Executive Summary

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

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

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]

Alcohol and drug abuse cost the North Carolina economy over $12.4 billion in direct and indirect costs in 2004.

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 DMHDDSAS have developed a number of programs to serve these adults. One of these initiatives involves outstationing

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 Addition 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.[a,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).

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.

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.

References

1 Friedman D. The biology of addiction and public policy. Presented to: The North Carolina Institute of Medicine Task Force on Substance Abuse Services; October 15, 2007; Cary, NC.

2 Office of Applied Studies, Substance Abuse and Mental Health Services Administration. National Survey on Drug Use and Health, 2004 and 2005. www.oas.samhsa.gov/2k5State/NorthCarolina.htm. Accessed February 27, 2008.

3 Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. *Overview of DMHDDSAS Total System Funding.* Raleigh, NC: North Carolina Dept of Health and Human Services; 2006. www.dhhs.state.nc.us/mhddsas/budget/06-07totalpublicmhddsasystemfunding.pdf. Accessed February 28, 2008.

4 Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. Report to the 2007 North Carolina General Assembly. http://www.ncga.state.nc.us/documentsites/legislativepublications/Study%20Reports%20to%20the%202007%20NCGA/Mental%20Health,%20Developmental%20Disabilities,%20and%20Substance%20Abuse%20-%20Joint%20Legislative%20Oversight.pdf. Published March 7, 2007. Accessed January 16, 2009.

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 The Schneider Institute for Health Policy. *Substance abuse: the nation's number one health problem.* Princeton, NJ: The Robert Wood Johnson Foundation; 2001.

7 North Carolina alcohol facts. University of North Carolina Highway Safety Research Center website. http://www.hsrc.unc.edu/index.cfm. Accessed February 28, 2008.

8 Division of Alcoholism 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.

9 Frequently asked questions. Substance Abuse and Mental Health Services Administration website. http://prevention.samhsa.gov/about/faq.aspx. Accessed March 5, 2008.

10 Babor TF, Higgins-Biddle JC. *Brief Intervention for Hazardous and Harmful Drinking: A Manual for Use in Primary Care.* 2001. Geneva, Switzerland: Dept of Mental Health and Substance Dependence, World Health Organization; 2001.

11 North Carolina Department of Juvenile Justice and Delinquency Prevention. 2007 annual report. http://www.ncdjjdp.org/resources/pdf_documents/annual_report_2007.pdf. Published March 2008. Accessed January 16, 2009.

12 *The Dollars and Sense of Employee Assistance.* Arlington, VA: EAPA Publications; 2003.

13 North Carolina Sentencing and Policy Advisory Commission, North Carolina Court System. Correctional program evaluation: offenders placed on probation or released from prison in fiscal year 1996/97. April 2000.

14 Price V, Rivenbark W. North Carolina Department of Correction, Division of Alcoholism and Chemical Dependency Programs. Presented to: The North Carolina Institute Medicine Task Force on Substance Abuse Services; May 30, 2008; Cary, NC.

15 Williams JW Jr. Serving the health needs of our military and veterans. *NC Med J.* 2008;69(1):23-26.

16 RTI International. 2005 Department of Defense survey of health related behaviors among active duty military personnel. http://www.ha.osd.mil/special_reports/2005_Health_Behaviors_Survey_1-07.pdf. Published December 2006. Accessed October 30, 2008.

17 Wheeler E. Self-reported mental health status and needs of Iraq veterans in the Maine Army National Guard. http://www.ptsd.ne.gov/publications/MENG-veterans-study-full-report.pdf. Accessed January 16, 2009.

18 Milliken CS, Auchterlonie JL, Hoge CW. Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq war. *JAMA.* 2007;298(18):2141-2148.

19 Stein F. Coming home: the NC focus on returning combat veterans and their families. Presented to: The North Carolina Institute Medicine Task Force on Substance Abuse Services; October 24, 2008; Cary, NC.

20 Holliman E. The future of our substance abuse workforce in North Carolina: increasing the availability of substance abuse counselors. Presented to: The North Carolina Institute of Medicine Task Force on Substance Abuse Services; September 26, 2008; Cary, NC.

21 Pharr M. Department of Juvenile Justice and Delinquency Prevention. Presented to: The North Carolina Institute of Medicine Task Force on Substance Abuse Services; June 23, 2008; Cary, NC.

22 Stein F. The substance abuse workforce. Presented to: The North Carolina Institute of Medicine Task Force on Substance Abuse Services; September 26, 2008; Cary, NC.

23 North Carolina Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services; North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. *The Workforce Development Initiative.* Raleigh, NC: North Carolina Dept of Health and Human Services; 2008. http://www.dhhs.state.nc.us/MHDDSAS/statspublications/reports/workforcedevelopment-4-15-08-initiative.pdf. Accessed November 19. 2008.

24 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 October1999. Accessed May 15, 2008.