Alcohol and drug use and misuse are major contributors to death and disability. Together, they comprise the 8th largest cause of premature death and are risk factors contributing to years of life lived with a disability. Substance use/abuse is the fifth leading contributor to disability-adjusted life years (DALYs)—years of life lost plus years lived with a disability—in North Carolina. Depression is the second leading cause of life lived with a disability in North Carolina. It contributes to the high suicide rate found among individuals ages 10-44 and is the 10th leading contributor to DALYs in North Carolina.[1] (For more information about DALYs, see Chapter 2.)

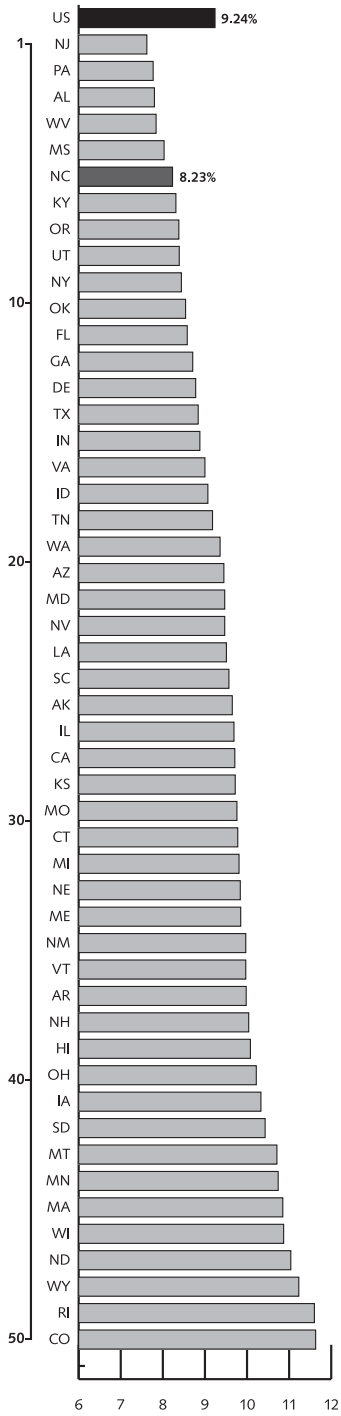
Addiction to alcohol and other drugs is a chronic illness, much like asthma, diabetes, or hypertension. Addiction cannot be "cured" in the sense that we can cure or fix someone with strep throat or a broken bone. However, substance use and addiction can be prevented—as can many of the other chronic illnesses discussed in this report. Further, addiction disorders can be managed to prevent more serious long-term health effects. While less is known about how to prevent mental illnesses, there are successful strategies for reducing or preventing stress and depression and for early intervention to successfully treat and mitigate exacerbation of mental health disorders.

Substance Abuse

People with substance abuse problems or dependence are at risk for premature death, comorbid health conditions, and disability. Furthermore, substance abuse carries additional adverse consequences for the individual, his or her family, and society at large. People with addiction disorders are more likely than people with other chronic illnesses to end up in poverty, lose their job, or experience homelessness. Addiction to alcohol and drugs contributes to the state's crime rate as well as to family upheaval and motor vehicle fatalities. Approximately 90% of the criminal offenders who enter the prison system have substance abuse problems.[2] More than two out of five youth in the state's juvenile justice system are in need of further assessment or treatment services for substance abuse.[3] Substance abuse is also one of the primary causes for motor vehicle fatalities, contributing to more than one-quarter (26.8%) of all crash-related deaths.[4] In addition, alcohol or drug use is a major contributor to family disintegration. Nationally, parental use of alcohol or drugs contributes to more than 75% of cases in which children are placed in foster care.[5] The direct and indirect costs of alcohol and drug abuse in North Carolina totaled more than $12.4 billion in 2004.[6]

The Substance Abuse and Mental Health Services Administration (SAMHSA) conducts a household survey of drug use and health each year. The 2006-2007 survey results showed that approximately 590,000 (8.1%) of North Carolinians

Percent of Adults (18+) with Dependence On or Abuse of Illicit Drugs or Alcohol in Past Year, 2006-2007



Source: Hughes A, Sathe N, Spagnola K. (2009). State Estimates of Substance Use from the 2006-2007 National Surveys on Drug Use and Health. Office of Applied Studies, Substance Abuse and Mental Health Services Administration, NSDUH Series H-35, HHS Publication No. SMA 09-4362. Rockville, MD. http://www.oas.samhsa.gov/2k7state/adultTabs.htm.

