

Substance Abuse in North Carolina

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Addiction to alcohol, tobacco, and other drugs is a chronic illness, much like many of the other chronic illnesses that health care professionals regularly treat. About one-half of people with addiction disorders have a genetic predisposition to addiction, similar to people with asthma, diabetes, and hypertension.¹⁻³ Additionally, adherence and relapse rates are similar across these chronic illnesses. Researchers and health care professionals who study brain chemistry and addiction disorders recognize that addiction is a chronic, relapsing disease with no complete cure. The goal of treatment should be to help the individual manage their chronic condition. Yet, as a society we often view addiction as a moral failure and blame the person for his or her dependence—making it difficult for people to seek care. As a result, we have a system that is largely unresponsive to the needs of people with addiction disorders.

The failure to properly recognize and address the needs of people with substance abuse disorders creates considerable problems for the individual, his or her family, employers, and society as a whole. In North Carolina, there are approximately 642,000 people age 12 or older who used illicit drugs in the past month (7.7%) and more than 1.6 million people (19.5%) who reported binge drinking.^{a,4} However, not everyone who uses alcohol or illicit drugs is

addicted to these substances. Nor does the occasional or moderate use of some of these substances automatically lead to poor health outcomes. For example, some data suggest that moderate consumption of certain types of alcoholic beverages (e.g., a glass of red wine) may be protective for certain types of health problems.^{5,6} Occasional use in moderate amounts

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must be distinguished from abuse or dependence. Abuse refers to misuse of a substance (usually in terms of frequency or quantity), which puts a person at heightened risk for adverse outcomes such as injury, motor vehicle accidents, job loss, family disruption, sexual assault, or a variety of medical conditions.

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

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Dependence or addiction connotes an emotional or physiological dependence on alcohol or drugs, where the individual loses control over his or her consumption despite the adverse and often very serious consequences in his or her life. In North Carolina, 8.5% of the population age 12 or older—more than 700,000 people—are addicted to alcohol, drugs, or both.⁴

Despite the large number of people who report addiction disorders, few people in North Carolina are receiving treatment. The 2005-2006 National Survey of Drug Use and Health reported that there were more than 550,000 people in North Carolina who reported alcohol dependence or abuse in the last year, and more than 250,000 who reported illicit drug use or abuse (see Table 1).^{7,8} Yet fewer than 5% of all people age 12 or older who reported alcohol addiction or abuse, and only about 10% of the people addicted to illicit drugs, received treatment.⁴ A slightly lower percentage of children age 12-17 receive treatment (5% of those with alcohol addiction and 9% of those who are addicted to illicit drugs). Even fewer young adults ages 18-24 receive treatment (3% of people with alcohol dependence or abuse and 7% of those who report illicit drug dependence).⁴

The failure to adequately reach and treat people with substance abuse disorders has significant societal implications. Alcohol and drug abuse was estimated to cost the North Carolina economy more than \$12.4 billion in direct and indirect costs in 2004.⁹ 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.¹⁰ Almost 90% of prisoners entering the prison system have substance abuse disorders requiring treatment, with 63% needing residential substance abuse treatment services.¹¹ Similarly, 43% of juveniles in the juvenile justice system are in need of substance abuse treatment services.¹² Moreover, national data suggest that alcohol and/or drug abuse are contributing factors to the placement of 75% of children who enter the foster care system.¹³

The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse System

(DMHDDSAS), within the North Carolina Department of Health and Human Services, is charged with providing and ensuring that substance abuse prevention and treatment services are available throughout the state. Most of the direct provision of publicly-funded services is managed by local governmental agencies, called Local Management Entities (LMEs). Overall, North Carolina spent \$138 million in 2006 on publicly-funded substance abuse services, a sum that left the North Carolina substance abuse system underfunded in relation to other states.¹⁴

The North Carolina General Assembly asked the North Carolina Institute of Medicine (NCIOM) to create a task force to study these problems and to determine why the state's substance abuse system was unable to serve more of the people in need.^b The NCIOM Task Force on Substance Abuse Services was chaired by Representative Verla Insko, Senator Martin L. Nesbitt Jr, JD and Dewayne Book, MD, medical director for Fellowship Hall. It included 63 additional members including legislators, state and local agency officials, substance abuse providers, health professionals, consumers, educators, and other knowledgeable and interested individuals. The Task Force met a total of 15 times over 16 months. A listing of Task Force and Steering Committee members is included in the acknowledgement section at the end of this issue brief. A full report detailing the work and recommendations of the Task Force is available on the North Carolina Institute of Medicine's website, www.nciom.org. In this issue brief, priority recommendations of the Task Force are presented in bold.

