Nothing Compares
NORTH CAROLINA

Governor's Task Force on Mental Health and Substance Use

March 10, 2016

Workgroup on Prescription Opioid Abuse and Heroin Resurgence: Brian Ingraham and Sheriff Asa Buck

Opioid abuse and heroin resurgence: A national problem with no "silver bullet" solution

- New data from the Centers for Disease Control and Prevention (CDC) show that opioids were involved in 28,647 deaths in 2014.
- Heroin overdose death rates more than *tripled* between 2010 to 2014.
- More Americans now die from drug overdoses than motor vehicle accidents each year.

The magnitude of the opioid epidemic requires a multi-faceted approach.

Opioid abuse and heroin resurgence: A national problem with no "silver bullet" solution

On February 2, the White House announced plans to invest $1.1 billion in FY 2017 to address the opioid epidemic.

1. $1 billion in new mandatory funding over two years to expand access to treatment for prescription drug abuse and heroin use
2. $500 million to build on current efforts across the Departments of Justice (DOJ) and Health and Human Services (HHS) to expand state-level strategies, increase the availability of treatment programs, improve access to naloxone and support enforcement activities

Challenges to Address

- Insufficient knowledge generally regarding addiction as a brain disease.
- Insufficient prevention & early intervention activities.
- Insufficient information regarding effectiveness of opioids for treating pain especially long term use.
- Inadequate funding for treatment, especially for uninsured & underinsured.
- Stigma, both associated with those suffering from addiction and related to Medication Assisted Treatment.
- Resistance to changing prescribing habits and mandatory checks of the CSRS.

Current capacity in North Carolina

- **52** Opioid Treatment Programs (OTPs) in North Carolina
- **432** physicians in the state can prescribe buprenorphine
- **2,390** community heroin overdose reversals using naloxone from August 1, 2013 to March 8, 2016
- **61** N.C. law enforcement departments have set up naloxone programs, with 43 rescues thus far. Nearly all the law enforcement departments began the program in 2015.
- **29,092** cumulative registered dispensers and prescribers participating in N.C. Controlled Substance Reporting System as of March 1, 2016 (8,599 dispensers, 19,485 prescribers, and 1008 delegates)
- **9,536,600** opiate prescriptions dispensed from January 1 – December 31, 2015

Current priority considerations

1. Examine efforts to heighten awareness of the dangers of prescription opioid misuse and provide considerations to improve these efforts
2. Examine efforts to heighten awareness of Medication Assisted Therapy (M.A.T.) and reduce stigma
3. Evaluate the use of heroin in North Carolina and recommendations to support prevention, treatment and recovery in the state
4. DHHS consideration: Review the state plan to reduce prescription drug use / misuse and provide recommendations
5. Other: Judicial, legal and court-related issues

Workgroup on Opioid Abuse and Heroin Resurgence

Current priority considerations:

1. Examine efforts to heighten awareness of the dangers of prescription opioid misuse and provide recommendations to improve these efforts. (Law Enforcement and Prescribers)

a. Significantly increase prescriber utilization of the Controlled Substance Reporting System (CSRS).

b. Provide designated, trained law enforcement agents the same access to the CSRS and pharmacy prescription drug profile information as state and federal agents.

c. Encourage and support local meetings and trainings regarding safe prescribing practices. Engage local law enforcement to provide prescribers with a "real picture" perspective.

d. Develop and fund a comprehensive public awareness campaign to address the dangers of prescription drug/misuse and the importance of safe storage and disposal of controlled substance medication.

Workgroup on Opioid Abuse and Heroin Resurgence

Current priority considerations:

2. Examine efforts to heighten awareness of Medication Assisted Therapy (M.A.T.) and reduce stigma.

a. Conduct both professional and public education sessions where medical professionals, individuals with lived experience, and practitioners together use science-based evidence that demonstrates the efficacy and effectiveness of M.A.T. coupled with evidence-based psychotherapy. Use powerful stories of success around M.A.T.

b. Increase availability of Naloxone throughout the state.

c. Provide long-term recovery supports like recovery community centers, Peer Support, collegiate recovery programs, recovery coaches and recovery clubs in high schools.

d. Appoint / include people with lived experience and in recovery from substance use disorders (SUDs), including Opioids, on work groups throughout the state and invite them to participate.