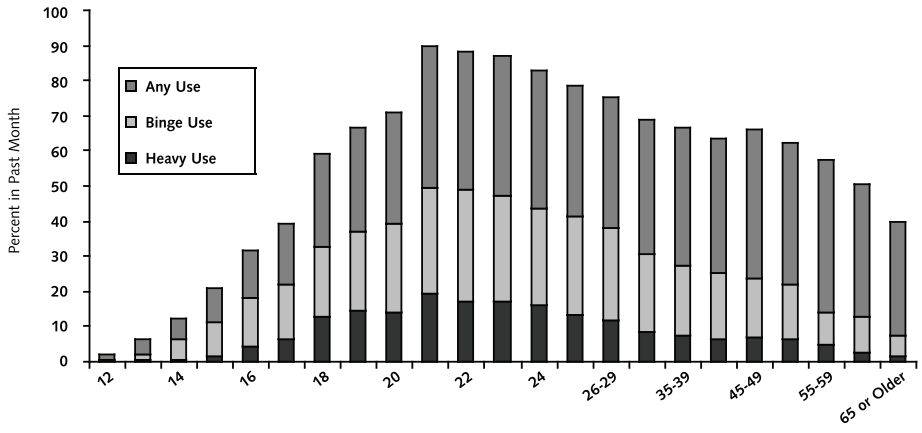
ages 12 or older reported alcohol or illicit drug dependence or abuse.[a,7] A large majority of these—470,000 North Carolinians—reported alcohol dependence or abuse, and 207,000 people reported illicit drug dependence or abuse. A much higher number of people reported binge alcohol use (1.5 million) and drug use (522,000).[b]

Youth are particularly susceptible to the influence of alcohol and drugs, as these substances affect the developing brain. Repeated exposure to alcohol and drugs can alter brain chemistry and microanatomy, making it harder for people to weigh the trade-offs of short-term pleasure derived from alcohol and drug use versus the longer term consequences to the individual and his/her family by the use or misuse of these substances.[8] Use and misuse of alcohol and other drugs is particularly problematic for youth and young adults under age 25, as the brain is still developing until that age.[9] Thus, the state should target prevention strategies to youth and adolescents.

Addiction to alcohol and other drugs is a chronic illness, much like asthma, diabetes, or hypertension.

North Carolina could be more effective in preventing the use of alcohol or drugs among youth and young adults. Nationally, we know that youth and young adults are the most likely individuals to use alcohol or illicit drugs. (See Figures 6.1 and 6.2.)

Figure 6.1
Alcohol Use Peaks Among Young Adults in Their Early 20s (2006)

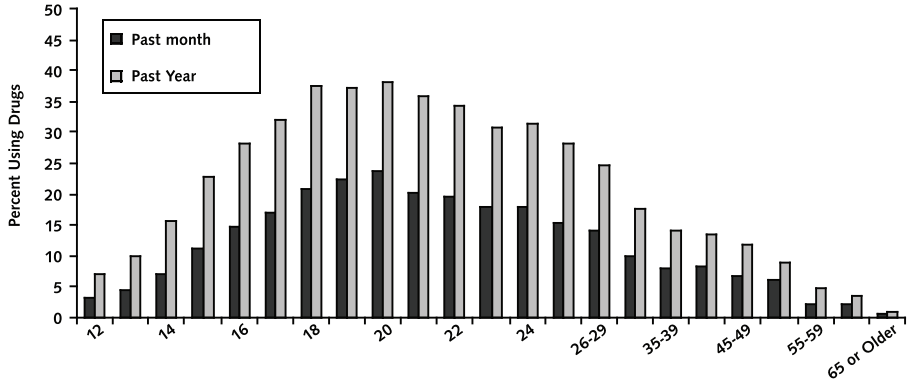


Source: Substance Abuse and Mental Health Services Administration. *Results From the 2006 National Survey on Drug Use and Health: National Findings.* Rockville, MD: Department of Health and Human Services; 2007. DHHS publication SMA 07-4293.

Almost 40% of North Carolina high school students reported having at least one drink in the last 30 days, and more than 20% reported binge drinking.[10] One in five high school students reported using marijuana in the last 30 days, and almost

a Illicit drugs include marijuana, hashish, cocaine, heroin, hallucinogens, inhalants, and prescription drugs that are used non-medically.
b Binge alcohol use is defined as having five or more drinks within a couple of hours of each other on at least one of the past 30 days.

Figure 6.2
Use of Drugs is Highest Among Adolescents and Young Adults (2006)



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.

