Governor's Task Force on Mental Health and Substance Use

Workgroup on Adults Meeting Notes

October 20, 2015
10:00am-4:00pm
Dogwood Room
NC Judicial Center
901 Corporate Center Drive, Raleigh, NC

Present: Dr. John Santopietro, Co-Chair; George Solomon, Co-Chair; Commissioner Ronald Beale; Chief District Judge Joseph Buckner; Dr. Bruce Capehart; Honorable N. Lorrin Freeman; Deborrah Newton; Jack Register; McKinley Wooten, Special Advisor; Sonya Brown, staff

Guests: Dr. Mark Mattiolli; Rebecca Murdock; Sara Perdue; Lao Rubert

Review of Duties and Timeline:

- Examine efforts that **heighten awareness and reduce stigma** related to substance use and mental health disorders and provide recommendations to improve efforts.
- **Evaluate linkages** between agencies of state and local government and provide recommendations for the transfer of existing **best practices**.
- Examine opportunities for the justice system to best manage the cases of **young adults** with mental health and substance use challenges.
- Examine the role of **specialty courts** and provide recommendations on how they can best be utilized.

Oct 29th 2015	Nov 2015	Dec 2015	Jan 19th 2016	Feb 2016	March 8th 2016	April 7th 2016	May 1st 2016
2nd TF mtg **Oct 20th 1st work-group mtg**	**2nd workgroup mtg mid-month**	**date & time TBD - workgroup conference call**	3rd TF mtg		4th TF mtg **Adult Recommen-dations ready for April 7th**	Final TF mtg - Review & Approval of Recomenda-tions	Recommend -ations due to Governor

Barbara Smith - Safety Net presentation – see powerpoint

Workgroup Member Introductions & Goals

Deborrah Newton - Criminal Justice presentation – videos to be posted at http://www.ncdhhs.gov/about/department-initiatives/task-force-mental-health-substance-use

McKinley Wooten - Specialty Courts Overview/Status – see handouts

Director Solomon - Overview of Recommendations from Prison Mental Health Task Force – see handout

Overview of Mapping the System – see handout

EMERGING CONCEPTS

A pro-active MH System, rather than a reactive MH System

Communication – where to go for help?; 211/911; hard to get good care across systems – public/private, with or without insurance;

Court Involvement/Alternatives to Incarceration – diversion & deferral programs – address inefficiencies that that prevent diversion opportunities; care coordination; specialty courts; stable transitions back to community; Stepping Up Initiative https://stepuptogether.org/

Workforce – need professionals & robust training systems, ensure appropriate roles for peer support;

Infrastructure – Maslow's hierarchy; case management; a bed, a buddy & a job; service availability; better use of technology; underrepresentation of rural areas that make up a majority of the state; consistency across the state needed, not zip code-driven

Linkages – housing – halfway & ¾ like federal system;

Accountability/Assessment/Narrative – reactive v. pro-active; problems across state are similar, solutions are local; reinvest funding spent on ineffective programs / identify current successful programs

LOW HANGING FRUIT

- CIT for 911 tele-communicators/dispatcher
- Bed board
- Geriatric beds
- Case management
- Trauma informed
- Team based approaches
- Rural challenges & strengths
- Evidence-based policies, practices, programs
- Stigma – court-involvement, veterans & language; MHFA, CIT
- Education
- Prevention
- Substance Use Disorders v. Mental Illnesses
- Trust

Need recommendations that are system-based, as well as those that directly help people.
Maybe 3-5 major recommendations – including revenue neutral.

- Suggested reading: Crazy: A Father's Search Through America's Mental Health Madness by Pete Earley http://www.peteearley.com/books/crazy/
- National Center for PTSD http://www.ptsd.va.gov/

Next Workgroup Meeting(s): mid-November – Doodle Poll to be sent out; December – planning a conference call

Presentation to Adult Work Group, Governor's Task Force on Mental Health and Substance Use

Barbara B. Smith, MSW, LCSW
Clinical Assistant Professor
UNC School of Social Work
Adjunct Assistant Professor
UNC Department of Psychiatry
10/20/15

How did I get here?