Comprehensive System of Care

As noted above, many North Carolinians use, abuse, or are dependent on alcohol, tobacco, or other drugs. Some are already physically or psychologically addicted, while others engage in risky or abusive behaviors that may later result in an addiction. Reducing substance use, abuse, and dependence requires a comprehensive system of care that starts with prevention,

Table 1.
Estimates of North Carolina Population Age 12 or Older with Addiction Disorders who Receive Treatment

	Number	Percent
Dependence on or abuse of illicit drugs or alcohol in the past year	709,000	8.5%
Alcohol dependence or abuse in past year	551,000	6.6%
<i>Of this, the number and percentage who report needing and receiving treatment</i>	25,000	(4.5%)
Illicit drug dependence or abuse in past year	250,000	3.0%
<i>Of this, the number and percentage who report needing and receiving treatment</i>	25,000	(10.0%)

Source: Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services. National Survey on Drug Use and Health, 2005-2006. Estimates of North Carolina population based on 8.3 million people age 12 or older (2008).

b §10.53 of Session Law 2007-323.

offers early intervention services before people become dependent, provides a range of treatment options that can appropriately address a person's needs, and includes recovery supports to help people with addiction disorders manage their chronic condition (see Figure 1).

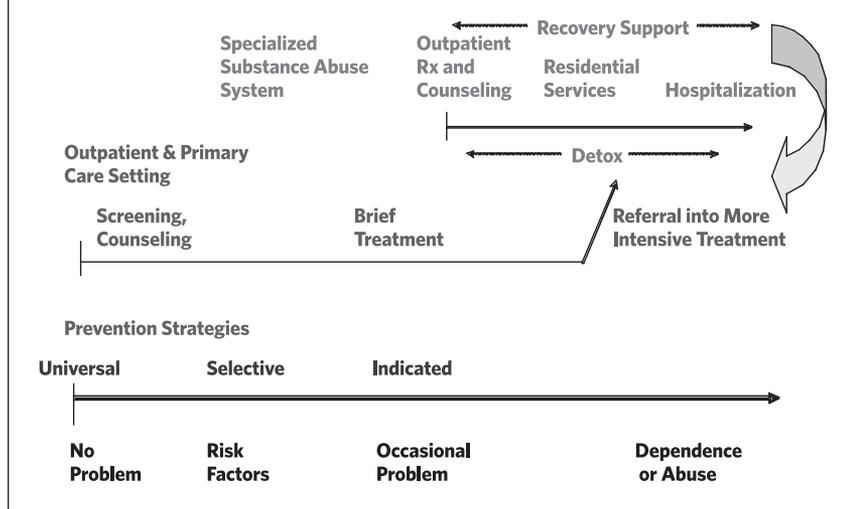
Prevention

A comprehensive system of care should begin with prevention and should focus on youth and adolescents. These individuals are particularly susceptible to addiction disorders, as the prefrontal cortex region of the brain—the part of the brain associated with long-term decision-making and the ability to balance trade-offs—does not fully develop until around age 25. Early use of tobacco and/or alcohol can impact the

structure and functioning of the developing brain.^{15,16} David Friedman discusses the impact of substance abuse on brain development in this issue of the *Journal*. Studies show that of the adults who reported alcohol abuse or dependence in the last year, approximately one-sixth (14.7%) first began using alcohol at age 14 whereas less than 3% first began using alcohol after age 21.¹⁷ Similarly, adults who first smoked marijuana at age 14 or younger were more likely to report being addicted to illicit drugs (15.9%) than were those who first smoked marijuana after age 18 (2.7%).¹⁷