North Carolina could be more effective in preventing the use of alcohol or drugs among youth and young adults.

as many (17%) reported that they took a prescription drug without a prescription. Further, more than one-fourth of all high school students reported that they were offered, sold, or given an illegal drug while on school premises. While not as large, a sizeable proportion of middle school students also report using these substances.[10] Studies have also shown that people who start using alcohol or drugs in childhood are more likely to be addicted as an adult than those who started using these substances later in life.[11] Thus, targeting youth and young adults for prevention efforts is particularly important in reducing the number of people who later have abuse or addiction problems.

Mental Health

A large proportion of North Carolinians reported serious psychological distress in the past year, including 17% of adults ages 18-25 and 10% of adults ages 26 or older.[7] Serious psychological distress is a nonspecific indicator of mental health problems such as anxiety or mood disorders.[c,12,13] In addition, approximately 8% of North Carolinians ages 12 or older reported having a diagnosable major depressive episode.[d]

Mental health disorders can have a profound effect on an individual, their interpersonal relations, their functioning in schools or in the workplace, and their overall sense of well-being.[14] Depression has been linked to an increase in

c Serious psychological distress is diagnosed when a person scores 13 or higher on the K6 scale (used by the US National Health Interview Survey). Individuals are asked about their mental health symptoms during one of the past 12 months when they were feeling worse emotionally. This survey instrument asks respondents how frequently they experienced symptoms of psychological distress—for example, whether they were so sad that nothing could cheer them up, feeling hopeless, worthless, nervous, or that everything was an effort.

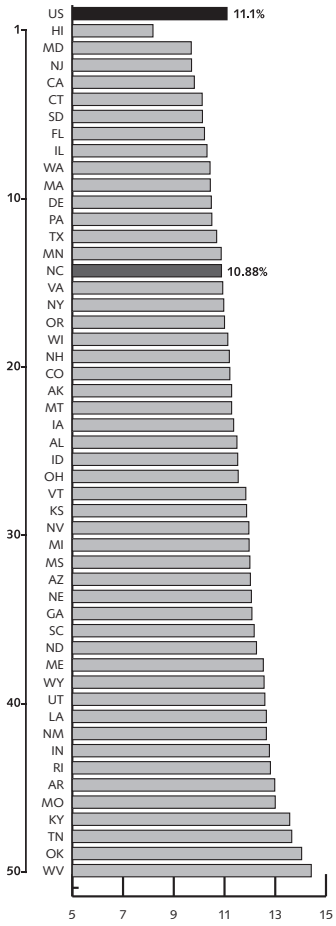
d A major depressive episode is defined as having a period of at least two weeks when the person experienced a depressed mood or loss of interest or pleasure in daily activities and experienced specified depression symptoms as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).

absenteeism in the workplace, as well as to lower productivity at work when the person is present, which is known as presenteeism.[15] Depression is also a leading cause of suicide and is associated with 60% of all suicides.[16] In 2007, suicide was the 6th leading cause of death for children ages 10-14 in North Carolina, the 4th leading cause of death for youth and adults ages 15-34, and the 5th leading cause of death for adults ages 35-44.[17]

Emerging research has also shown the impact of mental illness—particularly depression—on the use and cost of health services. People that are depressed or have anxiety disorders have more unexplained medical symptoms than do people without these mental health problems. Depression has been associated with a 50% increase in medical costs for other chronic illnesses, even after controlling for the type and severity of physical illness. Depression has also been linked to longer lengths of stays in the hospital, even after controlling for severity of medical illness, and it has been linked to higher mortality rates for people who have diabetes or heart disease.[14] It is likely that the relationship between chronic illnesses and depression is bidirectional. That is, depression may be a secondary reaction to the advent of the chronic illness (or a side-effect of the medications), and depression may be a risk factor for the development of certain diseases.

Depression also makes it more difficult to treat or manage chronic conditions, as people who are depressed are less likely to take their medications as prescribed or to otherwise follow their treatment regimens.[14] People who are depressed are also more likely to engage in risky health behaviors including smoking, overeating, and sedentary lifestyles. Thus, prevention of and early intervention for mental health disorders are critical to being able to effectively address some of the other preventable risk factors described in this report.

Percent of Adults (18+) with Serious Psychological Distress in Past Year, 2006-2007



Source: Hughes, A., Sathe, N., & Spagnola, K. (2009). State Estimates of Substance Use from the 2006-2007 National Surveys on Drug Use and Health. Office of Applied Studies, Substance Abuse and Mental Health Services Administration, NSDUH Series H-35, HHS Publication No. SMA 09-4362. Rockville, MD. http://www.oas.samhsa.gov/2k7state/adultTabs.htm.