- 1984: Shenley Hospital, Hertfordshire, England
- 1991: UNC School of Social Work
- 1992: Club Nova
- 1993: Durham Mental Health Center
- 1993: John Umstead Hospital
- 1995: UNC Schizophrenia Treatment and Evaluation Program
- 2005: OASIS, Early Intervention and Prevention
- 2009: UNC Center for Excellence in Community Mental Health
- 2012: UNC School of Social Work; CTI Project

Challenges

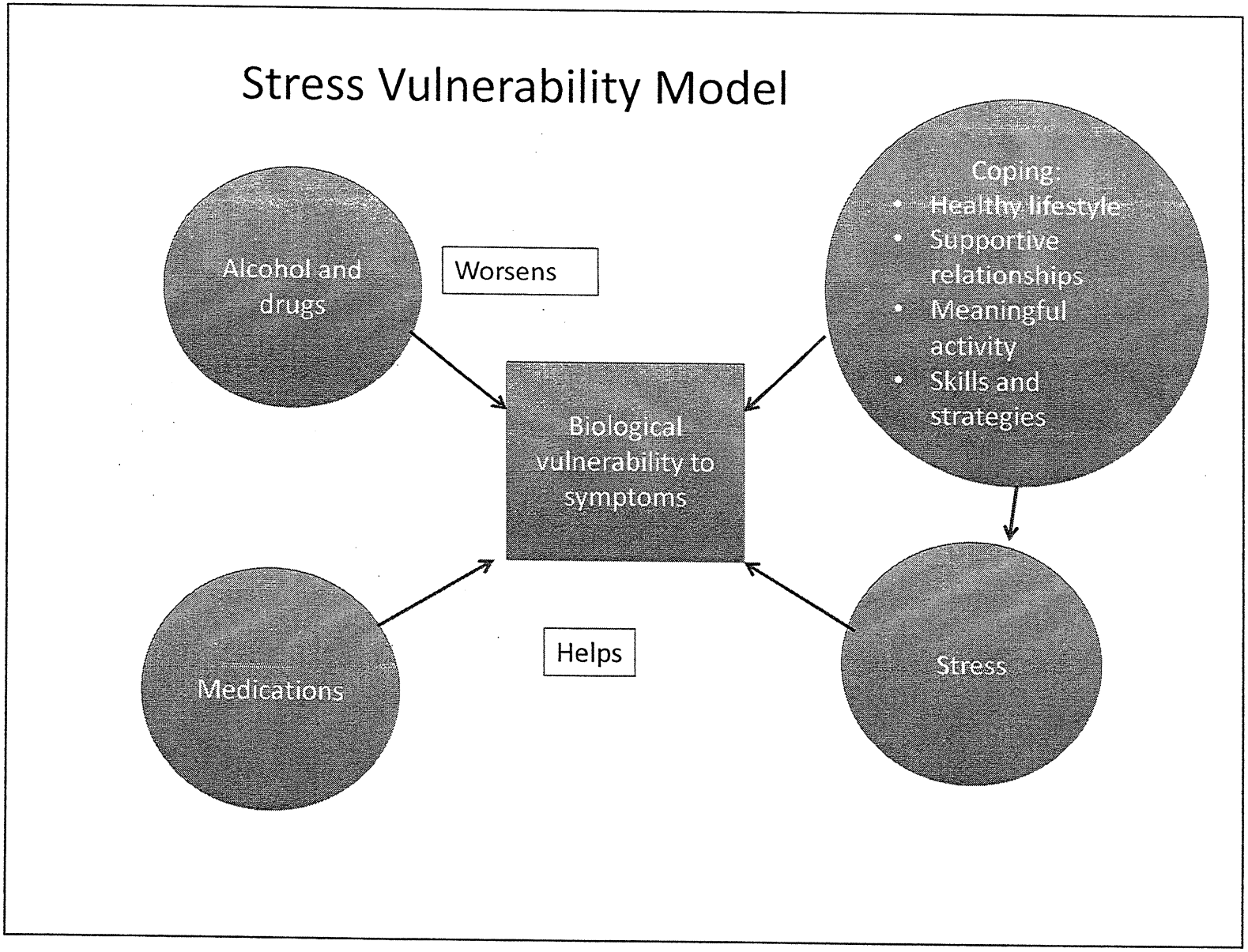
- People don't know where to go for help
- Response to crisis often inhumane
- Workplace weary of reform/stress level has been high for years — no one at their best under consistent high stress
- Loss of good, experienced clinicians
- Separate child/youth and adult systems — transition age a very vulnerable time
- Stigma
- Services designed to be short-term; most severe mental illnesses are chronic conditions
- Turf issues/competition over constrained funds
- Ever-changing provider landscape, huge administrative burden for providers
- LME/MCOs focused on their own growth and reorganization
- What you get based on what payer source you have
- Private insurance does not pay for enhanced mental health services — pushes persons with complex needs to the public system
- Medicare — limited coverage, yet often the insurance for disabled persons with complex needs
- Hospitals and community systems very separate — don't share records/cultural differences/shutting out community-based workers

