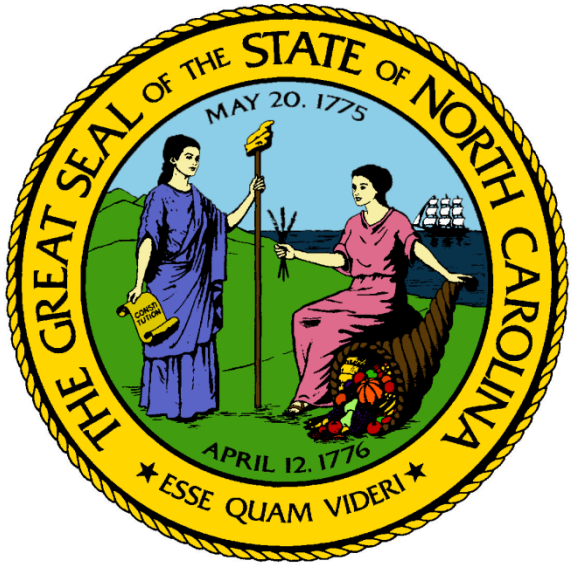


Governor's Task Force on Mental Health and Substance Use

Workgroup on Adults

www.ncdhhs.gov/mhsu

Proportion of Adults with Substance Use & Mental Health Disorders

	General Public	Probation & Parole	State Prison	Jail
Substance Use Disorder	16%	40% & 35%	53%	68%
Serious Mental Illness	5.4%	7-9%	16%	17%
- w/ Co-occurring SUD	25%	49%	59%	72%

Adults with Behavioral Health Needs Under Correctional Supervision, Council of State Governments, 2012

Number of North Carolinians with Substance Use & Mental Health Disorders

	General Public	Probation & Parole	State Prison	Jail
Substance Use Disorder	1,225,096	35,870 & 4440	19,926	12,430
Serious Mental Illness	413,470	7165-9212	6015	3108
w/ Co-occurring SUD	103,368	3511-4514	3549	2238

Adults with Behavioral Health Needs Under Correctional Supervision, Council of State Governments, 2012
2014 US Census
Population on 11.30.2015, DACJJ, NCDPS
Average Daily Population Jan-Dec 2013, BJS

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, & Walter B 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
- NC is behind national average in nearly all MH/SUD professions
- Therapeutic Courts: 8 Family, 18 Adult, 4 Youth, 7 DWI, 6 Mental Health, 4 Veterans & 1 Tribal
- 203 halfway houses and 207 Oxford Houses

Recommendations

Changes that Directly Improve Consumers Lives

1. Appropriate, Affordable & Available Housing*
2. Expand Employment Opportunities
3. Expand Case Management / Recovery Navigation Services*
4. Develop Behavioral Health Workforce

Cross-Systems

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 whenever possible*

MHSU System Improvements

9. Care should be Easy to Access; "No Wrong Door"
10. Trauma-informed Systems of Care
11. Improve Behavioral Health Payment System
12. Promote Leadership on MH & SU Issues at all Levels

1. **Appropriate, Affordable & Available Housing***
   - Develop therapeutic housing where individuals can develop a sense of community
   - Establish partnerships with builders
   - Promote development of half-way houses that can provide comprehensive services
   - Tiny Homes Community Collaborative https://www.indiegogo.com/projects/the-tiny-home-community-collaborative#/
2. **Expand Employment Opportunities**
   - Work with state Vocational Rehabilitation to implement "place & train" models
   - Greater use of peers (e.g., TROSA model)
   - Promote coaching for job success
   - Request Dept. of Commerce to evaluate programs & services for consumers; report findings & develop recommendations to expand employment opportunities