Substance Abuse and Mental Health Prevention Plan

Effective programs, policies, and health care interventions are integral to a comprehensive substance abuse prevention plan in North Carolina. Programs that reach children, adolescents, young adults, and parents with the intention of preventing or delaying use of alcohol, tobacco, or other drugs are vital. Minimizing risk factors and maximizing protective factors, while increasing knowledge and skills, is critical, particularly for youth. In addition, a comprehensive substance abuse prevention plan should include tailored outreach targeted to different groups at various risk levels.

Evidence-based prevention strategies have been shown to be effective in delaying initiation and reducing use of alcohol and other drugs.[e] Many of these evidence-based programs have also demonstrated other positive effects, such as reduced depression, delinquency, teen pregnancy, risky sexual behavior, and violence among school-aged children and improved academic performance and sense of

e For more information on evidence-based strategies, see Appendix B.

well-being.[f] Different evidence-based programs or other strategies have been shown to be effective in different settings, including homes, schools, workplaces, or other community venues. In fact, communities can save four to five dollars for every one dollar spent on substance abuse prevention.[18] The most effective prevention strategies are those that involve multifaceted interventions that include the individual, family, schools, and community and are reinforced by supportive public policies. Less is known about effective depression prevention strategies. While there are studies that have shown reduced depressive symptoms resulting from universal, selective, and indicated mental health prevention programs, fewer studies have shown a reduction in the incidence of depression.[19]

The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) has two sources of funds to support community-based prevention efforts. DMHDDSAS receives Substance Abuse Prevention and Treatment block grant funds from SAMHSA. These funds are distributed to local mental health and substance abuse agencies called Local Management Entities (LMEs) and are used to support needs assessments and to implement evidence-based prevention programs, practices, and policies.[20] In addition to the federal funds, the North Carolina General Assembly also appropriated $800,000 over two years (SFY 2006-2007) to support local substance abuse coalitions.[21] State funds were used to build eight community coalitions with the intent of implementing evidence-based prevention strategies. Despite these different funding sources, few communities have implemented comprehensive substance abuse prevention programs targeted at youth and young adults. The current funds are inadequate to support a statewide comprehensive substance abuse prevention plan that reaches all North Carolinians in need of prevention interventions. DMHDDSAS estimates that only about 42,000 of the more than 275,000 youth who were in need of prevention services (because of early use or specific risk factors) actually received prevention services in SFY 2007.[g,22] Unfortunately, there are no federal funds that specifically target the prevention of mental health disorders.

North Carolina public schools are required to teach information about substance use and abuse, mental health, and emotional well-being as part of the Healthful Living Standard Course of Study. However, one study that examined the type of substance abuse prevention programs being implemented in North Carolina

Evidence-based prevention strategies have been shown to be effective in delaying initiation and reducing use of alcohol and other drugs.[e] Many of these evidence-based programs have also demonstrated other positive effects, such as reduced depression, delinquency, teen pregnancy, risky sexual behavior, and violence among school-aged children and improved academic performance and sense of well-being.

f Examples of substance abuse prevention initiatives with other demonstrated positive impacts include: Positive Action, a replicated school-based program that has shown to have positive effects on behavior and academic achievement (http://ies.ed.gov/ncee/wwc/reports/character_education/pa/effectiveness.asp); Family Behavior Therapy, an outpatient program shown to reduce use and initiation of alcohol and drug use and depression (http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=73); Guiding Good Choices, a school-based initiative shown to reduce initiation of substance use and aid in reducing/preventing delinquency and symptoms of depression (http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=123); and Life Skills Training, another school-based program designed to reduce substance use, violence, and delinquency (http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=230).

g Certain groups have a higher risk of developing a substance abuse disorder, including those who have a parent with substance abuse problems, have academic difficulties in school, and/or have started experimenting with substances themselves.

public schools found that most schools had not implemented evidence-based substance abuse prevention programs.[23] Evidence-based prevention programs generally are interactive and include a skills building or competency-based curricula.[19,21] Because these programs focus heavily on skills building, they generally take more time to implement than do courses that just aim to impart knowledge. For example, a meta-analysis of different mental illness prevention programs showed that the most effective programs were those that included more than eight sessions, with lengths of 60-90 minutes each. Evidence-based courses may also involve more costs to implement (due to cost of materials, teacher training, etc.). This is part of the reason that so few public schools implement these programs.[24]

Multifaceted interventions are generally more effective than single-pronged prevention programs.