Solutions

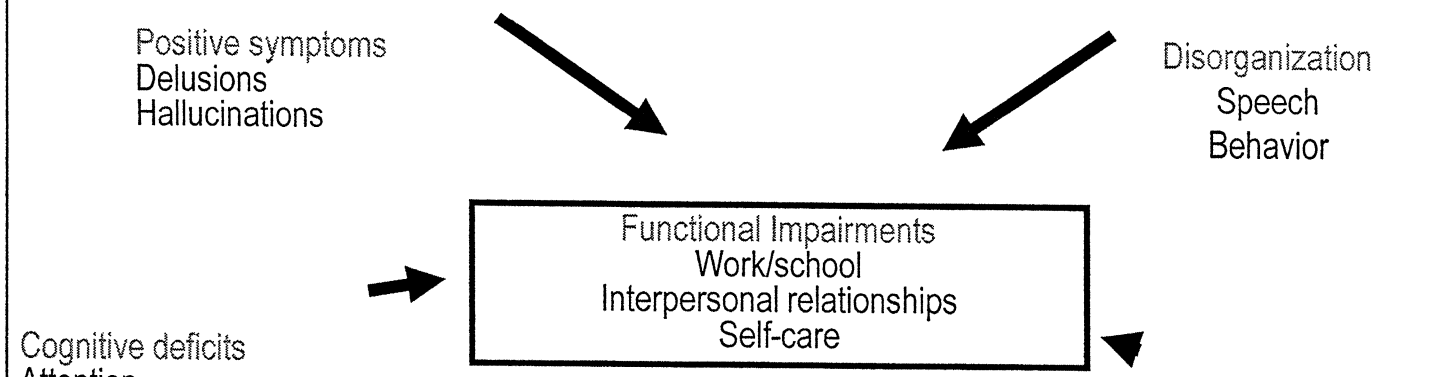
- Increase public awareness of importance of mental health
- Health promotion; focus on youth wellbeing – schools, faith communities
- *Increase and simplify access — across private and public sector*
- Better outcomes with early identification and early intervention
- Improve continuity of care between settings
- Foster peer-to-peer support — youth will talk to other youth before adults
- Seek private insurance coverage of treatment for severe mental illness, and enhanced services
- *Case management—linchpin for anyone with complex needs who has difficulty functioning*
- Simplify the service array
- Enhance quality; monitor meaningful outcomes
- *Creative collaboration/breaking down barriers between health, mental health, and addiction systems — and health disciplines*
- Smart use of technology — use tools that youth use to reach them
- *Workforce development — better knowledge transfer*

Schizophrenia facts

- Schizophrenia affects 1% of the population (1 person in 100 will have schizophrenia; 1 in 50 some kind of psychotic illness)
- Evidence suggests some forms of schizophrenia begin as the brain starts developing before birth
- More common in men than women
- Usually emerges in late teens to mid-thirties
- Peak onset is in early to mid 20s for males, late 20s for females
- About 20% of people have a favorable course, a few have complete recovery
- Most need ongoing treatment and support