Targeting youth and adolescents with evidence-based prevention strategies should be a top priority for the state. North Carolina high school students reported in the 2007 Youth Risk Behavior Survey that almost 40% of high school students had at least one drink in the last 30 days, more than 20% reported binge drinking, and almost 20% have used marijuana in the last month.¹⁸ Further, a sizable proportion of middle school students have also used these substances. In the 2007 Youth Risk Behavior Survey, 33.6% of North Carolina middle school students reported having drunk alcohol (more than a few sips) and 11.9% of middle school students reported ever having used marijuana.¹⁹ To be effective, communities should develop multifaceted prevention efforts that target the general population ("universal"), people at increased risk ("selective" populations), and people who have already begun to use or misuse tobacco, alcohol, or other drugs ("indicated" populations). The state has already implemented a similar multifaceted approach to reduce underage smoking. Although youth smoking is still far too high, the smoking rate has declined in recent years. Smoking among high school students has declined from 27.8% in 2001 to 19% in 2007.^{20,21} There has also been a decline in smoking among middle school students. The state can build on these strategies by

Figure 1.
Comprehensive Substance Abuse Services System



targeting efforts to reduce the use of tobacco, alcohol, and other drugs among youth. The Task Force recommended that the General Assembly provide funding to pilot six comprehensive community-wide prevention efforts, prioritizing efforts to reach children, adolescents, young adults, and their parents. The communities must involve multiple community partners including: schools, community colleges, universities, LMEs, public health, social services, juvenile justice, and other community groups. Communities that are selected must conduct a local needs assessment to prioritize prevention goals and develop a plan to implement a mix of evidence-based prevention programs, policies, and strategies aimed at delaying initiation and reducing the use of tobacco, alcohol, and other drugs among children, adolescents and young adults.^c The Task Force also recommended funding to expand campus and community coalitions aimed at reducing underage drinking. Phillip W. Graham and Phillip A. Mooring describe successful community-based prevention campaigns in their commentary.

Public policies aimed at reducing youth smoking or drinking can also help support broader community-based prevention activities, as both tobacco and alcohol can be precursors to other illegal drug use.²² Increasing the tax on tobacco products and alcohol has led to decreased consumption of these substances, particularly among youth who are more price-sensitive. Thus, the Task Force recommended that North Carolina increase the cigarette tax and the tax on other tobacco products to the national average, increase the excise tax on malt beverages (including beer), and periodically update the taxes for tobacco products, malt beverages, and wine. Funding generated from these increased taxes should be used for prevention programs aimed at changing the cultural norms to prevent initiation, to reduce use, and to help people stop using tobacco, alcohol

c SAMHSA has a registry of evidence-based programs (NREPP) that is searchable based on targeted populations, intervention points, and types of evaluation studies. The information is available at <http://www.nrepp.samhsa.gov>.

and other substances. **The Task Force also recommended prohibiting smoking in all public buildings in order to further reduce cigarette smoking and exposure to secondhand smoke.**

Early Intervention

Comprehensive prevention efforts will help reduce the number of people who use, abuse, or are dependent on tobacco, alcohol, and other drugs. However, it is unlikely that a comprehensive prevention effort will eliminate all abuse of these substances. Thus, we also need to develop early intervention programs to target the occasional user before they become dependent on these substances.

Because of the stigma associated with addiction disorders, many people with problems are reluctant to seek care from specialized substance abuse professionals. In contrast, visiting a primary care practice does not carry the same social stigma. Nationally, more than one-half of the US population visited a primary care provider in one year, compared to less than 1% of people who seek care for substance abuse services from office-based providers.^d Primary care providers need to be able to identify both people with and at-risk of addiction disorders so they can appropriately treat their underlying health condition. Certain drugs that are appropriate to the general population are contraindicated for people with addiction disorders. Primary care providers are well situated to screen people to identify those who are using tobacco, alcohol, and other drugs, and to provide counseling and brief interventions, including medication assisted treatment. There are many new forms of medication management that are appropriate for people with substance use disorders, such as methadone, buprenorphine and naltrexone for people with opiod addictions, or disulfiram, naltrexone, and acamprosate for people with alcohol addictions.

Substance abuse screening, brief intervention, and referral to treatment (SBIRT) has been studied for over 20 years in a number of populations and settings and has been found to be effective. SBIRT has been used in rural and urban primary care practices, emergency departments, federally-qualified health centers, public health departments, and school-based health centers, and has been successful in helping reduce consumption among people who abuse alcohol and/or illegal drugs.²³⁻²⁶ New federal monies are providing grants to study the effectiveness of SBIRT in prescription drug abuse.