Similarly, multifaceted interventions are generally more effective than single-pronged prevention programs. Thus, community-based and school-based substance abuse or mental health illness prevention programs should be augmented with supportive public policies. For example, anti-bullying laws can reduce bullying, and this helps reduce feelings of isolation or stress among bullying victims.[h,25] Similarly, increasing taxes on alcohol products has been shown to reduce use, just as increased tobacco taxes reduces use of tobacco. Both youth and heavy drinkers have been shown to respond to tax increases.[26-28] Taxes on beer are especially important as malt beverages (including beer) are popular alcoholic drinks among youth.[29,30] Although North Carolina has the 4th highest beer tax and the 18th highest wine tax in the country, 2009 was the first time either had been raised in 30 years.[i] Raising taxes on these alcoholic beverages to adjust for inflation would raise the beer tax to 29 cents per bottle ($3.13 per gallon) and the wine tax to $2.36 gallon.[31] In 2009, the North Carolina General Assembly increased the alcohol excise tax; for example, the beer excise tax was increased from 53.177 to 61.71 cents per gallon.[j,k] Table 6.1 shows projected increased revenues and decreased consumption from different levels of tax increases. Raising the alcohol tax should also help improve mental health and well-being. Alcohol acts as a depressant that lowers serotonin levels in the blood; therefore reducing alcohol consumption can help reduce feelings of depression.[32,33] In addition, part of the money raised from the increased revenues could be used for use for substance abuse and mental health prevention and treatment.

The state can and should do more to effectively prevent use of alcohol and drugs among youth and young adults and prevent depression and improve feelings of well-being among the general population. The Task Force recommends broad

h The North Carolina General Assembly passed an anti-bullying bill effective the 2009-2010 school year. The bill amends NCGS §115C-407.5 et. seq. Session Law 2009-212.

i The beer tax was last increased in 1969; the wine tax was last increased in 1979.

j Since finalizing the Task Force's work, the North Carolina General Assembly enacted the SFY 2009-2010 budget. The budget included an 16% increase on the beer tax (from 53.177¢ to 61.71¢ per gallon); an 25% increase on unfortified wine (from 21¢ to 26.34¢ per liter) and a 22% increase on fortified wine (from 24¢ to 29.34¢ per liter); and a 20% increase on distilled liquor (from 25% to 30% excise tax on the distiller's price plus the state ABC warehouse freight and bailment charges and markup for local ABC boards).

k NCGS § 105-113.80.

community-based approaches, as well as supportive public policies, to prevent the initiation, use, and abuse of alcohol and other drugs and to reduce feelings of depression. The state should initially focus on implementing evidence-based substance abuse prevention initiatives, particularly those that have also been shown to be effective in improving emotional well-being, reducing youth violence

Table 6.1
Projected Increased Revenues and Decreased Consumption Due to Tax Increases in Beer and Wine[l]

Beer Tax		
2007 Tax Per Gallon	2007 Revenues	
$0.53	$100,533,960	
Potential New Tax Per Gallon	Increased Revenue	Decrease in Consumption
$0.6171 (Effective 9/1/09)	$19,304,437	0.22%
$0.75	$44,622,243	0.56%
$1.00	$91,776,514	1.19%
$1.50	$184,238,359	2.45%

Wine Tax (unfortified wine)		
2007 Tax Per Gallon	2007 Revenues	
$0.79	$14,320,319	
Potential New Tax Per Gallon	Increased Revenue	Decrease in Consumption
$0.99 (Effective 9/1/09)	$1,111,327	0.31%
$1.50	$8,875,532	1.10%
$2.00	$16,365,089	1.88%
$2.36	$21,682,526	2.43%

Notes: Calculations are based on 2007 North Carolina 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 ($14.87 per gallon of beer, $40.22 per gallon wine) as provided by the Alcohol Policies Project (as of September 2009). The -0.35 was the price elasticity used for beer (Cook PJ. ITT/Terry Sanford Professor of Public Policy Studies; Professor of Economics and Sociology and Associate Director, Terry Sanford Institute of Public Policy, Duke University. Written communication. January 19, 2009). The price elasticity used for wine was -0.58. (Nelson JP. Economic and demographic factors in U.S. alcohol demand: a growth-accounting analysis. *Empirical Econ.* 2007;22(l):83-102.

Increasing taxes on alcohol products has been shown to reduce use, just as increased tobacco taxes reduces use of tobacco. Both youth and heavy drinkers have been shown to respond to tax increases.

l 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. (Center for Science in the Public Interest. Beer consumption and taxes. http://www.cspinet.org/booze/Fact Sheets/0308Beer &Taxes.pdf. Published August 2003. Accessed January 19, 2009.)

or delinquency, or reducing risky sexual behavior.[m] Therefore, the Task Force recommends:

Recommendation 6.1: Develop and Implement a Comprehensive Substance Abuse Prevention Plan (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; promote emotional and mental health well-being; identify those who need treatment; and help them obtain services earlier in the disease process.