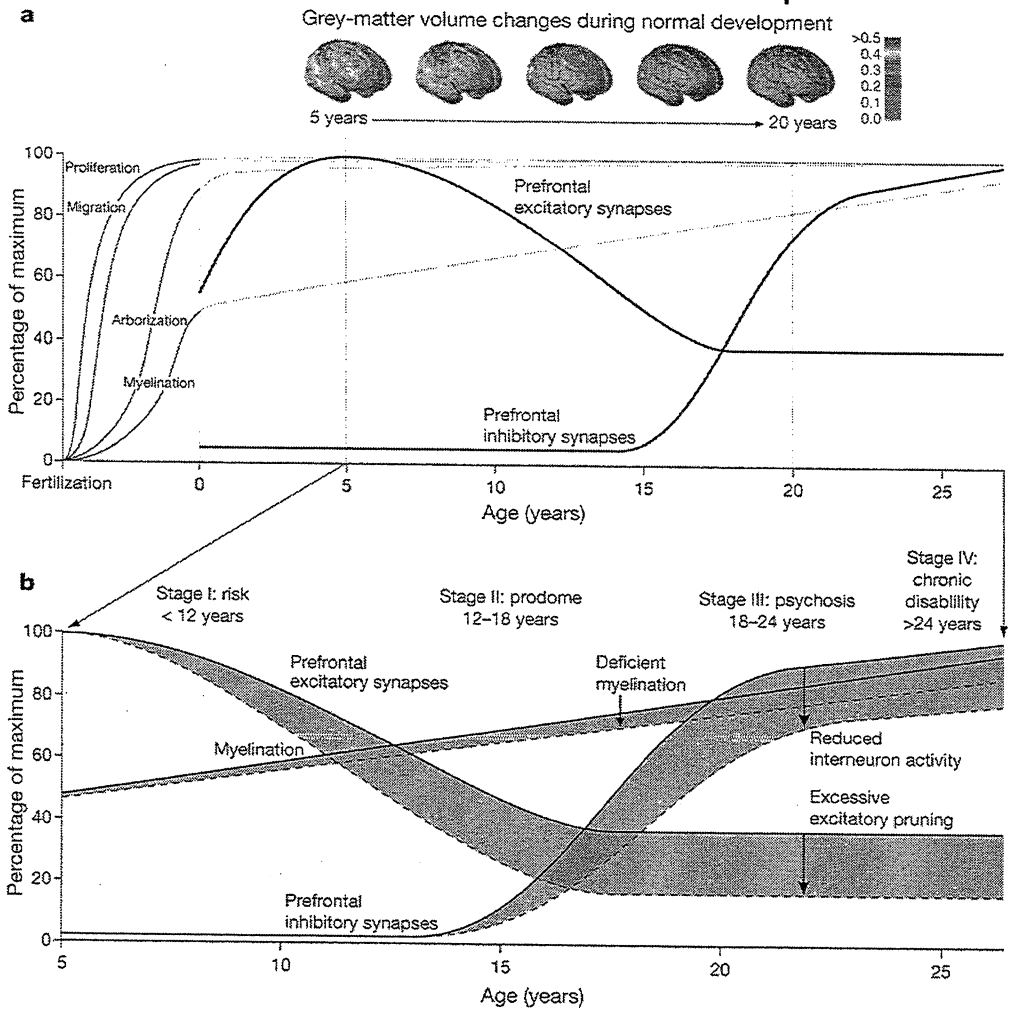

Stress Vulnerability Model
Alcohol and drugs
Worsens
Coping:
• Healthy lifestyle
• Supportive relationships
• Meaningful activity
• Skills and strategies
Biological vulnerability to symptoms
Medications
Helps
Stress

Features of Schizophrenia



Negative symptoms may be due to primary "deficit pathology" or secondary to positive symptoms and/or drug side effects