Workgroup on Opioid Abuse and Heroin Resurgence

Current priority considerations:

3. Evaluate the use of heroin in NC and offer considerations to support prevention, treatment, and recovery in NC.

a. Require continuing education for prescribing opioids for physicians and other health personnel. This is consistent with Board requirements.

b. Expand access to Medication Assisted Treatment (M.A.T.) for Opioid addiction in the community to include approved medications and behavioral treatment with appropriate monitoring.

c. Develop Opioid Overdose Prevention Plans that include increasing access to Naloxone availability in the community to reduce overdose deaths.

d. Expand prevention and early intervention programs targeted to high risk populations (i.e., adolescents, individuals with mental illness, and those with injury and chronic pain).

Workgroup on Opioid Abuse and Heroin Resurgence

Current priority considerations:

4. Review the state plan to reduce prescription drug use / misuse and provide recommendations.

Support the Prescription & Illicit Drug Use Prevention and Treatment Advisory Committee to implement & monitor the State Strategic Plan as per S.L. 2015-241, Section 12F.16.(m-p)

Workgroup on Opioid Abuse and Heroin Resurgence

Current priority considerations:

5. Other: Judicial, legal and court-related issues

a. Establish uniform standards, eligibility criteria, and goals for use by treatment courts in attempting to reduce recidivism.

b. Provide adequate funding for treatment courts and uniform training for treatment court staff.

c. Provide adequate recovery-related services for pre-trial detainees, individuals placed on probation or post-release supervisions, and incarcerated individuals.

Workgroup on Children, Youth, and Families: William Lassiter

Challenges to Address

- Access and Workforce Development
- Stigma
- Trauma-Informed Care
- Foster Care
- Juvenile Justice

Workgroup on Children, Youth, and Families

Current Priority Considerations:

1. Standardization / Accountability
2. Increase Access and Workforce Development
3. Education/Stigma Reduction/Primary Prevention
4. Data and Technology
5. Trauma-Informed State

Workgroup on Children, Youth, and Families

Current priority considerations:

1. Standardization and Accountability

a. Standardization and portability of services among LME/MCOs for children in vulnerable populations for foster care and Juvenile Justice across multiple catchment areas

b. Review and revise service definition for Intensive In-Home services and Day Treatment and ensure use of high-fidelity, evidence-based, and outcome-oriented programs in the Medicaid State plan.

c. Performance of clinical assessments by an independent party contracted with the LME/MCO.

d. Continue to spread programs that train clinicians in high-fidelity and evidence-based interventions

e. Ensure consistency of agency & provider credentialing across LME/MCOs

Workgroup on Children, Youth, and Families

Current priority considerations:

2. Increase access

a. Allow parents to obtain treatment when their child enters foster care.

b. Development of an Integrated Care Transformation Council (FHNC, CCCN, Hospitals, LME/MCOs, Medication Oversight, DMA, DSS, DMH/DD/SAS)

Workgroup on Children, Youth, and Families

Current priority considerations:

3. Stigma, Education, and Primary Prevention

Mental Health First Aid

a. Evidence-based, train-the-trainer, comprehensive mental health education program for youth and adults.

b. Training targets include:
   - School personnel: teachers, coaches, bus drivers, counselors, administrators/assistants, driver's education instructors, and county employees
   - College and university faculty and staff
   - Primary care providers and staff
   - Faith-based communities, sports leagues, and social/community clubs.

Workgroup on Children, Youth, and Families

Current priority considerations:

4. Data and technology

a. Support the investment by child-serving agencies in adequately staffed research and evaluation sections and in the infrastructure (e.g., visual reporting platforms) needed to inform optimal data-driven management at the agency level.

b. Data Investigative Council (MOUs regarding data sharing)

- Child-serving agencies report that they have an insufficient number of staff assigned to transform raw data into meaningful and useful information that can be used to enable more effective strategic and operational insights and decision-making. This leads to the under-utilization of available data.
- There is a great opportunity within the state for sharing data across agencies. In 2008, the General Assembly established the North Carolina Government Data Analytics Center (GDAC) to serve as an information utility for use by state leadership in making program investment decisions, managing resources, and improving financial programs, budgets, and results.
- At present, there are very limited data warehoused via the GDAC by child-serving agencies.