1) **DMHDDSAS should pilot test this prevention plan in six counties or multi-county areas and evaluate its effectiveness. DMHDDSAS should develop a competitive process and select at least one rural pilot and one urban pilot in the three DMHDDSAS regions across the state. DMHDDSAS should provide technical assistance to the selected communities. If effective, the prevention plans should be implemented statewide.**

2) **The pilot projects should involve multiple community partners, including but not limited to Local Management Entities, primary care providers, health departments, local education agencies, local universities and community colleges, and other appropriate groups.**

3) **The pilots should incorporate evidence-based programs, policies, and practices that include a mix of strategies including universal and selected populations. Priority should be given to evidence-based programs that have been demonstrated to yield positive impacts on multiple outcomes, including but not limited to preventing or reducing substance use, improving emotional well-being, reducing youth violence or delinquency, or reducing teen pregnancy.**

4) **The North Carolina General Assembly should appropriate $1.95 million in recurring funds in SFY 2011 and $3.72 million in recurring funds in SFY 2012 to DMHDDSAS to support and evaluate these efforts.**

b) The excise taxes on malt beverages and wine should be indexed to the consumer price index so they can keep pace with inflation.

m Section 10.15 of the 2009 Appropriations Act "strongly encourages" Local Management Entities to fund substance abuse prevention and education activities.

1) **The increased fees should be used to fund effective prevention and treatment efforts for alcohol, tobacco, and other drugs.**
2) **The North Carolina General Assembly should appropriate $2.0 million in recurring funds in SFY 2011 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, offer early intervention, and support recovery among adolescents and adults.**

Early Intervention

Prevention should be the cornerstone of North Carolina's efforts to reduce inappropriate use, misuse, and dependence on alcohol and other drugs and to prevent the incidence and severity of stress, depression, or other anxiety disorders. Evidence-based prevention programs have been shown to help reduce use and misuse of substances as well as reduce symptoms of depression. However, no prevention intervention will totally eliminate all harmful use of alcohol or other drugs or feelings of isolation, depression, or stress. Thus, it is important to combine prevention with early intervention activities.

No prevention intervention will totally eliminate all harmful use of alcohol or other drugs or feelings of isolation, depression, or stress. Thus, it is important to combine prevention with early intervention activities.

Many people with substance abuse or mental health problems are reluctant to admit they have a problem and thus are unlikely to seek care directly from treatment professionals. Even those who know they have a problem may not seek care because of the stigma or the costs attached to this condition.[22,34,35] Primary care practices are an optimal setting in which to provide early intervention services. Additionally, the faith community may be an appropriate and ideal place for early intervention, especially for people who are uncomfortable seeking help, unaware of needing help, or unsure of how to begin the help process.

Primary Care Providers

While many people with behavioral health problems are reluctant to seek care from substance abuse or mental health treatment professionals, most people do seek care from primary care providers throughout the year. Nationally, 55% of the population visit a primary care provider during the year, whereas only 0.1% seeks care from an office-based provider for substance abuse services.[n] Screening, early intervention, and referral into more intensive treatment when appropriate has been found to be effective for both substance abuse and for mental health services.

n North Carolina Institute of Medicine calculations using the 2005 Medical Expenditures Panel Survey, Agency for Healthcare Research and Quality. Substance abuse vsits are defined as visits with an ICD-9 code diagnosis 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.

Substance Abuse Services: There is a robust body of literature that shows that screening, brief intervention, and referral into treatment—also know as SBIRT—is effective in reducing the use of tobacco, alcohol, and other drugs.[o,36,37] This model has been studied for more than 20 years in different settings, including primary care providers' offices, federally qualified health centers, health departments, school-based clinics, emergency departments, and hospitals.[38-40] It has been shown to be effective with adolescents as well as adults.[41] Primary care providers should screen their patients (using a validated screening instrument) to determine if they are beginning to abuse alcohol or are using other drugs. Individuals who are identified as having, or at risk of having, a substance abuse problem should be offered motivational counseling. Those with more significant problems should be referred into more specialized substance abuse treatment services.

Screening, brief intervention, and referral into treatment—also known as SBIRT—is effective in reducing the use of tobacco, alcohol, and other drugs.

Implementation of SBIRT within the primary care setting can halt substance use before it progresses to abuse and addiction. National studies show a four to seven dollar decline in overall health care costs (due to reduced hospitalizations and emergency department costs) for every one dollar spent on SBIRT.[36] However, many primary care practitioners are unaware of SBIRT, and as a result, most practitioners are not offering this evidence-based practice to their patients. The North Carolina Governor's Institute on Alcohol and Substance Abuse; the Area Health Education Centers (AHEC) program; and the Integrated, Collaborative, Accessible, Respectful and Evidence-Based care project (ICARE) are currently working together to provide training and technical assistance to North Carolina primary care providers and to encourage more practices to implement SBIRT. (ICARE is described more fully below.) However, more work is needed to increase the number of primary care practices equipped to identify people who have problems with alcohol, tobacco, and other drugs.