Neurodevelopmental Model of Schizophrenia



TR Insel *Nature* **468**, 187-193 (2010) doi:10.1038/nature09552

October 2015

Type of Courts	Number of Courts	Number of Counties	Name of Counties	County/City Funding	Grant Funding	No Funding
Family Drug Treatment Court	8	8	Cumberland			5 courts
			Halifax			
			Lenoir			
			Orange			
			Wayne			
			Robeson	3 courts		
			Buncombe			
			Mecklenburg			
Adult Drug Treatment Court	18	14	Catawba			1 court
			Brunswick(superior)		Oct 1, 2015-Sept 30, 2018	
			Pitt		July 1, 2015-June 30, 2017	
			Person	1 court		
			Wake (2)		Aug 1,2013-Jul 31,2016	
			Avery	2 courts		
			Buncombe (superior)			
			Cumberland		July 1, 2014-Oct 31,2016	
			Durham	9 courts		
			Guilford (2)			
			Mecklenburg (3) (1superior, 2district)			
			New Hanover			
			Orange			
			Watauga			
Youth Drug Treatment Court	4	3	Mecklenburg	3 courts		
			Guilford (2)			
			Forsyth		Oct 1 2012-Sept 30, 2016	
DWI Courts	7	7	New Hanover	1 court		
			Buncombe		Oct 1, 2015-Sept 30, 2016	
			Union	2 courts		
			Brunswick			
			Cumberland		Oct 1, 2015-Sept 30, 2016	
			Mecklenburg (2)	2 courts		
Mental Health Courts	6	5	Orange	6 courts		
			Brunswick			
			Guilford (2)			
			Mecklenburg			
			Forsyth			
Tribal Courts	1	1	Cherokee	1 court		
Veterans Treatment Courts	3	1	Harnett		Oct 1, 2015-Sept 30, 2016	
		1	Cumberland		July 1, 2015-June 30, 2016	
		1	Buncombe		Nov 1, 2014-June 30, 2016	

Total Drug Treatment Courts	30	25
All Problem Solving Courts	47	39

North Carolina Mental Health Courts

District 13B—Brunswick County

Brunswick County Government Center
310 Government Center Drive, Suite 3
Bolivia, NC 28422

District MHC Coordinator: Carrie Menke
Phone: (910) 253-4353
Email: carrie.menke@yahoo.com

District 15B—Orange County

Mailing Address:
P.O. Box 1088
Hillsborough, NC 27278
Physical Address:
Orange County Courthouse
106 Margaret Lane
Hillsborough, NC 27278

District MHC Coordinator: Marie Lamoureaux
Phone: (919) 644-4659
Fax: (919) 644-4647
Email: marie.lamoureaux@nccourts.org

District 18—Guilford County (2 courts)

Greensboro Office

Mailing Address:
P.O. Box 3008
Greensboro, NC 27402

Physical Address:
201 S. Eugene St.
Suite 311
Greensboro, NC 27401

Specialty Courts Manager: Carri Munns
Phone: (336) 412-7798
Email: clmunns@uncg.edu
MHC Coordinator: William Ferguson
Phone: (336) 412-7878
Email: wmfergus@uncg.edu

High Point Office

Mailing Address:
P.O. Box 2434
High Point, NC 27620

Physical Address:
505 East Greene St.
High Point, NC 27620

Specialty Courts Manager: Carri Munns
Phone: (336) 412-7798
Email: clmunns@uncg.edu
MHC Coordinator: Sandra Tucker
Phone: (336) 822-6842
Email: sktucker@uncg.edu

District 21—Forsyth County

Physical and Mailing Address:
200 N. Main St.
Winston-Salem, NC 27120

District MHC Coordinator: Amber Humble
Phone: (336) 714-9152
Email: ahumble@cphs.org

District 26—Mecklenburg County

Mecklenburg County Criminal Courts Bldg.
832 East 4th Street, Suite 4351
Charlotte, NC 28202

Administrator: Janeanne Gonzales
Phone: (980) 314-1966
Court Coordinator: Rosalind Banks-Brewer
Phone: (980) 314-1954
District MHC Coordinator: Wendy Kauffman
Phone: (980) 314-1959
Fax: (704) 686-0172
Email: wendy.kauffman@mecklenburgcountync.gov

Recommendations from Prison Mental Health Task Force

1. Intake and Assessment: The need to identify offenders with mental health problems along the continuum of mental illness – from episodic adjustment disorders and severe major depression to chronic and persistent severe mental illness – is critical. At the more serious end of the spectrum, major mental disorders such as schizophrenia, psychotic disorders, bipolar disorder and posttraumatic stress disorder should be identified using reliable and valid screening assessments. Positive screens on brief mental health screening instruments should initiate more in-depth screening and diagnostic assessments by qualified mental health professionals.

Recommendation 1.1. Continue to use reliable and valid brief screening instruments to identify offenders with mental health problems. Identify valid and reliable diagnostic tools (e.g., SCID, MINI) to establish major mental disorders for those who screen positive on initial mental health screen.

Recommendation 1.2. Establish protocol for re-administering brief and/or more in-depth mental health assessment at regular intervals or during critical events (e.g., bizarre behavior, indication of auditory or visual hallucinations).