Workgroup on Children, Youth, and Families

Current priority considerations:

5. Trauma-informed state

Develop a Trauma Advisory Council consisting of cross-agency staff, trauma experts, service providers, trauma survivors and service consumers, and community stakeholders to:

a. Identify how each state human service or public safety agency shall be involved in the initiative, likely through the convening of an expert panel;

b. Develop a workforce that is knowledgeable and skilled in the recognition, assessment, treatment, and support of persons traumatized by childhood and/or current sexual and physical abuse, and other traumatic experience;

c. Develop a comprehensive, integrated, accessible system of trauma screenings, assessments, services, and support across agencies;

d. Create state policies which address the needs of trauma survivors, eliminate practices which traumatize or re-traumatize those with histories of trauma, and support the provision of trauma-informed services, resources, and training; and

e. Develop a plan for evaluating the impact of these efforts.

Workgroup on Children, Youth, and Families

Current priority considerations:

- Develop a plan to raise the age of juvenile jurisdiction from 16 to 18 years old, which would increase access to age-appropriate treatments that are available in the juvenile justice system that are not available in the adult system.
- North Carolina is the only state in the nation that considers all 16- and 17-year-olds adults.
- Recidivism rates among 16-and 17-year-olds handled by the adult criminal justice system are significantly higher than those handled by the juvenile justice system.
- The juvenile system can order parents to be more involved in the juvenile's treatment.

Workgroup on Adults: George Solomon, Director

Challenges to address

- Appropriate, Affordable & Available Housing
- Coordination of Care for Veterans
- Integrated Behavioral & Physical Healthcare
- Efficiency, Transparency, & Innovation
- Diversion to Treatment from Criminal Justice
- Trauma-Informed Systems of Care
- Behavioral Health Payment System

Current capacity

- State Operated Healthcare Facilities:
  - Mental health disorders: Broughton Hospital, Cherry Hospital, & Central Regional Hospital
  - Substance use disorders: RJ Blackley ADATC, JF Keith ADATC, & WB Jones ADATC
- 8 Local Management Entities-Managed Care Organizations (LME/MCOs)
- 382 addiction treatment centers
- 23 maternal & perinatal substance abuse programs
- 307 licensed mental health facilities; 10 licensed private psychiatric facilities; 412 licensed nursing facilities
- Approximately 30 Assertive Community Treatment Teams
- Integration of behavioral health care services into primary care:
  - Co-location in the 14 Community Care of NC networks
  - County Health Departments
- Therapeutic Courts: 8 Family, 18 Adult, 4 Youth, 7 DWI, 6 Mental Health, 3 Veterans, & 1 Tribal
- 203 halfway houses and 207 Oxford Houses

Workgroup on Adults: Current Considerations

Changes that Directly Improve Consumers' Lives

1. Appropriate, Affordable & Available Housing *
2. Expand Employment Opportunities
3. Expand Case Management / Recovery Navigation Services *
4. Promote Use of Psychiatric Advanced Directives *NEW*

Cross-System Collaboration

5. Well-integrated Behavioral & Physical Healthcare
6. Collect Data & Use to Guide Actions, including Funding Decisions
7. Develop Public-Private Partnerships that Foster Efficiency, Transparency, & Innovation
8. Consumers should be Diverted from Criminal Justice to Treatment *
9. Take care of our Veterans *NEW*

MHSU System Improvements

10. Care should be Easy to Access; "No Wrong Door"
11. Trauma-informed Systems of Care
12. Improve Behavioral Health Payment System
13. Promote Leadership on MH & SU Issues at all Levels
14. Sufficient Numbers of Inpatient Beds *NEW*

Workgroup on Adults

Current priority considerations:

1. **Appropriate, Affordable & Available Housing**
   a. Develop therapeutic housing where individuals can develop a sense of community.
   b. Conduct a statewide needs assessment.
   c. Expand community-based supportive housing. Each LME/MCO should develop a housing plan for their geographic area, report quarterly on progress, and update the plan annually.
   d. Establish partnerships with builders.
   e. Explore promotion of development of halfway houses that can provide comprehensive services.

