alcohol, tobacco, or other drugs.

xx For more information on SBIRT, visit the Substance Abuse and Mental Health Services Administration Web site at <http://sbirt.samhsa.gov/index.htm>.

Chart 4.3
SBIRT Core Components



further information about billing strategies to ensure that they can be compensated for the time spent in counseling, assessment, and brief treatment. Others may need help establishing linkages between primary care providers and available substance abuse specialists. The Task Force recommended additional training of health care professionals to encourage them to implement SBIRT in their practices. However, this training must go hand-in-hand with payment reform to enable providers to be reimbursed for their time (discussed more fully in Recommendation 4.15). To educate more providers about SBIRT, the Task Force recommends:

Recommendation 4.12

- a) North Carolina health professional schools, the Governor's Institute on Alcohol and Substance Abuse, the North Carolina Area Health Education Centers (AHEC) program, residency programs, health professional associations, and other appropriate organizations should expand as Screening, Brief Intervention, and Referral to Treatment (SBIRT) training for primary care providers and other health professionals in academic and clinical settings, residency programs or other continuing education programs with the goal of expanding the health professional workforce that has demonstrated competencies in SBIRT. The curriculum should include information and skills-building training on:
- 1) Evidence-based screening tools to identify people who have or are at risk of tobacco, alcohol, or substance abuse or dependency.
 - 2) Motivational interviewing.
 - 3) Brief interventions including counseling and brief treatment.
 - 4) Assessments to identify people with co-occurring mental illness.
 - 5) Information about appropriate medication therapies for people with different types of addiction disorders.
 - 6) Successful strategies to address commonly cited disincentives to care for patients in a primary care.
 - 7) Strategies to successfully engage people with more severe substance abuse disorders and refer them to specialty addiction providers for treatment services.
 - 8) The importance of developing and maintaining linkages between primary care providers and trained addiction specialists to ensure bi-directional flow of information and continuity of care.

Ideally, early intervention strategies such as SBIRT, or counseling individuals about the risks of using alcohol, tobacco, or other drugs, should occur in the primary care office. National data show 55% of individuals visited a primary care physician at least once during 2005. This far exceeds the percentage of people who seek care for substance abuse services from an office-based provider (0.1%).^{yy} While some people may be wary of seeking help for substance abuse problems through specialized mental health or substance abuse providers because of the stigma, there is little stigma attached to care given by primary care providers. Thus, to further encourage primary care providers to incorporate SBIRT into their primary care practices, the Task Force recommends:

^{yy} Source for both: NCIOM calculations using 2005 MEPS. Agency for Healthcare Research and Quality. Substance abuse visits are defined by visits with at least diagnosis for ICD-9 code 303, 304, or 305. This estimate is almost certainly low as both patients and providers may face incentives not to include billing codes related to substance abuse.

Recommendation 4.13 (PRIORITY RECOMMENDATION)

- a) The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) should work collaboratively with the North Carolina Office of Rural Health and Community Care (ORHCC), the Governor’s Institute on Alcohol and Substance Abuse, North Carolina Area Health Education Centers (AHEC) program, and other appropriate professional associations to educate and encourage healthcare professionals to use evidence-based screening tools and offer motivational counseling, brief intervention, medication assisted therapies, and referral to treatment to help patients prevent, reduce, or eliminate the use of or dependency on alcohol, tobacco, and other drugs as outlined in the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model.
- b) The North Carolina General Assembly should appropriate \$1.5 million in recurring funds to DMHDDSAS to work with the aforementioned groups to develop a plan to implement as Screening, Brief Intervention, and Referral to Treatment within primary care and ambulatory care settings. The plan should include:
 - 1) Mental health and substance abuse system specialists to work with the 14 Community Care of North Carolina (CCNC) networks and other provider groups. These staff will work directly with the CCNC practices to implement and sustain evidenced-based practices and coordination of care between primary care and specialty services. This would include but not be limited to the SBIRT model allowing for primary care providers to work toward a medical home model that has full integration of physical health, mental health, and substance abuse services. In keeping with the SBIRT model, the mental health and substance abuse system specialists would work within communities to develop systems that facilitate smooth bidirectional transition of care between primary care and specialty substance abuse care.
 - 2) Efficient methods to increase collaboration between providers on the shared management of complex patients with multiple chronic conditions that is inclusive of mental health, developmental disabilities, and substance abuse. An effective system would smooth transitions, reduce duplications, improve communication, and facilitate joint management while improving the quality of care.
 - 3) A system for online and office-based training and access to regional quality improvement specialists and/or a center of excellence that would help all healthcare professionals identify and address implementation barriers in a variety of practice settings such as OB/GYN, emergency room, and urgent care.
 - 4) Integrated systems for screening, brief intervention, and referral into treatment in outpatient settings with the full continuum of substance abuse services offered through DMHDDSAS.

North Carolina has also developed other promising practices to help address the mental health needs of patients in primary care practices. These models involve co-locating licensed mental health professionals in a primary care practice, or conversely, locating a primary care provider in a mental health practice. Individuals identified with mental health problems can be directly referred to the licensed mental health practitioner who is located in the same facility. Co-location facilitates appropriate referral and treatment and improves coordination of care between the primary care provider and the licensed mental health professional.⁹³ Patients who are treated in an integrated care setting are more likely to receive preventive care and experience improved health outcomes.^{94,95}

The North Carolina General Assembly appropriated nonrecurring funds to the Office of Rural Health and Community Care (ORHCC) to pilot strategies for the Aged, Blind, and Disabled population. A portion of these funds were utilized in SFY 2007 and SFY 2008 to expand access to licensed mental health professionals with primary care providers and to increase access to preventive primary care services for patients served within the specialty mental health system. There are currently 57 primary practices across the state that received state funds to develop mental health co-location models. These models have been successful in offering early intervention services and identifying and treating problems before they reach a crisis. However no further funding has been appropriated to maintain or expand ORHCC work to integrated care.

The Task Force believed that a similar co-location model was warranted to provide accessible services for people with substance abuse problems. However, rather than develop a whole new initiative that focuses exclusively on people with substance abuse problems in the primary care setting, the Task Force recommended building on the existing successful co-location model. Many people with substance abuse problems also have mental health problems. Thus, the professionals who are trained to address the mental health problems should be cross-trained to identify and provide brief treatment and referrals for people with substance abuse disorders and licensed substance abuse professionals should be similarly trained to identify and provide brief treatment and referrals for people with coexisting mental health problems.

Thus, to support further expansion of co-location models across the state, the Task Force recommends:

Recommendation 4.14

- a) The North Carolina Office of Rural Health and Community Care should work in collaboration with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; the Governors Institute on Alcohol and Substance Abuse; the ICARE partnership; and other professional associations to support and expand co-location in primary care practices of licensed health professionals trained in providing substance abuse services.
- b) The North Carolina General Assembly should provide \$750,000 in recurring funds to the North Carolina Office of Rural Health and Community Care to support this effort. Primary care practices eligible for state funding include private practices, federally qualified health centers, local health departments, and rural health clinics that participate in Community Care of North Carolina. Funding can be used to help support the start-up costs of co-location of licensed substance abuse professionals in primary care practices for services provided to Medicaid and uninsured patients. Alternatively, funding may be used to support continuing education of mental health professionals who are already co-located in an existing primary care practice in order to help them obtain substance abuse credentials to be qualified to provide substance abuse services to Medicaid and uninsured

Co-location of mental health and substance abuse professionals with primary care providers can improve coordination of care and facilitate appropriate referrals and treatment.

patients with substance use disorders. The goal is to offer evidence-based screening, counseling, brief intervention, and referral to treatment to help patients prevent, reduce, or eliminate the use of or dependency on tobacco, alcohol, and other drugs. Funding priority should be given to practices that meet one or more of the following criteria:

- 1) Primary care practices with a co-located mental health professional.
- 2) Primary care practices with a significant population of dually diagnosed patients with mental health and substance abuse problems who have prior experience in screening and intervention for mental health and/or substance abuse problems.
- 3) Primary care practices actively involved in other chronic disease management programs.

The Task Force strongly supported building on this collaborative model of interdisciplinary care. But the current third-party reimbursement system creates barriers which make it difficult to sustain these models without ongoing state or grant funding. For example, some insurers will not reimburse for brief counseling and referrals.^{zz} Some insurers have policies which prohibit paying two professionals for health services rendered at the same location on the same day. In addition, coverage for the treatment of substance abuse is not the same as coverage for other medical conditions.

Approximately 19.2 million US workers (15%) reported using or being impaired by alcohol at work at least once during the last year.⁹⁶ Studies have suggested that investments in substance abuse treatment can exceed costs by a ratio of 12 to 1.⁹⁷ Yet, under current North Carolina laws, health insurers need only offer a total of \$8,000/year in coverage for “chemical dependency” or a lifetime maximum of \$16,000.^{aaa} Few health plans limit coverage of other health conditions to such a low annual or lifetime limit. Further, many health plans offer this limited substance abuse coverage with higher deductibles or coinsurance. Congress recently passed the Mental Health Parity and Addiction Equity Act as part of the Emergency Economic Stabilization Act of 2008, which should expand third-party coverage of substance abuse services.^{bbb} Under the new statute, group health plans must generally provide mental health and substance abuse coverage in parity with medical and surgical

zz The Division of Medical Assistance has recently changed its coverage policy to begin paying for screening and brief intervention. These changes are anticipated to go into effect on January 1, 2009. The changes will include new CPT codes for substance abuse screening and intervention, therapy codes for primary care providers who integrate qualified mental health professionals into their practices, telephone and face-to-face consultations between primary care providers and psychiatrists or other specialists, and allowing for reimbursement on the same day if the patient visits both a medical provider and a licensed mental health or substance abuse professional.

aaa NCGS §§ 58-51-50; 58-65-75, 58-67-70.

bbb Subtitle B—Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Public Law 110-343, codified at 29 USC § 1185a, 42 USC § 300gg-5.

benefits.^{ccc} The law only applies to employer groups with 50 or more employees and only if the employer offers insurance with mental health coverage. In these instances, the coverage of mental health and substance abuse may not have higher cost sharing (including deductibles, copayments, and annual or lifetime limits) or more restrictive treatment limitations for the mental health and substance abuse coverage than what is provided as part of the medical and surgical benefits. The federal mental health and addiction parity act will become effective for most plans on January 1, 2010.

In 2007, the North Carolina General Assembly enacted a mental health parity law.^{ddd} It applies to all groups, including small employers, which purchase insurance from regulated insurance companies (e.g. it does not cover self-funded or ERISA plans). However, it does not apply to people who are diagnosed with a substance disorder. The North Carolina law went into effect on July 1, 2008.^{eee}

Despite these changes in state and federal law, additional actions are needed to ensure complete parity for substance abuse services. The federal law does not apply to employer groups with fewer than 50 employees, and the state law does not provide parity for substance abuse disorders. These barriers need to be addressed to support large-scale expansion of substance abuse early intervention and treatment services by primary care and other providers across the state. Therefore, the Task Force recommends:

The North Carolina General Assembly should enact a substance abuse parity law.

Recommendation 4.15 (PRIORITY RECOMMENDATION)

- a) **The North Carolina General Assembly should mandate that insurers offer coverage for the treatment of addiction diseases with the same durational limits, deductibles, coinsurance, annual limits, and lifetime limits as provided for the coverage of physical illnesses.**
- b) **The North Carolina General Assembly should direct the Division of Medical Assistance, North Carolina Health Choice program, State Health Plan, and other insurers to review their reimbursement policies to ensure that primary care and other providers can be reimbursed to screen for tobacco, alcohol, and drugs, provide brief intervention and counseling, and refer necessary patients for specialty services.**

^{ccc} Group health plans can be exempt from this requirement if a licensed actuary demonstrates that the costs of coverage will increase more than 2% in the first plan year or 1% for each subsequent year as a result of this new coverage.

^{ddd} Session Law 2007-268. Under the new state law, North Carolina insurers must provide the same coverage of certain mental health disorders as provided other physical illnesses generally, including bipolar disorder, other major depressive disorder, obsessive compulsive disorder, paranoid and other psychotic disorder, schizoaffective disorder, schizophrenia, post-traumatic stress disorder, anorexia nervosa, and bulimia. In addition, insurers must provide at least 30 days of inpatient and outpatient treatment and at least 30 days of office visits for other mental health disorders. People with substance abuse disorders (recognized as 291.0 through 292.2 and 303.0 through 305.9 of the Diagnostic Manual of Mental Disorders (DSM-IV)) are not eligible for this coverage.

^{eee} Session Law 2007-268, Section 6.

- 1) Specifically, the plans should provide reimbursement for:
 - i) Screening and brief intervention in different health settings including, but not limited to, primary care practices (including OB/GYN, federally qualified health centers, rural health clinics, and hospital-owned outpatient settings), emergency departments, Ryan White Title III medical programs, and school-based health clinics.
 - ii) CPT codes for health and behavior assessment (96150-96155), health risk assessment (99420), substance abuse screening and intervention (99408, 99409), and tobacco screening and intervention (99406, 99407) and should not be subject to therapy code preauthorization limits.
 - iii) Therapy codes (90801-90845) for primary care providers who integrate qualified mental health professionals into their practices.
 - iv) Appropriate telephone and face-to-face consultations between primary care providers and psychiatrists or other specialists. Specifically, payers should explore the appropriateness of reimbursing for CPT codes for consultation by a psychiatrist (99245).
 - 2) Reimbursement for these codes should be allowed on the same day as a medical visit's evaluation and management (E&M) code when provided by licensed mental health and substance abuse staff.
 - 3) Fees paid for substance abuse billing codes should be commensurate with the reimbursement provided to treat other chronic diseases.
 - 4) Insurers should allow psychiatrists to bill using E&M codes available to other medical disciplines.
 - 5) Providers eligible to bill should include licensed healthcare professionals including, but not limited to, primary care providers, mental health and substance abuse providers, emergency room professionals, and other healthcare professionals trained in providing evidence-based substance abuse and mental health screening and brief intervention.
- c) The Division of Medical Assistance should work with the Office of Rural Health and Community Care (ORHCC) to develop an enhanced Carolina Access (CCNC) per member per month (PMPM) for co-located practices to support referral and care coordination for mental health, developmental disabilities, and substance abuse services.
 - d) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, in collaboration with the ORHCC, should work collaboratively with the Governor's Institute on Alcohol and Substance Abuse, Academy of Family Physicians, North Carolina Pediatric Society, North Carolina Psychiatric Association, North Carolina Primary Health Care Association, ICARE, and other appropriate groups to identify and address barriers that prevent the implementation and sustainability of co-location models and to identify other strategies to promote evidence-based screening, counseling, brief intervention, and referral to treatment in primary care and other outpatient settings.

Comprehensive System of Specialized Substance Abuse Services

In an ideal system, people would not become addicted to alcohol, tobacco, or other drugs. Multifaceted prevention strategies would be implemented targeting the general public, individuals at higher risk, and people who have engaged in risky behaviors. Further, there would be a system of early intervention services to intercede before a person becomes addicted to these substances. However, this idealized system does not exist. National estimates show that 6.6% of North Carolinians aged 12 years or older abuse or are dependent on alcohol, and 3% have abused or are dependent on illicit drugs. Combined, 8.5% have abused or are addicted to alcohol or drugs. However, few of the North Carolinians who need treatment received it from the publicly-funded substance abuse system. The North Carolina data from the National Survey on Drug Use and Health showed that 95.5% of those who reported alcohol abuse or dependence needed but did not receive treatment, and 90% of North Carolinians age 12 or older who reported illicit drug dependence or abuse needed but did not receive treatment. This equates to 526,000 who needed but did not receive treatment for alcohol in 2008 and 225,000 North Carolinians who needed but did not receive treatment for illicit drugs.^{98,99} (See Table 4.4.)

Several studies have examined why people who need treatment do not receive it.¹⁰⁰⁻¹⁰³ These studies challenge the assumption that the primary reason that individuals with substance abuse problems fail to seek treatment or stay in treatment is their own lack of motivation. Rather, the failure to seek or stay in treatment has more to do with the treatment system's inability to meet the client's needs rather than the individual's lack of desire to seek help.¹⁰⁴ These findings are supported by focus groups conducted in two counties in North Carolina (Dare and Rockingham) with consumers and professionals. Participants in these focus groups noted that alcohol and drug issues were pervasive in their communities, but the system was not adequate to address these needs.¹⁰⁵ Some of the common themes identified in the North Carolina focus groups include:

- **Stigma.** Consumers reported that they perceived a stigma in seeking services both from providers who referred the consumers into treatment and from the LME staff directly. Consumers also noted that substance abuse treatment programs treated addicts with different addictions differently.
- **Services were inadequate or nonexistent.** Communities lacked a complete continuum of services. Focus group participants particularly noted the lack of inpatient and residential substance abuse treatment and recovery supports needed to help consumers successfully integrate back into the community. A common theme across both communities was the lack of services to treat addicted adolescents.
- **Workforce and competency issues.** There are too few licensed substance abuse professionals. Most of the healthcare professionals who work with people with substance abuse problems do not recognize the problem and do not know how to assess, treat, or refer patients into treatment.

The failure to seek or stay in treatment has more to do with the treatment system's inability to meet the client's needs rather than the individual's lack of desire to seek help.

Table 4.4
Few North Carolinians Who Need Substance Abuse Treatment Services Are Receiving Services (NSDUH 2005-2006)

	12 or older Estimate	12-17 Estimate	18-25 Estimate	26+ Estimate
North Carolina Population Projections (July, 2008)	8,341,746	1,356,908	1,079,771	5,905,067
Dependence on or Abuse of Illicit Drugs or Alcohol in Past Year	~709,000 (8.5%)	~106,000 (7.8%)	~204,000 (18.9%)	~402,000 (6.8%)
Alcohol Dependence or Abuse in Past Year	~551,000 (6.6%)	~66,000 (4.9%)	~155,000 (14.4%)	~331,000 (5.6%)
Needing but not Receiving Treatment for Alcohol Use in Past Year	~526,000 (95.5%)	~64,000 (95.9%)	~149,000 (95.8%)	~307,000 (92.9%)
Needing and Receiving Treatment for Alcohol Use in Past Year	~25,000 (4.5%)	~2,700 (4.1%)	~6,500 (4.2%)	~23,600 (7.1%)
Illicit Drug Dependence or Abuse in Past Year	~250,000 (3.0%)	~65,000 (4.8%)	~96,000 (8.9%)	~112,000 (1.9%)
Needing but not Receiving Treatment for Illicit Drug Use in Past Year	~225,000 (90.0%)	~62,000 (95.8%)	~84,000 (87.6%)	~94,000 (84.2%)
Needing and Receiving Treatment for Illicit Drug Use in Past Year	~25,000 (10.0%)	~2,700 (4.2%)	~12,000 (12.4%)	~18,000 (15.8%)

Sources: Hughes A, Sathe N, Spagnola, K. State estimates of substance use from the 2005-2006 National Surveys on Drug Use and Health. Tables B.16, B.18, B. 20, B.21, B.22. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies Web site. <http://www.oas.samhsa.gov/2k6state/AppB.pdf>. Published February 2008. Accessed March 24, 2008. North Carolina population projections (2008) from North Carolina state demographics; North Carolina population by age 2000-2009. North Carolina Office of State Budget and Management Web site. <http://demog.state.nc.us/>. Accessed March 24, 2008.

- **Services are too rushed to make a difference.** People noted that they did not receive services for enough time to make a difference.
- **Inadequate linkages between detox providers and other substance abuse services.** Consumers noted that they did not receive referrals out of the detox system.

As noted in Chapter 3, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services has created a framework for a comprehensive system of treatment and recovery supports that follows the American Society of Addiction Medicine (ASAM) levels of care. Theoretically, each LME should be able to offer a comprehensive array of substance abuse services, depending on the clinical needs of the client. Services that meet the client's needs would be offered

in a timely fashion, and clients would be engaged long enough to address their underlying alcohol, tobacco, or substance abuse problems. A full continuum of services would be available, including screening and assessment, brief intervention, outpatient services, medication management, intensive outpatient and partial hospitalization, clinically managed low-intensity residential services, clinically managed medium-intensity residential treatment, inpatient services, and crisis services including detox. In addition, individuals also need access to recovery supports in order to help individuals live without use of alcohol, tobacco, and other drugs. Recovery supports include, but are not limited to, transportation to and from treatment and other support activities (such as employment), employment services and job training, case management, housing assistance and services, child care, parent education and child development, family and marriage counseling, life skills, education, spiritual and faith-based support, relapse prevention, and self-help and support groups (such as Narcotics Anonymous, Alcoholics Anonymous, or other 12-step groups). Group homes for recovering substance abusers, such as Oxford Houses, are another important type of recovery support. Oxford Houses, started in 1975, are peer-run, responsible for all household expenses, and have a no tolerance policy for use of alcohol or drugs. House residents are expected to participate in recovery programs and are encouraged to complete outpatient treatment and counseling. There is also education on adjusting to living in communities. Research has shown that over the last five years the average rate of success (i.e. five years of sobriety after leaving an Oxford House) for Oxford House alumni has been between 65% and 87%.¹⁰⁶

A full continuum of care requires prevention, early intervention and engagement, a full continuum of treatment services, and recovery supports. Chart 4.4 shows a recovery-oriented system of care that meets the substance abuse, mental health, physical health, housing, educational, family, employment, and spiritual needs of the individual. This model involves multiple agencies who work together to meet the substance abuse and other needs of the individual and family. Individuals who need substance abuse services will not all need every service listed in the chart. However, a similar array of services should be reasonably available in the community to ensure that people with substance abuse dependence disorders can receive appropriate services based on their needs. Recovery-oriented systems of care incorporate chronic care management approaches, recognizing that individuals with substance abuse disorders may need lifelong assistance in helping them manage their health problem.

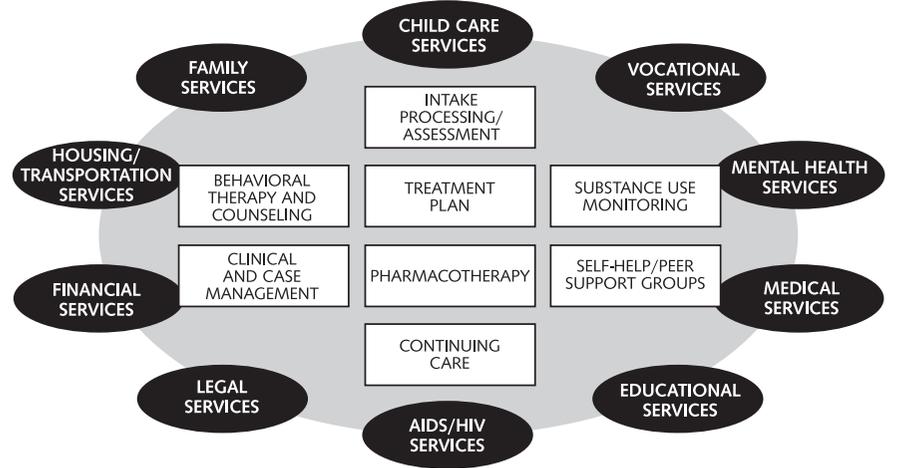
Currently, most communities lack an adequate infrastructure to meet all the needs of people with substance abuse disorders, and the availability of services varies across LMEs. Further, services are not always provided in a timely manner. DMHDDSAS tracks the number and percentage of patients within each LME who were determined to need emergent (within two hours), urgent (within 48 hours), and routine services (within 14 days) care, as well as those who received services

Currently, most communities lack an adequate infrastructure to meet all the needs of people with substance abuse disorders, and the availability of services varies across Local Management Entities.

Local Management Entities ranged from 13% to 100% in the provision of urgent care within the specified time frames... There was wide variation in the provision of routine care, with Local Management Entities ranging from 28% to 90% in the proportion of consumers being served within the required 14-day time frame.

Chart 4.4
Recovery-Oriented System of Care

North Carolina Substance Abuse Treatment Components & Comprehensive Services



Source: National Institute for Drug Abuse, Principles of Drug Addiction Treatment.

within the prescribed time.^{fff} (See Appendix B) Statewide, 43,567 individuals with mental health, substance abuse, or developmental disabilities requested services in the fourth quarter of SFY 2007-2008. A little less than one-fifth (19%) of those requesting services were determined to need emergent care.^{ggg} Almost all of the LMEs met this standard for all of the people who were determined to need emergency care. Fifteen percent of the population was determined to need urgent care. Statewide, 79% of these individuals were provided care within 48 hours. However, LME performance varied considerably. LMEs ranged from 13% to 100% in the provision of urgent care within the specified time frames. Statewide, 68% of the cases determined to need routine care were provided a face-to-face assessment

^{fff} Performance standards are based on national measures, when available. For example, the performance standards for timely access to care (emergent, urgent, and routine) and timely follow-up after inpatient care (ADATCs) are based on the Healthcare Enterprise Data Information System (HEDIS) measures, supported by the federal Centers for Medicare and Medicaid Services. The performance standards for timely initiation and engagement in services (two visits in first 14 days, four visits in first 45 days) are based on national standards, Washington Circle Public Sector Workgroup (www.washingtoncircle.org).

^{ggg} Timely access to care includes access for people with substance abuse problems, mental health problems, and developmental disabilities. Timely access measures have been based on Local Management Entities self-reported data. These data are not subject to external verification. With other data, the state calculates the percentages based on claims data. Because of the way these data were collected, Division of Mental Health Developmental Disabilities, and Substance Abuse Services did not have the ability to separate out the timely access measures for people by specific disability (such as those with a substance abuse disorders) at the time of this report. These data problems are being addressed. The data collected in SFY 09 is based on claims data, so can be reported separately for each disability group.

and/or treatment service within 14 calendar days. There was wide variation in the provision of routine care, with LMEs ranging from 28% to 90% in the proportion of consumers being served within the required 14-day time frame.¹⁰⁷

Best practice guidelines for initiating and engaging consumers into care suggests that an individual receive two visits within the first 14 days of care and then two more in the next 30 days (a total of four visits within 45 days of engagement with the system). The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services sets both LME performance standards and performance targets.^{hhh} The current performance contract *standards* are set based on the statewide average in the prior fiscal year. LMEs may be sanctioned for failure to meet these minimum standards. The performance *targets* are set to emphasize high priority areas, while trying to be realistic about what can be achieved in a single year. Under the current performance *targets*, 71% of consumers should receive two visits within the first 14 days of care, and 50% should receive four visits within the first 45 days of care.ⁱⁱⁱ Statewide, LMEs are falling short of this target, with only 62% of substance abuse consumers receiving two visits within the first 14 days of care (ranging from 36% to 82% among LMEs). Statewide, 46% of consumers had four visits within the first 45 days of care (ranging from 27% to 63% among LMEs).

Best practice also dictates that individuals should be seen by a community provider within seven days of being released from an institution (or ADATC). DMHDDSAS's performance target for this measure is that 36% of people who leave an ADATC be seen within seven days of release. Despite this low performance target, only 23% of the people who leave an ADATC are seen by a community provider within the first seven days. Again, this varied across LMEs, ranging from 0% to 53%. An additional 15% were seen within 8-30 days of discharge.¹⁰⁸

Of even greater concern, North Carolina data show that across the state very few people with substance abuse disorders are being treated through the LMEs. (See Table 4.5) The LMEs with the highest percentage served are only serving approximately 11% of the adults or children who need services, whereas the LMEs with the lowest percentage served are serving 5% of adults and only 4% of children who need services.¹⁰⁸

With the privatization of the mental health and substance abuse system under the state's mental health reform efforts, the availability of services is dependent, in large part, on the willingness of private providers to contract with the LME to provide

The Local Management Entities with the highest percentage served are only serving approximately 11% of the adults or children who need services, whereas the LMEs with the lowest percentage served are serving 5% of adults and only 4% of children who need services.

hhh Division of Mental Health Developmental Disabilities, and Substance Abuse Services sets both performance standards and performance targets. Local Management Entities that meet a certain level of performance based on a composite score across 21 distinctive service-related measures are offered the opportunity for single stream funding, a more flexible funding approach. These performance standards include measures of services access, penetration, initiation, engagement, appropriate state hospital and residential program use, and post-discharge follow-up and continuity of care.

iii The current performance contract standards set achievable bars which push the poorer performing Local Management Entities to reach the level of their colleagues while simultaneously pushing up the overall standard each year. In terms of performance targets, the goal is to continuously raise these targets as statewide performance increases. Over time, Division of Mental Health Developmental Disabilities, and Substance Abuse Services plans to establish best practice benchmarks.

Table 4.5**Few People who Needed Substance Abuse Services were Served in the LMEs with State Funds (April 1, 2008 – June 30, 2008)***Estimated percent of those needing substance abuse services who received them with state funds*

	Children		Adults
Durham	11%	Southeastern Regional	11%
East Carolina Behavioral Health	10%	Johnston	11%
CenterPoint	9%	Five County	10%
Five County	9%	Pathways	10%
Cumberland	8%	Albemarle	10%
Pathways	8%	Western Highlands	9%
Sandhills Center	8%	Burke-Catawba	9%
Western Highlands	8%	Smoky Mountain	9%
Burke-Catawba	7%	Southeastern Center	9%
Orange-Person-Chatham	7%	Durham	8%
Smoky Mountain	7%	CenterPoint	8%
Southeastern Regional	7%	Crossroads	8%
Alamance-Caswell-Rockingham	6%	Guilford	8%
Albemarle	6%	Mecklenburg	8%
Crossroads	6%	East Carolina Behavioral Health	7%
Guilford	6%	Sandhills Center	7%
Onslow-Carteret	6%	Orange-Person-Chatham	7%
Southeastern Center	6%	Alamance-Caswell-Rockingham	7%
Beacon Center	5%	Foothills	7%
Eastpointe	5%	Cumberland	6%
Mecklenburg	5%	Onslow-Carteret	6%
Foothills	4%	Eastpointe	6%
Johnston	4%	Beacon Center	5%
Wake	4%	Wake	5%
SFY 2008 Performance Target	9%	SFY 2008 Performance Target	10%
SFY Performance Contract Requirement	7%	SFY Performance Contract Requirement	8%
Statewide Average	7%	Statewide Average	8%

Note: These data do not include the five counties that are part of Piedmont Behavioral Health LME which has not been reporting data to the state. In addition, it does not capture services provided through county appropriations, grant funds, or other funding sources. Some of the larger urban counties, such as Mecklenburg, provide substantial county funding to augment the state appropriations and federal SAPT block grant funds. Services provided through county funds will be reported beginning July 1, 2009.

services. Yet in some regions, substance abuse providers are unwilling to contract with the LME because of administrative and paperwork hassles, low reimbursement, and lack of appropriate service definitions that allow some services to be reimbursed.^{jjj} Providers that serve consumers in multiple LMEs have even greater administrative barriers, with different LMEs using different contracts and procedures. DMHDDSAS has developed standardized policies and forms for use by LMEs as a means of reducing barriers.^{kkk} Some of the standardized forms and policies include contracts between LMEs and providers of Medicaid and state services, service definitions for Medicaid and state services, the consumer appeal process, the Standardized Consumer STR Interview and Registration Form, the LME Consumer Admission and Discharge Form, the incident report form, and the NC-TOPPS Initial Interview, Update Interview and Episode Completion Interview forms.^{lll,mmm} Other providers are unwilling to participate because of low reimbursement rates. Others may want to participate but are unable to because the service is not currently reimbursed by the state. For example, DMHDDSAS does not have a service definition that specifically covers long-term residential or therapeutic communities, potentially leaving out a class of licensed substance abuse providers.