3. **Expand Case Management / Recovery Navigation Services***
   - Independent, Standalone Case Management Service Definition
   - Promote Assertive Community Treatment Teams (ACTT):
     - Incentivize ACTT where it does not exist with start-up funds
     - Develop forensic ACTT (or FACT), in areas of highest need
     - Create "step-down" lower intensity case management service definition for periodic ongoing support to prevent decompensation, following ACTT
   - Critical Time Intervention statewide for consumers who would benefit from this time-limited, intensive service (e.g., discharge from state hospital, release from incarceration)
   - Develop "navigator" case management service to assist consumers less disabled by MI &/or SUDs but need occasional assistance
4. **Develop Behavioral Health Workforce**
   - Expand role of Peer Support
   - Professional Case Managers are necessary
   - Community Colleges offer AA degrees for Certified Case Managers

5. Well-integrated Behavioral & Physical Healthcare

- In behavioral healthcare settings, consumers should be routinely screened for physical health conditions, like diabetes & high blood pressure
- In primary care settings, patients should be routinely screened for common behavioral health problems, like depression, substance use & suicide risk
- Care should be convenient for consumers & families
- "Health homes" that address both physical & behavioral health concerns should be established for people with complex, co-occurring behavioral health & physical health challenges.
- The role of public county health departments should be expanded to include screening & referring individuals for MH & SU treatment, with greater coordination with LME-MCOs, including co-location

6. Collect Data & Use to Guide Actions, including Funding Decisions

- Establish high-level quality improvement workgroups that include NC Sheriffs' Association, AOC, NC Association of County Commissioners, DHHS, DPS, existing MH & SU Coalitions, etc. for data driven cross-system problem-solving.

7. **Develop Public-Private Partnerships that foster Efficiency, Transparency & Innovation**
   - State/Local partnerships with private & teaching hospitals & the Hospital Association to develop bed board registries
   - State/Local partnerships with private agencies to provide tele-psychiatry in rural & other underserved areas
   - State/Local partnerships with private nursing homes that have excess capacity to study the feasibility of converting to therapeutic/ supportive housing options
   - Engage with private Trusts/Foundations/Endowments for seed funding to promote innovative practices. Examples: construction of "tiny homes" & mobile behavioral health clinics

