

NCPA Addictions Committee
Response to the NC Institute of Medicine Task Force on Substance Abuse Services Interim Report
September 2008

The Addiction Committee of the North Carolina Psychiatric Association has studied the Interim Report dated May 2008 and offers the following comments.

1. The task force has expended a large amount of effort in hearing expert testimony and developing the initial recommendations. We appreciate the work done in behalf of those persons suffering from addictive disorders in North Carolina. The report documents the extent of substance use and its consequences – the clinical and financial burden, the state of substance abuse services in NC and the newest concepts in the science of addictionology. Recommendations for prevention, early intervention and treatment will, if implemented, result in greatly improved services in our state, and the NCPA pledges to work with the IOM to support its recommendations to the legislature. We applaud recommendation 4.13 in particular – mandated insurance parity for treatment of addictive disorders. The NCPA has made this a priority item for legislative action.
2. We are concerned at the inadequate mention of the pharmacological aspects of addiction treatment. “Scientists now know that drug addiction is a brain disorder,” and the neural mechanisms that underlie drug craving, dependence and relapse are increasingly being clarified; with this comes the development of medications that are more targeted and effective in their action. The place of Medications Assisted Treatment is mentioned (Chapter 3, p 42) but this is not developed as a component of the system of specialized services.
3. The report does a good job of promoting prevention services, something that North Carolina has woefully under-funded in the past. The increasing burden of addiction with such high costs to the individual, families and societies as well as the overburdened treatment systems, makes it imperative that more attention be placed on prevention. The report documents the effectiveness of school based Student Assistance programs; we are disappointed that this important initiative and Recommendation 4.2 did not make it to the list of priority recommendations.
4. The role of screening and brief intervention is highlighted as is the role of the primary care physician in providing this. The development of medical homes and insurance coverage for SBIRT will make this more feasible in the future. However the role of psychiatrists and other specialists, in supporting and interacting with primary care practices is not spelled out. In addition the care of the dually diagnosed (estimated to be 50% of individuals with addiction) is not adequately addressed other than for a brief mention (Ref 4.9, a, 2) concerning training of primary care providers in how to assess for mental illness. There is no mention of supporting an increase in psychiatric trainees in addictionology. At present there is a minimum requirement of one month experience in the four year program, and the extensive collaboration that exists between medical school Departments of Psychiatry and the state regional mental hospitals and community mental health centers does not exist in the substance abuse service system. Training experiences of psychiatric residents must be addressed by the task force to make the specialized care component a viable resource.

5. The report calls for the training of primary care staff, especially in the Community Care networks, to implement SBIRT and making of referrals (Recommendation 4.10). We request that psychiatrists participate in the provision of this training.
6. We support the recommendation (4.13.b) that reimbursement of CPT codes be extended to psychiatric consultation and specialized services.
7. The report calls on the Division Mental Health, Developmental Disabilities and Substance Abuse Services to work collaboratively with certain other professional societies “to identify and address barriers that prevent the implementation and sustainability of collocation 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” (Recommendation 4.13.d). We request that the North Carolina Psychiatric Association be added to the list of identified professional societies.