Further, even when services are offered, they may not be provided with the level of intensity needed to help a person achieve sobriety. More than three-quarters (76.6%) of the adults and more than four-fifths of children (84.5%) served in the LME system are receiving the lowest intensity of services (outpatient treatment, Level I of the ASAM levels of care).^{nmm,109} Part of the underlying rationale for the mental health reform was to focus treatment on those most in need. However, providing the lowest level of treatment to more than three-quarters of the clients served suggests that the level of services provided is inadequate. DMHDDSAS needs to develop expectations for the LMEs about appropriate numbers of people served, the array of services available, intensity of services, and frequency of treatment.

The ability of the state to address the ongoing needs of people with addiction disorders rests in large part on the performance of the LMEs in engaging people into treatment, keeping people in treatment, and ensuring that people receive the right intensity of services. In turn, the ability of the LMEs to meet their responsibility rests in large part on the availability of a well trained workforce, adequate and flexible

The ability of the state to address the ongoing needs of people with addiction disorders rests in large part on the performance of the Local Management Entities in engaging people into treatment, keeping people in treatment, and ensuring that people receive the right intensity of services.

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- jjj Task Force members specifically identified reimbursement problems for long-term residential treatment programs and therapeutic communities as well as the adequacy of reimbursement rates for residential treatment and diversion programs. In addition to these issues, the Task Force recommended that the Division evaluate the availability of substance abuse services to determine if changes in service definitions or reimbursement policies could help address shortages in the availability of substance abuse services.
- kkk The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services has a complete list of standardized forms on their website, available at <http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/index.htm#forms>.
- lll Clark S. Community Policy Management, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, NC Department of Health and Human Services. Written communication regarding Division of Mental Health Developmental Disabilities, and Substance Abuse Services standardized forms. December 17, 2008.
- mmm Stein F. Chief, Community Policy Management, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, NC Department of Health and Human Services. Written communication regarding Division of Mental Health Developmental Disabilities, and Substance Abuse Services standardized forms. December 17, 2008.

funding sources to provide incentives for qualified providers to appropriately engage and treat people with addiction disorders, technical assistance from DMHDDSA to identify and address barriers to improvement and to transfer successful innovations from one LME to all LMEs and the internal management and leadership skills to promote change. Other states have begun to implement performance-based incentive contracts to improve the capacity of the substance abuse system.^{104,110}

The Task Force recommended that DMHDDAS develop and implement similar performance contracts to incentivize LMEs and providers to improve the substance abuse treatment system. Specifically, LMEs and providers must ensure that substance abuse services are accessible and that consumers receive services when they first seek care. A responsive system will also ensure that consumers are provided appropriate levels (intensity) of services, that they are engaged in treatment for long enough periods of time to be effective, and that they are provided recovery supports. If, with adequate funding, these recommendations do not yield meaningful improvements, then broader system redesign may be necessary.

To monitor performance, LMEs and providers must report standardized screening, triage and referral (STR), NC-TOPPS, consumer data warehouse (CDW) admissions and discharge, consumer perception of care, and IPRS and Medicaid claims data to DMHDDAS. These data systems are described more fully in Chapter 7.

To ensure that the LME system is effective in treatment people with addiction disorders, the Task Force recommends:

Recommendation 4.16 (PRIORITY RECOMMENDATION)

- a) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDAS) should develop a plan organized around a recovery-oriented system of care to ensure that an appropriate mix of substance abuse services and recovery supports for both children and adults is available and accessible throughout the state. The plan should utilize the American Society of Addiction Medicine (ASAM) levels of care. In developing this plan, DMHDDAS should:
- 1) Develop a complete continuum of locally and regionally accessible substance abuse crisis services and treatment and recovery supports.
 - 2) Ensure effective coordination of care between substance abuse providers within and between different ASAM levels of care as well as with other health professionals such as primary care providers, emergency departments, or recovery supports.
 - 3) Develop a minimum geographic-based access standard for each service. In developing its plan, DMHDDAS should identify strategies for building an infrastructure in rural and underserved areas.
 - 4) Include evidence-based guidelines for the number of patients to be served, array of services, and intensity and frequency of the services.

nmn This lowest level of intensity accounts for approximately one-half of all Local Management Entities spending on adults and about one-third of the spending for children.

- b) DMHDDSAS should work with be Local Management Entities and providers to develop a more comprehensive performance-based accountability plan that includes incentives and contract requirements between the Division, LMEs and providers.
 - 1) The plan should include meaningful substance abuse performance measures for LMEs and providers to ensure that: substance abuse services are successfully extended to a significant portion of those persons in need, substance abuse services are provided to individuals in a timely fashion, people are provided the intensity of services appropriate to their needs, people are engaged in treatment for appropriate lengths of time, individuals successfully complete treatment episodes, and that these individuals are provided appropriate recovery supports.
 - 2) This plan may include, but not be limited to, financial incentive payments, regulatory and/or monitoring relief, advantages in the competitive bidding process, independent peer review recognition, and broader infrastructure support.
 - 3) The plan should strengthen the Division's current performance benchmarking system for LMEs, including the establishment of more rigorous performance standards and targets for LMEs.
 - 4) The plan should develop a similar performance benchmarking system for LMEs to use with providers. The benchmarking system for providers should include, but not be limited to, measures of active engagement, consumer outcomes, fidelity with evidence-based or best practices, client perception of care, and program productivity.
 - 5) In developing the plan, DMHDDSAS, LMEs and providers should consider other incentive strategies developed by the National Institute on Drug Abuse Blending Initiative.
 - 6) The plan should include data requirements to ensure that program performance is measured consistently by LMEs and providers across the state.
- c) DMHDDSAS should develop a plan to implement electronic health records for providers that use public funds.
- d) DMHDDSAS should develop consistent requirements across the state that will reduce paperwork and administrative barriers including but not limited to:
 - 1) Uniform forms for admissions, screening, assessments, treatment plans, and discharge summaries that are to be used across the state.
 - 2) Standard contract requirements and a system that does not duplicate paper work for agencies that serve residents of multiple LMEs.
 - 3) Methods to ensure consistency in procedures and services across LMEs along with methods to enforce minimum standards across the LMEs. Enforcement methods should include, but not be limited to, remediation efforts to help ensure consistent standards.
 - 4) Standardized outcome measures.

- e) DMHDDSAS should develop a system for timely conflict resolutions between LME and contract agencies.
- f) DMHDDSAS should work with its Provider Action Agenda Committee to identify barriers and strategies to increase the quality and quantity of substance abuse services and providers in the state. These issues include, but are not limited to, administrative barriers, service definitions, and reimbursement issues.
- g) DMHDDSAS, in collaboration with the Department of Juvenile Justice and Delinquency Prevention and the Department of Public Instruction, should immediately begin expanding the capacity of needed adolescent treatment services across the state including new capacity in the clinically intensive residential programs, consistent and effective screening, assessment, and referral to appropriate treatment and recovery supports for identified youth. In addition, the plan should systematically strengthen early intervention services for youth and adolescents in mainstream settings such as schools, primary care, and juvenile justice venues.
- h) DMHDDSAS should report the plans specified in Recommendation 4.16.a-b, report on the progress in developing the plan for electronic health records in Recommendation 4.16.c, and report on progress made in implementing Recommendations 4.16.d-g to the NCIOM Task Force on Substance Abuse Services and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services no later than September 2008.

The Task Force also recommends providing enhanced funding on a competitive basis to develop model programs in six LMEs (one rural and one urban in each of the DMHDDSAS three regions). This pilot would implement the recovery-oriented system of care plan, pursuant to Recommendation 4.16, to test and evaluate this system of care before implementing it statewide.

Recommendation 4.17

- a) The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) should select six county or multi-county regions to develop and implement a recovery-oriented system of care.
- b) The North Carolina General Assembly should appropriate \$17.2 million in SFY 2010 and \$34.4 million in SFY 2011 to DMHDDSAS in recurring funding to support these six pilot programs. DMHDDSAS should make funding available on a competitive basis, selecting one rural pilot and one urban pilot in the three DMHDDSAS regions across the state. Funding should include planning, evaluation, and technical assistance. The pilot programs should:
 - 1) Identify those in need of treatment.
 - 2) Ensure or provide a comprehensive continuum of services for adolescents and adults. Services should include screening, counseling, brief treatment, and the full spectrum of American Society of Addiction Medicine (ASAM) services for both adolescents and adults.

- 3) Provide recovery supports for those who return to their communities after receiving substance abuse specialty care, including Oxford Houses or other appropriate recovery supports. The goal of the project is to reduce the length and duration of relapses that require additional specialty substance abuse care. Programs should work closely with existing recovery services, programs, and individuals and build on the foundations that exist in their local communities.
- 4) Ensure effective coordination of care between substance abuse providers within and between different ASAM levels of care as well as with other health professionals such as primary care providers, hospitals, or recovery supports.
- c) The North Carolina General Assembly should appropriate \$750,000 of the Mental Health Trust Fund or general appropriations to the DMHDDSAS to arrange for an independent evaluation of these pilot programs. The evaluation should compare the performance of the pilot programs to comparison (control) counties to determine whether the comprehensive pilot programs lead to increased number of patients served, timely engagement, active participation with appropriate intensity of services, and program completion.
- d) The DMHDDSAS should use the findings from the independent evaluation of the pilot programs implementing county or multi-county recovery-oriented systems of care to develop a plan to implement the successful strategies statewide. The plan should be presented to the Legislative Oversight Committee on Mental Health within six months of when the evaluation is completed.

The Task Force also recognized that any effort to reform the state's publicly-funded substance abuse system would fail without the proper infrastructure. As noted in Chapter 3, with the state's mental health reform DMHDDSAS was reorganized with few staff who concentrated solely on substance abuse services. Thirteen new staff positions are needed in the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to implement the Task Force's recommendations, including one full-time employee (FTE) recovery supports director, two FTE adult substance abuse treatment continuum regional consultants, one FTE DWI consultant, one substance abuse prevention services information system manager, two quality management substance abuse research analysts, three substance abuse prevention services and coalition development regional consultants, and three child and adolescent substance abuse treatment continuum regional clinical consultants.^{ooo} (See Appendix C for more description of position responsibilities).

^{ooo} A total of \$650,000 in recurring funds is needed for 13 new FTE positions. This would be matched with an additional \$325,000 in federal Medicaid funds. The funding would be used to support seven positions on the Best Practice Team and two positions on the Quality Management Team. These positions would cost approximately \$75,000 each (including benefits) for a total of \$675,000, of which approximately \$350,000 would be required from state-supported sources and \$325,000 through Medicaid match. Four additional positions are needed for the Prevention and Early Intervention Team at an anticipated cost of \$75,000 each. This totals \$300,000. Medicaid matching funds are not available for these positions.

Additionally, staff are needed in other state agencies to implement other Task Force recommendations.^{PPP} Thus the Task Force recommends:

Recommendation 4.18 (PRIORITY RECOMMENDATION)

The North Carolina General Assembly should appropriate:

- a) \$650,000 in recurring funds to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to hire 13 FTE staff to assist in developing and implementing a statewide comprehensive prevention plan, a recovery-oriented system of care, a plan for performance-based incentive contracts, and consistent standards across the state to reduce paperwork and administrative barriers; oversee and provide technical assistance to the pilot programs; and otherwise help implement the Recommendations 4.1-4.3, 4.9-4.10, 4.13, 4.14-4.17, and Recommendation 5.1, supra.
- b) \$100,000 in recurring funds to the Department of Public Instruction to hire staff to implement Recommendations 4.1-4.3 and 4.16 above.
- c) \$130,000 in recurring funds to Office of Rural Health and Community Care to hire a statewide coordinator and administrative support to work directly with the regional Community Care of North Carolina quality improvement specialists funded in recommendation 4.13 and to assist in implementing recommendation 4.14.
- d) \$81,000 in recurring funds and \$50,000 in nonrecurring funds to the Department of Health and Human Services, Division of Medical Assistance, to hire five positions to implement Recommendations 4.13-4.15 above.

^{PPP} The Division of Medical Assistance needs a total of \$81,000 in recurring funds to support five new positions. Two of these positions would be clinical positions with expertise in substance abuse who would be assigned to the Behavioral Health Section, working in collaboration with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the Office of Rural Health and Community Care, and the Division of Public Health in the planning, development, and implementation of the recommendations. The other three positions would be in the support sections of Rate Setting, Information Technology, and Program Integrity. The \$81,000 in state funds would be matched by federal funds. An additional \$50,000 is needed, in nonrecurring funds, to support programming changes at the Division of Medical Assistance's fiscal agent (EDS). This will allow the state to add new codes and service definitions to support changes in payments to providers.

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Substance Abuse Prevention and Treatment Programs Targeted to Specific Subpopulations

Chapter 5



In addition to the services provided to the general public through the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) system described in Chapter 3, other state agencies fund and/or provide prevention, treatment, and recovery supports. Most of these services are targeted to specific subpopulations, such as youth involved in the juvenile justice system, adults in workforce settings, welfare recipients or those involved with Child Protective Services, adults in the prison system or community corrections, or active or returning military. Sometimes, the services are provided through Local Management Entities (LMEs) or DMHDDSAS under a Memorandum of Agreement (MOA) with another agency. Other times, the services are provided jointly by DMHDDSAS and another state or local agency. In other cases, another state agency or organization provides the services directly.

This chapter is organized around subpopulations. The chapter begins with programs aimed at youth involved in the juvenile justice system and follows with a discussion of services available to adults whether as employees, families involved in Work First and/or Child Protective Services, adults in the criminal justice system, or active or retired military personnel. This report describes the programs and services available to these populations and highlights barriers, if any, which hamper effective prevention, early intervention, treatment, and recovery supports for these targeted populations.

CHILDREN, YOUTH AND YOUNG ADULTS Youth Involved in the Juvenile Justice System

The Department of Juvenile Justice and Delinquency Prevention (DJJDP) is responsible for providing prevention and intervention services to reduce delinquency, as well as providing treatment services and sanctions for juvenile offenders. Unlike the adult criminal justice system, the juvenile justice system is more rehabilitative in nature. By statute, the juvenile court can use a continuum of graduated sanctions to step up or down the intensity of control based on the risks and needs of the juvenile and his or her family. Juveniles are assessed at disposition to determine their risks and needs. This assessment includes questions about substance use. In 2007, 43% of juveniles were found to need further assessment or treatment for substance use.¹ The assessments are used by court counselors to determine the level and type of supervision a juvenile needs as well as the individual's plan of care. Adjudicated juveniles may be placed into community programs with varying levels of supervision. High-risk offenders may be placed into a Youth Detention Center or Youth Development Center.

Prevention and Intervention Services to Reduce Delinquency

Each county has a Juvenile Crime Prevention Council (JCPC) charged with assessing the need for juvenile delinquency prevention and treatment programs for at-risk

There are only a handful of programs funded by the Juvenile Crime Prevention Council that focus primarily on providing substance abuse services.

youth and their families.^a JCPCs are required to assess the risks of youth delinquency in the county and determine the availability of services to meet the needs of youth, including juveniles at risk of delinquency or those involved in juvenile justice system. The JCPCs are also charged with developing recommendations for the County Commissioners for services needed to meet the needs of at-risk youth. However, the array of services offered in particular counties is ultimately contingent on county funding or other funding sources.

Most JCPC funds are used to support broad prevention efforts. Thus, there are only a handful of JCPC-funded programs that focus primarily on providing substance abuse services. These include four programs providing substance abuse prevention services, two providing substance abuse assessments, and ten providing assessments and treatment services. JCPC-funded substance abuse services are geographically maldistributed, with few substance abuse programs available in the eastern parts of the state.¹ Although the majority of JCPCs do not fund programs whose primary purpose is to provide targeted substance abuse services, some do fund programs that provide general psychological assessment services and counseling services.

Community-Based Services for Juveniles Involved in the Juvenile Justice System

There are several programs that provide community-based services to youth with substance abuse problems involved in the juvenile justice system. The largest is the Managing Access for Juvenile Offender Resources and Services (MAJORS) program. It is available in a majority of counties throughout the state. The state also has juvenile drug treatment courts that supervise the treatment services for youth involved in the juvenile justice system. In addition, the state is piloting a DMHDDSAS-DJJDP Cross Area Service Program and partnering with Reclaiming Futures.

MAJORS: The MAJORS program provides the majority of substance abuse services for youth involved in the juvenile justice system. MAJORS is funded by DMHDDSAS and administered by DMHDDSAS in collaboration with DJJDP. MAJORS provides specialized community-based substance abuse treatment services to children and adolescents under 18 years of age who are involved in the DJJDP system and have substance abuse problems. Youth are referred to MAJORS by juvenile court counselors or judges.^b MAJORS provides substance abuse screening and assessment, therapy, life skills training, and ongoing monitoring. MAJORS staff also provide services to youth transitioning from youth development centers and residential programs back to their home communities. MAJORS is currently offered in 31 judicial districts spanning 61 counties.

Juvenile Drug Treatment Courts (JDTCs): JDTCs work with non-violent juvenile offenders whose drug and/or alcohol use is negatively impacting their lives at home, in school, and in the community. JDTCs may require that the child and family participate in treatment, submit to drug testing, appear at court hearings,

^a County commissioners in each county appoint members of a JCPC as mandated by General Statute. DJJDP provides funds to the JCPC that are matched by local funding sources.

^b Judges in JDTCs often refer youth to MAJORS as part of their court ordered treatment.

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and other conditions with the goal of rehabilitation and cessation of delinquent activity. JDTCs include a treatment court judge and court-based team who provide on-going, active involvement and oversight of the youth. The goals are to support youth to help them perform well in school, develop healthy family relationships, and connect to their communities. JDTCs are available in five counties.^c

In addition to these ongoing initiatives, DMHDDSAS, in collaboration with DJJDP and other agencies, are involved in testing two new models:

DMHDDSAS/DJJDP Cross Area Program: DMHDDSAS and DJJDP are currently developing a new system of providing substance abuse services to juveniles. This new model is a Cross Area Service Program that will provide a single point of contact for juvenile courts and court counselors, reduce over utilization of Community Support, be based on evidence-based practices and address substance use, mental health, and co-occurring disorders. MAJORS programs will function as a substance abuse services provider within the new model. Initially DMHDDSAS intended to pilot this program in each of the four DJJDP regions, but funding was only available to test the model in two regions. The first pilot program begins in January 2009. The University of North Carolina at Greensboro has received a contract to provide project management and to evaluate this model.

To ensure that the DMHDDSAS-DJJDP Cross Area Service Program model is adequately tested to determine its effectiveness before statewide implementation, the Task Force recommended:

Recommendation 5.1

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

Reclaiming Futures: Six Reclaiming Futures sites in North Carolina were officially launched in September 2008 by the Kate B. Reynolds Charitable Trust and the Robert Wood Johnson Foundation.^d The Robert Wood Johnson Foundation originally provided resources to 10 founding communities to create and test a 6-step model that helps young people in trouble with drugs, alcohol, and crime by reinventing

^c JDTCs are located in: Durham (Dist. 14), Forsyth (Dist. 21), Mecklenburg (Dist. 26), Rowan (Dist. 19C) and Wake (Dist. 10).

^d More information about reclaiming futures is available at: www.reclaimingfutures.org.

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treatment programs
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the way police, courts, detention facilities, treatment providers, and the community work together to meet this urgent need. While communities need to hold teens accountable for their actions, they must provide drug and alcohol treatment and support in the community. To be effective, treatment programs must work in a coordinated fashion and use evidence-based practices. They also must involve families, address cultural, age, and gender issues, and coordinate with judges, probation programs, and schools. The Reclaiming Futures framework and the goals of the DMHDDSAS-DJJDP Cross Area Service Program model are in alignment. DMHDDSAS and DJJDP will be working closely with these sites over the next two years.

Institutional Services

At the institutional level, juveniles in juvenile detention centers or youth detention centers are assessed for substance abuse problems and can receive substance abuse services.

Juvenile Detention Centers (JDCs): JDCs are short-term, secure facilities for youth who are waiting to go to court, being detained as part of a dispositional sanction, awaiting placement in a Youth Development Center (YDC), or needing secure custody until placement in an appropriate community setting can be found. Using DMHDDSAS funding, DHHS, through Memoranda of Agreement with DJJDP and the local county-operated detention centers, contracts with substance abuse professionals to provide assessments and counseling (group and individual) to youth detained in the detention facilities. There are nine state-operated and four county-operated detention centers in the state.^e

Youth Development Centers (YDCs): YDCs are state-operated residential facilities for juvenile offenders. YDCs provide screening and assessment services, medical and psychiatric services, individual and group counseling, psycho-educational groups, and intensive therapeutic interventions. There are five long-existing YDCs and four new YDCs that have opened as replacement beds.^f The MAJORS program provides referral and aftercare services for participating youth as they are released from YDCs.

ADULTS

Employees

Behavioral health problems often affect individuals' ability to be productive employees. Individuals with substance abuse problems may have performance or conduct problems—including attendance problems or diminished productivity—that adversely impact their job performance. Additionally, employees with substance abuse problems may be at increased risks for work related accidents and health care

^e State JDCs are located in the following counties: Alexander, Buncombe, Cumberland, Gaston, New Hanover, Perquimans, Pitt, Richmond and Wake. County-operated JDCs are located in Durham, Forsythe, Mecklenburg, and Guilford counties.

^f Current YDCs include: C.A. Dillon, Samarkand, Swannanoa, Dobbs, and Stonewall Jackson youth detention centers. These facilities will be replaced by a 96-bed facility in Cabarrus County and three 36-bed facilities in Chatham, Lenoir and Edgecombe counties.

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costs which impact employer costs. Loss of productivity, depression, and alcohol and drug addiction cost businesses \$287 billion each year.² Many companies turn to employee assistance programs (EAPs) to help them identify and resolve employee productivity problems because of the large impact that employees' personal concerns, including substance abuse, can have on a business's bottom line.

Employee Assistance Programs (EAP) are worksite-based programs that help identify and resolve productivity problems with employees. Employees identified with problems affecting their job performance are offered EAP assistance. EAPs use a combination of problem identification, assessment, constructive confrontation, and referral for diagnosis and treatment. For example, if an assessment reveals that an employee has a problem, such as substance abuse, the EAP then provides a referral for diagnosis, treatment, and assistance and may provide case monitoring and follow-up services. Ensuring the people with substance abuse problems obtain treatment helps the work environment. Studies show that reported job problems such as incomplete work, absenteeism, tardiness, work-related injuries, mistakes, and disagreements among employees are cut by an average of 75% among employees who have received treatment.³

Two EAP models exist: the Medical/Network Model, typically offered by some type of insurance company, and the Human Resources/Worksite Model, offered by an EAP service organization working closely with the company. Worksite Models are more visible in the workplace, have greater utilization, received more supervisory referrals, and identified more employee substance abuse cases than the Medical Model.⁴ However the Medical Model may cost less. A company's choice of EAP (if any) depends on many factors including the size and location of the firm, availability and fit of a network or worksite model, and cost.

Finding an affordable Worksite Model EAP can be quite challenging, especially for small rural firms. Many of these companies would benefit from using a local EAP service organization which has strong relationships with local services providers and can quickly respond in person to worksite concerns.

Recommendation 5.2:

- a) As part of the annual community assessment, Local Management Entities (LME) should explore and report on the need for Employee Assistance Program (EAP) services by employers in their catchment area and the availability of organizations providing EAP services to meet this need.
- b) If the LME determines that there are insufficient EAP providers to address the needs of employers, then the LMEs should work with the local Chambers of Commerce, other business organizations, and others to develop a strategy to promote the availability of EAP services in the community.

Loss of productivity, depression, and alcohol and drug addiction cost businesses \$287 billion each year.

North Carolina has a “title” licensure law that requires professionals who hold themselves out as Licensed Employee Assistance Professionals to be licensed by the North Carolina Board of Employee Assistance Professionals (NCBEAP). However, other non-licensed individuals also offer EAP services. As long as these individuals do not hold themselves out to be EAP professionals, North Carolina law does not require these individuals to have specific EAP training. Additionally, companies that profess to offer EAP services do not always provide the six core services, defined in the statute. These include: 1) Expert consultation and training of appropriate persons in the identification and resolution of job performance issues related to the employees’ personal concerns; 2) The confidential, appropriate, and timely assessment of problems; 3) Short-term problem resolution for issues that do not require clinical counseling or treatment; 4) Referrals for appropriate diagnosis, treatment, and assistance to certified or licensed professionals when clinical counseling or treatment is required; 5) Establishment of linkages between workplace and community resources that provide such services; and 6) Follow-up services for employees and dependents who use such services.^g

To ensure that professionals providing EAP services have actual training to provide the services and that EAP providers have the capability of providing all of the statutorily defined services, the Task Force recommends:

Recommendation 5.3:

The North Carolina General Assembly should ensure that by 2014:

- a) All individuals advertising and promoting themselves as providing Employee Assistance Program (EAP) services in North Carolina must be licensed or have EAP specific training and work under the supervision of professionals licensed to provide EAP services by the North Carolina Board of Employee Assistance Professionals.
- b) All programs or organizations located in North Carolina that advertise, or promote themselves, as providers of EAP services should be able to document that they have the capability of providing the core services as defined in statute and that the services are provided under the supervision of North Carolina licensed EAP staff.

Work First Recipients or Those Involved in the Child Protective Services System

The North Carolina Division of Social Services (DSS), within the North Carolina Department of Health and Human Services, is responsible for administering the Work First and Child Protective Services (CPS) system. The goal of the Work First program is to move families with dependent children into employment and self-sufficiency. However, substance abuse and mental health issues are significant barriers to self-sufficiency. All Work First applicants and recipients are screened

^g NCGS § 90-500(3).

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for possible substance abuse problems. If the outcome of the screening is positive, the individual is referred to a Qualified Professional in Substance Abuse (QPSA)^h for additional assessment and treatment if deemed appropriate by the QPSA. If an individual refuses to be screened or is non-compliant once referred to the QPSA, the individual is ineligible to receive Work First benefits.ⁱ

Substance abuse problems also contribute to cases of child abuse and neglect. In SFY 2006-2007, more than one-fourth (27.6%) of adults in the North Carolina CPS system with a finding of substantiated child abuse or neglect or services needed, had alcohol or substance abuse problems. More than one-third (37%) of the adults who had their children removed and placed in foster care also had alcohol or substance abuse problems.⁵ This is a very low estimate as the current state data system only lists the primary factor contributing to abuse, neglect, or removal from the home. Substance use or abuse is often listed as the second or third factor leading the substantiated cases of child abuse or neglect. According to studies by the Child Welfare League of America, alcohol and/or drug abuse are factors in the placement of at least 75% of children entering foster care.⁶

There are a number of different programs or services available to identify and treat adults with substance abuse problems who are receiving Work First or involved in the CPS system. The Work First/CPS Substance Abuse Initiative helps provide assessments, link adults into community treatment, provide care coordination, and provide case consultation with the Department of Social Services. District courts also supervise treatment for some adults who have lost, or are at risk of losing their children due to abuse, neglect or dependence. In these instances, substance abuse treatment may be required as a condition of reunification. In addition, North Carolina is piloting a new, more coordinated system to provide services to families with children at risk of out of home placements or who have been placed out-of-home due to their parents' substance use. This initiative is called Bridges for Families. The state also offers more intensive residential services to some women and children.

Community Based Services

The Work First/CPS Substance Abuse Initiative was designed to provide early identification of Work First recipients who have substance abuse problems severe enough to impact their ability to become self-sufficient. This initiative was also designed to help parents involved with CPS who have substance abuse problems engage in appropriate treatment. This program is funded by DMHDDSAS, administered by the LMEs, and operates in accordance with a memorandum of

According to studies by the Child Welfare League of America, alcohol and/or drug abuse contribute to the placement of at least 75% of children entering foster care.

^h A Qualified Professional in Substance Abuse includes: an individual who holds a license, provisional license or certification from the NC Substance Abuse Professional Practice Board; is a graduate of a college or university with a Masters degree in a human service field and who has one year of full-time, post-graduate degree accumulated supervised experience in alcoholism and drug abuse counseling; is a graduate of a college or university with a bachelor's degree in a human service field and who has two years of full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling; or is a graduate of a college or university with a bachelor's degree in a field other than human services and who has four years of full-time, postbachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling.

ⁱ North Carolina General Statutes. § 108A-29.1. substance abuse treatment required; drug testing for work first program recipients.

agreement between DMHDDSAS and DSS at the state and local levels. Each LME receives funding to support this initiative. Qualified Professionals in Substance Abuse (QPSAs) are outstationed, when possible, in the local departments of social services to provide screening, assessment, care coordination, and referral to treatment. Ideally, QPSAs, LMEs, and the Work First case manager or CPS worker jointly develop a substance abuse treatment plan for the family to ensure success.