Workgroup on Adults

Current priority considerations:

3. Expand Case Management / Recovery Services

a. Independent, Stand-alone Case Management Service Definition.
b. Promote Assertive Community Treatment Teams (ACTT).
c. Incentivize ACTT where it does not exist with start-up funds.
d. Develop forensic ACTT (or FACT) in areas of highest need.
e. Create “step-down” lower intensity case management service definition for periodic ongoing support to prevent decompensation.
f. Implement Critical Time Intervention statewide for consumers who would benefit from this time-limited, intensive service (e.g., discharge from state hospital, release from incarceration).
g. Develop case management service to assist consumers less disabled by MI &/or SUDs but need occasional assistance.
h. Case management certification programs offered through community colleges to professionalize case management as an entry-level career path for behavioral health professionals.

Workgroup on Adults

New priority considerations:

4. Promote consumers' use of Psychiatric Advance Directives.

a. Develop a promotional campaign to educate consumers & others about the advantages of PADs - presentations at consumer conferences, workshops for consumers & others, and special promotional efforts through advocacy organizations.

b. Waive filing fees.

c. Develop an online educational video & other training materials to assist consumers, families, & peer support/crisis navigators.

d. Recommend the Secretary of State upgrade the Advance Directives database to enable tracking of *Psychiatric* Advance Directives & to enable forms to be electronically uploaded to the system.