Recommendation 1.3. Revisit inmate classification system to establish if current system is meeting the needs of offenders with mental illness. Can diagnostic classification be aligned with inmate classification? How is classification information developed, shared within and across facilities, communicated to staff, tracked and updated, and shared with community providers prior to or upon community release?

Recommendation 1.4. It is the recommendation of the Task Force that a reliable and valid measure of trauma be used to assess for and treat posttraumatic stress disorder. (One resource which may be of assistance is SAMHSA's publication, "Roadmap to Seclusion and Restraint Free Mental Health Service.")

Recommendation 1.5. Develop memorandums of understanding (MOUs) with other state agencies to share information with the Division of Prisons. To the extent possible, ensure receipt of mental health information and data from other sources (e.g., community-based behavioral health services, managed care organizations, jails, probation, and state hospital).

2. Housing, Special Units and Control Status

3. Suicide Prevention

4. Transportation

5. Disciplinary Policy and Hearings for Offenders with Mental Illness

6. Restraints

7. Behavioral Health Services. Offenders with mental illness may need ongoing treatment and support, including medication, psychiatric assessment and services, and psychosocial programs and supports. The Task Force is impressed with the treatment mall witnessed at Central Prison. Providing offenders with mental illness "out of cell" treatment is noteworthy of comment. The need for treatment which incorporates more than just medication is essential if the goal is to return these offenders to the general population and ultimately the community.

We are encouraged by the plan to open transitional care units at all closed custody facilities. We recognize this is a significant funding issue; however, we know without such units any ability to remove the most serious mentally ill offenders from restrictive housing will generally not occur. The development of alternative housing for many offenders is essential to their treatment and hopeful reintegration into general population. While we are encouraged, we also caution the leadership to ensure that appropriate multi-disciplinary staffing is accomplished prior to opening these units and that a treatment curriculum is developed which measures activities such that staffing and programming across units are standardized and consistent.

Recommendation 7.1. In any institution having mental health or medical staff, policies should be developed to require that custody, medical and mental health staff should meet daily in person or by conference call to discuss significant cases or issues for the day.

Recommendation 7.2. Assessment and treatment of trauma disorders, and provision of trauma-informed care, should be provided to all our offenders, especially women. Although the incidence of trauma is high among male prison offenders, the experience of trauma is nearly universal among incarcerated women. Various programs for the treatment of trauma disorders have been developed (Seeking Safety, TREM, and Cognitive Processing Therapy). However, the effectiveness of these treatments will be limited unless efforts are also made to provide this treatment within an environment that is trauma-informed. Developing a Trauma-Informed Care (TIC) environment will require a commitment by prison administrators to examine and reform the processes and practices of the prison system to minimize the re-traumatization of offenders. Training on TIC would need to be provided to correctional staff, as well as treatment staff, to assist them in building a supportive, compassionate and emotionally safe environment that will allow the inmate to begin to heal from their trauma. Trauma-informed care has also been found to improve the outcomes of women's prison systems by decreasing their number of disciplinary infractions, reducing violent conflict between offenders in these institutions, and reducing inmate-on-staff assaults.

Recommendation 7.3. Ensure that appropriate multi-disciplinary staffing is accomplished prior to opening transitional care units and that a treatment curriculum is developed which measures activities such that staffing and curricula across units are standardized and consistent.

Recommendation 7.4. Explore the creation of specialized case managers to coordinate care and services for offenders with mental illness (i.e., M2 – M5). Case managers will follow offenders from intake to release. The Task Force appreciates this may require additional staff and will require additional specialized mental health training. These case managers additionally take on the responsibilities traditionally managed by social workers at facilities were social work is not on site.

Recommendation 7.5. It is recommended by the Task Force that the Director of DAC put out a memorandum to the Wardens' at Central Prison, NCCIW and Maury reiterating that medical and mental health beds are system beds and should only be used as "security beds" in rare circumstances that are justified in writing and authorized in writing by the warden. Guidelines for when these system beds can be used as security beds should be outlined. It is also recommended the Director conduct a six-month follow-up to see if hospital beds continue to be used.

Recommendation 7.6. It is the recommendation of the Task Force that the distinction between outpatient and inpatient mental health departments should be eliminated at medical centers. Moving forward, one supervisory organizational structure should be responsible for the provision of all mental health services at each of these facilities.