Substance abuse services are typically provided by local substance abuse professionals under contract with the LMEs. However, in many communities, there is a lack of coordination between the QPSAs, LMEs, and DSS workers which hampers the most effective provision of services to these families. Further, there are insufficient substance abuse resources to meet the needs of all families who need services. There is high turnover of QPSA staff and a limited availability of QPSA staff for county DSS offices. Further, limited treatment services are available locally.⁷ The federal government conducted a review of the North Carolina Child and Family Services system in March 2007 and identified the lack of substance abuse services—both in terms of accessibility and the array of services offered—as a primary concern.⁵

To address the shortage of QPSAs in the Work First/CPS program, the Task Force recommended:

Recommendation 5.4

The North Carolina General Assembly should appropriate \$475,000 in recurring funds to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for seven full-time Licensed Clinical Addiction Specialists to be distributed to the Local Management Entities with the highest number of referrals for the Work First, Class H or I Controlled Substance felons, and Child Protective Services populations compared to existing Qualified Professionals in Substance Abuse.

District Court: District courts judges preside over civil abuse, neglect, and dependency hearings. Parents whose children have been removed from their care in abuse, neglect or dependency cases cannot regain custody of their children until they complete a recommended course of treatment and/or other services and stipulations. The Administrative Office of the Courts (AOC) has entered into a Memorandum of Agreement with the Division of Social Services regarding coordination of efforts and responsibilities related to those children and families served in district court in abuse, neglect, or dependency cases.

While District Courts typically serve families with cases of abuse, neglect, or dependency, Family Drug Treatment Courts (FDTCs) are also available in some judicial districts. FDTCs work with parents who have been determined to be addicted or have a high likelihood of addiction to drugs and/or alcohol and who have lost custody or are in danger of losing custody of their children due to abuse and/or neglect. FDTC participants are also assessed for domestic violence, trauma, and other mental health concerns and are referred to treatment. Although the FDTC cannot promise that the children will be returned to the parents if they

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successfully complete treatment, a parent who is successful in the FDTC is much more likely to be determined by DSS and the Abuse, Neglect, and Dependency Court to be fit to have their child(ren) returned. Parents who do not comply with the requirements of the FDTC will be sanctioned by the court and may be ordered to serve jail time.^{j,k}

Bridges for Families: In addition to the ongoing services available through the Work First/CPS Substance Abuse Initiative or offered in conjunction with abuse, neglect and dependency cases, North Carolina obtained a five-year, \$2.5 million grant from the US Department of Health and Human Services for Children and Families to provide more coordinated substance abuse treatment and services to families with children at risk of out-of-home placement due to their caretaker's substance abuse problems. The initiative, Bridges for Families, is being piloted in Robeson County. It is an attempt to create a broad-based community collaborative that implements evidence-based programs and practices involving the family drug treatment courts, LME, and child welfare programs.⁸ This initiative is in the early stages of implementation and will be evaluated. If successful, the state will determine whether it should be implemented statewide.

Residential Services

While offering a comprehensive array of outpatient services will help meet the needs of many people with addiction disorders, some individuals need more intensive services than can be offered on an outpatient basis. DMHDDSAS offers a limited number of residential placements for certain women with more intensive needs through CASAWORKS for Families and the Maternal and Perinatal Substance Abuse Initiative.

CASAWORKS for Families Residential Initiative: The NC CASAWORKS for Families Residential Initiative is a collaborative project between DMHDDSAS and DSS. This Initiative supports nine comprehensive residential substance abuse programs for Work First women and their children. To help Work First families become economically self-sufficient, this program integrates gender-specific substance abuse treatment and job readiness supports, vocational training, and employment.⁹

Maternal and Perinatal Substance Abuse Initiative: There are currently 21 perinatal and maternal substance abuse residential programs, 12 residential, and 9 comprehensive outpatient. On average, about half of the women in the program are mandated into treatment, and of these, 75% were mandated into treatment by DSS.⁸ These programs provide comprehensive family-focused, gender-specific substance abuse services that include, but are not limited to, screening, assessment, case management, outpatient services, parenting skills, residential care, referrals for preventive and primary care, and referrals for appropriate interventions for

While offering a comprehensive array of outpatient services will help meet the needs of many people with addiction disorders, some individuals need more intensive services than can be offered on an outpatient basis.

j FDTCs are located in: Buncombe (Dist. 28), Chatham (Dist. 15B), Cumberland (Dist. 12), Durham (Dist. 14), Gaston (Dist. 27A), Halifax (Dist. 6A), Lenoir (Dist. 8), Mecklenburg (Dist. 26), Orange (Dist. 15B), Robeson (Dist. 16B), Union (Dist. 20), and Wayne (Dist. 8).

k FDTC team members include: Juvenile Court Judge, DSS/County Attorney, Parent Attorney, Guardian ad Litem, County Department of Social Services staff, FDTC Coordinator and Treatment professional(s). The court team may also include professionals from the Health Department, Housing or others.

Approximately 90% of the criminals who enter the prison system have a substance abuse problem, and 63% require residential treatment.

the children. The goal of this initiative is to help the women achieve abstinence, improve birth outcomes, develop and strengthen parenting skills, establish a stable living environment free of domestic or family violence, and develop a safety net of recovery and emotional support.

Adults Involved the Criminal Justice System

Use and abuse of alcohol and other drugs can contribute to disorderly and illegal behaviors. Many of the people arrested for criminal activities have underlying addiction disorders. Driving while impaired is a criminal offense; more than one-quarter of motor vehicle fatalities involved the use of alcohol. Approximately 90% of the criminals who enter the prison system have a substance abuse problem, and 63% required residential treatment.¹⁰ In response to these problems, North Carolina agencies have developed special substance abuse assessment, treatment and monitoring programs for people convicted of driving while impaired, including those who have been convicted and are serving their sentences or probation in the community (community services) as well as for those serving active prison sentences (institutional services).

There are two major considerations which significantly impact on the success of substance abuse treatment for adult offenders. First, sufficient resources must be available to pay for the necessary treatment services and supervision. Second, individuals must be offered and stay in treatment for long enough periods of time for the treatment to be effective.

Four national studies, which began as early as 1968 and ended as recently as 1995, assessed approximately 70,000 patients, 40% to 50% of whom were court ordered or otherwise mandated into residential and outpatient treatment programs. Two major findings emerged. First, the length of time a patient spent in treatment was a reliable predictor of his or her post-treatment performance. Beyond a 90-day threshold, treatment outcomes improved in direct relation to the length of time spent in treatment, with one year generally found to be the minimum effective duration of treatment. Second, coerced patients tended to stay in treatment longer than their non-coerced counterparts. In short, the longer a patient stays in drug treatment, the better the outcome.¹¹⁻¹⁴

Community-Based Services for People Convicted of Driving While Impaired

In 1983, the North Carolina General Assembly enacted the Safe Roads Act, which repealed all previous laws on drunk driving in North Carolina and replaced them with a single offense of Driving While Impaired (DWI). As a result of this change, North Carolina developed a substance abuse intervention system for individuals with DWI offenses. The system requires individuals undergo a clinical substance abuse assessment and then complete an educational program or treatment as determined by the assessment. While DWI offenders use the court system like others involved in the criminal system, the treatment system for DWI offenders has evolved as its own system, largely because the vast majority of DWI offenders receive treatment through the private sector, unlike other adult criminal offenders receiving publicly financed services.

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In North Carolina, 5.4% of motor vehicle crashes are committed by people who are under the influence of alcohol or drugs.¹⁵ However, 29% of motor vehicle fatalities were alcohol-related in 2007—an increase of 66 alcohol-impaired driving fatalities from the previous year—representing the largest increase in number of fatalities among all the states.¹⁶ Individuals who have either been convicted of driving while impaired, or are under 21 and have been found to be under the influence of alcohol or drugs while driving, have their drivers licenses revoked.

In order to have their licenses restored by the Division of Motor Vehicles (DMV), individuals must have a substance abuse assessment and complete any required education or treatment services. Individuals who do not have significant risk factors or clinical symptoms of a substance use disorder must complete an educational intervention called Alcohol and Drug Education Traffic School (ADETS). Individuals with a substance use disorder must complete substance abuse treatment which may include short-term outpatient, longer-term outpatient, day treatment/intensive outpatient, or residential/inpatient treatment. In SFY 2007, of the 28,097 assessments reported, 84% were referred to some form of substance abuse treatment.¹⁷ The majority of these services are provided through private agencies and paid for by the individual. Slightly over 2% of individuals received publicly-funded substance abuse services. DMHDDSAS authorizes and monitors agencies that provide DWI-related services and verifies the completion of services prior to the DMV considering restoration of an individual's driver's license.

Community Services for other Adult Offenders

Most adult offenders remain in the community where they are supervised and referred to services and supports that are provided by a variety of state, local, and non-profit agencies. There are multiple agencies involved in the provision of services, oversight, or care coordination for adult offenders with substance abuse disorders. For example, Treatment Accountability for Safer Communities program (TASC) provides screening, assessment, and care management services. This program is administered by DMHDDSAS. The Criminal Justice Partnership Program (CJPP) provides grants to support community-based programs, including some programs that address the needs of people with substance abuse problems. This is funded through the Division of Community Corrections (DCC). In addition, some counties operate adult drug treatment courts. These courts are operated through the Administrative Office of the Courts (AOC).

These three agencies, DCC, AOC, and DMHDDSAS, developed an interagency Memorandum of Agreement to improve communication and coordination of the adult offenders with substance abuse disorders. This interagency coordination occurs through the Offender Management Model (OMM), a team-based approach to manage the treatment and ongoing monitoring of offenders sentenced to

Twenty-nine percent of motor vehicle fatalities were alcohol-related in 2007—an increase of 66 alcohol-impaired driving fatalities from the previous year—representing the largest increase in number of fatalities among all the states.

In SFY 2008, Treatment Accountability for Safer Communities provided screening, assessment, and case management services for individuals involved in the criminal justice system who needed substance abuse and/or mental health services...however, more than 75,000 people may need these services.

intermediate punishments or community punishments or people who have been released from prison who are completing a treatment program.^l

Under the OMM model, the Courts (primarily through existing Drug Treatment Courts) provide judicial oversight and intervention. The DCC serves as the lead agency for adult criminal offenders who remain in the community. They provide supervision to offenders on probation or who were sentenced to the community service work program. To remain in the community, probationers must work, pay taxes and restitution, support their families, perform community services, and participate in treatment or other order support services. DMHDDSAS provides care management through TASC (Treatment Accountability for Safer Communities), overseeing all treatment support services including screening, assessment, and treatment services. DCC, through the Criminal Justice Partnership Program, provides and/or funds treatment services in local communities.^m These programs are described in more detail below.

Treatment Accountability for Safer Communities (TASC): TASC is administered by DMHDDSAS and provides screening, assessment, and care management services for individuals involved in the criminal justice system who needed substance abuse and/or mental health services.¹⁸ TASC care managers work in conjunction with partner agency staff to link clients to appropriate levels of treatment and support, using the authority of the criminal justice system to engage and retain people in treatment with the goal of reducing drug use and corresponding criminal behavior. An NC Sentencing and Policy Advisory Commission recidivism study found that adult offenders who received TASC services and completed their treatment were less likely to be rearrested over the next 2 years.¹⁹

TASC services are available in all 100 counties throughout the state. In SFY 2008, TASC served more than 18,000 people but did not have the resources to serve all in need. In SFY 2008, the Division of Community Corrections supervised 24,773 offenders convicted of non-trafficking drug offenses; however, as many as 75,710

^l Intermediate and community levels of punishment are outlined in North Carolina's structured sentencing guidelines. An intermediate punishment requires that the offender be placed on supervised probation with one or more of the following special conditions: split sentence, electronic house arrest, intensive supervision, day reporting center and drug treatment court. Generally, offenders must follow strict rules, work, pay restitution, and participate in drug or other types of treatment. A community punishment is generally thought of as basic probation (does not involve prison, jail time or an intermediate punishment). A community punishment may also include fines, restitution, community service and/or substance abuse treatment.

^m Case management for adult offenders, provided by probation officers, includes general supervision, monitoring to ensure compliance with Court orders, providing feedback to the Court, and connecting offenders with services in the community. Care management for adult offenders, provided by TASC, includes securing and coordinating mental health and substance abuse services.

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people may need substance abuse services.ⁿ To adequately begin serving this population, TASC needs an additional 258 care managers with a caseload of 60 offenders and 18 additional clinical supervisors to provide supervision to care managers. This will cost approximately \$14 million. The North Carolina General Assembly should incrementally increase appropriations to the TASC program by \$2.8 million over five years to provide drug treatment to offenders who have been placed on probation or released back into the community.

To further expand the availability of TASC services, the Task Force recommends:

Recommendation 5.5

The North Carolina General Assembly should appropriate \$2.8 million in recurring funds in SFY 2010 and an additional \$2.8 million in recurring funds in SFY 2011 to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to expand the availability of Treatment Accountability for Safer Communities (TASC) program services.

Criminal Justice Partnership Program (CJPP): CJPP provides grants to support community-based programs aimed at reducing recidivism, probation revocations, alcoholism and other drug dependencies, with the goal of decreasing the costs of incarceration to the state and counties. DCC administers the CJPP program. TASC care managers may link offenders to programs funded by CJPP in their community. The eligible offender population includes adult sentenced offenders who receive an intermediate punishment, post-release offenders, and parole offenders.

There are 83 CJPP funded programs operating in 93 counties. CJPP operates three types of programs: Day Reporting Centers, Resource Centers, and Satellite Substance Abuse Programs.^o Services offered through CJPP programs include combinations of substance abuse treatment, drug testing, cognitive behavioral interventions, employment assistance, and academic/vocational education assistance.²⁰ In some small, rural counties, particularly in the eastern and western parts of the state, CJPP resources represent the sole source of substance abuse treatment services for offenders.

The Criminal Justice Partnership Program provides grants to support community-based programs aimed at reducing recidivism, probation revocations, alcoholism, and other drug dependencies, with the goal of increasing the costs of incarceration to the state and counties.

n The US Department of Justice estimated that about 67% of people on probation “can be characterized as alcohol- or drug- involved offenders.” (Bureau of Justice Statistics, Special Report. Substance Abuse and Treatment of Adults on Probation, 1995. March 1998. NCJ 166611). There are currently approximately 113,000 people on probation in North Carolina, which suggests that as many as 75,710 people on probation may need substance abuse services. TASC is currently serving only 18,045 people.

o *Day Reporting Centers* (DRCs) offer a variety of treatment and support services, including drug screening, regular and intensive outpatient treatment services, cognitive behavioral interventions, education and employment assistance, and supportive and aftercare services. DRCs are open both day and night to facilitate compliance and to work within the schedules of offenders. DCC officers are housed within each center, providing a measure of control alongside treatment. There are currently 20 DRCs located throughout the state.

Resource Centers are similar to DRCs except that they are not required to offer a set of core services. Services are based on community need and funding constraints. There are currently 18 resource centers operating in the state.

Satellite Substance Abuse (SSA) Programs provide a central point of contact for substance abuse assessment, treatment, and aftercare services. Services are provided through contractual agreements with substance abuse treatment providers in the community. DCC officers provide oversight and program compliance. There are 44 SSA programs throughout the state.

To further expand the availability of CJPP-funded substance abuse services, the Task Force recommends:

Recommendation 5.6

The North Carolina General Assembly should appropriate \$500,000 in recurring funds in SFY 2010 to the Division of Community Corrections to expand the availability of Criminal Justice Partnership Program (CJPP)-funded substance abuse services.

Individuals who are involved in the drug treatment courts are subject to frequent alcohol and drug testing and receive sanctions and incentives based upon their compliance with the court expectations.

Adult Drug Treatment Courts (DTCs): Adult drug treatment courts operate in 21 counties and receive referrals from public defenders, judges, prosecutors, probation officers, and/or private defense attorneys.^p Each referral is screened for legal eligibility based on local court policies and likelihood of chemical dependency based upon the Substance Abuse Subtle Screening Inventory II (SASSI). All Adult DTCs limit eligibility to individuals addicted to alcohol and/or other drugs. DTCs use a court-based legal supervision and treatment team to provide intensive case management and judicial supervision to ensure that the individuals remain active in treatment and other support services. Individuals who are involved in the DTCs are subject to frequent alcohol and drug testing and receive sanctions and incentives based upon their compliance with the court expectations.

To better match DTC eligibility to the public treatment available for offenders, Adult DTCs, funded by the AOC, target sentenced, intermediate punishment offenders or community punishment offenders at risk of revocation. Those adult DTCs that admit DWI offenders target sentenced Level 1 and 2 DWI offenders (highest risk) who have an accompanying charge of Driving While License Revoked.

Typically, North Carolina's drug treatment courts begin through federal grants. This is done to provide the community an opportunity to launch the court and work through any systemic challenges. However, once implemented the courts require on-going funding from the state. Providing funding solely to the AOC to sustain the work of the drug treatment courts is not sufficient; for drug treatment courts to be successful, the services that support such courts (treatment services, oversight, and monitoring) must also receive additional funding.

To ensure that sufficient resources are available to fund additional drug treatment courts, the Task Force recommended:

^p Adult DTCs are located in: Avery (Dist. 24), Buncombe (Dist. 28), Brunswick (Dist. 13B), Burke (Dist. 25), Carteret (Dist. 3B), Caswell (Dist. 9A), Catawba (Dist. 25), Craven (Dist. 3B), Cumberland (Dist. 12), Durham (Dist. 14), Forsyth (Dist. 21), Guilford--one in Greensboro and one in High Point (Dist. 18), McDowell (Dist. 29A), Mecklenburg--five criminal DTCs (Dist. 26), New Hanover (Dist. 5), Person (Dist. 9A), Pitt (Dist. 3A), Orange (Dist. 15B), Randolph (Dist. 19B), Rutherford (Dist. 29A), and Wake (Dist. 10). Adult DTC team members include: District or Superior Court Judge, Assistant District Attorney, Defense Attorney, Specialized Probation Officer, TASC provider, DTC Coordinator and Treatment professional. The courts may also include professionals from the Health Department, Housing, Vocational/Rehabilitation, or others.

Recommendation 5.7 (PRIORITY RECOMMENDATION)

- a) The North Carolina General Assembly should increase the annual appropriations to the Administrative Office of the Courts to fund eight new adult drug treatment courts. The amount of the increased appropriations should be as follows:
 - 1) \$500,000 in recurring funds in SFY 2010 for four new adult drug treatment court coordinators
 - 2) \$500,000 in recurring funds in SFY 2011 for four new adult drug treatment court coordinators
- b) The North Carolina General Assembly should increase the appropriations to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services by \$570,000 in recurring funds in SFY 2010 and an additional \$570,000 in recurring funds in SFY 2011 to support treatment services for adult drug treatment court participants.
- c) The North Carolina General Assembly should increase the annual appropriations to the Department of Correction, Division of Community Corrections, by \$269,940 in recurring funds in SFY 2010 to fund four new probation officers and an additional \$269,940 in recurring funds in SFY 2011 to fund an additional four probation officers to support the new drug treatment courts.

Institutional Services

At the institutional level, most prisoners receive an assessment upon entering prison in North Carolina.⁹ Prison officials are trained through the Substance Abuse Screening and Intervention Program to provide substance abuse screening and assessments in order to identify appropriate treatment services.^{r,21} Of the 23,111 offenders screened in SFY 2007, 63% needed residential substance abuse treatment, and another 23% needed some other substance abuse intervention.¹⁰ In total, almost 90% of the offenders who were screened had an underlying substance abuse problem. The Division of Alcoholism and Chemical Dependency (DACDP) provides different levels of substance abuse services, depending on the needs of the prisoners: DACDP intervention-48 programs, intermediate DACDP programs, long-term treatment programs, and DART-Cherry therapeutic community.

q In SFY 2007, 86% of all offenders who entered prison were screened, using the Substance Abuse Subtle Screening Inventory (SASSI), a validated screening instrument. Some prisoners are not screened when they enter prison due to serious health conditions, language barriers, or other issues.

r The Substance Abuse Screening and Intervention Program (SASIP) is a statewide program that provides drug testing lab services, training for DCC officers and outside agencies on drug testing procedures, education of DCC officers on drugs and other substance abuse issues, and trend monitoring.³³ (Division of Community Corrections, North Carolina Department of Correction. Coming together: annual report of program services, FY2005-2006. <http://www.doc.state.nc.us/dcc/annualreport/2005-06Annual%20Rpt%20Programs.pdf>. Accessed March 28, 2008.)

Because of limited resources, only about one-third of the prisoners who need services receive them.

DACDP Intervention-48: The DACDP Intervention-48 program is designed to provide 48 hours of content over a period of six to eight weeks for male and female prison inmates determined to be substance abusers, but not dependent. This program is under implementation across the prison system in late summer and fall of 2008.

Intermediate DACDP programs: Intermediate programs range from 35-180 days and are available in 13 residential settings located in prisons across the state for male and female prison inmates.

Long-term treatment programs: There are 2 types of long-term treatment programs: those offered directly in the prison system (5 programs) and those provided under contract with private treatment facilities (2 facilities). Each is designed to treat seriously addicted male and female prison inmates. Participants remain in long-term treatment programs for 180-365 days.²²

DART-Cherry Therapeutic Community: DART-Cherry is a community-based residential treatment program for male probationers/parolees. DART offers one 28-day program (100 beds), and two 90-day programs (100 beds each). The North Carolina General Assembly funded a female version of this program in Black Mountain for 50 beds in 2008.

Altogether there were 1,490 treatment beds in SFY 2007. Between SFY 2001-2007, the prison population grew by 20% (from 31,899 to 38,423), but the treatment beds declined by 21% (from 1,898 to 1,490).²¹ Because of limited resources, only about one-third of the prisoners who need services receive them.

Other states have had success developing single mission treatment prisons for inmates with substance abuse addiction disorders. The Sheridan drug prison and reentry program in Illinois has been shown to be successful in reducing recidivism among offenders (either re-arrest or re-incarcerations). The Sheridan prison offers a therapeutic community that provides drug treatment and cognitive skills development, as well as mental health services. Inmates are also required to participate in job preparedness programs prior to release to give them the skills needed find work. TASC works with offenders while still in prison to develop reentry plans including ongoing treatment and recovery supports. After the first year of operation, an evaluation found that those released from the Sheridan drug prison and reentry program had a 21% lower risk of re-arrest for a new crime, with those who had been in the program for longer periods of time experiencing an even lower re-arrest rate. Offenders who had nine or more months of the Sheridan program also had a much lower risk (49%) of re-incarceration than a comparison group.²³

In order to more adequately address the needs of prisoners with substance abuse problems, the Task Force recommended:

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Recommendation 5.8:

The North Carolina General Assembly should:

- a) Appropriate \$1,500,000 in recurring funds in FY 2010 to the North Carolina Department of Correction, Division of Alcoholism and Chemical Dependency Programs, to expand the availability of state substance abuse services to adults within the prison system.
- b) Appropriate \$2,000,000 in recurring funds in FY 2010 to the Department of Correction, Division of Alcoholism and Chemical Dependency Programs, to build one additional residential treatment facility for female adult offenders with substance abuse and addiction problems who are on probation or parole.
- c) Appropriate \$1,000,000 in recurring funds in FY 2010 to the North Carolina Department of Correction, Division of Alcoholism and Chemical Dependency Programs, to expand the existing residential treatment facility at DART Cherry in Goldsboro for adult male offenders with substance abuse and addiction problems who are on probation and parole.
- d) Appropriate \$12,500 in non-recurring funds to the Department of Correction, Division of Alcoholism and Chemical Dependency Programs, to study the feasibility of establishing a single mission drug treatment and re-entry prison for offenders with substance abuse and addiction problems.

MILITARY PERSONNEL

North Carolina has the fourth largest number of military personnel in the country. In North Carolina, there are currently 107,000 active duty personnel based at one of seven military bases or deployed overseas.²⁴ Because of base closings and consolidations across the nation, North Carolina is likely to receive another 45,000 active duty members by 2011. There are another 11,500 soldiers, marines, and airmen who live in North Carolina and serve in the National Guard or reserves. Most of the active duty military, reserves, and National Guard have served in Operation Iraqi Freedom (OIF) or Operation Enduring Freedom (OEF) in Afghanistan. In addition to these men and women actively serving in our armed forces, we have another 773,630 veterans who live in North Carolina.

Alcohol and other drug use is a serious problem for many in the military. Almost one-fourth (24%) of active duty military personnel reported alcohol dependence symptoms in a recent Department of Defense anonymous survey of health-related behaviors among active duty personnel.²⁵ Similarly, 24% of the returning National Guard reported alcohol abuse.²⁶ The rate of all psychological problems, including substance abuse, increases with repeated deployments. As of March 2007, of the 1.4 million United States' military troops that have served in Iraq or Afghanistan, approximately 30% have been deployed more than once.²⁷ Nearly 25% of National Guard and Reservists have been deployed more than once.²⁷ Further, many of the returning veterans report post-traumatic stress disorder, depression and substance abuse disorders. A study of more than 88,000 soldiers who returned from active duty in Iraq showed that 20.3% of active duty soldiers and 42.4% of the National

Alcohol and other drug use is a serious problem for many in the military.

While some mental health and substance abuse services are available to active and returning military personnel and their families, these services are not sufficient to address all of the needs of the returning veterans.

Guard and reserve component were identified as needing mental health or substance abuse treatment post-deployment.²⁸

TRICARE provides health care services to active duty service members, retirees, their families, survivors and certain other individuals connected to the military as well as National Guard and Reserve members while they are active. TRICARE, through its contract with the Department of Defense, provides treatment at military treatment facilities or through a broader civilian provider network. In addition to TRICARE, the Veterans Administration (VA) provides health services to certain veterans. Returning OEF/OIF veterans are entitled to five years of free care after returning from active duty for health problems related to their military service.²⁹ Veterans who have a combat-related disability may continue to receive health care services after the initial five-year period, but may have to pay income-related copayments. There are four VA medical centers, three outpatient clinics, six community-based outpatient clinics, and five vet centers in North Carolina.⁵ Both the VA and the active military have moved to integrating mental health and substance abuse services into the primary care setting. In North Carolina, three VA centers have collocated mental health and substance abuse professionals in the primary care setting, making these services more accessible to a broader array of veterans.³⁰

While some services are available to active and returning military personnel and their families, these services are not sufficient to address all of the needs of the returning veterans. The state and federal governments, community agencies, and other partners have been working together since 2006 as part of the North Carolina Focus on Returning Combat Veterans and their Families. The goal of this initiative is to develop broader systems of care for returning veterans and their families, including mental health and substance abuse services. As part of this initiative, the Alcohol and Drug Counsel of North Carolina is developing a statewide registry of trained Licensed Clinical Addiction Specialists who can respond to requests for assistance from the Guard and Reservists for substance abuse problems. In addition, the Governor's Institute on Alcohol and Substance Abuse, AHEC, Behavioral Healthcare Resource Program at the School of Social Work at The University of North Carolina at Chapel Hill, and the Durham VA Medical Center developed a statewide training initiative to increase the skills and awareness of community mental health, substance abuse, and medical practitioners on the medical and behavioral health needs of returning veterans and their families.^{t,31} While the training can be made available and tailored to different health professionals across the state, more work is needed to ensure that this information is disseminated more broadly. For example, health professionals may be unaware of the need to

s The VA Medical Centers are located in Asheville, Durham, Fayetteville, and Salisbury. The outpatient clinics are located in Charlotte, Hickory and Winston-Salem. There are six community based outpatient clinics located in Durham, Greenville, Jacksonville, Morehead City, Raleigh and Wilmington. In addition, there are five Vet centers located in Charlotte, Fayetteville, Greenville, Greensboro, Greenville, and Raleigh. United States Department of Veterans Affairs. <http://www1.va.gov/directory/guide/state.asp?STATE=NC>.

t AHEC provides 6-hour trainings for different health professionals, and one-hour webinars are available to primary care providers through I-CARE.

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check returning veterans or their families for post traumatic stress disorder, depression, or substance abuse disorders. School personnel outside of military communities may not know about a parent's connection to the National Guard or reserves, and thus may not know when a child's discipline problem is due to the deployment or return of a parent from OEF/OIF.

Returning veterans and their families often need other non-health related services. North Carolina has a 24-hour, 7-day a week, 365-day a year information and referral hotline, NC Care Link, which can help link veterans and their families to services at www.nccarelink.gov.^u In addition, the VA offers other services, such as housing vouchers, for returning veterans. However, returning veterans do not always know about the availability of these services. The VA also offers the annual Homeless Providers Grant and Per Diem Program to fund community agencies providing supportive housing, such as transitional housing, and service centers to homeless veterans. The grants provide 65% of funding for construction, renovation, or acquisition of buildings for supportive housing or service centers. Recipients must provide the remaining 35% in matching funds.³²

Because North Carolina has such a large number of returning veterans who are living throughout the state, the Task Force recommended:

Recommendation 5.9

- a) The Veterans Administration should:
 - 1) Continue to work with appropriate partners to provide training for mental health and substance abuse professionals, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and Local Management Entities agency staff, primary care providers, psychiatrists, school personnel, and other appropriate organizations about the medical and behavioral health needs of returning veterans and their families.
 - 2) Provide consultation services for veterans being treated by community-based primary care providers, mental health, or substance abuse professionals.
 - 3) Work with the North Carolina Division of Social Services, Department of Housing and Urban Development, and other community agencies to ensure that veterans learn of other support services, such as housing vouchers, employment opportunities, and family services.
- b) The North Carolina General Assembly should appropriate \$200,000 to pay the 35% match for the Veterans Administration Homeless Providers Grant and Per Diem Program for transitional housing for homeless veterans with substance abuse or mental health disorders.

^u North Carolina operates a statewide information and referral system, NC Care Line, that is available to anyone throughout the state. NC Care Line also has specific referral information for veterans and their families. Information can be accessed through the internet at: <http://www.nccarelink.gov/> or at: 1-800-662-7030.