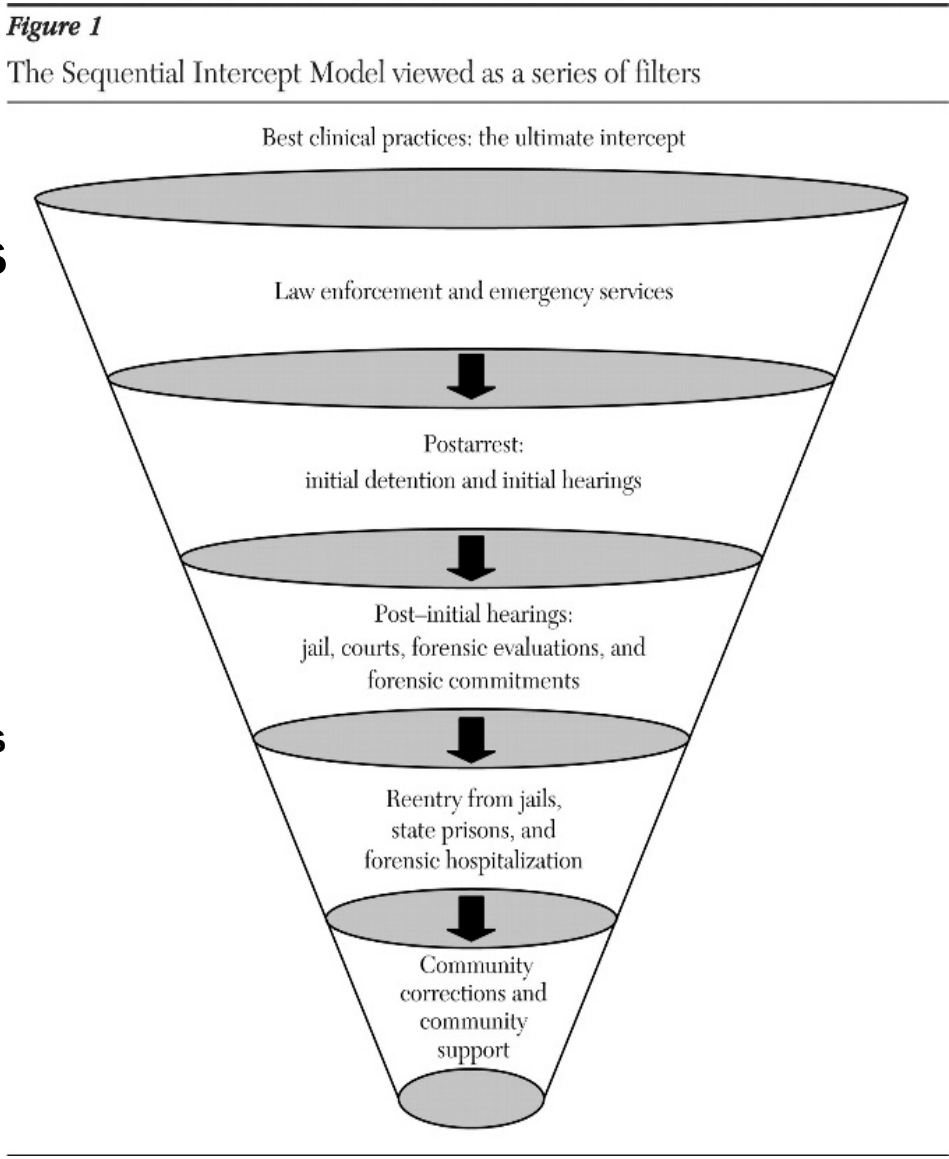
Workgroup on Adults

Current priority considerations

8. Diversion to treatment from criminal justice system whenever appropriate.

- *Sequential Intercept Model*
  - Intercept 1: Law enforcement & emergency services
  - Intercept 2: Post-arrest - initial hearings & initial detention
  - Intercept 3: Post-initial hearings - jails, courts, forensic evaluations & commitments
  - Intercept 4: Reentry from jails, state prisons & forensic hospitalization
  - Intercept 5: Community corrections & community support

Best Clinical Practices at all points is the ultimate intercept.



Workgroup on Adults

Current priority considerations:

8. Consumers should be diverted from the criminal justice system to treatment whenever appropriate (continued)

a. DHHS should continue to educate police chiefs, sheriffs, LME/MCOs, fire & rescue, EMS, dispatchers, & other local entities about CIT & provide technical assistance.

b. Effective CIT requires additional resources for Behavioral Health Urgent Care Centers to provide law enforcement a quick handoff. Rural communities may require other options (e.g., more robust mobile crisis, in-home stabilization, increased consultation for EDs serving as the CIT drop-off site).

c. Other solutions may include crisis "navigators" – including peers – assigned at crisis/intercept points to assist officers, families, and the consumer navigate the system in order to get the individual engaged in services.

d. DHHS should continue to support Mental Health First Aid. Special emphasis should be made to train criminal justice professionals.

e. Enhance therapeutic courts (mental health, drug, recovery, veterans)
- Identify goals to include in therapeutic courts that reduce recidivism.
- Where specialized courts are not feasible, judicial districts should consider using special dockets.

Workgroup on Adults

New priority considerations:

9. Take Care of our Veterans.

a. Encourage primary care & behavioral health clinicians, faith leaders, & others to complete a course on military culture (http://deploymentpsych.org/military-culture).

b. Encourage all clinicians to ask about current or prior military service & health concerns related to that service.

c. Continue to educate clinicians about unique risks for certain health issues faced by veterans as well as resources available to assist them.

d. Secretaries of DHHS & Dept. of Military & Veteran Services should meet quarterly to ensure health & human services are coordinated to meet the unique health needs of NC veterans.

e. Explore creation of a statewide electronic medical record (EMR); Consider NC HIE plan, Prison's HERO, Vista/CPRS or other open-source software systems; ability for information sharing with other EMRs (e.g., US Dept. of Veterans Affairs; DoD; large private healthcare providers).

Workgroup on Adults

New priority considerations:

13. Sufficient numbers of inpatient beds

a. Explore jail-based psychiatric care & capacity restoration services to ensure that people in jail receive services they need, while ensuring state psychiatric hospital beds are reserved for those in greatest need.

b. Examine policies to assure that jail detainees are not encouraged, via inadvertent incentives, to remain in state hospitals.

c. DHHS should collaborate with the NC Hospital Association, College of Emergency Physicians, Nurses' Association, & NC Psychiatric Association to find solutions to the state's crisis in psychiatric bed capacity & ED boarding.