The SBIRT model is similar in many ways to recommended clinical guidelines to screen and counsel people who use

tobacco products.²⁷ Under SBIRT, providers screen patients to determine the severity of their use of alcohol or other drugs, provide brief counseling for those who are not yet addicted, and refer others into appropriate levels of substance abuse treatment services. The success of this model is contingent on three key factors: (1) trained primary care providers or others who can appropriately screen, provide brief interventions, and when necessary, refer to specialty treatment; (2) accessible substance abuse providers who can provide an array of treatment services and recovery supports for people with more extensive needs; and (3) coordination of care and a bi-directional flow of information between primary care providers and qualified substance abuse professionals. In her commentary, Sara McEwen discusses the elements needed to successfully implement SBIRT.

To encourage early intervention, the Task Force recommended that the General Assembly appropriate \$1.5 million in recurring funds to DMHDDSAS to work with other appropriate organizations to educate health care professionals about the SBIRT model. This would include education on substance use disorders, screening tools, brief intervention/motivational counseling, referral, and treatment options. The initiative could involve a range of primary care and other ambulatory care providers. The focus, however, would be to involve primary care providers who participate in Community Care of North Carolina to facilitate the development of more comprehensive medical homes that integrate physical health, mental health, and substance abuse services. Primary care professionals would be trained to use evidence-based screening tools, offer counseling and brief intervention, and refer patients to more intensive substance abuse services when appropriate. **In addition, the Task Force recommended that public and private payers/insurers pay for substance abuse services in parity with other illnesses, as well as pay for screening and brief intervention in different health care settings.^e The state, local LMEs, and other partners should develop systems that facilitate bi-directional transitions and coordination of care between the primary care providers and substance abuse providers.**

Recovery-Oriented System of Care

While prevention and early intervention will be sufficient to help reduce the number of people with addiction problems, there will be some people who need more intensive services. In most state level estimates of alcohol and drug use (2005-

d These data are based on NCIOM calculations using 2005 MEPS, Agency for Healthcare Research and Quality. Substance abuse visits are defined as visits for people with a substance abuse diagnosis using ICD-9 codes 303, 304, or 305. This estimate is low, as both patients and providers may face incentives to use diagnosis codes other than substance abuse.

e Subsequent to the release of the interim report from the NCIOM Task Force on Substance Abuse Services, Congress enacted a mental health parity bill. This legislation, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, was part of the Emergency Economic Stabilization Act of 2008, Public Law 110-343 codified at 29 USC §11815a, 42 USC §300gg-5. The new law requires businesses of 50 or more employees to provide the same coverage of mental health and substance abuse services as is provided for other illnesses—if the employer offers a plan with any coverage of mental health or substance abuse services. However, state mental health parity applies to all health insurance plans of any size. NCGS § 58-51-50; 58-65-75, 58-67-70. Similar state substance abuse parity laws should be enacted to extend parity to groups of less than 50.

2006), 8.5% of North Carolinians age 12 or older reported that they abused or were addicted to alcohol or drugs.²⁸ Yet few of these individuals receive treatment. Several studies suggest that the primary reasons people fail to seek or stay in treatment has more to do with the system's inability to meet the client's needs rather than the individual's lack of desire to seek help.^{8,29-33} Focus groups conducted in two counties in North Carolina (Dare and Rockingham) reached similar conclusions.³⁴

North Carolina needs to create a recovery-oriented system of care that includes a comprehensive array of substance abuse services and recovery supports needed to meet the clinical needs and desires of the clients. A recovery-oriented system of care begins with screenings, assessments, and brief intervention services but also offers a range of specialized substance abuse services for people with more severe addiction disorders. These services include 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). Dewayne Book discusses the array of services and medication management that is needed to effectively address underlying addiction disorders.

Many individuals with addiction disorders will also need an ongoing support system to help them manage their addiction disorders, including case management, relapse prevention, self-help, and support groups. This is similar in concept to chronic disease management provided to people with chronic illnesses. In addition to these services, some people with severe addiction disorders need other services to help address the adverse consequences resultant from years of addiction. People who have achieved sobriety may soon return to alcohol or drugs if they also fail to address issues such as homelessness, loss of employment, and/or marital or family strife. Thus, a recovery-oriented system of care should include linkages to a broader array of services such as employment services or job skill training for people who lost their jobs, or housing for homeless individuals. Others may also need help with family or marital counseling in order to stay in recovery. Donna M. Cotter more fully explains recovery-oriented systems of care in her commentary, and Kathleen Gibson describes her personal path to recovery in her commentary. **To ensure that these services are available statewide, the Task Force recommended that the state develop a plan organized around a recovery-oriented system of care that ensures an appropriate mix of services and recovery supports is available throughout the state for adults and adolescents.**