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As noted in the preceding chapters, North Carolina should offer community-based prevention programs and early intervention services to prevent people from becoming addicted to tobacco, alcohol or other drugs. In addition, the state needs to develop an accessible recovery-oriented system of care to ensure that the 8.5% of the state's population with addiction disorders can obtain appropriate treatment and recovery supports. The Task Force developed a roadmap that, if implemented, would make significant progress in delaying initiation, decreasing use, and reducing addiction disorders among our population. However, even with increased funding, North Carolina will have difficulties implementing these services and supports without an adequate substance abuse workforce. North Carolina has begun to build a cadre of qualified substance abuse professionals, but more people are needed to expand the supply of licensed and certified substance abuse providers, as well as physicians and other health care professionals, and counselors with addiction training.

Supply Of Substance Abuse Professionals

Various types of professionals are authorized to provide substance abuse services. The North Carolina Substance Abuse Professional Practice Board (NCSAPPB) was given statutory authority in 1994 to credential different types of substance abuse professionals.^a Currently, the NCSAPPB offers seven different types of substance abuse credentials: Licensed Clinical Addiction Specialists (LCAS), LCAS-Provisional (LCAS-Provisional), Certified Clinical Supervisor (CCS), Certified Substance Abuse Counselor (CSAC), Certified Substance Abuse Prevention Consultant (CSAPC), Certified Substance Abuse Residential Facility Director (CSARFD), and Certified Criminal Justice Addictions Professional Credential (CCJP). (See Appendix D). The type of credential varies, depending on the level of educational achievement (i.e. master's degree, other health professional degree, bachelor's degree, or less than a bachelor's degree), hours of supervised experience, practice location, and type of exam taken. These substance abuse professionals have a different scope of practice, depending on the credential. Only LCAS and CCS can practice independently and bill third-party payers. The other substance abuse professionals are authorized to provide direct services to individuals under the supervision of another licensed substance abuse professional. In addition, peer support specialists can provide substance abuse services as part of a larger team that is supervised by a LCAS, CCS, or physician. Peer support specialists are people in recovery who work with people with addiction disorders to promote recovery and provide support. This certification is managed by the Behavioral Health Resource Program at the University of North Carolina at Chapel Hill.



Even with increased funding, North Carolina will have difficulties implementing these services and supports without an adequate substance abuse workforce.

^a NCGS §90-113.30. Information about the Board available at: www.ncsappb.org.

In September 2008, there were eight counties that had no qualified substance abuse clinicians, and another 33 counties with five or fewer clinicians.

The number of qualified substance abuse professionals varies considerably across the state. Although all LMEs have some substance abuse clinicians who can provide services directly to people with addiction disorders (either LCAS, LCAS-P, CCS or CSAC), the availability of these professionals varies considerably across the state. In September 2008, there were eight counties that had no qualified substance abuse clinicians (Anson, Camden, Clay, Graham, Hyde, Pamlico, Tyrrell, Warren), and another 33 counties with five or fewer clinicians (Alexander, Alleghany, Avery, Bertie, Bladen, Carteret, Caswell, Chatham, Cherokee, Chowan, Currituck, Davie, Edgecombe, Gates, Greene, Halifax, Hertford, Jones, Madison, Martin, McDowell, Mitchell, Montgomery, Northampton, Pasquotank, Perquimans, Person, Richmond, Sampson, Stokes, Washington, Yadkin, Yancey).¹ (See Appendix E) However, the total number of substance abuse professionals does not adequately describe the sufficiency of the substance abuse workforce—as less populated counties presumably need fewer clinicians than counties with more people with addiction disorders. The ratio of people who are expected to seek services *in the public system* per substance abuse licensed, credentialed, or certified clinician varies from 1,465 people per one clinician in Pasquotank, to 30:1 in Polk.^b (See Appendix E) Although many people cross county lines to seek services, this wide disparity in the availability of qualified substance abuse counselors suggests a significant workforce shortage in the public substance abuse system in many areas of the state.

The North Carolina Substance Abuse Professional Practice Board deems other health professionals to be licensed clinical addiction specialists (LCAS) if they have been recognized by their own board as having met the standards of a substance abuse specialist. Many of the health and counseling professions offer additional training and certification for certain specialty areas. For example, the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) and the National Board of Certified Counselors offers a Masters in Addiction Counseling (MAC) certificate, and the National Association of Social Workers offers an Alcohol, Tobacco, and Other Drug Proficiency (ATOD) certificate. Physicians can become certified with a specialty in alcohol and drug abuse from the American Society of Addiction Medicine. Although the North Carolina Substance Abuse Professional Practice Board (NCSAPPB) will license these health and counseling professionals as LCAS, these professionals do not need to obtain the LCAS licensure to provide addiction services. In fact, only 120 of the 1,105 LCAS in the state are other health or counseling professionals who received their LCAS licensure as a result of a deemed status.^c

Other health professionals—such as physicians, nurse practitioners, physician assistants, licensed clinical social workers, psychologists, licensed marriage or family therapists, or licensed professional counselors—are authorized under their licensure

^b This is a conservative estimate, as DMHDDSAS only anticipates that approximately 40% of youth and 48% of adults who need services will actually seek services through the public system.

^c Misenheimer A. Executive Director, North Carolina Substance Abuse Professional Practice Board. Written communication. November 17, 2008

laws to provide substance abuse services. These professionals can provide substance abuse services directly under their own licensure laws and need not seek deemed substance abuse professional status. Although these health professionals are legally authorized to provide substance abuse services, the available data suggests that most do not do so. Only 88 (0.5%) of the 18,913 non-federally licensed physicians in North Carolina (2007) reported that they practice addiction medicine or psychiatry as their primary or secondary specialty areas.² Similarly, only 8 (0.5%) of the 2,933 Nurse Practitioners, and 16 (0.5%) of the 3,054 Physician Assistants reported addiction medicine as their primary or secondary specialty areas. More registered nurses reported drug or alcohol as their major clinical practice area (171), but this is an even smaller percentage of the 84,820 registered nurses in the state (0.2%). Data about specialties from the other licensed health professionals (clinical psychologists or psychology associates, licensed clinical social workers, licensed marriage or family therapists, or licensed professional counselors) was not readily available. Because there are so few other health professionals with addiction specialties, the availability of these health professionals does little to alleviate the overall substance abuse workforce shortage. There are no health professionals with addiction specialties in the eight counties that lack licensed, credentialed or certified substance abuse professionals. Further, there continues to be a large discrepancy in the availability of all substance abuse clinicians even when including licensed health professionals. Polk County has the highest proportion of licensed, credentialed or certified substance abuse clinicians (including both substance abuse and health professionals) to estimated population *in need of substance abuse services*, with one clinician to every 48 people with a substance abuse disorder.^d Aside from the eight counties with no clinicians, Pasquotank has the fewest clinicians, with one clinician for every 3,092 people estimated to be in need of substance abuse services.

Unfortunately, it is very difficult to know the total number of people providing addiction services, because of the gaps in licensure data and the different types of people who can provide services under the supervision of LCASs, CCSs, Clinical Supervisor Interns (CSI), or physicians. Although data are not available about the total number of licensed health and counseling professionals who provide substance abuse services, anecdotal information presented to the Task Force from organizations that hire qualified substance abuse professionals to provide counseling and other substance abuse services all point to the serious workforce shortage.³⁻⁵ DMHDDSAS commissioned a workforce study to examine the adequacy of the behavioral health workforce and found significant behavioral health workforce shortage in the state.⁶

Only 88 (0.5%) of the 18,913 non-federally licensed physicians in North Carolina (2007) reported that they practice addiction medicine or psychiatry as their primary or secondary specialty areas.

d This ratio examines the number of substance abuse or health professionals to population estimated to be in need of substance abuse services. The population figure includes all people who are estimated to have substance abuse disorders, not just those expected to seek services through the public substance abuse system. The clinicians include CSAC, LCAS-P, LCAS, Certified Substance Abuse Peer Specialists, physicians, physicians assistants, nurse practitioners, registered nurses, and licensed practical nurses.

North Carolina has several other scholarship or loan forgiveness programs targeted to produce certain types of professionals who are in short-supply in the state.

Currently, there are seven community colleges that offer an Associates Degree in Human Services whose substance abuse courses have been approved by the NCSAPPB.^e In addition, there are undergraduate programs throughout the state that offer substance abuse courses within a variety of human service departments. Eight universities offer master's degrees in addiction counseling.^f Graduates from these programs meet all the requirements for licensure except supervised work experience and successful completion of the written exam. Additionally, The University of North Carolina at Wilmington has been approved to offer a PhD program in substance abuse.

North Carolina has several other scholarship or loan forgiveness programs targeted to produce certain types of professionals who are in short-supply in the state. For example, the North Carolina General Assembly created the Teaching Fellows program in 1986 to encourage more students to enter the teaching profession. Similarly, the North Carolina Office of Rural Health and Community Care administers the federal and state loan forgiveness programs to encourage health professionals to set up practice in underserved areas. The Governor's Institute on Alcohol and Substance Abuse administers the Education for Substance Abuse Professionals (ESAP) scholarship program to assist students in seeking substance abuse training. Since SFY 2005, the program has provided \$163,000 in stipends for higher education courses and scholarships for continuing education programs required for people to obtain substance abuse certification.^g Through ESAP, the Governor's Institute also provides full scholarships for people working on master's degrees. The program targets people who live in geographic areas with a shortage of licensed substance abuse professionals, especially experienced certified professionals who, once they complete a masters degree, can then immediately take the licensure test. The goal of this program is to assist some of North Carolina's most experienced counselors in advancing in their profession and then utilizing them to meet critical workforce needs.^g

To encourage more students to enter the substance abuse profession, the Task Force recommends that the current initiative within the Governor's Institute on Alcohol and Substance Abuse be expanded. To do so, the Task Force recommends:

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- e Seven community colleges offer substance abuse degrees: Central Piedmont Community College, Guilford Tech Community College, Pitt Community College, Sandhills Community College, Southwestern Community College, Wake Tech Community College and Western Piedmont Community College.
 - f The eight universities that offer master's degrees in addiction counseling include: Appalachian State University, East Carolina University, North Carolina A & T State University, North Carolina State University, The University of North Carolina at Chapel Hill, The University of North Carolina at Charlotte, The University of North Carolina at Wilmington, Western Carolina University.
 - g McEwen S. Executive Director, Governor's Institute on Alcohol and Substance Abuse. Written communication. December 2, 2008.

Recommendation 6.1 (PRIORITY RECOMMENDATION)

- a) The North Carolina General Assembly should appropriate \$750,000 in recurring funds in SFY 2010, and an additional \$750,000 in recurring funds in SFY 2011 for a total of \$1.5 million in SFY 2011, increasing to \$2.0 million in SFY 2013 to the Governor's Institute on Alcohol and Substance Abuse to create a scholarship program to increase the number of qualified professionals in the field of substance abuse treatment. Funding should be used to:
- 1) Pay up to \$3,000 per year for up to two years of community college training for 50 students enrolled in a human services program with the intention to enter the substance abuse field.
 - 2) Pay up to \$5,000 per year for up to four years of undergraduate training for 50 qualified undergraduates who have declared a major in a human services occupation that would meet the requirements for LCAS, CSAC, CSAPC, CSARFD, or CCJP
 - 3) Pay up to \$5,000 per year for up to two years of graduate level substance abuse training to 50 eligible individuals with a bachelor's degree who have been accepted into one of North Carolina's master's level substance abuse programs.
 - 4) Pay up to \$2,000 per year for up to two years to purchase training or supervision hours for 50 qualified individuals with a bachelor's or master's degree in an appropriate field who are working towards CSAC, LCAS, or CCS licensure.
 - 5) Students who receive scholarship funds would be required to work for one year in a public or private not-for-profit substance abuse treatment program for every \$4,000 received in scholarship funds and would be required to pursue substance abuse licensure or certification.
 - 6) Students who do not complete their substance abuse training or licensure, or who fail to meet the work requirements would be required to pay back the scholarship funds with 10% interest with appropriate time standards.
- b) The North Carolina General Assembly should appropriate \$200,000 in recurring funds in FY 2010 to the Area Health Education Centers program to create and incentivize five programs to serve as substance abuse clinical training sites for people seeking CSAC, LCAS, CCS, CCJP, CSARFD or CSAPC credential.

In addition to producing more licensed or certified substance abuse professionals, North Carolina should do more to train physicians in addiction medicine. To accomplish this, the Task Force recommends:

Recommendation 6.2

- a) The Area Health Education Centers Program should work with the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, the North Carolina Psychiatric Association, and other relevant organizations to develop residency rotations for psychiatrists and other physicians in addiction medicine. The goal is to develop clinical training opportunities in existing residency programs in Alcohol and Drug Abuse Treatment Centers and other appropriate settings to improve the substance abuse training of psychiatrists, family physicians, emergency medicine or other physicians likely to enter into the addiction field in both inpatient and outpatient settings.
- b) The North Carolina General Assembly should appropriate \$200,000 in recurring funds in SFY 2010 to the Area Health Education Centers program to develop and support new clinical training rotations for residents in substance abuse.

Public agencies that provide substance abuse services have greater difficulties than other substance abuse providers in attracting and retaining substance abuse professionals.

Substance Abuse Professionals in the Publicly Funded System

Public agencies that provide substance abuse services have greater difficulties than other substance abuse providers in attracting and retaining substance abuse professionals. Not only is there a low number of qualified substance abuse providers, but public agencies have problems because of the low job classification and salary that can be offered to substance abuse workers. In 2005, the North Carolina General Assembly changed the substance abuse licensure and credentialing laws to require all substance abuse professionals to have appropriate credentials (i.e. licensure, registration or certification).^h The Office of State Personnel recently increased the grade level for certain substance abuse professionals; however, additional increases and flexibility in hiring are still needed.^{7,8}

Under the North Carolina Office of State Personnel, substance abuse clinicians who work for local and state governments can be classified from grade 60 to grade 72 (depending on the job responsibilities). The salary for substance abuse workers with a high school degree and one year of experience begins at \$26,584 (grade 60). A Licensed Clinical Addiction Specialist can be classified as a grade 70, with a starting salary of \$38,174. The highest job classification is a Certified Clinical Supervisor (grade 72) with a salary beginning at \$41,173. The 72 level has only been approved for CCS level substance abuse supervisors who are in very short supply in the state.

^h Session Law 2005-431, NCGS §90-113.30.

One of the major problems for state and local substance abuse agencies is the starting grade level for LCAS. Licensed Clinical Social Workers who have similar education and training requirements as LCAS can start at grade level 72, but LCAS are limited to grade level 70. In addition the two substance abuse professional positions that are a grade 70 and 72 do not allow a trainee progression. This means that it is difficult to hire individuals who are in the process of completing their licensure or supervisory certification. This will continue to cause problems with hiring.

In order to ensure an adequate supply of substance abuse professionals willing to work for public agencies, the Task Force recommended:

Recommendation 6.3

The North Carolina State Personnel Commission should:

- a) Reevaluate and increase the pay grades for substance abuse professionals with a LCAS, CCS, CSAC, CCJP, and CSAPC credentials.
- b) Allow for a trainee progression for LCAS and CCS.

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Policy makers need good data to make informed policy choices. This is particularly important in the context of substance abuse services. Approximately 8.5% of the state’s population has substance abuse problems, but less than 10% of those in need of services are receiving them through the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) community service system.¹ At least another 10% of those in need receive treatment services through programs that are not included in the DMHDDSAS data systems.² Despite the large percentage of the population that needs services, state and local agencies were unable to spend all the money the North Carolina General Assembly appropriated for substance abuse services. Data are needed to profile sections of the population most at risk for substance use and abuse and to identify the populations in need of substance abuse services; the type of services used both within DMHDDSAS and through other public and private providers of care; the availability and accessibility of services and recovery supports; service use, intensity, and completion rates; and recidivism rates. Ideally, data would be available at both the state and the local level. Further, programs and services should be evaluated to determine that the funding is well spent and programs are achieving positive outcomes.

Data about the need and use of substance abuse services are collected by many different agencies. Yet there is not a state agency charged with collecting and synthesizing the data across agencies to gain a complete picture of the substance abuse problems in our state. (As described in more detail below, the Center for Child and Family Policy at Duke University is attempting to synthesize substance abuse data for adolescents for each county. However, this same integrated data source is not available for adults). In addition, while many data sources exist, there are still information gaps in the data the state does collect. This chapter describes data available to assess the scope of the substance abuse problem, information on prevention and treatment being provided by DMHDDSAS, and data needed to help improve substance abuse surveillance and services.

Available Data on The Scope of the Substance Abuse Problem

There are a number of data sources available to help monitor tobacco, alcohol, and drug use in North Carolina. Most of the data come from population-based surveys, which capture information on the prevalence and use of different types of substances, frequency of use, and perceptions of risk. The surveys are targeted to different populations (i.e. adults and youth). Most provide reliable estimates at the state level but stop short of generating valid estimates at either the regional or county levels. The survey data include:

Data about the need and use of substance abuse services are collected by many different agencies. Yet there is not a state agency charged with collecting and synthesizing the data across agencies to gain a complete picture of the substance abuse problems in our state.

- **Behavioral Risk Factor Surveillance Survey (BRFSS)** is a telephone survey sponsored by the Centers for Disease Control and Prevention and managed locally by the NC Center for Health Statistics.^a The BRFSS measures the medical and behavioral health needs of the adult population by state, including tobacco and alcohol use, tobacco cessation efforts, and tobacco prevention. BRFSS data are available for the state as well as at the regional level and at the county level for the 22 largest counties.
- **Child Health Assessment Monitoring Program (CHAMP)** is a call-back survey of the BRFSS, where questions on a child's health are asked of the parent or other caregiver.^b CHAMP is administered by the NC Center for Health Statistics. CHAMP asks parents about tobacco prevention and their child's tobacco use. CHAMP data are available at the state level only
- **Youth Risk Behavior Survey (YRBS)** is a self-administered school-based survey sponsored by the Department of Public Instruction.^c The YRBS monitors selected risk behaviors among middle and high school students, including detailed questions about tobacco, alcohol, and drug use (including questions about individual illicit drugs) and tobacco cessation efforts. School participation is voluntary in North Carolina. YRBS data are available at the state and regional level from the Department of Public Instruction.
- **National Survey of Drug Use and Health (NSDUH)**, formerly the National Household Survey of Drug Use, is a national survey of states' populations sponsored by the Substance Abuse and Mental Health Services Administration.^d The NSDUH surveys people aged 12 and older. Results are available for the whole population, youth, young adults, and older adults and include information on tobacco, alcohol, and drug use; abuse and dependency; and perceptions of risk. Data are available at the state level.

In addition to survey data, there are a number of other sources of information on the scope of the substance abuse problem in North Carolina, including information from the NC Disease Event Tracking and Epidemiological Collection Tool, State Center for Health Statistics, Social Services, Department of Public Instruction, Higher Education Institutions, Law Enforcement Agencies and regulatory data, Highway Safety Research Center, and Department of Corrections, Division of Alcoholism and Chemical Dependency Programs.

a Information from the Behavioral Risk Factor Surveillance Survey can be found at:
<http://www.schs.state.nc.us/SCHS/data/brfss.cfm>.

b CHAMPS information can be obtained at: <http://www.schs.state.nc.us/SCHS/champ/index.html>.

c Youth Risk Behavior Survey data are available at: <http://www.nhealthyschools.org/data/yrbs/>.
Charlotte-Mecklenburg data is available from the Centers for Disease Control and Prevention at:
<http://www.cdc.gov/HealthyYouth/yrbs/index.htm>.

d The National Survey on Drug Use and Health (NSDUH) data are available at:
<http://www.oas.samhsa.gov/nhsda.htm>.

NC Disease Event Tracking and Epidemiological Collection Tool (NC-DETECT) is a collaboration between NC Division of Public Health and the North Carolina Hospital Association. It captures admissions data from community hospital emergency departments, including admissions related to substance or alcohol diagnoses. Data have been reported at the state and LME level quarterly by DHHS starting in SFY 2008. The most recent report found that 3% of all emergency room admissions are for substance abuse. This is likely an undercount of the number of people with a substance abuse diagnosis who are admitted to emergency rooms, because of stigma associated with the diagnoses, lack of capacity to diagnose substance abuse problems definitively, and lack of reimbursement for substance abuse services in comparison to other diagnoses.

State Center for Health Statistics data provide information on the number of deaths related to substance use.^f Data are available at the state and county level. However, because alcohol and drug use are often underreported, these data may undercount the number of deaths in the state related to substance use.

Departments of Social Services provide data on whether alcohol or substance abuse was a contributing factor in child protective services investigations. Data are available for the state and all counties.^g In SFY 2006, 5% of substantiated child maltreatment cases were due to substance abuse. DSS also collects information on the percentage of cases where substance abuse was a contributing factor in the investigation and the number of children removed to foster care due to parental or child substance use. These data must be requested from DSS.

Department of Public Instruction data provide information on the possession of alcohol and illicit substances on school property at the school LEA and state levels. In SFY 2007, there were 2 instances of alcohol possession and 8 instances of drug possession per 1,000 high school students. Data are reported in the Annual Report of School Crime and Violence.^h

Higher Education Institutions are required by law to disclose crime statistics for their campuses and surrounding areas, including liquor and drug law violations if they result in an arrest or disciplinary referral. Data are available from the US Department of Education, Office of Postsecondary Education (for all public and private institutions of postsecondary education).ⁱ

e Data from NC-DETECT are available at:
<http://www.ncdhhs.gov/mhddsas/statspublications/reports/emergdeptreport10-15-08.pdf>.

f The State Center for Health Statistics produces two reports with mortality data related to substance abuse. The annual Detailed Mortality Statistics report (<http://www.schs.state.nc.us/SCHS/deaths/dms/2006/>) includes information on deaths directly linked to substance use (i.e. harmful use, dependence and behavioral/mental disorders due to substance use). The annual Vital Statistics Report, Vol. II: Leading Causes of Death, (<http://www.schs.state.nc.us/SCHS/data/vitalstats.cfm>) includes data on causes of death related to substance use such as lung cancer and chronic liver disease and cirrhosis.

g Data from Child Protective Services are available at: <http://www.dhhs.state.nc.us/dss/stats/cr.htm>.

h The Annual Report of School Crime and Violence can be found at: <http://www.ncpublicschools.org/research/discipline/reports/#schoolviolence>.

i Data about liquor and drug law violations for higher education institutions can be found at:
<http://ope.ed.gov/security/>.

Currently, the Center for Child and Family Policy at Duke University is working on creating an online data system for all 100 counties which compiles multiple adolescent substance abuse surveillance data sources through a single portal.

The Department of Juvenile Justice and Delinquency Prevention (DJJDP) conducts needs assessments that provide data on the needs of individuals in the system, including substance abuse services. State level data are available in the DJJDP Annual Report.^j In 2006, 22% of juveniles assessed needed further assessment for substance abuse, and 20% needed substance abuse treatment.

Law Enforcement and Regulation data provide information on substance abuse arrests, read Alcoholic Beverage Control (ABC) and Alcohol Law Enforcement (ALE) permit violations, and drug seizures. Law enforcement data sources include the State Bureau of Investigations, Alcohol and Beverage Control, and the Drug Enforcement agency:

- The State Bureau of Investigation has data on arrests for drug offenses, DWI, drunk and disorderly conduct, and liquor law violations for the state and county.^k In 2006, 24% of arrests were for drug or alcohol offenses.
- Data from NC Alcoholic Beverage Control and Alcohol Law Enforcement (ABC/ALE violations) must be obtained from local offices.
- The Drug Enforcement Agency has data on drug seizures, by state.^l In 2007, over 12,000 pounds of illegal drugs were seized in North Carolina and 153 methamphetamines labs raided.

Highway Safety Research Center has information on alcohol-related crashes and impaired-driving court cases.^m Data are available at the state and county level. In 2006, 5% of crashes were alcohol-related, and there were 60,000 cases of driving while impaired.

Department of Corrections, Division of Alcoholism and Chemical Dependency Programs (DACDP) Annual Legislative Report includes state level data on inmates with substance abuse problems, inmates receiving treatment, and evaluations of the various treatment programs offered.ⁿ In SFY 2007, 63% of entering inmates indicated a need for residential substance abuse treatment. In total, approximately 90% of entering inmates needed some type of substance abuse treatment services.

Currently, the Center for Child and Family Policy at Duke University is working on creating an online data system for all 100 counties which compiles multiple adolescent substance abuse surveillance data sources through a single portal. The goal is to create a user-friendly single-point entry portal that will allow visitors to identify drug abuse patterns in each county, identify changes in drug abuse patterns

j Data from the Department of Juvenile Justice and Delinquency Prevention are available at: <http://www.ncdjdp.org/>.

k Information from the State Bureau of Investigation is available at: <http://sbi2.jus.state.nc.us/crp/public/Default.htm>. Select a year, then arrests and clearances, then statewide or county.

l Information from the Drug Enforcement Agency is available at: <http://www.usdoj.gov/dea/pubs/states/northcarolina.html>.

m Information from the NC Alcohol Facts Website from the Highway Safety Research Center is available at: <http://www.usdoj.gov/dea/pubs/states/northcarolina.html>.

n Data from the Department of Corrections, Division of Alcoholism and Chemical Dependency Programs are available at: <http://www.doc.state.nc.us>.

over time, and detect emerging substance abuse trends. Data will come from a variety of sources including the Youth Risk Behavior Survey, the State Bureau of Investigation, and the Department of Public Instruction. Over time, data from state agencies such as the State Medical Examiner, the Department of Juvenile Justice and Delinquency Prevention, Division of Social Services, Administrative Office of the Courts, US Census Bureau, the Centers for Disease Control and Prevention, Health Resource and Service Administration, and others will be added. This project is funded by a Substance Abuse and Mental Health Services Administration grant with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and the University of North Carolina at Greensboro. These data will be available online in January 2009.

Available Data for Monitoring Prevention and Treatment Services Funded Through DMHDDSAS

DMHDDSAS collects information on clients served within the DMHDDSAS system. These data include information about the individual users (i.e. demographics, financial eligibility), the number of people who seek services, the number who receive services, length of time in treatment, services rendered, the cost of services, program performance, individual outcomes, and consumer satisfaction. Data sources within DMHDDSAS include:

- **Client Data Warehouse (CDW)** is the hub of DMHDDSAS data for the state. It captures individual consumer demographics, financial eligibility, clinical information, and specialized substance abuse data such as drug(s) of choice. Data may be submitted by LMEs on a daily basis. CDW can be linked to the other DMHDDSAS data systems described below and may potentially be linked to other external data systems within the Division of Social Services or the Division of Public Health, although this has not been pursued due to federal regulations concerning consumer confidentiality. CDW is the basis for the annual DMHDDSAS statistical reports. Using the CDW, DMHDDSAS can generate local, state, and federal reports for the block grants.
- **Integrated Payment and Reporting System (IPRS)** is the behavioral health claims system for LMEs. It captures substance abuse diagnostic information; the type, date and volume of services rendered; and the cost of services.^o The IPRS also captures state mental health and substance abuse expenditures. These data can be combined with Medicaid use and expenditure data. However, the IPRS and Medicaid data cannot currently be combined with non-state expenditures (such as county or grant funds). The IPRS will be able to report services paid through county-specific funds in SFY 2009.

^o Data from the IPRS system is reported at: <http://www.ncdhhs.gov/mhddsas/iprsmenu/index.htm>.

Division of
Mental Health,
Developmental
Disabilities, and
Substance Abuse
Services data do
not include
information on
patients receiving
treatment in the
private sector or
services funded
through self-pay,
grants, private
partnerships, or
expenditures for
prisoners treated in
jail treatment
programs.

- **Healthcare Enterprise Accounts Receivable Tracking System (HEARTS)** is a complement to the IPRS that captures information for services provided in the 14 state institutions, including ADATCs. Similar to IPRS, HEARTS collects data on individual consumer diagnostic information; the type, date, and volume of services rendered; and the cost of services.
- **North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS)** is a Web-based performance and outcomes database.^p DMHDDSAS requires providers to do initial, update, and discharge interviews with consumers 6 years of age or older who are receiving treatment services. NC-TOPPS captures descriptive information (i.e. demographics, drug problem, diagnoses, treatment attendance, services received), information on consumers' daily lives before and during treatment (i.e. employment, living arrangement, substance use, involvement with the law), outcomes (i.e. quality of life, participation in positive activities, behavior problems), and program performance (consumer ratings of whether treatment helped them reduce substance use and increase positive outcomes in their lives). Statewide data are available online. NC-TOPPS can be used by providers for consumer-specific, local, regional, or state planning. DMHDDSAS generates biannual reports for the state and LMEs. Reports are also run for specific providers upon request.
- **Mental Health Statistics Improvement Program (MHSIP) Consumer Satisfaction Survey** is administered to mental health and substance abuse consumers.^q These surveys offer consumers a confidential opportunity to evaluate service quality based on overall satisfaction, access, appropriateness, participation in treatment, and outcomes. The surveys are administered annually but are not able to obtain information from consumers who drop out of treatment. DMHDDSAS is currently reevaluating the survey methodology in order to expand the frequency of the survey administration and size of the survey sample.

It is important to note that these data do not include information on patients receiving treatment in the private sector or services funded through self-pay, grants, private partnerships, or expenditures for prisoners treated in jail treatment programs. County expenditures have not previously been included in DMHDDSAS data but will be collected in SFY 2009.

^p NC TOPPS data are available at: <http://www.ncdhhs.gov/mhddsas/nc-topps/index.htm>.

^q The 2005-2006 consumer satisfaction report is available at: <http://www.ncdhhs.gov/mhddsas/statspublications/reports/consumersatis/consumersatisreport05-06.pdf>. More recent data are available at: http://www.ncdmh.net/dsis/CSS_Combined_Menu.html.

Gaps in DMHDDSAS Data Collection

Although there are a number of data sources providing state-level data on substance abuse prevalence, there are far fewer sources of comparable information at the county or regional level. LMEs need enhanced data on substance abuse prevalence at the local level. While data on treatment and outcomes in their areas are available, LME utilization of this information needs to be strengthened in order to enhance planning to ensure that there is adequate capacity at the local level to respond effectively.

The state collects extensive information on substance abuse prevention efforts locally but does not currently assess whether such prevention efforts are impacting community and family norms and behaviors. The North Carolina Prevention Outcomes and Performance System was implemented in July 2009. This online system collects information from providers on the impact of prevention services. It will allow evaluation of prevention efforts in coming years.