Recommendation 7.7. It is also the recommendation of the Task Force that physical health and mental health services are integrated under one organizational structure for all offenders at the institutional setting and that one physician is responsible for overseeing the provision of all health and mental health services at each institution. Moreover, interdisciplinary team meetings should be standard practice for all facilities (from 1997 NIC Recommendations). The purpose of this recommendation is to emphasize the integration of services. Nothing in this recommendation should be construed to suggest how the hierarchy of positions be organizationally managed.

Recommendation 7.8. The electronic medical record (HERO) is essential to the provision of continuity of care for all offenders. It is the recommendation of the Task Force that the EMR (HERO) for DAC be funded and completed for all male facilities. Currently, the EMR has been implemented at female facilities. Moreover, it is the recommendation of the Task Force that the DAC receive two new positions to be devoted to EMR data management and analysis, communication and monitoring and reporting.

Recommendation 7.9. Pharmaceuticals are a costly part of providing care to all offenders, especially those with mental illness. It is the recommendation of the Task Force that the DAC be granted permission by the state legislature to participate in a federal prescription drug program called 340B Drug Discount Program. Though it is targeted for medications to treat sexually transmitted diseases, such as HIV, participation in this program could

free up resources that are needed to treat other illnesses. That is, by participating in the program, money saved from not having to pay for pharmaceuticals for sexually transmitted diseases could be put towards medications for offenders with mental illnesses. This would require the cooperation of UNC Hospitals.

Recommendation 7.10. When the demand for psychiatric services at any facility in the DAC outpaces capacity of in-house staff to meet the demand, the DAC should be prepared to provide for required services commensurate with good care. It is suggested that DAC develop a strategy to obtain telemedicine services not from a university provider where you always have to deal with unused capacity, but from a vendor providing such service as part of their business model.

8. Hiring and Retaining Medical and Mental Health Staff

9. Training and Employee Support

10. Discharge and Community Transition Planning. Few transitions are more difficult to achieve than from life in prison to freedom in the community. Offenders live in an institutional environment with routines prescribed to the minute, where choices are few, freedom is limited, movements are restricted, but where all essential needs for food, clothing, and shelter are provided. Upon release, offenders are thrust into the community where options are many, choices are overwhelming, movement is unlimited, but where they are also suddenly responsible for their own well-being. Their transition to the community is further hampered by the barriers presented by their legal histories to obtaining employment, housing, and social support.

When released to the community, offenders who are beset with mental illness and/or substance abuse problems face even greater challenges. While they have the same barriers to success as other offenders returning the community, they have fewer mental and emotional resources to overcome them. Transitions are stressful, and people with mental illness are vulnerable to stress. When under stress, their symptoms may be exacerbated, their behaviors may regress, and the emotional turmoil created by those transitions makes more difficult the process of learning new behaviors necessary for success in the new environment. Such individuals require intensive support and assistance through this transition process, or risk failure. And failure for such individuals might not only result in their re-incarceration, but may endanger the lives and welfare of others in their community.

Below, the Task Force provides recommendations for improving the transition of offenders with mental illness and/or substance abuse problems to our North Carolina communities. Because the re-entry of offenders with mental illness to the community requires the coordination of prison staff with agencies and organizations available to support them in the community, the recommendations contained herein address both policies and practices of our prisons, as well as those of the various organizations in the community to which their care is transitioned.

These recommendations are not the result of an exhaustive or comprehensive review of all of the mental health services in our North Carolina prisons; such a review would require more time and resources than are currently available. Therefore, the conclusions and resulting recommendations contained below should be considered tentative and as only a preliminary step towards a more thorough examination of ways to improve services to offenders with mental illness being served in our state's prison system.

Recommendation 10.1. Improve the mutual understanding of and collaboration between the LME-MCO and prisons social work staff on behalf of releasing offenders needing public mental health systems services.

a. Educate LME-MCO access staff members about the administrative process involved in releasing offenders from prison to the community, and the needs of such inmates who are returning to the community.

Prison social workers consistently report frustration with the community service system's lack of familiarity with the administrative requirements and challenges in developing release plans for offenders. For example, although prison social workers are required to develop release plans no less than 30 days in advance of an inmate's release, some LME-MCOs are reluctant to schedule appointments more than two weeks in advance.