Our current publicly-funded system of care includes some of the elements needed for a recovery-oriented system of care. Prior to mental health reform, area programs (now called Local Management Entities or LMEs) provided services directly. After reform, LMEs stopped providing these services directly. Instead, LMEs contract with local substance abuse providers to provide services. LMEs are responsible for ensuring that individuals obtain services and that they receive services at

an intensity level appropriate to their needs. Yet most individuals who need services are not able to access them. LMEs serving the highest percentage of the estimated need served 11% of adults and a similar percentage of children (fourth quarter, SFY 2008), whereas the LMEs serving the lowest percentage of estimated need only reached 5% of adults and 4% of children.³⁵

Not only do LMEs assist few of the people with addiction disorders, state data show that many of the people who seek care through LMEs are not receiving it within the appropriate time standards. For example, individuals who need emergent care should be able to access it within two hours of first seeking treatment, urgent care within 48 hours, and routine care within 14 calendar days.

While most of the LMEs ensure that people needing emergent or urgent care receive treatment within the appropriate time standards, the LMEs have only a limited number of substance abuse providers who are actively engaging people in treatment (see Table 2). For example, individuals should receive four substance abuse visits within the first 45 days of initiating contact with the system. The state has established performance targets to ensure that at least 50% of people receiving substance abuse services through the LMEs receive the appropriate number of visits during this timeframe. Yet only six of the 24 LMEs that reported data provide four visits within the first 45 days to at least 50% of their clients. Some only meet this standard with as few as 27% of their clients. Studies show that people who stay in active treatment for longer periods of time have better treatment outcomes.³⁶⁻³⁹

The state's data suggest that people are not actively engaged for appropriate periods of time, and that consumers generally receive low-intensity services. For example, many people in North Carolina are receiving individual or group therapy services immediately after entry into the system. This level of treatment is not appropriate by itself for people with diagnosable addiction disorders, most of whom need some period of stabilization to address their addiction disorder. A more appropriately balanced system of care would ensure that people with addiction disorders immediately enter detox or other residential treatment program, or receive intensive outpatient services. Individual or group therapy services may be appropriate after the person has received more intensive services, if provided in conjunction with other services such as medication assisted therapies. In her commentary, Flo Stein focuses on ways to make the publicly-funded substance abuse system more accessible.

There are barriers in the current system that make it difficult for LMEs to appropriately engage people with addiction disorders. The lack of availability of a well trained workforce in many parts of the state hampers the delivery of appropriate services. Some LMEs face challenges finding providers willing to participate in the public system, given the funding levels and administrative complexities. Other states have begun to implement performance-based incentive contracts to improve the capacity of the substance abuse system.^{40,41} **To address this concern, the Task Force recommended that**

Table 2.
Standards and Achievement of Care in LMEs in North Carolina
(SFY 2008, 4th Quarter)

	Best Practices (State Established Performance Targets) [1]	Meeting Required Treatment Guidelines (Average LMEs)	Percentage of People who Received Recommended Treatment (LMEs)	Number of LMEs Meeting DMHDDSAS Performance Targets
Timely access to care				
Needing emergent care (statewide, 19% of people who seek services determined to need emergency care)[2]	Within 2 hours (100%)	100%	88-100%	22
Needing urgent care (statewide, 15% of people who seek services determined to need urgent care)[2]	Within 48 hours (88%)	79%	13-100%	9
Routine care (statewide, 62% of people who seek services determined to need routine care)[2]	Within 14 calendar days (69%)	68%	28-90%	13
Active participation in treatment, retention				
Number of visits when care initiated	Individuals receive 2 visits within 14 days (71%)	62%	36-82%	3
	Individuals receive 4 visits within 45 days (50%)	46%	27-63%	6
People discharged from Alcohol Drug Abuse Treatment Centers (ADATC) receiving care in community	Receive community-based service within 7 days of discharge (36%)	23%	0-53%	5

Table Notes: [1] Best practices for timely initiation of care have been adopted from the Healthcare Effectiveness Data and Information Set (HEDIS) performance measures. The best practices for active participation in treatment were adopted from the Washington Circle Public Sector Workgroup. www.washingtoncircle.org. 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.