While DMHDDSAS collects a vast array of data, there are some limitations in the current data systems. For example, data are not always reported consistently across LMEs (especially among LMEs that operate managed care systems). LMEs and providers do not always report their required data fully or accurately. This has been particularly problematic in the collection of timely and complete data through NC-TOPPS. Further, the multiple systems that the Division utilizes for the collection of data are not integrated, but are stand-alone systems serving one specific purpose, including NC-TOPPS.^r The Division does not have sufficient staff capacity to analyze all the captured data or identify trends. If data collection were enhanced and analyzed, programs and services could be better informed.

The DMHDDSAS is currently developing and implementing an electronic health record system in the state facilities, including the Alcohol and Drug Abuse Treatment Centers (ADATCs). This system is a customization of the Veteran Administration's VistA system. It will allow real-time access to information on consumers' needs and services to all state facility staff involved in their care. In order for LMEs to provide good coordination and continuity of care between ADATCs and community providers and among community providers, a similar electronic health record system is needed for community services. This electronic health record must be able to connect to medical providers as well other substance abuse professionals.

The Task Force was particularly interested in identifying appropriate performance measures to gauge individuals' interactions with their LME. As part of the DHHS-LME Performance Contract, the DMHDDSAS currently tracks LME performance against annual statewide standards and targets for five measures specific to substance abuse services, including treated prevalence for adults and adolescents, timely initiation and engagement in services, and timely follow-up care after discharge from an

Local Management Entities need enhanced data on substance abuse prevalence at the local level.

^r The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services is planning an evaluation of their data systems. One issue they will evaluate is whether it is possible to integrate the different data systems.

ADATC. These measures are based on the work of national experts in the Washington Circle Public Sector Workgroup.³ An additional seven measures track LME performance on all three disabilities combined. These include timely access to services after initial requests for emergent, urgent or routine care; overuse of state psychiatric hospitals for acute care (including substance abuse consumers); 30-day and 180-day readmissions to state psychiatric hospitals; and child services in non-family settings. Similar standardized measures and standards have not yet been set for evaluating providers' performance statewide, although some LMEs have developed local performance measures for their community providers. If payments are ultimately linked to LME or provider performance measures—for example, through incentive-based performance payments—then the state needs to ensure that organizations do not selectively serve low risk consumers, while eschewing more complex consumers, in order to enhance their perceived performance and payments.⁴

To enhance the state's data collection system, the Task Force recommends:

Recommendation 7.1

- a) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMDDAS) should develop a long-term consumer-centered Information Technology (IT) vision and plan to meet the state's data needs through enhanced integration of current systems, including the statewide adoption of an Electronic Health Record among community providers and LMEs.
- b) The North Carolina General Assembly should appropriate \$1.2 million in recurring funds to DMDDAS to enhance and expand current data collection systems and develop new data systems as needed to provide epidemiological information on people with substance abuse issues across the lifespan.
- c) The DMDDAS should develop capacity to utilize data to identify patterns and trends in the prevalence, prevention, and treatment of substance abuse so as to provide an evidence-based process for the development and evaluation of prevention and treatment interventions, as well as provide a data-driven platform for the funding of prevention and treatment programs across the state.
- d) The DMDDAS should review national research on patterns of consumer participation and client referral within the substance abuse prevention and treatment systems. Special studies should be undertaken as needed to determine if there are systemic patterns and barriers to identification, referral, and engagement of substance abuse consumers into treatment in North Carolina.
- e) The DMDDAS should enhance their collection and analysis of data on substance abuse services to include information on:
 - 1) Active identification and timely screening, triage, and referral into care for substance abuse consumers separately from other disability groups.
 - 2) Timely and effective coordination of care between screening, triage, and referral (STR) and engagement in treatment.

- 3) Length of time in treatment.
- 4) Responsiveness of community systems, including utilization of inpatient programs, as is currently done for detox and outpatient programs.
- 5) Admission and readmission into Alcohol and Drug Addiction Treatment Centers, as is currently done for state hospitals.
- 6) Continuity of care after discharge from detox and inpatient programs, as is currently done for Alcohol and Drug Addiction Treatment Centers, and state hospitals.
- 7) Provision of recovery-oriented treatment and support within communities.

In addition to improving data collection, analysis, and evaluations of current programs, the Task Force also focused on the need for more comprehensive data about the various funding streams for substance abuse services. DMHDDSAS currently collects data on services funded through DMHDDSAS and Medicaid and will soon collect data on services funded through county expenditures. DMHDDSAS data do not include information on people receiving prevention and treatment services in the private sector or services funded through self-pay, grant, private partnerships, or expenditures by other state agencies (e.g. the Department of Corrections or the Department of Public Instruction). Although DMHDDSAS may not be able to collect data on services funded through insurers, grants, or out-of-pocket payments, obtaining information on services provided through all federal, state, and local funds will give a more complete understanding of the availability and gaps in the current service system. Therefore, the Task Force recommends:

Recommendation 7.2

- a) The Department of Juvenile Justice (Juvenile Crime Prevention Council), Department of Corrections (Criminal Justice Partnership program), Division of Public Instruction, Division of Social Services, Division of Public Health, and county commissioners should provide data to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services quarterly on public funds used to support substance abuse prevention and treatment services, number of people served, and types of services provided in each county.
- b) The North Carolina General Assembly should choose and implement an equalization formula to ensure that Local Management Entities (LMEs) receive comparable funding to achieve equity in access to care and services while recognizing the inherent challenges of delivering services in low-wealth rural counties. This equalization formula should be used to distribute any new state funds provided to support substance abuse prevention and treatment activities, with low-funded LMEs obtaining a higher proportion of the funding.

References

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- 2 Quality Management Team, Community Policy Management Section, North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, North Carolina Department of Health and Human Services. MHDDSAS community systems progress indicators: report for the fourth quarter SFY 2007-2008. <http://www.dhhs.state.nc.us/MHDDSAS/announce/commbulletins/commbulletin98/communityprogressrptq4sfy08.pdf>. Published September 15, 2008. Accessed April 10, 2008.
- 3 Garnick DW, Lee MT, Horgan CM, Acevedo A. Adapting Washington Circle performance measures for public sector substance abuse treatment systems [published online ahead of print August 21, 2008]. *J Subst Abuse Treat*. doi:10.1016/j.jsat.2008.06.008.
- 4 Shen Y. Selection incentives in a performance-based contracting system. *Health Serv Res*. 2003;38(2):535-552.

Substance abuse is a complex and costly chronic illness. The prevention, diagnosis, and treatment of substance abuse is difficult, as it is with many other chronic illnesses. Many individuals with substance abuse problems either do not recognize they have a problem or do not seek treatment due to access barriers. More than 90% of people that abuse or depend on alcohol or illicit drugs in North Carolina do not obtain services. Many of those who do seek treatment may find a system that is inadequate to meet their needs.

Not only does the failure to identify and appropriately treat people with substance abuse disorders harm the individual and his or her family, it has much larger societal implications. There were approximately 642,000 people age 12 or older (7.7%) who reported using illicit drugs over the last month and more than 1.6 million people (19.5%) who reported binge drinking in North Carolina (2005-2006 NSDUCH data, using 2008 NC population figures).^a In 2005, more than 5% of all traffic accidents in the state were alcohol related, as were more than one-fourth (26.8%) of all traffic-related deaths.¹ Almost 90% of prisoners entering the prison system have substance abuse disorders requiring treatment, with 63% needing residential substance abuse treatment services.² Substance abuse is a major contributor to juvenile delinquency, with 43% of youth in the juvenile justice system needing further assessment or treatment for substance abuse.³ Nationally, approximately 75% of adults who have had their children placed in foster care have alcohol or substance abuse problems.⁴ Alcohol and drug addiction is also a major problem among active and returning military, national guard, and reservists. Moreover, it leads to loss of worker productivity among the general population. In total, alcohol and drug abuse was estimated to cost the North Carolina economy more than \$12.4 billion in direct and indirect costs in 2004.⁵

Given the major role that substance abuse plays in crime, motor vehicle accidents, worker productivity, and family disintegration, it is perhaps surprising how few resources are devoted to prevent, treat, and provide recovery supports to people with addiction disorders. North Carolina spent less than \$140 million to fund substance abuse services in the state in 2006, a sum that left North Carolina substance abuse services underfunded in relation to other states.^{1,4} A report presented to the North Carolina General Assembly in 2007 estimated it would take an additional \$35 million in appropriations to achieve parity with national per capita funding for substance abuse services.⁴

The North Carolina General Assembly asked the North Carolina Institute of Medicine (NCIOM) to convene a Task Force to study substance abuse services in the state (SL-2007-323 §10.53A). The Task Force was charged with developing interim recommendations for the 2008 session and with presenting its final report to the 2009 session.



Given the major role that substance abuse plays in crime, motor vehicle accidents, worker productivity, and family disintegration, it is perhaps surprising how few resources are devoted to prevent, treat, and provide recovery supports to people with addiction disorders.

^a Binge drinking is defined as drinking five or more drinks on the same occasion (i.e. at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days.⁸

Early screening and intervention strategies are needed for people who are starting to engage in risky behaviors but who have not yet become addicted.

The Task Force met 14 times between October 2007 and December 2008. Most of the Task Force's work focused on developing a comprehensive system of care to provide evidence-based interventions based on a person's need. This comprehensive system begins with a strong prevention effort, targeted at youth and adolescents. Targeting youth and young adults will help reduce the number of people who later become addicted, as evidence shows that people who initiate substance use in childhood or adolescence are more likely to later become addicted.

Early screening and intervention strategies are needed for people who are starting to engage in risky behaviors but who have not yet become addicted. Without these early intervention services, these individuals are likely to progress to worse stages of abuse and/or dependence.

At the far end of the spectrum, individuals with more severe problems need different levels of treatment offered through the specialized substance abuse system. Even after they have been treated and have become sober, they will likely need recovery supports to prevent relapse. Local Management Entities are charged with making these services available to people with diagnoses of addiction or abuse, but less than about 10% of the people who need services are receiving it. More needs to be done to ensure that services are available and accessible to the people in need.

The Task Force also examined the special systems designed to prevent, reduce use, or treat subpopulations within the state, including youth in the juvenile justice system, offenders in the courts or criminal justice system, adults involved with the Work First or Child Protective Services system, and active military and returning veterans.

One of the most significant barriers in addressing gaps in services is the availability of a qualified substance abuse workforce. In the last 15 years, the North Carolina General Assembly has made significant steps to improve the qualifications of the substance abuse workforce, but there are too few qualified substance abuse professionals practicing in the state. Further, the available workforce is unevenly distributed with many communities having few if any qualified substance abuse professionals available to provide services. Thus, North Carolina needs to do more to encourage people to enter the substance abuse profession and to practice in underserved areas.

Additionally, the Task Force considered the data needs of the state. North Carolina needs good data to make informed policy choices. Not only does the state need to enhance its data collection capacity, it also needs to enhance its analytic capability to better identify needed changes in the existing substance abuse service system.

The following is a list of the Task Force's recommendations, in an abridged format, along with the agency or organization charged with addressing the recommendation. (See Appendix F for full recommendations.) Eleven of these recommendations were considered top priorities, although all of the recommendations are important. Recognizing that not all of the recommendations could be implemented at once, the Task Force prioritized those that members believed would have the biggest impact on preventing people from using or abusing alcohol, tobacco, or other drugs as well as treating those who have substance abuse problems. These priority recommendations are noted below.

The importance of a comprehensive substance abuse delivery system cannot be overstated. Our failure to adequately prevent, treat, and provide recovery supports to people with addiction problems has huge implications to our state. We can no longer afford to stigmatize and ignore people with addiction problems. Rather, we need to work together to ensure that appropriate evidence-based education, prevention, treatment, and recovery resources are available and accessible throughout the state. This will take the involvement of many different agencies, providers, and treatment professionals.

This report provides a roadmap that can be used to ensure that comprehensive publicly-funded substance abuse services are available throughout the state. In total, if all of the Task Force recommendations were implemented it would cost \$38,943,440 in SFY 2010 and \$62,060,380 in SFY 2011, with an additional \$1,050,000 in non-recurring funds. Implementing the priority recommendations alone would cost the state \$9,105,940 in SFY 2010 and \$12,222,880 in SFY 2011, with an additional \$300,000 in non-recurring funds. However, the recommended increase in the cigarette tax alone would generate approximately \$297 million per year, much more than the new funding needed to fully implement the Task Force recommendations.

Some may argue that we cannot afford to implement the Task Force recommendations in our current economic crisis. In reality, we cannot afford to wait. We are already paying far more for our failure to appropriately address addiction disorders. We pay for our failure through increased crime, broken households, children in the foster care system, lost worker productivity, and preventable motor vehicle deaths. Funding evidence-based prevention, early intervention, treatment, and recovery supports will lead to longer-term cost savings, with savings of four to five dollars for every one dollar spent on substance abuse prevention,⁶ and up to \$12 for every dollar spent on substance abuse treatment (after factoring in reduced costs of crime, criminal justice costs, and treatment of other health-related expenses).⁷ North Carolina can make significant progress in reducing the burden of substance abuse on individuals, their families, and society by implementing the Task Force recommendations.

The importance of a comprehensive substance abuse delivery system cannot be overstated.

	NCGA	DMHDDSAS	LME	Providers	Other Public Agencies	Other
Prevention						
<p>Recommendation 4.1 (PRIORITY RECOMMENDATION) The North Carolina General Assembly should appropriate \$1,945,000 in SFY 2010 and \$3,722,000 in SFY 2011 in recurring funds to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to develop comprehensive state and local substance abuse prevention plans. Of these funds, \$1,770,000/\$3,547,000 would be used to fund six comprehensive prevention pilot projects at local level. Eligible Local Management Entities must develop a comprehensive plan that includes a mix of evidence-based strategies, and should include a wide array of community partners. The North Carolina General Assembly should appropriate \$250,000 to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to evaluate these pilots and, if successful, to recommend roll-out to other parts of the state.</p>	✓ \$1,945m (SFY2010) (R) \$3,722m (SFY2011) (R)	✓	✓	✓ SA providers	✓ DPI, DJJ, DSS, DPH, Univ.	✓ Cons. & family groups, other
<p>Recommendation 4.2 The North Carolina General Assembly should direct the State Board of Education, Office of Non-Public Education; NC Community College system; and University of North Carolina system to review their existing substance abuse prevention, early intervention, and treatment services, plans, and policies and report on these plans to the North Carolina General Assembly.</p>	✓	✓			✓ DPI, NCCCS, UNC, Office Non-Public Educ.	
<p>Recommendation 4.3 The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; Division of Public Health; Division of Alcohol Law Enforcement; and Department of Public Instruction should develop a plan to further reduce tobacco and alcohol sales to minors.</p>		✓			✓ ALE, DPI, DPH	
<p>Recommendation 4.4 (PRIORITY RECOMMENDATION) The North Carolina General Assembly should further increase the tobacco tax to meet the national average, with the increased revenues used to support evidence-based prevention and treatment efforts.</p>	✓					
<p>Recommendation 4.5 The North Carolina General Assembly should appropriate \$1.5 million in recurring funds to the Division of Public Health to support Quitline NC.</p>	✓ \$1.5M (SFY2010) (R)				✓ DPH	
<p>Recommendation 4.6 (PRIORITY RECOMMENDATION) The North Carolina General Assembly should enact a law which prohibits smoking in all public buildings including, but not limited to, restaurants, bars, and worksites.</p>	✓					

	NCGA	DMHDDSAS	LME	Providers	Other Public Agencies	Other
<p>Recommendation 4.7 (PRIORITY RECOMMENDATION) In order to reduce underage drinking, the North Carolina General Assembly should increase the excise tax on malt beverages (including beer). In addition, the excise taxes on malt beverages and wine should be indexed to the consumer price index so they can keep pace with inflation. Funds raised should be used to support evidence-based prevention and treatment efforts.</p>	✓ \$2m (SFY2010) (R)	✓				
<p>Recommendation 4.8 The North Carolina General Assembly should not lower the drinking age to less than age 21.</p>	✓					
<p>Recommendation 4.9 (PRIORITY RECOMMENDATION) The North Carolina General Assembly should appropriate \$610,000 in recurring funds in SFY 2010 to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services over three years to support efforts to reduce high-risk drinking on college campuses.</p>	✓ \$610K (SFY2010) (R)	✓			✓ NC Univ. System	
<p>Recommendation 4.10 The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; Division of Public Health; Division of Social Services; and other providers should develop a prevention plan to prevent alcohol spectrum disorders and report the plan to the Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services no later than July 1, 2009.</p>	✓ Report to LOC	✓		✓	✓ DSS	
<p>Recommendation 4.11 The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services should work with the Controlled Substances Reporting System (CSRS), Attorney General's Office and other appropriate health professional organizations to explore options to allow the exchange of prescription information obtained through the CSRS between health care practitioners.</p>		✓		✓	✓ Off. Atty. General	✓ Gov. Inst. on Alc. and Subs. Abuse, health prof. org.
Early Intervention						
<p>Recommendation 4.12 North Carolina health professional schools, the Governor's Institute on Alcohol and Substance Abuse, the North Carolina Area Health Education Centers program, residency programs, health professional associations, and other appropriate organizations should expand training for primary care providers and other health professionals in academic and clinical settings, residency programs, or other continuing education programs on screening, brief treatment, and referral (SBIRT) for people who have or are at risk of tobacco, alcohol, or substance abuse or dependency.</p>					✓ AHEC	✓ Gov. Inst., health prof'l schools, resid. pgms

	NCGA	DMHDDSAS	LME	Providers	Other Public Agencies	Other
<p>Recommendation 4.13 (PRIORITY RECOMMENDATION) The North Carolina General Assembly should appropriate \$1.5 million in recurring funds to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to work with the Office of Rural Health and Community Care, Governors Institute on Alcohol and Substance Abuse, and Area Health Education Centers program to expand use of SBIRT in Community Care of North Carolina (CCNC) networks and other primary care and outpatient settings.</p>	✓ \$1.5m (SFY2010) (R)	✓			✓ AHEC CCNC	✓ Gov. Inst.
<p>Recommendation 4.14 The North Carolina General Assembly should appropriate \$750,000 in recurring funds to the Office of Rural Health and Community Care. Funding can be used to help support co-location of licensed substance abuse professionals in primary care practices, or to support continuing education of mental health professionals who are already co-located in an existing primary care practice in order to help them obtain substance abuse credentials to provide substance abuse services to Medicaid and uninsured patients. The goal is to offer evidence-based screening, counseling, brief intervention, and referral to treatment to help patients prevent, reduce, or eliminate the use of or dependency on tobacco, alcohol, and other drugs.</p>	✓ \$1.5m (SFY2010) (R)	✓			✓ ORHCC, CCNC	✓ Gov. Inst., ICARE, health prof.
<p>Recommendation 4.15 (PRIORITY RECOMMENDATION) The North Carolina General Assembly should mandate that insurers offer the same coverage for treatment of addiction diseases as for other physical illnesses. Insurers should reimburse for substance abuse screening, intervention, and treatment services whether offered through primary care providers or specialized substance abuse providers. Insurers should also reimburse for telephone consultations by psychiatrists, as well as for mental and behavioral health services provided on the same day as medical services are provided.</p>	✓	✓		✓	✓ DMA, NC Health Choice, SHP, ORHCC, CCNC	✓ Gov. Inst., Insurers, Prof. Assoc.
Comprehensive System of Specialized Substance Abuse Services						
<p>Recommendation 4.16 (PRIORITY RECOMMENDATION) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) should develop a plan for a recovery oriented system of care for adults and adolescents, ensure that services are available and accessible across the state, and are coordinated among different providers. DMHDDSAS should develop plans for performance based incentive contracts to ensure that services are provided to a significant portion of those in need, that the services are provided in a timely fashion, that people are provided the intensity of services appropriate to their needs and engaged for appropriate lengths of time, and that people are provided</p>	✓ LOC	✓	✓	✓ Subst. Abuse providers	✓ DJJDP, DPI	

	NCGA	DMHDDSAS	LME	Providers	Other Public Agencies	Other
appropriate recovery supports. In addition, DMHDDSAS should identify barriers and strategies to increase the quality and quantity of substance abuse providers in the state including, but not limited to, electronic health records, reduced paperwork, streamlined administrative processes, expanded service definitions, and adequacy of reimbursement rates. DMHDDSAS should also immediately begin expanding the capacity of adolescent treatment services across the state.						
Recommendation 4.17 The North Carolina General Assembly should appropriate \$17.2 million in SFY 2010 and \$34.4 million in recurring funds in SFY 2011 to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS). DMHDDSAS should make funding available on a competitive basis to Local Management Entities (LMEs) to support six pilot programs to implement county or multi-county comprehensive recovery oriented system of care. The North Carolina General Assembly should appropriate \$750,000 to DMHDDSAS to independently evaluate these projects and, if successful, build a plan to expand systems across the state.	✓ \$17.2m (SFY2010) (R), \$34.4m (SFY2011) (R), \$750K (NR)	✓	✓	✓ Subst. Abuse providers		
Recommendation 4.18 (PRIORITY RECOMMENDATION) The North Carolina General Assembly should appropriate recurring funding for additional staff in the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (\$650,000); Office of Rural Health and Community Care (\$130,000); Division of Medical Assistance (\$81,000); and Department of Public Instruction (\$100,000) to provide substance abuse services in support of the Task Force recommendations.	✓ \$880K (SFY2010) (R)	✓			✓ DPI, DMA, ORHCC	
Children, Youth, and Young Adults						
Recommendation 5.1 The North Carolina General Assembly should appropriate \$500,000 in recurring funds to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to expand the Cross Area Service Program model in two additional Department of Juvenile Justice and Delinquency Prevention regions. If successful, the program should be rolled out statewide.	✓ \$500K (SFY2010) (R)	✓			✓ DJJDP	
Adults						
Recommendation 5.2: Local Management Entities (LMEs) should assess the availability and need for Employee Assistance Program (EAP) services in their catchment area. If there are insufficient providers to address this need, the LMEs should work with the local Chambers of Commerce or other business organizations to develop a strategy to expand the availability of EAP services.			✓			✓ Bus. Org.

	NCGA	DMHDDSAS	LME	Providers	Other Public Agencies	Other
<p>Recommendation 5.3: The North Carolina General Assembly should ensure that all individuals advertising and promoting themselves as providing EAP services must be licensed or have EAP specific training and work under the supervision of licensed EAP professionals, no later than 2014. All organizations that promote themselves as providing EAP services should be able to offer all the statutorily defined core services.</p>	✓					✓ NC Board of EAP
<p>Recommendation 5.4 The North Carolina General Assembly should appropriate \$475,000 in recurring funds to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to hire seven additional Licensed Clinical Addition Specialists to work with parents involved with the Work First or Child Protective Services System.</p>	✓ \$475K (SFY2010) (R)	✓	✓		✓ DSS	
<p>Recommendation 5.5 The North Carolina General Assembly should appropriate \$2.8 million in recurring funds in SFY 2010 and an additional \$2.8 million in SFY 2011 to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to expand the availability of Treatment Accountability for Safer Communities (TASC) program services.</p>	✓ \$2.8m (SFY2010) (R) \$5.6m (SFY2011) (R)	✓			✓ DOC, DCC	
<p>Recommendation 5.6 The North Carolina General Assembly should appropriate \$500,000 in recurring funds in SFY 2010 to the Division of Community Corrections to expand the availability of Criminal Justice Partnership Program (CJPP)-funded substance abuse services.</p>	✓ 500K (SFY2010) (R)				✓ DCC	
<p>Recommendation 5.7 (PRIORITY RECOMMENDATION) The North Carolina General Assembly should appropriate \$500,000 in recurring funds in SFY 2010 to the Administrative Office of the Courts to support four new adult treatment courts, and \$500,000 in recurring funds in SFY 2011 to the Administrative Office of the Courts for an additional four adult treatment courts. In addition, the North Carolina General Assembly should increase appropriations to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services by \$570,000 in recurring funds in SFY 2010 and \$570,000 in recurring funds in SFY 2011 to support treatment services for people involved in the drug treatment courts. The North Carolina General Assembly should also appropriate \$269,940 in recurring funds in SFY 2010 and an additional \$269,940 in SFY 2011 to the Department of Corrections, Division of Community Corrections to fund probation officers to support the drug treatment courts.</p>	✓ \$1.34 mill (SFY2010) (R) \$2.68m (SFY 2011) (R)	✓			✓ DOC, Admin. Off. of the Courts	

	NCGA	DMHDDSAS	LME	Providers	Other Public Agencies	Other
<p>Recommendation 5.8: The North Carolina General Assembly should appropriate \$4.5 million in recurring funds to the Department of Corrections to expand the availability of substance abuse services to adults within the prison system, as well as residential services for those on probation or parole.</p>	<p>✓ \$4.50 m (SFY2010) (R) \$12,500 (SFY2010) (NR)</p>				<p>✓ DOC</p>	
Military Personnel						
<p>Recommendation 5.9 The Veterans Administration should continue to work with appropriate partners to provide training for mental health and substance abuse professionals; Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and LME agency staff; primary care providers; psychiatrists; school personnel; and other appropriate organizations about the medical and behavioral health needs of returning veterans and their families. In addition, the North Carolina General Assembly should appropriate \$200,000 in SFY 2010 to pay the 35% match for the Veterans Administration Homeless Providers Grant and Per Diem Program for transitional housing for homeless veterans with substance abuse or mental health disorders.</p>	<p>✓ \$200K</p>	<p>✓</p>	<p>✓</p>	<p>✓</p>	<p>✓ VA, DSS, DHUD, other comm. agency</p>	
Supply of Substance Abuse Professionals						
<p>Recommendation 6.1 (PRIORITY RECOMMENDATION) The North Carolina General Assembly should appropriate \$750,000 in recurring funds in SFY 2010, \$1.5 million in recurring funds in SFY 2011, increasing to \$2.0 million in SFY 2013 to the Governor’s Institute on Alcohol and Substance Abuse to create a scholarship program to increase the number of qualified professionals in the field of substance abuse treatment. Funding should be provided to help support people seeking training through the community colleges, undergraduate education, master’s degrees, or those who are seeking to pay for their hours of supervised training needed for their license. Individuals who receive state funds must agree to work for one year in a public or private not-for-profit substance abuse treatment program for every \$4,000 in scholarship funds. In addition, the North Carolina General Assembly should appropriate \$200,000 in recurring funds to the Area Health Education Centers program to establish clinical training sites for people seeking their substance abuse professional credentials.</p>	<p>✓ \$750K (SFY2010) (R) \$1.5m (SFY2011) (R) \$2m (SFY2013) (R)</p>				<p>✓ AHEC</p>	<p>✓ Gov. Inst.</p>

	NCGA	DMHDDSAS	LME	Providers	Other Public Agencies	Other
<p>Recommendation 6.2 The North Carolina General Assembly should appropriate \$200,000 in recurring funds in SFY 2010 to the Area Health Education Centers program to develop and support new residency training rotations for psychiatrists, family physicians, emergency medicine, or other physicians likely to enter the addiction field.</p>	✓ \$200K (SFY2010) (R)	✓			✓ AHEC	✓ Prof. org.
<p>Recommendation 6.3 The North Carolina State Personnel Commission should reevaluate and increase the pay grades for substance abuse professionals with appropriate credentials recognized by the North Carolina Substance Abuse Professional Practice Board.</p>					✓ NC State Pers. Comm.	
Data						
<p>Recommendation 7.1 The North Carolina General Assembly should appropriate \$1.2 million in recurring funds to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to enhance and expand current data system. Funding should be used to develop an information technology plan, including adoption of electronic health records, and to develop additional analytic capacity and undertake studies to understand systemic patterns and barriers to identification, referral, and engagement of consumers in treatment.</p>	✓ \$1.2m (SFY2010) (R)	✓				
<p>Recommendation 7.2 The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services should work with other agencies, including the Departments of Juvenile Justice and Delinquency Prevention, Corrections, and other Health and Human Services agencies to collect comprehensive data on substance abuse prevention and treatment services and people served with public funds. Further, the North Carolina General Assembly should adopt an equalization formula to ensure that Local Management Entities receive comparable funding to achieve equity in access to care and services.</p>	✓	✓	✓		✓ DJJ, DOC, DPI, DSS, DPH	✓ County comm.

References

- 1 North Carolina alcohol facts. University of North Carolina Highway Safety Research Center website. <http://www.hsrc.unc.edu/index.cfm>. Accessed February 28, 2008.
- 2 Division of Alcohol and Chemical Dependency Programs, North Carolina Department of Correction. Annual legislative report, 2006-2007. http://www.doc.state.nc.us/Legislative/2008/2006-07_Annual_Legislative_Report.pdf. Published March 2008. Accessed October 14, 2008.
- 3 North Carolina Department of Juvenile Justice and Delinquency Prevention. 2007 annual report. http://www.ncdjdp.org/resources/pdf_documents/annual_report_2007.pdf. Published March 2008. Accessed January 16, 2009.
- 4 The Schneider Institute for Health Policy. *Substance abuse: the nation's number one health problem*. Princeton, NJ: The Robert Wood Johnson Foundation; 2001.
- 5 Alcohol/Drug Council of North Carolina. 2004 North Carolina epidemiologic data. <http://www.alcoholdrughelp.org/education/documents/sdata2004.pdf>. Accessed October 14, 2007.
- 6 Frequently asked questions. Substance Abuse and Mental Health Services Administration website. <http://prevention.samhsa.gov/about/faq.aspx>. Accessed March 5, 2008.
- 7 National Institute on Drug Abuse, National Institutes of Health. *Principles of drug addiction treatment: a research-based guide*. Bethesda, MD: National Institutes of Health; 1999. NIH Publication No. 99-4180. <http://www.nida.nih.gov/podat/PODATIndex.html>. Published October 1999. Accessed May 15, 2008.
- 8 Office of Applied Studies, Substance Abuse and Mental Health Services Administration. State estimates of substance abuse and mental health from the 2005-2006 National Surveys on Drug Use and Health. <http://oas.samhsa.gov/2k6State/NorthCarolina.htm>. Accessed December 1, 2008.