Mental Health Services: Early detection and treatment of mental health disorders can improve outcomes and lessen long-term disability.[35] However, many people with mental health disorders are not identified or provided with appropriate treatment.

The primary care office is an ideal place to screen and offer mental health services. About half of the care for mental health disorders occurs in the primary care setting. In fact, primary care providers prescribe the majority of psychotropic drugs for children and adults. Nonetheless, studies suggest that primary care providers fail to diagnose many people with mental health disorders including depression, anxiety, or suicide ideation. Further, many people with common mental health disorders do not receive appropriate care in the primary care setting.[35] Enhanced training for primary care providers is important but is unlikely to change practice patterns without other changes in the service delivery system.[42] Rather, to improve the quality of care and patient outcomes, primary care providers need training

o For more information on SBIRT, visit the SAMHSA website at http://sbirt.samhsa.gov/index.htm.

(discussed more fully in Recommendation 12.5), effective tools to diagnose and treat, closer coordination of care with behavioral health specialists, and changes in the payment system.

Primary care providers should screen their patients to identify people with mental health disorders. The US Preventive Services Task Force (USPSTF) recommends that primary care providers screen adolescents (ages 12-18) and adults for major depressive disorder.[43,44] Just as with provider training, screening patients is insufficient in and of itself to ensure that people receive appropriate treatment. In fact, the USPSTF only recommends screening "when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up."[43] Other studies have shown that it is not effective for primary care providers to merely screen and refer, as one-third to one-half of the people who are referred to mental health specialty care do not follow through with the referral.[42] Instead, a new collaborative care model should be developed in which the primary care provider can work with mental health specialists and care managers to provide appropriate treatment.

A new collaborative care model should be developed in which the primary care provider can work with behavioral health specialists and care managers to provide appropriate treatment [of behavioral health disorders].

Studies have shown that effective collaborative care models have two key components: 1) care management by a nurse, social worker, or other clinical staff, and 2) consultation between the mental health specialist, care manager, and primary care provider.[42] North Carolina is working to develop a similar approach in its Medicaid program through the ICARE partnership.[p] ICARE, funded by the Kate B. Reynolds Charitable Trust, The Duke Endowment, and others, was created to improve collaboration and communication between primary care and behavioral health providers.[q] Another goal of the ICARE initiative is to increase the capacity of primary care physicians to provide appropriate, evidence-based behavioral health services. ICARE has developed and tested several models of integrating behavioral health and primary care. Initially, primary care providers in pilot sites were trained to provide better mental health services (particularly aimed at depression) and then to develop stronger linkages with the local LME for other more specialized behavioral health services. There are six sites covering 12 counties involved in these ICARE pilots. Later, ICARE staff worked with the North Carolina Office of Rural Health and Community Care (ORHCC) to develop co-location models, funded initially through the North Carolina General Assembly. In this model, mental health professionals are co-located in the primary care practices (often in pediatric practices). Individuals in need of mental health services can be referred "down the hall" to a mental health provider. There are currently over 50 practices involved in the co-location model. Integrated approaches such as ICARE also show improvements in behavioral health outcomes.[45,46]

p Information about ICARE is available at www.icarenc.org.

q ICARE is funded by the Kate B. Reynolds Charitable Trust, The Duke Endowment, AstraZeneca, North Carolina Area Health Education Centers Program, the North Carolina Department of Health and Human Services, and the North Carolina Foundation for Advanced Health Programs.

Primary care providers' offices can be a very effective place to provide early intervention and treatment services for both substance abuse and mental health disorders. However, practitioners need enhanced training, and systems need to be changed to support high-quality behavioral health services.

The initial experiences with the ICARE and co-location models in the Medicaid program have been positive, but there are problems replicating this model for people with other forms of insurance coverage. Historically, insurers did not cover mental health and substance abuse services to the same extent as they covered other physical illnesses. While this problem has largely been addressed for large employer groups of 50 or more people through the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, the law does not apply to smaller employer groups or to people who purchase insurance in the private non-group market.[r] North Carolina passed legislation mandating mental health parity in 2007, which requires insurers to provide the same coverage for certain mental health disorders as provided for other physical illnesses. This applies to all health insurance plans offered in North Carolina, including insurance sold to small-employer groups with fewer than 50 employees and non-group plans. However, the legislation does not provide parity for substance abuse services or for all mental illnesses.[s]