[2] Timely access to care includes access for people with substance abuse problems, mental health problems, and developmental disabilities. Timely access measures are based on LME self-reported data. These data are not subject to external verification as there are no secondary data collected at the state level that records when the person first sought assistance. With other data, the state calculates the percentages based on claims data.

DMHDDSAS develop performance-based incentive contracts for LMEs to use with local substance abuse providers. The performance-based contracts should include incentives for active engagement, consumer outcomes, fidelity with evidence-based or best practices, client perception of care, and program productivity.

Specialized Services for Subpopulations

In addition to the services offered to the general public with substance abuse disorders, other services are available to certain subpopulations. Specialized services have been developed for:

juvenile and adult offenders in the criminal justice system, adults in workforce settings, adults who are receiving Work First training and services or who are involved in the Child Protective Services system, and active and returning veterans and their families.

Some of the judicial districts across the state have developed specialized drug treatment courts to address the underlying substance abuse needs of people who appear in court. For example, there are currently 12 family drug treatment courts across the state. These courts oversee child abuse and neglect cases in which parents have either lost custody of their children

or are at risk of losing custody due to underlying addiction disorders. As one of the conditions of reunification, parents must agree to drug treatment and intensive monitoring. Similarly, adult drug treatment courts currently operate in 21 counties. These courts oversee the treatment of criminal offenders with addiction disorders who have been convicted of intermediate sanctions. As with the family drug treatment courts, offenders must participate in active treatment, be subject to random drug tests to determine compliance, and meet other court ordered requirements in order to stay out of prison. Kirstin Frescoln discusses the role of drug courts and challenges they face in her commentary.

In order for drug courts to be successful, the parents or criminal offenders must have access to available treatment services. Further, probation officers and/or Social Services staff must be available to monitor the individuals' compliance with the treatment regimen and other court ordered requirements. **Therefore, the Task Force recommended that whenever the General Assembly expands funding for additional drug courts, that it also provide funding for additional treatment services and needed staff.**

Approximately 90% of all prisoners entering the prison system need substance abuse services, and 63% need inpatient substance abuse services.⁴² The Division of Alcoholism and Chemical Dependency offers different levels of substance abuse services to prisoners, including outpatient and residential treatment. However the North Carolina Department of Correction is only able to provide services to approximately one-third of the prisoners who need substance abuse treatment. Studies have shown that prisoners who receive treatment for appropriate lengths of time are less likely to be repeat offenders.³⁶⁻³⁹ Further, offenders who are released on probation or parole need substance abuse services and ongoing monitoring. The Treatment Accountability for Safer Communities (TASC) program offers screening, assessment, and care management services for offenders with mental health or substance abuse services who have been placed on probation or released back into the community. TASC staff link these offenders to appropriate treatment services and work with probation officers to ensure that they stay in active treatment. But as with other services, TASC is unable to serve all those in need. Last year (SFY 2008), TASC served more than 18,000 people; however there may be as many as 75,000 people on probation who need TASC services. Additional funding will be needed to expand TASC services to more people on probation. Virginia Price provides more detailed information about available services and the gaps in treatment availability for incarcerated adult offenders in her

commentary. Robert Lee Guy, Timothy Moose, and Catherine Smith discuss substance abuse issues for those on probation and parole in their commentary.

Many Active Duty and returning military personnel also use or abuse alcohol and other drugs. North Carolina currently has the fourth largest concentration of military personnel in the country. We have more than 100,000 Active Duty personnel in our seven military bases or deployed overseas and another 11,500 soldiers, marines, and airmen who serve in the National Guard or Reserves. In addition, there are more than 750,000 veterans who live in North Carolina. Almost one-fourth of all Active Duty military personnel and returning National Guard report alcohol dependence.

The Veterans Administration offers some services to returning veterans, but veterans must go to one of the 22 different Veteran Affairs (VA) medical centers or clinics to receive these services.^f These services are not sufficient to meet the needs of all returning Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) personnel, particularly for those who are not located close to one of the VA centers. The state and federal government have collaborated with other community partners to create broader systems of care for returning veterans and their families, including mental health and substance abuse services. A. Meade Eggleston, Kristy Straits-Tröster, and Harold Kudler describe the services available through the VA and through this broader community collaboration in their commentary. One of the goals of the broader state-federal-local partnership is to create awareness and inform community practitioners about the behavioral health needs of returning veterans and their families. However more effort is needed to ensure that community health professionals check returning veterans and their families for depression, substance abuse disorders, or post-traumatic stress disorder.