Topics and Presenters

October 15, 2007

Overview of Task Force charge

Pam Silberman, JD, DrPH
President & CEO
North Carolina Institute of Medicine
(NCIOM)

Addiction is a chronic illness

David P. Friedman, PhD
Professor of Physiology
Deputy Associate Dean for Research
Wake Forest University School of
Medicine

The disease and the population

Phillip W. Graham, DrPH, MPH
Crime, Violence, and Justice Research
Program
RTI International

Introduction to North Carolina's publicly-funded substance abuse system

Flo Stein
Chief
Community Policy Management
Division Mental Health, Developmental
Disabilities, and Substance Abuse Services
(DMHDDSAS)
NC Department of Health and
Human Services (NC DHHS)

November 16, 2007

Summary of 10-31-07 Legislative Oversight Committee

Mark Holmes, PhD
Vice President
NCIOM

American Society of Addiction Medicine criteria

Clinical Innovators Series DVD
Features David Mee-Lee, MD
Author of ASAM Criteria

Follow-up discussion

Flo Stein
Chief
Community Policy Management
DMHDDSAS
NC DHHS

Dewayne Book, MD
Medical Director
Fellowship Hall

Prevention of substance abuse

Phillip A. Mooring, MS, CSAPC, LCAS
Executive Director
Families in Action, Inc

Evidence-based practices and their implementation

Sara McEwen, MD, MPH
Executive Director
Governor's Institute on Alcohol and
Substance Abuse

Types of data collected and what the data show

Spencer Clark
Community Policy Management
DMHDDSAS
NC DHHS

December 10, 2007**Prevention: evidence-based strategies
focused on children and adolescents**

Janice Petersen, PhD
Director
Office of Prevention
DMHDDSAS
NC DHHS

Consumer perspective and engagement

Syd Wiford, MRC, CCS, CSAS
Assistant Clinical Professor/Coordinator
Behavioral Healthcare Resource Program
Jordan Institute for Families
School of Social Work
University of North Carolina at
Chapel Hill

**Network for the Improvement of
Addiction Treatment (NIATX.net)**

Paul Toriello, RhD
Assistant Professor
Department of Rehabilitation Studies
College of Allied Health Sciences
East Carolina University

**Panel of providers: what's working in
North Carolina**

Misty Fulk, MEd, CSAPC, ICPS
Community Choices, Inc
Director of NC Operations

Thomas O. Savidge, MSW
CEO
Port Human Services

Wes Stewart, MSW, CCJP
Region 1 Treatment Accountability for
Safer Communities (TASC) Director

January 14, 2008**Screening, Brief Intervention, Referral,
and Treatment (SBIRT)**

Thomas F. Babor, PhD., MPH
Professor
Physicians Health Services Chair in
Community Medicine & Public Health
University of Connecticut Health Center

**Integration of primary care and
behavioral health**

Chris Collins, MSW
Assistant Director for Managed Care
NC Division of Medical Assistance
Deputy Director
Office of Rural Health and Community
Care
NC DHHS

North Carolina data update

Spencer Clark, MSW
Shealy Thompson, PhD
Community Policy Management
DMHDDSAS
NC DHHS

**Discussion of potential
recommendations**

February 15, 2008

Recovery services
 Melanie Whitter
 Project Director, Partners for Recovery Initiative
 Senior Associate, Center for Substance Abuse Treatment
 Abt Associates, Inc.

Evidence-based strategies focused on children and adolescents revisited

Flo Stein
 Chief
 Community Policy Management
 DMHDDSAS
 NC DHHS

Discussion of potential recommendations

March 14, 2008

Crisis services
 Steve Day
 Executive Director
 Technical Assistance Collaborative

Bonnie Morrell
 Best Practice Team Leader
 Head, Crisis Services
 DMHDDSAS
 NC DHHS

Effect on hospital emergency rooms

Mike Vicario
 Vice President
 Regulatory Affairs
 North Carolina Hospital Association

Discussion of potential recommendations

April 24, 2008

Presentation of potential recommendations

Discussion of potential recommendations and priority recommendation voting

May 30, 2008

Drug treatment courts
 Gregg Stahl
 Senior Deputy Director
 Administrative Office of the Courts

Honorable James E. Ragan, III
 Emergency Superior Court Judge
 Judicial District 3B
 Chairman
 North Carolina Drug Treatment Court Advisory Committee

Department of Corrections, Division of Alcohol and Chemical Dependency programs

Virginia Price
 Assistant Secretary
 Division of Alcohol and Chemical Dependency Programs
 NC Department of Correction

Wrenn Rivenbark
 Clinical Director
 Division of Alcohol and Chemical Dependency Programs
 NC Department of Correction

**Substance abuse in child welfare and
Work First in North Carolina**
Sherri Green, PhD, LCSW
Professor
Appalachian State University
Perinatal Consultant for the Governor's
Institute for Alcohol and Substance
Abuse

Sara Mims
Program Administrator for Work
First/CPS Policy
NC Division of Social Services

Melissa Godwin, MSW, LCSW
Clinical Instructor
Jordan Institute for Families Behavioral
Health Resource Program
UNC School of Social Work

**Division of Mental Health,
Developmental Disabilities, and
Substance Abuse Services Juvenile
Justice Programs**
Kelly Crowley, LCSW
System of Care Coordinator
Community Policy Management,
Prevention and Early Intervention Team
DMHDDSAS
NC DHHS

Paul Savery
CSAT Adolescent Substance Abuse
Treatment Coordination Grant Project
Coordinator
Community Policy Management,
Best Practices
DMHDDSAS
NC DHHS

June 23, 2008

**Department of Corrections, Division of
Community Corrections**
Robert Guy
Director
Division of Community Corrections
North Carolina Department of Correction

**Department of Juvenile Justice and
Delinquency Prevention**
Martin Pharr, PhD
Clinical Director and Legislative Liaison
Department of Juvenile Justice and
Delinquency Prevention

August 25, 2008

Legislative update
Flo Stein
Chief
Community Policy Management
DMHDDSAS
NC DHHS

Performance-based contracts
Tom McLellan, PhD
CEO
Treatment Research Institute

Mady Chalk, PhD
Director
Center for Policy Analysis and Research
Treatment Research Institute

**Flexible funding: Local Management
Entities and providers working
together successfully**
Tom Lucking
Consultant

September 26, 2008

Recognition of Recovery Month

Ashley Cox
 Coordinator of Resource Development
 Alcohol/Drug Council of North Carolina

**North Carolina substance abuse
 workforce policies and oversight**

Flo Stein
 Chief
 Community Policy Management
 DMHDDSAS
 NC DHHS

Flay J. Lee, LCAS, CAS
 Chair of the Executive Committee
 North Carolina Substance Abuse
 Professional Practice Board

Employee assistance programs

Patrice Alexander, SPHR
 Director of Human Resources
 Greenville Utilities

Frank Horton
 President
 Frank Horton Associates

**Future of the substance abuse workforce
 in North Carolina**

Becky Brownlee
 President, Power Steering, Inc.
 Contractor, Governor's Institute on
 Alcohol and Substance Abuse

Ellen Holliman
 Director
 The Durham Center

October 24, 2008

**Substance abuse on college campuses
 and the drinking age**

Michael Eisen
 State Coordinator for Preventing Underage
 Drinking Initiatives
 DMHDDSAS
 NC DHHS

Thomas Szigethy
 Associate Dean
 Director of the Alcohol and Substance
 Abuse Prevention Center
 Duke University

**Military: substance abuse services for
 veterans**

Greg Hughes
 Chief of Social Work Services
 Durham VA Medical Center

**Military: what should Local Management
 Entities do?**

Flo Stein
 Chief
 Community Policy Management
 DMHDDSAS
 NC DHHS

Military: active duty and veterans

Harold Kudler, M.D.
 Coordinator,
 Mental Health Service Line for the Mid
 Atlantic Veterans Integrated Service
 Network
 Associate Director
 VA Mental Illness Research, Education,
 and Clinical Center (MIRECC) on
 Deployment Mental Health.
 Associate Clinical Professor
 Department of Psychiatry and Behavioral
 Sciences
 Duke University

November 21, 2008**Access barriers**

Cynthia “Syd” Wiford, MRC, CCS, CSAS
Assistant Clinical Professor/Coordinator
Behavioral Healthcare Resource Program
Jordan Institute for Families
School of Social Work
University of North Carolina at
Chapel Hill

Improving access to services:**Dare Substance Abuse Initiative**

Anne B. Thomas, BSN, MPA
Public Health Director
Dare County Department of Public Health

Improving access to services:**Oxford House**

Kathleen Gibson
State Coordinator
Oxford House

**What would a DMHDDSAS designed
performance-based system look like**

Flo Stein
Chief
Community Policy Management
DMHDDSAS
NC DHHS

**North Carolina Psychiatric Association’s
Addiction Committee Response to Interim
Report**

David Ames, MD, DLFAPA
Chair
North Carolina Psychiatric Association
Addictions Committee

**Presentation and review of potential
recommendations****December 15, 2008****Overuse of prescription pills and the
Controlled Substances Registration
System**

Bill Bronson
Manager
Drug Control Unit
DMHDDSAS
NC DHHS

James Finch, M.D.

Medical Director
Changes by Choice and BAART Programs

Review of recommendations**Prioritization of recommendations**

Local Management Entities'

Appendix B

Performance Data, April 1–June 30, 2008

	Treated Prevalence		Timely Access to Services [1][2]			Timely Initiation & Engagement [1]		Timely Follow Up [1]
	Treated Prevalence: Adults who Receive Public Substance Abuse Services	Treated Prevalence: Children who Receive Public Substance Abuse Services	Emergent (within 2 hours)	Urgent (within 48 hours)	Routine (within 14 calendar days)	2 visits in first 14 days	4 visits in first 45 days	Seen in 1-7 days after release from ADATC
SFY 2008 Performance Target [3]	10%	9%	100%	88%	69%	71%	50%	36%
SFY Performance Contract Requirement [3]	8%	7%	100%	80%	63%	59%	42%	24%
Statewide Average	8%	7%	100%	79%	68%	62%	46%	23%
Alamance-Caswell-Rockingham	7%	6%	100%	100%	52%	56%	33%	17%
Albemarle (Camden, Chowan, Currituck, Dare, Hyde, Martin, Pasquotank, Perquimans, Tyrrell, Washington)	10%	6%	100%	68%	53%	36%	27%	21%
Beacon Center (Edgecombe, Greene, Nash, Wilson)	5%	5%	100%	13%	51%	56%	38%	8%
Burke-Catawba	9%	7%	100%	100%	28%	63%	51%	27%
CenterPoint (Davie, Forsyth, Stokes)	8%	9%	100%	78%	58%	57%	46%	14%
Crossroads (Iredell, Surry, Yadkin)	8%	6%	100%	66%	57%	69%	48%	25%
Cumberland	6%	8%	100%	78%	71%	58%	46%	0%
Durham	8%	11%	100%	77%	90%	82%	63%	25%
East Carolina Behavioral Health (Beaufort, Bertie, Craven, Gates, Hertford, Jones, Northampton, Pamlico, Pitt)	7%	10%	100%	75%	86%	67%	47%	15%
Eastpointe (Duplin, Lenoir, Sampson, Wayne)	6%	5%	100%	78%	90%	49%	31%	16%
Five County (Franklin, Granville, Halifax, Vance, Warren)	10%	9%	100%	100%	82%	42%	30%	24%
Foothills (Alexander, Caldwell, McDowell)[4]	7%	4%				60%	51%	14%
Guilford	8%	6%	100%	100%	84%	72%	52%	38%
Johnston	11%	4%	100%	100%	55%	53%	44%	43%
Mecklenburg	8%	5%	100%	95%	61%	70%	52%	17%
Onslow-Carteret	6%	6%	100%	71%	65%	54%	39%	17%
Orange-Person-Chatham	7%	7%	100%	93%	85%	66%	46%	16%
Pathways (Cleveland, Gaston, Lincoln)	10%	8%	88%	77%	61%	59%	45%	41%
Piedmont (Cabarrus, Davidson, Rowan, Stanly, Union)[5]								

	Treated Prevalence		Timely Access to Services [1][2]			Timely Initiation & Engagement [1]		Timely Follow Up [1]
	Treated Prevalence: Adults who Receive Public Substance Abuse Services	Treated Prevalence: Children who Receive Public Substance Abuse Services	Emergent (within 2 hours)	Urgent (within 48 hours)	Routine (within 14 calendar days)	2 visits in first 14 days	4 visits in first 45 days	Seen in 1-7 days after release from ADATC
Alamance-Caswell-Rockingham	7%	6%	100%	100%	52%	56%	33%	17%
Sandhills Center (Anson, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond)	7%	8%	100%	90%	81%	64%	42%	33%
Smoky Mountain (Alleghany, Ashe, Avery, Cherokee, Clay, Graham, Haywood, Jackson, Macon, Swain, Watauga, Wilkes)	9%	7%	100%	69%	70%	58%	46%	24%
Southeastern Center (Brunswick, New Hanover, Pender)	9%	6%	100%	77%	77%	57%	45%	36%
Southeastern Regional (Bladen, Columbus, Robeson, Scotland)	11%	7%	100%	86%	77%	65%	42%	53%
Wake	5%	4%	100%	92%	74%	58%	44%	25%
Western Highlands (Buncombe, Henderson, Madison, Mitchell, Polk, Rutherford, Transylvania, Yancey)	9%	8%	100%	58%	87%	75%	60%	25%

Source: MH/DD/SAS Community Systems Progress Report. (Fourth Quarter SFY 2007-2008. April 1-June 30, 2008). September 15, 2008.

[1] Performance standards are based on national measures, when available. For example, the performance standards for timely access to care (emergent, urgent and routine) and timely follow-up after inpatient care (ADATCs) are based on the Healthcare Enterprise Data Information System (HEDIS) measures, supported by the federal Centers for Medicare and Medicaid Services. The performance standards for timely initiation and engagement in services (2 visits in first 14 days, 4 visits in first 45 days) are based on national standards, Washington Circle Public Sector Workgroup (www.washingtoncircle.org).

[2] Timely access to care includes access for people with substance abuse problems, mental health problems, and developmental disabilities. Timely access measures have been based on LME self-reported data. These data are not subject to external verification. With other data, the state calculates the percentages based on claims data. Because of the way these data were collected, DMHDDSAS did not have the ability to separate out the timely access measures for people by specific disability (such as those with a substance abuse disorders) at the time of this report. These data problems are being addressed. The data collected in SFY 09 is based on claims data, so can be reported separately for each disability group.

[3] The percentage targets and contract performance standards (minimums) were established by the Division. The performance contract standards are set based on the statewide average in the prior fiscal year. LMEs may be sanctioned for failure to meet these minimum standards. The current performance contract standards set achievable bars, which push the poorer performing LMEs to reach the level of their colleagues while simultaneously pushing up the overall standard each year. The performance targets are set by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to emphasize high priority areas, while trying to be realistic about what can be achieved in a single year. The goal is to continuously raise these targets as statewide performance increases. Over time, DMHDDSAS plans to establish best practice benchmarks.

[4] Data for Foothills was not provided for the "Timely Access to Care" measures

[5] Data for Piedmont not available

Staff and Key Activities Recommended for Implementation of the NCIOM Task Force Report

No. of FTE Staff Positions Recommended	Position Title	Key Activities Recommended in Areas of Primary Focus
One (1) FTE		<ul style="list-style-type: none"> ■ Development and coordination of a statewide recovery-oriented system of care and development of local and regional recovery centers. These centers will facilitate the adoption of a person-centered and holistic system of care for the individual that recognizes the critical role of both services and supports across the lifespan in addressing substance abuse as a chronic, relapsing illness requiring attention to natural and community supports and individualized care and services.
Three (3) FTEs: 2 FTEs: Adult 1 FTE: DWI	Adult Substance Abuse Treatment Continuum Regional Clinical Consultant	<ul style="list-style-type: none"> ■ Oversight, coordination, and technical assistance for regionally funded, locally hosted Cross Area Service Program (CASP) Adult Substance Abuse Treatment and Residential Services Pilot Program Initiatives. ■ Implementation of provider relational contracting and incentive-based measures of program performance and consumer outcomes. ■ Liaison with Alcohol and Drug Addiction Treatment Centers, State Hospitals, residential programs, homeless shelters, and local detoxification centers to ensure access to timely and effective community-based treatment and continuity of care. ■ Consultation regarding adoption, enhancement, and expansion of the utilization of adult substance abuse evidence-based programs and practices such as substance abuse intensive outpatient program, substance abuse comprehensive outpatient treatment program, and community support teams in coordination with residential treatment programs and recovery housing options. ■ Consultation regarding enhancement of person-centered, culturally competent, and gender-specific programs for women and their children, persons with HIV disease, criminal justice consumers, and other specialty treatment populations. ■ Support and technical assistance to substance abuse provider agencies in organizational, clinical, and business functions related to the successful operation of a viable substance abuse provider agency.
	DWI Consultant	<ul style="list-style-type: none"> ■ Monitoring and technical assistance to authorized DWI services providers and Alcohol and Drug Education Traffic School (ADETS) instructors across the state to ensure

No. of FTE Staff Positions Recommended	Position Title	Key Activities Recommended in Areas of Primary Focus
		<p>compliance with laws, rules, and policies governing DWI providers and services.</p> <ul style="list-style-type: none"> ■ Consultation and training for DWI services providers and ADETS instructors in implementing evidence-based supports, services, and treatments for DWI offenders. ■ Planning, collaboration, and policy development to improve responses to driving while impaired offenses and services to offenders. ■ Monitoring provider performance and consumer outcomes through data collected via the electronic Certificate of Completion system.
One (1) FTE	Substance Abuse Prevention Services Information System Manager	<ul style="list-style-type: none"> ■ Coordination of the statewide adoption, implementation, and evaluation of a recognized provider-based system for the measurement of local program, community, county, Local Management Entities (LME), regional, and statewide performance measures in the areas of participant outreach, education, identification, engagement, retention, program completion, consumer outcomes, and program efficiency. Implementation will include be Substance Abuse and Mental Health Services Administration’s National Outcome Measures (NOMs) for alcohol, tobacco, and other drug (ATOD) prevention, including measurement of pre- and post-intervention measures of individual, family, and community change in targeted areas of individual knowledge, attitudes, perceptions, and behaviors as well as community norms in such areas as alcohol, tobacco, and other drug access, availability, supervision, enforcement, and public acceptance and community norms regarding causes, consequences, and patterns of use, misuse, abuse, and dependence.
Two (2)FTEs	Quality Management Substance Abuse Research Analyst	<ul style="list-style-type: none"> ■ Coordination of research, analysis, and consultation regarding epidemiological trends in substance abuse prevalence and penetration levels at statewide, regional, and local levels across consumer populations and development of effective planning strategies for recognition of needs as a prerequisite to effectively targeting populations, programs, and resources. ■ Coordination of research, analysis, and consultation regarding statewide, regional, and local substance abuse program efficiency and effectiveness in implementation of established evidence-based programs and practices, including assisting

and Key Activities Recommended for Implementation of the NCIOM Task Force Report

No. of FTE Staff Positions Recommended	Position Title	Key Activities Recommended in Areas of Primary Focus
		<p>LMEs and providers in integrating practice fidelity measures as a routine part of clinical practice implementation, evaluation, and improvement.</p> <ul style="list-style-type: none"> ■ Initiation of routine and ongoing research and analysis regarding the elimination or reduction of state, regional, and local business and substance abuse clinical services policies and practices that are cumbersome, counterproductive, inefficient, and costly, and provision of ongoing recommendations for quality improvement measures for more standardized, streamlined, barrier-free, and efficient processes that contribute positively to the business and clinical services environment for substance abuse provider agencies. ■ Coordination of research, analysis, and consultation regarding statewide, regional, and local substance abuse program patterns of service authorization for necessary, adequate, and efficient utilization of Medicaid and other federal, state, and local resources. ■ Consultation and technical assistance for LMEs and substance abuse providers regarding use of established and promising substance abuse program performance measures in benchmarking and use of incentive-based initiatives in recognizing and improving program performance across the domains of identification, engagement, retention, continuity of care, and treatment program completion. ■ Consultation, teaching, and technical assistance for LMEs and substance abuse providers regarding use of established and promising substance abuse program consumer clinical outcomes measures in benchmarking and use of incentive-based initiatives in recognizing and improving program performance across the domains of abstinence or reduction in substance abuse, housing, education and employment, arrests, self-help group participation, social connectedness, family functioning, physical and emotional health, and perception of care.
Three (3) FTEs	Substance Abuse Prevention Services & Coalition Development Regional Consultant	<ul style="list-style-type: none"> ■ Assistance in developing and implementing a statewide, regional, and local comprehensive prevention plan. ■ Coordination of regionally funded, locally hosted CASP Comprehensive Prevention Pilot Program Initiatives.

No. of FTE Staff Positions Recommended	Position Title	Key Activities Recommended in Areas of Primary Focus
		<ul style="list-style-type: none"> ■ Consultation regarding expansion and enhancement of availability of evidence-based programs and practices in coordination with Department of Public Instruction, Department of Juvenile Justice and Delinquency Prevention (DJJDP), and other youth-serving agencies. ■ Consultation regarding enhancement of person-centered culture and gender-specific programs for specialty populations at high risk for substance abuse. ■ Support and technical assistance to substance abuse provider agencies in organizational, service, and business functions related to the successful operation of a viable substance abuse provider agency.
Three (3) FTEs	Child and Adolescent Substance Abuse Treatment Continuum Regional Clinical Consultant	<ul style="list-style-type: none"> ■ Oversight, coordination, and technical assistance for regionally funded, locally hosted Cross Area Service Program (CASP) Child and Adolescent Substance Abuse Treatment and Residential Services Pilot Program Initiatives. ■ Implementation of provider relational contracting and incentive-based measures of program performance and consumer outcomes. ■ Liaison with residential programs and DJJDP youth development centers and detention centers to ensure access to timely and effective community-based treatment and continuity of care. ■ Consultation regarding adoption, enhancement, and expansion of the utilization of adolescent substance abuse evidence-based programs and approaches such as intensive in-home services, multi-systemic therapy, and Day Treatment in coordination with residential treatment programs and recovery housing options. ■ Consultation regarding enhancement of person-centered, culturally-competent, and gender-specific programs for teen parents and their children, persons with HIV disease, juvenile justice, and other specialty treatment populations. ■ Support and technical assistance to substance abuse provider agencies in organizational, clinical, and business functions related to the successful operation of a viable substance abuse provider agency.
Total = Thirteen (13) FTEs		

Professional Practice Board Substance Abuse Professionals Credentialing Requirements

Licensed Clinical Addiction Specialists (LCAS): There are four ways to become licensed as a clinical addiction specialist: 1) The person must have a master's degree in a human services field with a clinical application, two years of post-graduate supervised substance abuse counseling experience, three letters of reference from appropriately trained substance abuse professionals, 180 hours of substance abuse specific training, and successful completion of a written exam from the Board. 2) The person must have a master's degree in a human services field with a clinical application, current certification as a Certified Substance Abuse Counselor, three letters of reference from appropriately trained substance abuse professionals, and successful completion of a written exam. 3) The person must have a master's degree in a human services field with a substance abuse specialty that includes 180 hours of substance abuse training and education, one year of post-graduate supervised substance abuse counseling experience, three letters of reference from appropriately trained substance abuse professionals, and successful completion of a written exam. 4) The person is a member of a professional discipline granted deemed status by the Board and is recognized by that discipline as having met the standards of a substance abuse specialist.

Licensed Clinical Addiction Specialists-Provisional (LCAS-Provisional): LCAS-Provisionals are individuals who have successfully registered with the Board and have completed the 300 hour supervised practicum. However, LCAS-Provisionals are still in the process of obtaining the supervised counseling experience. Individuals who are recognized as LCAS-Provisional can provide counseling services under the supervision of a Certified Clinical Supervisor (CCS) or Clinical Supervisor Intern (CSI) physician.

Certified Clinical Supervisor (CCS): To be recognized as a Certified Clinical Supervisor, the person must be credentialed as a Licensed Clinical Addiction Specialist, have 8,000 hours experience in the field, a master's degree in a human services field with a clinical application, 4,000 hours of experience as a substance abuse clinical supervisor, 30 hours of substance abuse clinical supervision specific education/training for initial certification, one letter of reference from the applicant's current supervisor, three letters of reference (one from a professional who can attest to supervisory competence and two from counselors who have been supervised or professionals who can attest to the applicant's competence), and successful completion of a written exam.

Certified Substance Abuse Counselor (CSAC): A Certified Substance Abuse Counselor (CSAC) must have 6,000 hours of supervised experience of practice in a setting or program that provides treatment for alcohol or drug abuse and have completed 270 hours of Board-approved education and training. In addition, the individual must also have successfully passed a competency-based examination administered by the Board. In addition to CCS, the Board also recognizes Clinical Supervisor Interns who are LCASs who have completed a master's degree in a human services field with a clinical application and completed at least 50% of the clinical supervision specific training.

Certified Substance Abuse Prevention Consultant (CSAPC): CSAPCs must have three years full-time experience in the field or two years if the person has a bachelor's degree or higher in a human services field, 270 hours of approved academic/didactic training (170 hours in primary prevention and 100 hours in substance abuse specific material), a minimum of 300 board-approved practicum hours documented by a qualified alcohol, drug, or substance abuse professional, evaluations from a supervisor and two colleagues, and successful completion of a written exam.

Certified Substance Abuse Residential Facility Director (CSARFD): To be recognized as a CSARFD, the person must be a CSAC and have 50 hours of NCSAPCB-approved academic/didactic management specific training, a positive recommendation from a supervisor, and a positive recommendation from a colleague or coworker.

Certified Criminal Justice Addictions Professional Credential (CCJP): The CCJP credential is provided to addiction professionals who work in law enforcement, judiciary, or corrections and who have received education/training of 270 hours or 180 hours if the applicant has a master's degree or higher in a human services field. Education/training must be related to the knowledge and skills needed to perform the tasks within one of six domains: dynamics of addiction and criminal behavior; legal, ethical, and professional responsibility; criminal justice system and processes; screening, intake and assessment; case management, monitoring and client supervision; and counseling. In addition, the person seeking the CCJP credential must have 300 hours supervised practicum with at least 10 hours supervision in each domain and 6,000 of supervised work experience for people with a high school/GED or fewer hours for people with higher education. The person must be supervised by a CCS or CSI and must be supervised providing direct services to individuals involved in the criminal justice system.

Substance Abuse Professionals By County

Appendix E

	Sep 2008 Number of Clinicians (NCAPPB) [1]				UNC-CH School of Social Work [2]	Total SA Providers (NCAPPB or UNC-CH School of Social Work)
	Certified Substance Abuse Counselors (CSAC)	Provisionally Licensed Clinical Addictions Specialists (LCAS-P)	Licensed Clinical Addictions Specialists (LCAS)	Total SA Providers Licensed or Credentialed by NCAPPB	Certified SA Peer Support Specialists	
Alamance	5	3	11	19	0	19
Alexander	0	0	3	3	0	3
Alleghany	0	0	4	4	0	4
Anson	0	0	0	0	0	0
Ashe	1	0	6	7	0	7
Avery	0	1	1	2	0	2
Beaufort	2	2	4	8	0	8
Bertie	1	0	0	1	0	1
Bladen	3	0	0	3	0	3
Brunswick	4	1	9	14	0	14
Buncombe	35	17	69	121	0	121
Burke	7	2	7	16	0	16
Cabarrus	11	4	21	36	0	36
Caldwell	7	0	8	15	0	15
Camden	0	0	0	0	0	0
Carteret	1	0	2	3	0	3
Caswell	1	0	1	2	0	2
Catawba	10	2	8	20	0	20
Chatham	2	0	3	5	0	5
Cherokee	1	0	2	3	0	3
Chowan	0	0	3	3	0	3
Clay	0	0	0	0	0	0
Cleveland	4	0	6	10	0	10
Columbus	7	0	2	9	0	9
Craven	10	3	8	21	2	23
Cumberland	25	8	37	70	0	70
Currituck	0	0	1	1	0	1
Dare	2	0	8	10	0	10
Davidson	5	2	6	13	0	13
Davie	0	0	5	5	0	5
Duplin	4	1	5	10	0	10
Durham	9	8	36	53	10	63
Edgecombe	1	0	4	5	0	5
Forsyth	18	4	33	55	0	55
Franklin	0	0	6	6	0	6

Appendix E

Substance Abuse Professionals by County

	Sep 2008 Number of Clinicians (NCAPPB) [1]				UNC-CH School of Social Work [2]	Total SA Providers (NCAPPB or UNC-CH School of Social Work)
	Certified Substance Abuse Counselors (CSAC)	Provisionally Licenses Clinical Addictions Specialists (LCAS-P)	Licensed Clinical Addictions Specialists (LCAS)	Total SA Providers Licensed or Credentialed by NCAPPB	Certified SA Peer Support Specialists	
Gaston	13	2	10	25	1	26
Gates	0	0	1	1	0	1
Graham	0	0	0	0	0	0
Granville	4	2	6	12	0	12
Greene	1	0	0	1	0	1
Guilford	39	3	57	99	1	100
Halifax	2	2	1	5	0	5
Harnett	5	2	5	12	0	12
Haywood	2	1	11	14	0	14
Henderson	6	0	9	15	0	15
Hertford	1	1	1	3	0	3
Hoke	3	1	3	7	0	7
Hyde	0	0	0	0	0	0
Iredell	6	3	16	25	0	25
Jackson	3	1	6	10	0	10
Johnston	10	1	25	36	1	37
Jones	0	0	1	1	0	1
Lee	4	0	3	7	0	7
Lenoir	3	0	5	8	0	8
Lincoln	8	0	3	11	0	11
Macon	1	0	5	6	0	6
Madison	2	0	2	4	0	4
Martin	1	0	1	2	0	2
McDowell	0	1	2	3	0	3
Mecklenburg	71	22	125	218	0	218
Mitchell	1	0	0	1	0	1
Montgomery	0	0	3	3	0	3
Moore	14	1	15	30	0	30
Nash	7	0	9	16	0	16
New Hanover	17	11	39	67	0	67
Northampton	1	0	3	4	0	4
Onslow	22	2	7	31	0	31
Orange	3	5	19	27	0	27
Pamlico	0	0	0	0	0	0
Pasquotank	0	0	1	1	0	1
Pender	6	0	2	8	0	8
Perquimans	0	0	3	3	0	3

	Sep 2008 Number of Clinicians (NCAPPB) [1]				UNC-CH School of Social Work [2]	Total SA Providers (NCAPPB or UNC-CH School of Social Work)
	Certified Substance Abuse Counselors (CSAC)	Provisionally Licenses Clinical Addictions Specialists (LCAS-P)	Licensed Clinical Addictions Specialists (LCAS)	Total SA Providers Licensed or Credentialed by NCAPPB	Certified SA Peer Support Specialists	
Person	1	0	0	1	0	1
Pitt	6	5	46	57	0	57
Polk	4	2	15	21	0	21
Randolph	3	0	10	13	0	13
Richmond	2	0	1	3	0	3
Robeson	11	4	10	25	0	25
Rockingham	4	0	5	9	0	9
Rowan	4	5	15	24	0	24
Rutherford	6	1	6	13	0	13
Sampson	1	0	2	3	0	3
Scotland	5	0	3	8	0	8
Stanly	5	3	3	11	0	11
Stokes	1	0	2	3	0	3
Surry	3	1	8	12	0	12
Swain	5	0	2	7	0	7
Transylvania	2	1	4	7	0	7
Tyrrell	0	0	0	0	0	0
Union	7	1	9	17	0	17
Vance	2	0	5	7	0	7
Wake	48	30	106	184	0	184
Warren	0	0	0	0	0	0
Washington	0	0	2	2	0	2
Watauga	3	3	13	19	0	19
Wayne	9	1	13	23	0	23
Wilkes	6	1	5	12	0	12
Wilson	0	0	9	9	0	9
Yadkin	2	0	1	3	0	3
Yancey	0	0	2	2	0	2
State Total	572	177	1015	1764	15	1779

[1] SA Counselor Data: NC Substance Abuse Professional Practice Board, September 15, 2008.