Further, there are other insurance barriers that deter primary care providers from offering mental health or substance abuse services. To reduce these barriers, insurers should provide reimbursement for the following:

- Screening and brief intervention in different health settings.
- Telephone and face-to-face consultations between primary care providers and psychiatrists or other behavioral health specialists.
- Care management to coordinate care for behavioral health services between the primary care provider and behavioral health specialist.
- Care provided by a behavioral health specialist and primary care provider on the same day in the same clinic (to support co-location models).[31,42]

Primary care providers' offices can be a very effective place to provide early intervention and treatment services for both substance abuse and mental health disorders. However, practitioners need enhanced training, and systems need to be changed to support high-quality behavioral health services. In addition, reimbursement systems should be modified to support the provision of these services in primary care practices and to further support co-location or integration efforts. To achieve this, the Task Force recommends:

r Congress recently passed a mental health and substance abuse parity law that covers all employer groups with 50 or more employees that offer mental health coverage. Under the new statute, group health plans must generally provide mental health and substance abuse coverage in parity with medical and surgical benefits offered. Insurers may not have higher cost sharing or more restrictive treatment limits for mental health or substance abuse services than what is provided generally for other medical and surgical benefits. This new law becomes effective January 1, 2010. 29 USC §1185a, 42 USC §300gg-5.

s Session Law 2007-268.

Recommendation 6.2: Expand the Availability of Screening, Brief Intervention, and Treatment for People with Behavioral Health Problems in the Primary Care Setting

a) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) should develop a Memorandum of Agreement with the North Carolina Office of Rural Health and Community Care (ORHCC), Governor's Institute on Alcohol and Substance Abuse, North Carolina Area Health Education Centers (AHEC) program, and other appropriate organizations to educate and encourage health care professionals to use evidence-based screening tools and offer counseling, brief intervention, 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. The North Carolina General Assembly should appropriate $1.5 million in SFY 2011 in recurring funds to the DMHDDSAS to support this effort.

b) DMHDDSAS, in collaboration with the ORHCC, should work collaboratively with the Governor's Institute on Alcohol and Substance Abuse, North Carolina 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 for substance abuse and mental health.

c) Health professionals should screen adolescents and adults ages 12 or older for major depressive disorders and for substance abuse disorders using systems that ensure accurate diagnosis, effective treatment, and follow-up.

d) 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.

e) The North Carolina General Assembly should direct public and private insurers to review their reimbursement policies to ensure that primary care and other providers can be reimbursed to:

    1) Screen for tobacco, alcohol, drugs, and mental health disorders.

    2) Provide brief intervention and counseling and refer necessary patients for specialty services.

    3) Support co-location of behavioral health and primary care providers.

    4) Pay for case management services to coordinate services and follow-up between primary care and behavioral health specialists.

    5) Pay for telephone or in-person consults between primary care providers and behavioral health specialists.

f) **The Division of Medical Assistance should work with the ORHCC to develop an enhanced Community Care of North Carolina (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.**

Faith communities represent a unique setting in which mental health illness and substance abuse prevention and early intervention can be incorporated.

Faith Community

Faith communities represent a unique setting in which mental health illness and substance abuse prevention and early intervention can be incorporated. The majority (53%) of North Carolinians attend church or synagogue once a week or almost every week.[47] Instead of seeking medical care, some people turn to their clergy or other faith leaders for help with mental health or substance abuse disorders. While physicians are trusted by the general population, they are less trusted by African Americans and other minority groups.[48] African Americans often rely on clergy for counseling, particularly when dealing with death and bereavement.[49] One study showed that African Americans who first turn to their clergy for assistance for depression or anxiety are less likely to seek help from health professionals. This may be due, in part, to their needs being met by their minister and also the stigma attached to treatment within the specialty medical system. However, it may also be due, in part, to the lack of relationships between health care professionals and clergy or other leaders in the faith community. This suggests that more outreach is needed to build relationships between members of the faith community and health professions—particularly as it relates to treatment of mental health and substance abuse problems. Working with the faith community has yielded positive impacts in other areas of primary prevention, such as cardiovascular health, cancer screenings, and general health maintenance.[50] For this reason, the Task Force recommends:

Recommendation 6.3: Expand Early Intervention Services in the Faith Community

The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services should partner with a variety of mental health and substance abuse organizations, faith-based institutions of higher education, and other faith leader training programs to develop and offer a training specifically designed to help leaders of all faiths recognize signs of stress, depression, and substance abuse in those they counsel and to develop linkages with outside referrals when appropriate. Faith communities at the local, regional, and state levels should encourage their faith leaders to attend these trainings.

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