Workforce

North Carolina needs an adequate supply of qualified substance abuse providers in order to be able to provide needed treatments and recovery supports. Over the last 15 years, the North Carolina General Assembly has passed several bills to enhance the skills of substance abuse professionals. In 1994, the General Assembly gave the North Carolina Substance Abuse Professional Practice Board (NCSAPPB) the statutory authority to credential different types of substance abuse professionals. Then in 2005, the General Assembly required substance abuse professionals to have appropriate training and credentials (licensure, registration, or certification)

f There are four VA medical centers, three outpatient clinics, six community-based outpatient clinics, and five Vet Centers in North Carolina. 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.

g NCGS 90-113.30.

from the NCSAPPB.⁸ Currently, the NCSAPPB offers seven different types of substance abuse credentials, based on the person's education, hours of supervised experience, and successful completion of an exam: Licensed Clinical Addiction Specialists (LCAS); LCAS-Provisional (LCAS-P); 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). People who are recognized by the board as a LCAS or CCS can practice independently and bill third-party payers. The other substance abuse providers can provide direct services to individuals under the supervision of another licensed substance abuse professional. Anna Misenheimer describes the state of the North Carolina substance abuse workforce in her commentary.

In addition to the substance abuse professionals credentialed by the NCSAPPB, other health care and counseling professionals can provide substance abuse services if allowed within their scope of license. For example, 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. Substance abuse, addiction, and dependence do not escape the health professional community. Warren Pendergast and Jim Scarborough discuss a unique program for health professionals needing substance abuse services in their commentary.

It is very difficult to ascertain the total number of people providing addiction services because of the different types of people who can provide services as part of their independent licensure, or licensure under the supervision of LCAS, CCS, clinical supervisor intern (CSI), or physicians. Nonetheless, available data about people licensed by the NCSAPPB indicate significant disparities in the availability of qualified substance abuse professionals. Eight counties lack any licensed or certified substance abuse counselors.⁴³ In the other counties, the ratio of people who are expected to seek services in the public system per substance abuse clinician varies from 1,465 people per one clinician in Pasquotank County to 30:1 in Polk County.^h 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 many areas of the state.ⁱ The Task Force heard from many speakers about the shortage of qualified substance abuse professionals in our state. Thus, the Task Force recommended

that the state create a substance abuse professional fellows program, similar to the teaching fellows programs. **The General Assembly should appropriate funds to start a scholarship program for individuals seeking two-year, four-year, or master's degrees in the substance abuse field. In return for the funding, students would be expected to work in North Carolina in a public or nonprofit substance abuse program for one year for every \$4,000 in scholarship funding.**

As the Task Force members learned over the last 16 months, we cannot overestimate the need to reform our current substance abuse system. Our failure to adequately prevent, treat, and provide recovery supports to people with addiction problems has major adverse consequences in the state. It is one of the underlying causes of much of the social unrest we experience including crimes, motor vehicle accidents and deaths, child abuse and neglect, and family violence. We can no longer afford to stigmatize and ignore people with addiction problems. This will require a paradigm shift away from an acute care model that expects people to be "cured" after one course of treatment and from the traditional view of addiction as a moral failing. Rather, North Carolina should begin to manage dependence as any other chronic disease and provide ongoing care and support to help people remain in recovery. Creating this new model of care—with strong investments in prevention, early intervention, treatment, and recovery supports—will require the active involvement of many different agencies, providers, and treatment professionals. Services need to be available and accessible throughout the state and provided by a qualified substance abuse workforce. With relatively small investments, North Carolina can create an effective system of care that helps people reduce their reliance on tobacco, alcohol, and other drugs. **NCMJ**

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h 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.

i Physicians, nurse practitioners, physician assistants, and certain other licensed health professionals can also provide treatment, but available data suggest that few of these professionals do so. Data from the Health Professions Data System showed that 0.5% or less of the physicians, nurse practitioners, and physician assistants report that they practice addiction medicine or addiction psychiatry as their primary or secondary specialty area, and only about 0.2% of registered nurses report drugs or alcohol as their major clinical practice area. 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, 2008. Data are not available about the number of licensed clinical social workers, psychologists, or psychology associates who practice in the addictions field.

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