8. Consumers should be diverted from the criminal justice system to treatment whenever possible*

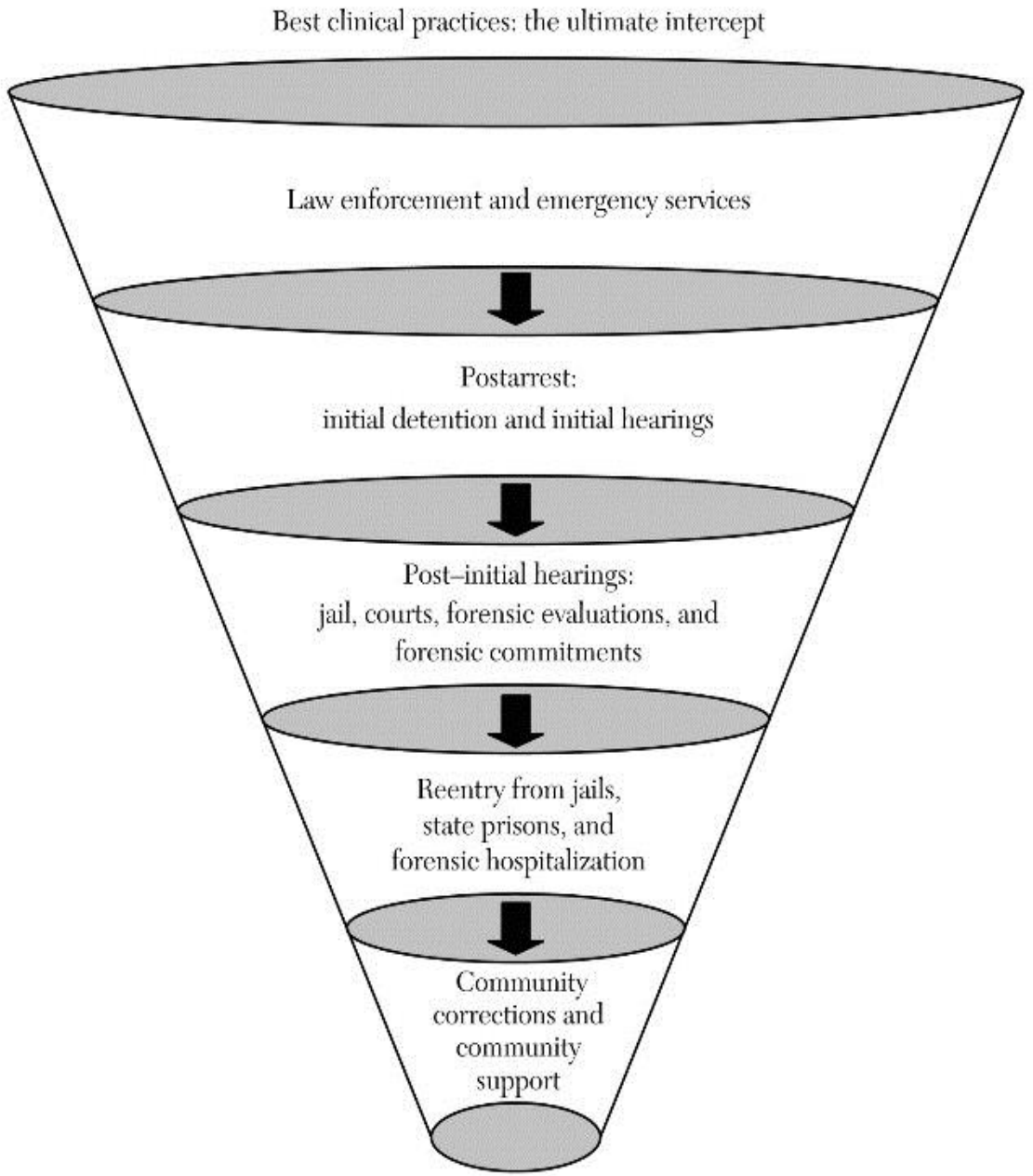
Sequential Intercept Model

- 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.

Figure 1

The Sequential Intercept Model viewed as a series of filters



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

- DHHS should continue to educate police chiefs, sheriffs, LME-MCOs, fire & rescue, EMS, dispatchers, & other local entities about CIT & provide technical assistance
- Effective CIT requires additional resources for Behavioral Health Urgent Care Centers that can provide law enforcement a quick hand off; Rural communities may require other options (e.g., more robust mobile crisis, in home stabilization, increased consultation for EDs serving as the intercept CIT drop-off site)
- 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.
- DHHS should continue to support Mental Health First Aid; Special emphasis should be made to train criminal justice professionals

9. **Care should be Easy to Access; "No Wrong Door"**
   - Each LME-MCO submits a plan to assure that care is easy to access & there is "no wrong door"
   - Conduct a "No Wrong Door" campaign
   - Expand on existing communication systems, such as 911/211
10. **Trauma-informed Systems of Care**
   - Dept of Veterans Affairs offers evidence-based care for PTSD that has demonstrated excellent clinical outcomes. Specific interventions for psychotherapies & pharmacotherapy are published at www.ptsd.va.gov
   - Substance use disorder treatment programs can decrease the rates of motor vehicle crashes & occupational injury, which in turn will decrease the risk for new cases of PTSD.
   - Coordination with the State Committee on Trauma to begin building a relationship with the MH-SUD community

11. **Improve Behavioral Health Payment System**
    - Enable greater flexibility in providing services needed, when needed
    - Place providers at risk via capitation contracts that incentivize care that is cost & clinically effective, reward creative solutions while assuring greater accountability
12. **Promote Leadership on MH & SU Issues at all Levels**
    - Raise awareness & reduce stigma through public education campaigns (e.g., Mental Health First Aid)
    - Encourage local/multi-county MH & SU task forces/coalitions. Include consumers, families, providers, first responders (EMS & law enforcement), LME-MCOs, County Commissioners, advocates & others
    - Encourage counties to participate in the Stepping Up Initiative, a national effort to divert people with mental illness from jail to treatment https://stepuptogether.org/
    - Encourage counties to use the Sequential Intercept Model to address concerns about the criminalization of people with MI & SUDs