[2] Peer Support Specialists Certified by the Behavioral Health Resource Program at the School of Social Work at The University of North Carolina at Chapel Hill.

[3] Source: North Carolina Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, with data derived from the North Carolina Medical Board and North Carolina Board of Nursing, 2008.

[4] Population Data: The Office of State Budget and Management (OSBM) State Demographics Branch website: <http://www.osbm.state.nc.us/demog/c08sage.html>. July 2008 Population Projection (Last Update: June 9, 2008. Downloaded 6/27/08).

[5] NC Substance Abuse Prevalence Rates Source: SAMHSA, Office of Applied Studies, National Surveys on Drug Use and Health, 2005 and 2006, published Feb 2008. Table B.20, Dependence on or Abuse of Illicit Drugs or Alcohol in Past Year, by Age Group and State: Percentages, Annual Averages Based on 2005 and 2006 NSDUHs.

Appendix E

Substance Abuse Professionals by County

Health Professionals (2007 Licensure Data, Health Professions Data System) [3]							
	Unduplicated Physicians with Addiction Specialty	Unduplicated Physician Assts with Addiction Specialty	Unduplicated Nurse Practitioners with Addiction Specialty	RNs with Drug/Alcohol as Major Clinical Practice Area	LPNs with Drug/Alcohol as Major clinical Practice Area	Total MDs PAs, NPs, RNS or LPNs with Drug/Alcohol Specialty	Total SA Licensed Credentialed or Certified and Health Professionals with SA Specialty
Alamance	1	0	0	2	0	3	3
Alexander	1	0	0	0	0	1	1
Alleghany	0	0	0	0	0	0	0
Anson	0	0	0	0	0	0	0
Ashe	0	0	0	0	0	0	0
Avery	1	0	0	0	0	1	1
Beaufort	0	0	0	0	1	1	1
Bertie	0	0	0	0	0	0	0
Bladen	0	0	0	0	0	0	0
Brunswick	0	0	0	0	0	0	0
Buncombe	9	3	1	29	7	49	49
Burke	1	1	0	1	0	3	3
Cabarrus	1	0	0	0	3	4	4
Caldwell	1	0	0	0	0	1	1
Camden	0	0	0	0	0	0	0
Carteret	0	0	0	0	0	0	0
Caswell	0	0	0	0	0	0	0
Catawba	0	0	0	0	3	3	3
Chatham	1	0	0	0	0	1	1
Cherokee	0	0	0	0	0	0	0
Chowan	0	0	0	0	0	0	0
Clay	0	0	0	0	0	0	0
Cleveland	0	0	0	0	0	0	0
Columbus	0	0	0	0	0	0	0
Craven	0	0	0	0	0	0	0
Cumberland	1	0	0	1	7	9	9
Currituck	0	0	0	1	0	1	1
Dare	0	0	0	0	0	0	0
Davidson	0	0	0	0	0	0	0
Davie	0	0	0	0	0	0	0
Duplin	0	0	0	0	0	0	0
Durham	4	0	1	5	4	14	14
Edgecombe	0	0	0	0	0	0	0
Forsyth	5	0	0	3	2	10	10
Franklin	0	0	0	0	0	0	0
Gaston	1	0	0	2	0	3	3
Gates	0	0	0	0	0	0	0

Health Professionals (2007 Licensure Data, Health Professions Data System) [3]							
	Unduplicated Physicians with Addiction Specialty	Unduplicated Physician Assts with Addiction Specialty	Unduplicated Nurse Practitioners with Addiction Specialty	RNs with Drug/Alcohol as Major Clinical Practice Area	LPNs with Drug/Alcohol as Major clinical Practice Area	Total MDs PAs, NPs, RNS or LPNs with Drug/Alcohol Specialty	Total SA Licensed Credentialed or Certified and Health Professionals with SA Specialty
Graham	0	0	0	0	0	0	0
Granville	1	0	0	14	3	18	18
Greene	0	0	0	0	0	0	0
Guilford	4	0	0	17	4	25	25
Halifax	0	0	0	0	1	1	1
Harnett	1	0	0	0	0	1	1
Haywood	0	0	1	2	0	3	3
Henderson	1	0	0	3	0	4	4
Hertford	0	0	0	0	2	2	2
Hoke	0	0	0	0	0	0	0
Hyde	0	0	0	0	0	0	0
Iredell	0	0	0	0	0	0	0
Jackson	0	0	0	0	0	0	0
Johnston	1	1	0	2	4	8	8
Jones	0	0	0	0	0	0	0
Lee	0	0	0	0	2	2	2
Lenoir	0	0	0	0	0	0	0
Lincoln	1	0	0	0	0	1	1
Macon	1	0	0	0	0	1	1
Madison	0	0	0	0	1	1	1
Martin	0	0	0	0	0	0	0
McDowell	0	0	0	0	0	0	0
Mecklenburg	14	1	0	11	6	32	32
Mitchell	0	0	0	0	0	0	0
Montgomery	0	0	0	0	0	0	0
Moore	4	0	0	2	0	6	6
Nash	0	0	0	1	1	2	2
New Hanover	7	1	1	11	10	30	30
Northampton	0	0	1	0	0	1	1
Onslow	2	1	1	0	2	6	6
Orange	3	0	0	0	1	4	4
Pamlico	0	0	0	0	0	0	0
Pasquotank	0	0	0	0	0	0	0
Pender	0	0	0	1	0	1	1
Perquimans	0	0	0	0	0	0	0
Person	0	0	0	0	0	0	0
Pitt	0	2	0	20	9	31	31

Health Professionals (2007 Licensure Data, Health Professions Data System) [3]							
	Unduplicated Physicians with Addiction Specialty	Unduplicated Physician Assts with Addiction Specialty	Unduplicated Nurse Practitioners with Addiction Specialty	RNs with Drug/Alcohol as Major Clinical Practice Area	LPNs with Drug/Alcohol as Major clinical Practice Area	Total MDs PAs, NPs, RNS or LPNs with Drug/Alcohol Specialty	Total SA Licensed Credentialed or Certified and Health Professionals with SA Specialty
Polk	2	0	0	3	2	7	7
Randolph	0	0	0	0	0	0	0
Richmond	0	0	0	0	0	0	0
Robeson	0	0	0	1	0	1	1
Rockingham	0	0	0	1	0	1	1
Rowan	0	0	0	1	2	3	3
Rutherford	1	0	0	0	0	1	1
Sampson	0	0	0	0	0	0	0
Scotland	0	0	0	0	0	0	0
Stanly	1	0	0	0	0	1	1
Stokes	0	0	0	0	0	0	0
Surry	1	0	0	0	1	2	2
Swain	0	0	0	1	1	2	2
Transylvania	0	0	0	0	0	0	0
Tyrrell	0	0	0	0	0	0	0
Union	0	1	0	7	1	9	9
Vance	0	0	0	0	0	0	0
Wake	14	5	2	27	3	51	51
Warren	0	0	0	0	0	0	0
Washington	0	0	0	0	0	0	0
Watauga	0	0	0	0	0	0	0
Wayne	2	0	0	1	0	3	3
Wilkes	0	0	0	0	0	0	0
Wilson	0	0	0	0	0	0	0
Yadkin	0	0	0	1	0	1	1
Yancey	0	0	0	0	0	0	0
State Total	88	16	8	171	83	366	366

[1] SA Counselor Data: NC Substance Abuse Professional Practice Board, September 15, 2008.

[2] Peer Support Specialists Certified by the Behavioral Health Resource Program at the School of Social Work at The University of North Carolina at Chapel Hill.

[3] Source: North Carolina Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, with data derived from the North Carolina Medical Board and North Carolina Board of Nursing, 2008.

[4] Population Data: The Office of State Budget and Management (OSBM) State Demographics Branch website: <http://www.osbm.state.nc.us/demog/c08sage.html>. July 2008 Population Projection (Last Update: June 9, 2008. Downloaded 6/27/08).

[5] NC Substance Abuse Prevalence Rates Source: SAMHSA, Office of Applied Studies, National Surveys on Drug Use and Health, 2005 and 2006, published Feb 2008. Table B.20, Dependence on or Abuse of Illicit Drugs or Alcohol in Past Year, by Age Group and State: Percentages, Annual Averages Based on 2005 and 2006 NSDUHs.

Appendix E

Substance Abuse Professionals by County

	July Population 2008 Estimates [4]				Estimated Persons in Need of SA Services [5]			
	Ages 12-17	Ages 18-25	Ages 26+	Total	Estimated Youth with SA (ages 12-17) Prevalence: 7.83%	Estimated Adults with SA (ages 18-25) Prevalence: 18.87%	Estimated Adults with SA (ages 26+) Prevalence: 6.84	Total Estimated Youth and Adults with SA (ages 12+)
Alamance	11,750	17,403	92,667	121,820	920	3,284	6,338	10,542
Alexander	2,985	3,547	24,642	31,174	234	669	1,686	2,589
Alleghany	738	864	8,177	9,779	58	163	559	780
Anson	2,108	2,403	16,778	21,289	165	453	1,148	1,766
Ashe	1,727	2,054	19,101	22,882	135	388	1,307	1,829
Avery	1,190	2,005	13,151	16,346	93	378	900	1,371
Beaufort	3,537	3,869	32,115	39,521	277	730	2,197	3,204
Bertie	1,654	1,751	13,452	16,857	130	330	920	1,380
Bladen	2,654	2,982	21,629	27,265	208	563	1,479	2,250
Brunswick	7,129	8,598	74,802	90,529	558	1,622	5,116	7,297
Buncombe	16,909	23,190	157,812	197,911	1,324	4,376	10,794	16,494
Burke	7,623	9,623	58,421	75,667	597	1,816	3,996	6,409
Cabarrus	14,365	17,522	107,503	139,390	1,125	3,306	7,353	11,784
Caldwell	6,322	7,533	54,143	67,998	495	1,421	3,703	5,620
Camden	785	867	6,648	8,300	61	164	455	680
Carteret	4,186	5,305	46,952	56,443	328	1,001	3,212	4,540
Caswell	1,838	2,196	16,199	20,233	144	414	1,108	1,666
Catawba	12,908	16,151	101,431	130,490	1,011	3,048	6,938	10,996
Chatham	4,209	5,784	41,578	51,571	330	1,091	2,844	4,265
Cherokee	1,851	2,024	20,081	23,956	145	382	1,374	1,900
Chowan	1,143	1,297	10,214	12,654	89	245	699	1,033
Clay	626	689	8,045	9,360	49	130	550	729
Cleveland	8,524	10,152	63,328	82,004	667	1,916	4,332	6,915
Columbus	4,636	5,218	35,798	45,652	363	985	2,449	3,796
Craven	7,154	13,023	61,757	81,934	560	2,457	4,224	7,242
Cumberland	27,370	48,889	182,809	259,068	2,143	9,225	12,504	23,873
Currituck	1,910	2,307	16,406	20,623	150	435	1,122	1,707
Dare	2,216	3,104	24,356	29,676	174	586	1,666	2,425
Davidson	12,790	15,122	104,954	132,866	1,001	2,854	7,179	11,034
Davie	3,439	3,601	27,664	34,704	269	680	1,892	2,841
Duplin	4,493	5,866	33,893	44,252	352	1,107	2,318	3,777
Durham	18,850	38,247	158,584	215,681	1,476	7,217	10,847	19,540
Edgecombe	4,760	5,123	33,327	43,210	373	967	2,280	3,619
Forsyth	28,137	38,624	221,654	288,415	2,203	7,288	15,161	24,653
Franklin	4,849	5,814	37,303	47,966	380	1,097	2,552	4,028
Gaston	16,308	20,509	135,631	172,448	1,277	3,870	9,277	14,424
Gates	1,066	1,145	8,024	10,235	83	216	549	848

	July Population 2008 Estimates [4]				Estimated Persons in Need of SA Services [5]			
	Ages 12-17	Ages 18-25	Ages 26+	Total	Estimated Youth with SA (ages 12-17) Prevalence: 7.83%	Estimated Adults with SA (ages 18-25) Prevalence: 18.87%	Estimated Adults with SA (ages 26+) Prevalence: 6.84	Total Estimated Youth and Adults with SA (ages 12+)
Graham	599	654	5,746	6,999	47	123	393	563
Granville	4,554	5,949	37,523	48,026	357	1,123	2,567	4,046
Greene	1,741	2,258	13,698	17,697	136	426	937	1,499
Guilford	37,993	59,051	297,923	394,967	2,975	11,143	20,378	34,496
Halifax	4,771	5,346	36,630	46,747	374	1,009	2,505	3,888
Harnett	9,778	13,770	66,671	90,219	766	2,598	4,560	7,924
Haywood	4,003	4,676	41,217	49,896	313	882	2,819	4,015
Henderson	6,906	8,408	74,073	89,387	541	1,587	5,067	7,194
Hertford	2,013	2,475	15,976	20,464	158	467	1,093	1,717
Hoke	4,038	5,245	25,767	35,050	316	990	1,762	3,068
Hyde	334	442	3,969	4,745	26	83	271	381
Iredell	13,095	15,165	100,514	128,774	1,025	2,862	6,875	10,762
Jackson	2,280	7,131	23,157	32,568	179	1,346	1,584	3,108
Johnston	13,482	16,265	102,770	132,517	1,056	3,069	7,029	11,154
Jones	849	956	7,069	8,874	66	180	484	730
Lee	4,769	6,026	36,885	47,680	373	1,137	2,523	4,033
Lenoir	5,008	5,305	38,265	48,578	392	1,001	2,617	4,011
Lincoln	6,132	7,384	49,280	62,796	480	1,393	3,371	5,244
Macon	2,401	2,727	24,735	29,863	188	515	1,692	2,394
Madison	1,476	2,183	14,136	17,795	116	412	967	1,494
Martin	2,035	2,133	15,955	20,123	159	402	1,091	1,653
McDowell	3,376	4,226	30,340	37,942	264	797	2,075	3,137
Mecklenburg	70,701	103,914	558,734	733,349	5,536	19,609	38,217	63,362
Mitchell	1,109	1,364	11,429	13,902	87	257	782	1,126
Montgomery	2,312	2,765	18,248	23,325	181	522	1,248	1,951
Moore	6,167	7,346	60,260	73,773	483	1,386	4,122	5,991
Nash	8,190	9,464	61,408	79,062	641	1,786	4,200	6,627
New Hanover	13,322	25,258	129,361	167,941	1,043	4,766	8,848	14,658
Northampton	1,680	1,859	14,638	18,177	132	351	1,001	1,484
Onslow	12,455	51,161	78,271	141,887	975	9,654	5,354	15,983
Orange	8,946	27,619	75,574	112,139	700	5,212	5,169	11,081
Pamlico	835	1,035	9,555	11,425	65	195	654	914
Pasquotank	3,113	5,375	26,813	35,301	244	1,014	1,834	3,092
Pender	3,945	4,848	36,231	45,024	309	915	2,478	3,702
Perquimans	933	1,114	9,279	11,326	73	210	635	918
Person	2,995	3,493	25,735	32,223	235	659	1,760	2,654
Pitt	12,051	28,995	89,602	130,648	944	5,471	6,129	12,544

Appendix E

Substance Abuse Professionals by County

	July Population 2008 Estimates [4]				Estimated Persons in Need of SA Services [5]			
	Ages 12-17	Ages 18-25	Ages 26+	Total	Estimated Youth with SA (ages 12-17) Prevalence: 7.83%	Estimated Adults with SA (ages 18-25) Prevalence: 18.87%	Estimated Adults with SA (ages 26+) Prevalence: 6.84	Total Estimated Youth and Adults with SA (ages 12+)
Polk	1,297	1,487	13,907	16,691	102	281	951	1,333
Randolph	11,454	14,611	91,697	117,762	897	2,757	6,272	9,926
Richmond	4,199	5,300	29,800	39,299	329	1,000	2,038	3,367
Robeson	12,342	15,097	78,669	106,108	966	2,849	5,381	9,196
Rockingham	7,159	8,405	62,732	78,296	561	1,586	4,291	6,437
Rowan	11,355	15,283	89,120	115,758	889	2,884	6,096	9,869
Rutherford	5,108	5,782	42,749	53,639	400	1,091	2,924	4,415
Sampson	5,587	6,709	41,512	53,808	437	1,266	2,839	4,543
Scotland	3,624	3,724	23,401	30,749	284	703	1,601	2,587
Stanly	5,082	6,291	38,933	50,306	398	1,187	2,663	4,248
Stokes	3,826	4,230	31,319	39,375	300	798	2,142	3,240
Surry	6,025	7,010	49,237	62,272	472	1,323	3,368	5,162
Swain	1,162	1,356	9,447	11,965	91	256	646	993
Transylvania	2,232	2,752	22,482	27,466	175	519	1,538	2,232
Tyrrell	277	423	3,071	3,771	22	80	210	312
Union	16,950	19,362	118,689	155,001	1,327	3,654	8,118	13,099
Vance	4,148	4,527	27,312	35,987	325	854	1,868	3,047
Wake	70,763	106,390	536,909	714,062	5,541	20,076	36,725	62,341
Warren	1,590	1,901	13,716	17,207	124	359	938	1,421
Washington	1,129	1,144	8,832	11,105	88	216	604	908
Watauga	2,415	12,864	25,485	40,764	189	2,427	1,743	4,360
Wayne	9,949	13,581	72,491	96,021	779	2,563	4,958	8,300
Wilkes	5,134	6,054	46,180	57,368	402	1,142	3,159	4,703
Wilson	6,842	7,877	50,972	65,691	536	1,486	3,486	5,509
Yadkin	3,146	3,590	25,362	32,098	246	677	1,735	2,659
Yancey	1,348	1,565	13,401	16,314	106	295	917	1,317
State Total	739,269	1,085,101	5,925,891	7,750,261	57,885	204,759	405,331	667,974

[1] SA Counselor Data: NC Substance Abuse Professional Practice Board, September 15, 2008.

[2] Peer Support Specialists Certified by the Behavioral Health Resource Program at the School of Social Work at The University of North Carolina at Chapel Hill.

[3] Source: North Carolina Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, with data derived from the North Carolina Medical Board and North Carolina Board of Nursing, 2008.

[4] Population Data: The Office of State Budget and Management (OSBM) State Demographics Branch website: <http://www.osbm.state.nc.us/demog/c08sage.html>. July 2008 Population Projection (Last Update: June 9, 2008. Downloaded 6/27/08).

[5] NC Substance Abuse Prevalence Rates Source: SAMHSA, Office of Applied Studies, National Surveys on Drug Use and Health, 2005 and 2006, published Feb 2008. Table B.20, Dependence on or Abuse of Illicit Drugs or Alcohol in Past Year, by Age Group and State: Percentages, Annual Averages Based on 2005 and 2006 NSDUHs.

	Number of Persons in Need of SA Services per Total SA Counselors (NCAPPB or UNC-CH School of Social Work)	Number of Persons in Need of SA Services per Total Licensed Health Professional	Number of Persons in Need of SA Services by SA Counselors or Health Professionals
Alamance	555	3,514	479
Alexander	863	2,589	647
Alleghany	195	NA	195
Anson	NA	NA	NA
Ashe	261	NA	261
Avery	686	1,371	457
Beaufort	400	NA	356
Bertie	1,380	NA	1380
Bladen	750	NA	750
Brunswick	521	NA	521
Buncombe	136	337	97
Burke	401	2,136	337
Cabarrus	327	2,946	295
Caldwell	375	5,620	351
Camden	NA	NA	NA
Carteret	1,513	NA	1513
Caswell	833	NA	833
Catawba	550	NA	478
Chatham	853	4,265	711
Cherokee	633	NA	633
Chowan	344	NA	344
Clay	NA	NA	NA
Cleveland	691	NA	691
Columbus	422	NA	422
Craven	315	NA	315
Cumberland	341	2,653	302
Currituck	1,707	1,707	854
Dare	243	NA	243
Davidson	849	NA	849
Davie	568	NA	568
Duplin	378	NA	378
Durham	310	1,396	254
Edgecombe	724	NA	724
Forsyth	448	2,465	379
Franklin	671	NA	671
Gaston	555	4,808	497
Gates	848	NA	848
Graham	NA	NA	NA

	Number of Persons in Need of SA Services per Total SA Counselors (NCAPPB or UNC-CH School of Social Work)	Number of Persons in Need of SA Services per Total Licensed Health Professional	Number of Persons in Need of SA Services by SA Counselors or Health Professionals
Granville	337	225	135
Greene	1,499	NA	1499
Guilford	345	1,380	276
Halifax	778	NA	648
Harnett	660	7,924	610
Haywood	287	1,338	236
Henderson	480	1,798	379
Hertford	572	NA	343
Hoke	438	NA	438
Hyde	NA	NA	NA
Iredell	430	NA	430
Jackson	311	NA	311
Johnston	301	1,394	248
Jones	730	NA	730
Lee	576	2,017	448
Lenoir	501	NA	501
Lincoln	477	5,244	437
Macon	399	2,394	342
Madison	374	NA	299
Martin	827	NA	827
McDowell	1,046	NA	1046
Mecklenburg	291	1,980	253
Mitchell	1,126	NA	1126
Montgomery	650	NA	650
Moore	200	998	166
Nash	414	3,314	368
New Hanover	219	489	151
Northampton	371	1,484	297
Onslow	516	2,664	432
Orange	410	2,770	357
Pamlico	NA	NA	NA
Pasquotank	3,092	NA	3092
Pender	463	3,702	411
Perquimans	306	NA	306
Person	2,654	NA	2654
Pitt	220	405	143
Polk	63	190	48
Randolph	764	NA	764

	Number of Persons in Need of SA Services per Total SA Counselors (NCAPPB or UNC-CH School of Social Work)	Number of Persons in Need of SA Services per Total Licensed Health Professional	Number of Persons in Need of SA Services by SA Counselors or Health Professionals
Richmond	1,122	NA	1122
Robeson	368	9,196	354
Rockingham	715	6,437	644
Rowan	411	3,290	366
Rutherford	340	4,415	315
Sampson	1,514	NA	1514
Scotland	323	NA	323
Stanly	386	4,248	354
Stokes	1,080	NA	1080
Surry	430	2,581	369
Swain	142	497	110
Transylvania	319	NA	319
Tyrrell	NA	NA	NA
Union	771	1,455	504
Vance	435	NA	435
Wake	339	1,222	265
Warren	NA	NA	NA
Washington	454	NA	454
Watauga	229	NA	229
Wayne	361	2,767	319
Wilkes	392	NA	392
Wilson	612	NA	612
Yadkin	886	2,659	665
Yancey	659	NA	659
State Total	375	1,825	311

[1] SA Counselor Data: NC Substance Abuse Professional Practice Board, September 15, 2008.

[2] Peer Support Specialists Certified by the Behavioral Health Resource Program at the School of Social Work at The University of North Carolina at Chapel Hill.

[3] Source: North Carolina Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, with data derived from the North Carolina Medical Board and North Carolina Board of Nursing, 2008.

[4] Population Data: The Office of State Budget and Management (OSBM) State Demographics Branch website: <http://www.osbm.state.nc.us/demog/c08sage.html>. July 2008 Population Projection (Last Update: June 9, 2008. Downloaded 6/27/08).

[5] NC Substance Abuse Prevalence Rates Source: SAMHSA, Office of Applied Studies, National Surveys on Drug Use and Health, 2005 and 2006, published Feb 2008. Table B.20, Dependence on or Abuse of Illicit Drugs or Alcohol in Past Year, by Age Group and State: Percentages, Annual Averages Based on 2005 and 2006 NSDUHs.

**Chapter 4:
Substance Abuse Comprehensive System of Care**

PREVENTION

Recommendation 4.1 (PRIORITY RECOMMENDATION)

- a) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) should develop a comprehensive substance abuse prevention plan for use at the state and local levels. The plan should increase the capacity at the state level and within local communities to implement a comprehensive substance abuse prevention system, prioritizing efforts to reach children, adolescents, young adults, and their parents. The goal of the prevention plan is to prevent or delay the onset of use of alcohol, tobacco, or other drugs, reduce the use of addictive substances among users, identify those who need treatment, and help them obtain services earlier in the disease process.
 - 1) DMHDDSAS should work with appropriate stakeholders to develop, implement, and monitor the prevention plan at the state and local level. Stakeholders should include, but not be limited to, other public agencies that are part of the Cooperative Agreement Advisory Board, consumer groups, provider groups, and Local Management Entities (LMEs).
 - 2) DMHDDSAS should direct LMEs to involve similar stakeholders to develop local prevention plans that are consistent with the statewide comprehensive substance abuse prevention plan.
- b) North Carolina General Assembly should appropriate \$1,945,000 in SFY 2010 and \$3,722,000 in SFY 2011 in recurring funds to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) to develop this comprehensive substance abuse prevention.
- c) Of the recurring funds appropriated by the North Carolina General Assembly, \$1,770,000 in SFY 2010 and \$3,547,000 in SFY 2011 should be used to fund six pilot projects to implement county or multi-county comprehensive prevention plans consistent with the statewide comprehensive substance abuse prevention plan. DMHDDSAS should make funding available on a competitive basis, selecting one rural pilot and one urban pilot in the three DMHDDSAS regions across the state. Technical assistance should be provided to the selected communities by the regional Centers for Prevention Resources. LMEs should serve as fiscal and management agencies for these pilots. The six pilot projects should:
 - 1) Involve community agencies, including but not limited to the following: Local Management Entities, local substance abuse providers, primary care providers, health departments, social services departments, local education agencies, local universities and community colleges, Healthy Carolinians, local tobacco prevention and anti-drug/alcohol coalitions, juvenile justice organizations, and representatives from criminal justice, consumer, and family advisory committees.
 - 2) Be comprehensive, culturally appropriate, and based on evidence-based programs, policies, and practices.

- 3) Be based on a needs assessment of the local community that prioritizes the substance abuse prevention goals.
 - 4) Include a mix of strategies designed for universal, selective, and indicated populations.
 - 5) Include multiple points of contact to the target population (i.e. prevention efforts should reach children, adolescents, and young adults in schools, community colleges and universities, and community settings).
 - 6) Be continually evaluated for effectiveness and undergo continuous quality improvement.
 - 7) Be consistent with the systems of care principles.
 - 8) Be integrated into the continuum of care.
- d) The North Carolina General Assembly should appropriate \$250,000 of the Mental Health Trust Fund or from general funds to the DMHDDSAS to arrange for an independent evaluation of these pilot projects and for implementation of the state plan. The evaluation should include, but not be limited to, quantifying the costs of the projects; identifying the populations reached by the prevention efforts; and assessing whether the community prevention efforts have been successful in delaying initiation and reducing the use of tobacco, alcohol, and other drugs among children, adolescents, and young adults. To determine effectiveness, the evaluation should include an analysis of the performance of the pilot communities with appropriate comparison groups. The evaluation should also include other community indicators that could determine whether the culture of acceptance of underage drinking or other inappropriate or illegal substance use has changed, including but not limited to arrests for driving under the influence, underage drinking, or use of illegal substances; alcohol and drug related traffic crashes; reduction in other problem indicators such as school failure; and incidence of juvenile crime and delinquency.
- e) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services should use the findings from the independent evaluation of prevention services to develop a plan to implement the successful strategies statewide. The plan should be presented to the Legislative Oversight Committee on Mental Health within six months of when the evaluation is completed.

Recommendation 4.2

- a) The North Carolina General Assembly should direct the State Board of Education, Office of Non-Public Education, North Carolina Community College System, and University of North Carolina System to review their existing substance abuse prevention plans, programs and/or policies, and availability of substance abuse screening and treatment services, in order to ensure that these educational institutions offer comprehensive substance abuse prevention, early intervention, and treatment services to students enrolled in their schools. These institutions should submit a description of their prevention plans, programs and/or policies, procedures for early identification of students with substance abuse problems, and information on screening, treatment, and referral services to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, the Appropriations Subcommittee on Education, and Education Committees no later than the convening of the 2010 session. The description should include the following:

- 1) Information about what evidence-based or promising prevention programs, policies, and practices have been or will be implemented to prevent or delay children, adolescents, and young adults from initiating the use of tobacco, alcohol, or other drugs, or reducing the use among those who have used these substances in public schools, community colleges, and the public universities.
 - 2) Information from the State Board of Education on how local education agencies have implemented the substance abuse component of the Healthful Living Curriculum, including the educational curriculum or other services provided as part of the Safe and Drug Free Schools Act.
 - 3) A plan from the Office of Non-Public Education to incorporate similar prevention strategies into home school and private school settings.
 - 4) Information from the State Board of Education, North Carolina Community College System, and University of North Carolina System on the schools treatment referral plans, including linkages to the Local Management Entities and other substance abuse providers, the criteria used to determine when students need to be referred, and whether follow-up services and recovery supports are available on campus or in the community.
- b) The Department of Public Instruction, North Carolina Community College System, and University of North Carolina system should coordinate their prevention efforts with the other prevention activities led by the DMHDDSAS to ensure the development of consistent messages and optimization of prevention efforts. Prevention efforts should be based on evidence-based programs that focus on intervening early and at each stage of development with age appropriate strategies to reduce risk factors and strengthen protective factors before problems develop.

Recommendation 4.3

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; the North Carolina Division of Alcohol Law Enforcement; the Division of Public Health; and the Department of Public Instruction should develop a strategic plan to further reduce tobacco and alcohol sales to minors. The plan may include, but not be limited to: additional compliance checks, outlet control or server education.

Recommendation 4.4 (PRIORITY RECOMMENDATION)

- a) The North Carolina General Assembly should increase the tax on a pack of cigarettes to meet the current national average. The cigarette tax should be regularly indexed to the national average whenever there is a difference of at least 10% between the national average cost of a pack of cigarettes (both product and taxes) and the North Carolina average cost of a pack of cigarettes.
- b) The North Carolina General Assembly should increase the tax on all other tobacco products to be comparable to the current national cigarette tax average, which would be 50% of the product wholesale price.
- c) The increased fees should be used to fund effective prevention and treatment efforts for alcohol, tobacco, and other drugs.

Recommendation 4.5

The North Carolina General Assembly should appropriate \$1.5 million in recurring funds to the Division of Public Health to support Quitline NC. The Division of Public Health should use some of this funding to educate providers and the public about the availability of this service.

Recommendation 4.6 (PRIORITY RECOMMENDATION)

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

Recommendation 4.7 (PRIORITY RECOMMENDATION)

- a) In order to reduce underage drinking, the North Carolina General Assembly should increase the excise tax on malt beverages (including beer). Malt beverages are the alcoholic beverages of choice among youth, and youth are sensitive to price increases.
- b) The excise taxes on malt beverages and wine should be indexed to the consumer price index so they can keep pace with inflation. The excise tax for beer was last increased in 1969, and wine was last increased in 1979. The increased fees should be used to support prevention and treatment efforts for alcohol, tobacco, and other drugs.
- c) The increased fees should be used to fund effective prevention and treatment efforts for alcohol, tobacco, and other drugs.
- d) The North Carolina General Assembly should appropriate \$2.0 million in recurring funds in SFY 2010 to support a comprehensive alcohol awareness education and prevention campaign aimed at changing cultural norms to prevent initiation, reduce underage alcohol consumption, reduce alcohol abuse or dependence, and support recovery among adolescents and adults.

Recommendation 4.8

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

Recommendation 4.9 (PRIORITY RECOMMENDATION)

The North Carolina General Assembly should appropriate \$610,000 in recurring funds in SFY 2010 to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services over three years to support efforts to reduce high-risk drinking on college campuses.

- a) \$500,000 per year should be used to be used to replicate the Study to Prevent Alcohol Related Consequences (SPARC) intervention at six additional North Carolina public universities by establishing campus/community coalitions that use a community organizing approach to implement evidence-based, environmental strategies.
- b) \$110,000 per year should be allocated to provide coordination, monitoring and oversight, training and technical assistance, and evaluation of these campus initiatives.

Recommendation 4.10

- a) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; the Division of Public Health; the Division of Social Services; and appropriate provider associations should develop a prevention plan to prevent fetal alcohol spectrum disorders and use of other drugs during pregnancy and report this plan to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services no later than July 1, 2009. The plan should include baseline data and evidence-based strategies that have been shown to be effective in reducing use of alcohol or other drugs in pregnant women and adolescents as well as strategies for early screening and identification, intervention, and treatment for children who are born with fetal alcohol spectrum disorders or addicted to other drugs in utero. The plan should:
- 1) Focus on women and adolescents at most risk of giving birth to children with fetal alcohol spectrum disorders.
 - 2) Identify a standardized substance abuse screening tool that local health departments, primary care, and obstetrical providers can use for early identification and appropriate referral for services for pregnant women.
 - 3) Include strategies to educate, train, and support caregivers of children born with fetal alcohol spectrum disorders.
 - 4) Identify strategies to educate primary care providers about early identification of infants and young children born with fetal alcohol syndrome disorder or addicted to other drugs, available treatment, and community resources for the affected children and their families.

Recommendation 4.11

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services should work with the North Carolina Medical Society, North Carolina Academy of Family Physicians, North Carolina Psychiatric Association, North Carolina Chapter of the American Society of Addiction Medicine, Governor's Institute on Alcohol & Substance Abuse, physician representation from the Controlled Substances Reporting System (CSRS) Advisory Committee, and North Carolina Office of the Attorney General to explore options to allow for the exchange of information obtained from the CSRS between health care practitioners.

EARLY INTERVENTION

Recommendation 4.12

- a) North Carolina health professional schools, the Governor's Institute on Alcohol and Substance Abuse, the North Carolina Area Health Education Centers (AHEC) program, residency programs, health professional associations, and other appropriate organizations should expand Screening, Brief Intervention, and Referral to Treatment (SBIRT) training for primary care providers and other health professionals in academic and clinical settings, residency programs or other continuing education programs with the goal of expanding the health professional workforce that has demonstrated competencies in SBIRT. The curriculum should include information and skills-building training on:

- 1) Evidence-based screening tools to identify people who have or are at risk of tobacco, alcohol, or substance abuse or dependency.
- 2) Motivational interviewing.
- 3) Brief interventions including counseling and brief treatment.
- 4) Assessments to identify people with co-occurring mental illness.
- 5) Information about appropriate medication therapies for people with different types of addiction disorders.
- 6) Successful strategies to address commonly cited disincentives to care for patients in a primary care.
- 7) Strategies to successfully engage people with more severe substance abuse disorders and refer them to specialty addiction providers for treatment services.
- 8) The importance of developing and maintaining linkages between primary care providers and trained addiction specialists to ensure bi-directional flow of information and continuity of care.

Recommendation 4.13 (PRIORITY RECOMMENDATION)

- a) The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) should work collaboratively with the North Carolina Office of Rural Health and Community Care (ORHCC), the Governor's Institute on Alcohol and Substance Abuse, North Carolina Area Health Education Centers (AHEC) program, and other appropriate professional associations to educate and encourage healthcare professionals to use evidence-based screening tools and offer motivational counseling, brief intervention, medication assisted therapies, and referral to treatment to help patients prevent, reduce, or eliminate the use of or dependency on alcohol, tobacco, and other drugs as outlined in the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model.
- b) The North Carolina General Assembly should appropriate \$1.5 million in recurring funds to DMHDDSAS to work with the aforementioned groups to develop a plan to implement SBIRT within primary care and ambulatory care settings. The plan should include:
 - 1) Mental health and substance abuse system specialists to work with the 14 Community Care of North Carolina (CCNC) networks and other provider groups. These staff will work directly with the CCNC practices to implement and sustain evidenced-based practices and coordination of care between primary care and specialty services. This would include but not be limited to the SBIRT model allowing for primary care providers to work toward a medical home model that has full integration of physical health, mental health, and substance abuse services. In keeping with the SBIRT model, the mental health and substance abuse system specialists would work within communities to develop systems that facilitate smooth bidirectional transition of care between primary care and specialty substance abuse care.
 - 2) Efficient methods to increase collaboration between providers on the shared management of complex patients with multiple chronic conditions that is inclusive of mental health, developmental disabilities, and substance abuse. An effective system would smooth transitions, reduce duplications, improve communication, and facilitate joint management while improving the quality of care.

- 3) A system for online and office-based training and access to regional quality improvement specialists and/or a center of excellence that would help all healthcare professionals identify and address implementation barriers in a variety of practice settings such as OB/GYN, emergency room, and urgent care.
- 4) Integrated systems for screening, brief intervention, and referral into treatment in outpatient settings with the full continuum of substance abuse services offered through DMHDDSAS.

Recommendation 4.14

- a) The North Carolina Office of Rural Health and Community Care should work in collaboration with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; the Governors Institute on Alcohol and Substance Abuse; the ICARE partnership; and other professional associations to support and expand co-location in primary care practices of licensed health professionals trained in providing substance abuse services.
- b) The North Carolina General Assembly should provide \$750,000 in recurring funds to the North Carolina Office of Rural Health and Community Care to support this effort. Primary care practices eligible for state funding include private practices, federally qualified health centers, local health departments, and rural health clinics that participate in Community Care of North Carolina. Funding can be used to help support the start-up costs of co-location of licensed substance abuse professionals in primary care practices for services provided to Medicaid and uninsured patients. Alternatively, funding may be used to support continuing education of mental health professionals who are already co-located in an existing primary care practice in order to help them obtain substance abuse credentials to be qualified to provide substance abuse services to Medicaid and uninsured patients with substance use disorders. The goal is to offer evidence-based screening, counseling, brief intervention, and referral to treatment to help patients prevent, reduce, or eliminate the use of or dependency on tobacco, alcohol, and other drugs. Funding priority should be given to practices that meet one or more of the following criteria:
 - 1) Primary care practices with a co-located mental health professional.
 - 2) Primary care practices with a significant population of dually diagnosed patients with mental health and substance abuse problems who have prior experience in screening and intervention for mental health and/or substance abuse problems.
 - 3) Primary care practices actively involved in other chronic disease management programs.

Recommendation 4.15 (PRIORITY RECOMMENDATION)

- a) The North Carolina General Assembly should mandate that insurers offer coverage for the treatment of addiction diseases with the same durational limits, deductibles, coinsurance, annual limits, and lifetime limits as provided for the coverage of physical illnesses.
- b) The North Carolina General Assembly should direct the Division of Medical Assistance, North Carolina Health Choice program, State Health Plan, and other insurers to review their reimbursement policies to ensure that primary care and other providers can be reimbursed to screen for tobacco, alcohol, and drugs, provide brief intervention and counseling, and refer necessary patients for specialty services.

- 1) Specifically, the plans should provide reimbursement for:
 - i) Screening and brief intervention in different health settings including, but not limited to, primary care practices (including OB/GYN, federally qualified health centers, rural health clinics, and hospital-owned outpatient settings), emergency departments, Ryan White Title III medical programs, and school-based health clinics.
 - ii) CPT codes for health and behavior assessment (96150-96155), health risk assessment (99420), substance abuse screening and intervention (99408, 99409), and tobacco screening and intervention (99406, 99407) and should not be subject to therapy code preauthorization limits.
 - iii) Therapy codes (90801-90845) for primary care providers who integrate qualified mental health professionals into their practices.
 - iv) Appropriate telephone and face-to-face consultations between primary care providers and psychiatrists or other specialists. Specifically, payers should explore the appropriateness of reimbursing for CPT codes for consultation by a psychiatrist (99245).
- 2) Reimbursement for these codes should be allowed on the same day as a medical visit's evaluation and management (E&M) code when provided by licensed mental health and substance abuse staff.
- 3) Fees paid for substance abuse billing codes should be commensurate with the reimbursement provided to treat other chronic diseases.
- 4) Insurers should allow psychiatrists to bill using E&M codes available to other medical disciplines.
- 5) Providers eligible to bill should include licensed healthcare professionals including, but not limited to, primary care providers, mental health and substance abuse providers, emergency room professionals, and other healthcare professionals trained in providing evidence-based substance abuse and mental health screening and brief intervention.
- c) The Division of Medical Assistance should work with the Office of Rural Health and Community Care (ORHCC) to develop an enhanced Carolina Access (CCNC) per member per month (PMPM) for co-located practices to support referral and care coordination for mental health, developmental disabilities, and substance abuse services.
- d) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, in collaboration with the ORHCC, should work collaboratively with the Governor's Institute on Alcohol and Substance Abuse, Academy of Family Physicians, North Carolina Pediatric Society, North Carolina Psychiatric Association, North Carolina Primary Health Care Association, ICARE, and other appropriate groups to identify and address barriers that prevent the implementation and sustainability of co-location models and to identify other strategies to promote evidence-based screening, counseling, brief intervention, and referral to treatment in primary care and other outpatient settings.

**COMPREHENSIVE SYSTEM OF SPECIALIZED
SUBSTANCE ABUSE SERVICES**

Recommendation 4.16 (PRIORITY RECOMMENDATION)

- a) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) should develop a plan organized around a recovery-oriented system of care to ensure that an appropriate mix of substance abuse services and recovery supports for both children and adults is available and accessible throughout the state. The plan should utilize the American Society of Addiction Medicine (ASAM) levels of care. In developing this plan, DMHDDSAS should:
 - 1) Develop a complete continuum of locally and regionally accessible substance abuse crisis services and treatment and recovery supports.
 - 2) Ensure effective coordination of care between substance abuse providers within and between different ASAM levels of care as well as with other health professionals such as primary care providers, emergency departments, or recovery supports.
 - 3) Develop a minimum geographic-based access standard for each service. In developing its plan, DMHDDSAS should identify strategies for building an infrastructure in rural and underserved areas.
 - 4) Include evidence-based guidelines for the number of patients to be served, array of services, and intensity and frequency of the services.
- b) DMHDDSAS should work with Local Management Entities (LMEs) and providers to develop a more comprehensive performance-based accountability plan that includes incentives and contract requirements between the Division, LMEs and providers.
 - 1) The plan should include meaningful substance abuse performance measures for LMEs and providers to ensure that: substance abuse services are successfully extended to a significant portion of those persons in need, substance abuse services are provided to individuals in a timely fashion, people are provided the intensity of services appropriate to their needs, people are engaged in treatment for appropriate lengths of time, individuals successfully complete treatment episodes, and that these individuals are provided appropriate recovery supports.
 - 2) This plan may include, but not be limited to, financial incentive payments, regulatory and/or monitoring relief, advantages in the competitive bidding process, independent peer review recognition, and broader infrastructure support.
 - 3) The plan should strengthen the Division's current performance benchmarking system for LMEs, including the establishment of more rigorous performance standards and targets for LMEs.
 - 4) The plan should develop a similar performance benchmarking system for LMEs to use with providers. The benchmarking system for providers should include, but not be limited to, measures of active engagement, consumer outcomes, fidelity with evidence-based or best practices, client perception of care, and program productivity.
 - 5) In developing the plan, DMHDDSAS, LMEs and providers should consider other incentive strategies developed by the National Institute on Drug Abuse Blending Initiative.
 - 6) The plan should include data requirements to ensure that program performance is measured consistently by LMEs and providers across the state.

- c) DMHDDSAS should develop a plan to implement electronic health records for providers that use public funds.
- d) DMHDDSAS should develop consistent requirements across the state that will reduce paperwork and administrative barriers including but not limited to:
 - 1) Uniform forms for admissions, screening, assessments, treatment plans, and discharge summaries that are to be used across the state.
 - 2) Standard contract requirements and a system that does not duplicate paper work for agencies that serve residents of multiple LMEs.
 - 3) Methods to ensure consistency in procedures and services across LMEs along with methods to enforce minimum standards across the LMEs. Enforcement methods should include, but not be limited to, remediation efforts to help ensure consistent standards.
 - 4) Standardized outcome measures.
- e) DMHDDSAS should develop a system for timely conflict resolutions between LME and contract agencies.
- f) DMHDDSAS should work with its Provider Action Agenda Committee to identify barriers and strategies to increase the quality and quantity of substance abuse services and providers in the state. These issues include, but are not limited to, administrative barriers, service definitions, and reimbursement issues.
- g) DMHDDSAS, in collaboration with the Department of Juvenile Justice and Delinquency Prevention and the Department of Public Instruction, should immediately begin expanding the capacity of needed adolescent treatment services across the state including new capacity in the clinically intensive residential programs, consistent and effective screening, assessment, and referral to appropriate treatment and recovery supports for identified youth. In addition, the plan should systematically strengthen early intervention services for youth and adolescents in mainstream settings such as schools, primary care, and juvenile justice venues.
- h) DMHDDSAS should report the plans specified in Recommendation 4.16.a-b, report on the progress in developing the plan for electronic health records in Recommendation 4.16.c, and report on progress made in implementing Recommendations 4.16.d-g to the NCIOM Task Force on Substance Abuse Services and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services no later than September 2008.

Recommendation 4.17

- a) The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) should select six county or multi-county regions to develop and implement a recovery-oriented system of care.
- b) The North Carolina General Assembly should appropriate \$17.2 million in SFY 2010 and \$34.4 million in SFY 2011 to DMHDDSAS in recurring funding to support these six pilot programs. DMHDDSAS should make funding available on a competitive basis, selecting one rural pilot and one urban pilot in the three DMHDDSAS regions across the state. Funding should include planning, evaluation, and technical assistance. The pilot programs should:

- 1) Identify those in need of treatment.
 - 2) Ensure or provide a comprehensive continuum of services for adolescents and adults. Services should include screening, counseling, brief treatment, and the full spectrum of ASAM services for both adolescents and adults.
 - 3) Provide recovery supports for those who return to their communities after receiving substance abuse specialty care, including Oxford Houses or other appropriate recovery supports. The goal of the project is to reduce the length and duration of relapses that require additional specialty substance abuse care. Programs should work closely with existing recovery services, programs, and individuals and build on the foundations that exist in their local communities.
 - 4) Ensure effective coordination of care between substance abuse providers within and between different ASAM levels of care as well as with other health professionals such as primary care providers, hospitals, or recovery supports.
- c) The North Carolina General Assembly should appropriate \$750,000 of the Mental Health Trust Fund or general appropriations to the DMHDDSAS to arrange for an independent evaluation of these pilot programs. The evaluation should compare the performance of the pilot programs to comparison (control) counties to determine whether the comprehensive pilot programs lead to increased number of patients served, timely engagement, active participation with appropriate intensity of services, and program completion.
 - d) The DMHDDSAS should use the findings from the independent evaluation of the pilot programs implementing county or multi-county recovery-oriented systems of care to develop a plan to implement the successful strategies statewide. The plan should be presented to the Legislative Oversight Committee on Mental Health within six months of when the evaluation is completed.

Recommendation 4.18 (PRIORITY RECOMMENDATION)

The North Carolina General Assembly should appropriate:

- a) \$650,000 in recurring funds to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to hire 13 FTE staff to assist in developing and implementing a statewide comprehensive prevention plan, a recovery-oriented system of care, a plan for performance-based incentive contracts, and consistent standards across the state to reduce paperwork and administrative barriers; oversee and provide technical assistance to the pilot programs; and otherwise help implement the Recommendations 4.1-4.3, 4.9-4.10, 4.13, 4.14-4.17, and Recommendation 5.1, supra.
- b) \$100,000 in recurring funds to the Department of Public Instruction to hire staff to implement Recommendations 4.1-4.3 and 4.16 above.
- c) \$130,000 in recurring funds to Office of Rural Health and Community Care to hire a statewide coordinator and administrative support to work directly with the regional Community Care of North Carolina quality improvement specialists funded in recommendation 4.13 and to assist in implementing recommendation 4.14.
- d) \$81,000 in recurring funds and \$50,000 in nonrecurring funds to the Department of Health and Human Services, Division of Medical Assistance, to hire five positions to implement Recommendations 4.13-4.15 above.

**Chapter 5:
Substance Abuse Prevention and Treatment Programs Targeted to Specific
Subpopulations**

CHILDREN, YOUTH, AND YOUNG ADULTS

Recommendation 5.1

- a) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) should continue to work with the Department of Juvenile Justice and Delinquency Prevention (DJJDP) to expand the pilot test of the DMHDDSAS-DJJDP Cross Area Service Program model in two additional DJJDP regions.
- b) The North Carolina General Assembly should appropriate \$500,000 in recurring funds to the DMHDDSAS to support this pilot.
- c) If successful, the DMHDDSAS-DJJDP Cross Area Service Program model should be rolled out statewide.

ADULTS

Recommendation 5.2:

- a) As part of the annual community assessment, Local Management Entities (LME) should explore and report on the need for Employee Assistance Program (EAP) services by employers in their catchment area and the availability of organizations providing EAP services to meet this need.
- b) If the LME determines that there are insufficient EAP providers to address the needs of employers, then the LMEs should work with the local Chambers of Commerce, other business organizations, and others to develop a strategy to promote the availability of EAP services in the community.

Recommendation 5.3:

The North Carolina General Assembly should ensure that by 2014:

- a) All individuals advertising and promoting themselves as providing EAP services in North Carolina must be licensed or have EAP specific training and work under the supervision of professionals licensed to provide EAP services by the North Carolina Board of Employee Assistance Professionals.
- b) All programs or organizations located in North Carolina that advertise, or promote themselves, as providers of EAP services should be able to document that they have the capability of providing the core services as defined in statute and that the services are provided under the supervision of North Carolina licensed EAP staff.

Recommendation 5.4

The North Carolina General Assembly should appropriate \$475,000 in recurring funds to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for seven full-time Licensed Clinical Addiction Specialists to be distributed to the Local Management Entities with the highest number of referrals for the Work First, Class H or I Controlled Substance felons, and Child Protective Services populations compared to existing Qualified Professionals in Substance Abuse.

Recommendation 5.5

The North Carolina General Assembly should appropriate \$2.8 million in recurring funds in SFY 2010 and an additional \$2.8 million in recurring funds in SFY 2011 to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to expand the availability of Treatment Accountability for Safer Communities (TASC) program services.

Recommendation 5.6

The North Carolina General Assembly should appropriate \$500,000 in recurring funds in SFY 2010 to the Division of Community Corrections to expand the availability of Criminal Justice Partnership Program (CJPP)-funded substance abuse services.

Recommendation 5.7 (PRIORITY RECOMMENDATION)

- a) The North Carolina General Assembly should increase the annual appropriations to the Administrative Office of the Courts to fund eight new adult drug treatment courts. The amount of the increased appropriations should be as follows:
 - 1) \$500,000 in recurring funds in SFY 2010 for four new adult drug treatment court coordinators
 - 2) \$500,000 in recurring funds in SFY 2011 for four new adult drug treatment court coordinators
- b) The North Carolina General Assembly should increase the appropriations to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services by \$570,000 in recurring funds in SFY 2010 and an additional \$570,000 in recurring funds in SFY 2011 to support treatment services for adult drug treatment court participants.
- c) The North Carolina General Assembly should increase the annual appropriations to the Department of Correction, Division of Community Corrections, by \$269,940 in recurring funds in SFY 2010 to fund four new probation officers and an additional \$269,940 in recurring funds in SFY 2011 to fund an additional four probation officers to support the new drug treatment courts.

Recommendation 5.8:

The North Carolina General Assembly should:

- a) Appropriate \$1,500,000 in recurring funds in FY 2010 to the North Carolina Department of Correction, Division of Alcoholism and Chemical Dependency Programs, to expand the availability of state substance abuse services to adults within the prison system.
- b) Appropriate \$2,000,000 in recurring funds in FY 2010 to the Department of Correction, Division of Alcoholism and Chemical Dependency Programs, to build one additional residential treatment facility for female adult offenders with substance abuse and addiction problems who are on probation or parole.
- c) Appropriate \$1,000,000 in recurring funds in FY 2010 to the North Carolina Department of Correction, Division of Alcoholism and Chemical Dependency Programs, to expand the existing residential treatment facility at DART Cherry in Goldsboro for adult male offenders with substance abuse and addiction problems who are on probation and parole.
- d) Appropriate \$12,500 in non-recurring funds to the Department of Correction, Division of Alcoholism and Chemical Dependency Programs, to study the feasibility of establishing a single mission drug treatment and re-entry prison for offenders with substance abuse and addiction problems.

MILITARY PERSONNEL

Recommendation 5.9

- a) The Veterans Administration should:
 - 1) Continue to work with appropriate partners to provide training for mental health and substance abuse professionals, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and Local Management Entities agency staff, primary care providers, psychiatrists, school personnel, and other appropriate organizations about the medical and behavioral health needs of returning veterans and their families.
 - 2) Provide consultation services for veterans being treated by community-based primary care providers, mental health, or substance abuse professionals.
 - 3) Work with the North Carolina Division of Social Services, Department of Housing and Urban Development, and other community agencies to ensure that veterans learn of other support services, such as housing vouchers, employment opportunities, and family services.
- b) The North Carolina General Assembly should appropriate \$200,000 to pay the 35% match for the Veterans Administration Homeless Providers Grant and Per Diem Program for transitional housing for homeless veterans with substance abuse or mental health disorders.

Chapter 6: Substance Abuse Workforce

Recommendation 6.1 (PRIORITY RECOMMENDATION)

- a) The North Carolina General Assembly should appropriate \$750,000 in recurring funds in SFY 2010, \$1.5 million in recurring funds in SFY 2011, increasing to \$2.0 million in SFY 2013 to the Governor's Institute on Alcohol and Substance Abuse to create a scholarship program to increase the number of qualified professionals in the field of substance abuse treatment. Funding should be used to:
- 1) Pay up to \$3,000 per year for up to two years of community college training for 50 students enrolled in a human services program with the intention to enter the substance abuse field.
 - 2) Pay up to \$5,000 per year for up to four years of undergraduate training for 50 qualified undergraduates who have declared a major in a human services occupation that would meet the requirements for LCAS, CSAC, CSAPC, CSARFD, or CCJP
 - 3) Pay up to \$5,000 per year for up to two years of graduate level substance abuse training to 50 eligible individuals with a bachelor's degree who have been accepted into one of North Carolina's master's level substance abuse programs.
 - 4) Pay up to \$2,000 per year for up to two years to purchase training or supervision hours for 50 qualified individuals with a bachelor's or master's degree in an appropriate field who are working towards CSAC, LCAS, or CCS licensure.
 - 5) Students who receive scholarship funds would be required to work for one year in a public or private not-for-profit substance abuse treatment program for every \$4,000 received in scholarship funds and would be required to pursue substance abuse licensure or certification.
 - 6) Students who do not complete their substance abuse training or licensure, or who fail to meet the work requirements would be required to pay back the scholarship funds with 10% interest with appropriate time standards.
- b) The North Carolina General Assembly should appropriate \$200,000 in recurring funds in FY 2010 to the Area Health Education Centers program to create and incentivize five programs to serve as substance abuse clinical training sites for people seeking CSAC, LCAS, CCS, CCJP, CSARFD or CSAPC credential.

Recommendation 6.2

- a) The Area Health Education Centers Program should work with the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, the North Carolina Psychiatric Association, and other relevant organizations to develop residency rotations for psychiatrists and other physicians in addiction medicine. The goal is to develop clinical training opportunities in existing residency programs in Alcohol and Drug Addiction Treatment Centers and other appropriate settings to improve the substance abuse training of psychiatrists, family physicians, emergency medicine or other physicians likely to enter into the addiction field in both inpatient and outpatient settings.

- b) The North Carolina General Assembly should appropriate \$200,000 in recurring funds in SFY 2010 to the Area Health Education Centers program to develop and support new clinical training rotations for residents in substance abuse.

Recommendation 6.3

The North Carolina State Personnel Commission should:

- a) Reevaluate and increase the pay grades for substance abuse professionals with a LCAS, CCS, CSAC, CCJP, and CSAPC credentials.
- b) Allow for a trainee progression for LCAS and CCS.

Chapter 7: Data

Recommendation 7.1

- a) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) should develop a long-term consumer-centered Information Technology (IT) vision and plan to meet the state's data needs through enhanced integration of current systems, including the statewide adoption of an Electronic Health Record among community providers and LMEs.
- b) The North Carolina General Assembly should appropriate \$1.2 million in recurring funds to DMHDDSAS to enhance and expand current data collection systems and develop new data systems as needed to provide epidemiological information on people with substance abuse issues across the lifespan.
- c) The DMHDDSAS should develop capacity to utilize data to identify patterns and trends in the prevalence, prevention, and treatment of substance abuse so as to provide an evidence-based process for the development and evaluation of prevention and treatment interventions, as well as provide a data-driven platform for the funding of prevention and treatment programs across the state.
- d) The DMHDDSAS should review national research on patterns of consumer participation and client referral within the substance abuse prevention and treatment systems. Special studies should be undertaken as needed to determine if there are systemic patterns and barriers to identification, referral, and engagement of substance abuse consumers into treatment in North Carolina.
- e) The DMHDDSAS should enhance their collection and analysis of data on substance abuse services to include information on:
 - 1) Active identification and timely screening, triage, and referral into care for substance abuse consumers separately from other disability groups.
 - 2) Timely and effective coordination of care between screening, triage, and referral (STR) and engagement in treatment.
 - 3) Length of time in treatment.

- 4) Responsiveness of community systems, including utilization of inpatient programs, as is currently done for detox and outpatient programs.
- 5) Admission and readmission into Alcohol and Drug Abuse Treatment Centers, as is currently done for state hospitals.
- 6) Continuity of care after discharge from detox and inpatient programs, as is currently done for Alcohol and Drug Abuse Treatment Centers, and state hospitals.
- 7) Provision of recovery-oriented treatment and support within communities.

Recommendation 7.2

- a) The Department of Juvenile Justice (Juvenile Crime Prevention Council), Department of Corrections (Criminal Justice Partnership program), Division of Public Instruction, Division of Social Services, Division of Public Health, and county commissioners should provide data to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services quarterly on public funds used to support substance abuse prevention and treatment services, number of people served, and types of services provided in each county.
- b) The North Carolina General Assembly should choose and implement an equalization formula to ensure that Local Management Entities (LMEs) receive comparable funding to achieve equity in access to care and services while recognizing the inherent challenges of delivering services in low-wealth rural counties. This equalization formula should be used to distribute any new state funds provided to support substance abuse prevention and treatment activities, with low-funded LMEs obtaining a higher proportion of the funding.



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