In addition, a consistent and effective response is needed for scheduling appointments for people discharged from prison. For example, while most consumers prefer "same day access" approaches to appointments, prison social

workers reported that inmates need specific appointment times, as they become frustrated with walk-in appointments, and are not willing to wait for "the next available appointment."

The availability of a LME-MCO staff who specializes in prison issues might help the LME-MCO and prisons work together more effectively. However, all LME-MCO access staff need to be aware of the needs of both inmates being released and the prison social workers who are planning for their release. Many of prison social workers serve different facilities, and some do not have telephone voice mail capability. Therefore, they are not easily reached via return phone call, and they need assistance from whomever they contact at the LME-MCO, rather than relying on a return phone call from a single staff member.

b. Educate prison social workers about the changing mental health system and role of LME-MCO's.

Changes to NC's mental health system have left prison social workers unsure about how to access services for releasing inmates, and unclear about the role of LME-MCO's. Mergers between LME-MCO's have further complicated referrals to service providers, as entities and individuals they used to contact to arrange referrals may no longer exist in the same capacity. Furthermore, LME-MCO's may differ in their processes, procedures and service availability, as they are charged with meeting the needs of a variety of people in diverse communities within each of their catchment areas – with limited state funding.

Periodic trainings about the state's mental health care system and meetings between LME-MCO staff and prison social workers many not only help the prison social workers better understand the community mental health systems and roles of the LME-MCO's, but would enable them to develop relationships with the LME-MCO's that they could then rely upon to help solve problems related to release planning. Consideration could also be given to cross training LME-MCO's and prison social work staff members on their assessment and treatment planning forms and processes, with an eye towards sharing these forms, and even establishing (where feasible) similar assessment and treatment planning forms and processes in hopes of facilitating as seamless as possible continuation of care.

If approved, with the assistance of DHHS staff, a meeting should occur between staffs as soon as practicable.

Recommendation 10.2. Establish services and needs aligned with critical time points prior to discharge (i.e., needs two weeks before release, needs on 1st day of release, first week of release). In addition, develop a release checklist prior to release to community and standardize this checklist across facilities and communities.

Recommendation 10.3. Coordinate care across mental health, substance use, physical health, domestic violence, sex offender, probation/parole etc. Address training and staffing needs for discharge planners and case managers.

Recommendation 10.4. Develop dedicated mental health discharge planner with dedicated resources and training (i.e., SSI/SSDI Outreach, Access and Recovery [SOAR] training). Assisting inmates to obtain Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) benefits and other entitlements prior to their release from prison will help assure that those inmates with disabilities receive reliable income and supports necessary for their transition to life in the community. The SOAR program has a proven track record of success in training social workers to help persons with disabilities successfully apply for these benefits. Often, without SOAR training, applications for these benefits are denied, requiring reapplication or a lengthy reconsideration process that delays their receipt of these benefits. Providing SOAR training to prison social workers will help assure that offenders who are disabled have financial assistance for support upon their release.

Recommendation 10.5. Establish Memoranda of Understanding/Agreement between, Division of Adult Correction, Division of Community Corrections and LME-MCOs to facilitate data sharing and planning regarding offenders' treatment needs. The medical files of offenders in the custody of the DAC contain information that is essential for meeting their treatment needs following their release. However, often that information is not conveyed to the LME-MCO responsible for their care once released from prison. Developing MOU/MOAs with the LME-MCOs would enable to prisons to share data commensurate with legal regulations will help assure these offenders' continuity of care in the community. Continued development of the HERO system may help facilitate information sharing between the prisons and LME-MCOs.

Recommendation 10.6. LME/MCOs should designate a prison reentry specialist to increase the LME/MCOs' understanding of the needs of offenders with mental illness and co-occurring substance use disorders who are returning to the community. Improve the mutual understanding of and collaboration between the LME-MCOs and prison social work staff on behalf of releasing offenders needing public mental health system services.

Recommendation 10.7. Partner with LME-MCOs who are providing care coordination for re-entering offenders with severe mental illness through policy adjustments that take into account in-prison health histories. This would require additional resources at DHHS. To inform this issue, more data on the numbers of offenders with co-occurring mental illness and substance use disorders are needed.

LME-MCOs and prisons should work together on prioritizing care coordination for those releasing inmates with mental illness who may present a risk to their communities, and particularly for those whose mental illness is severe, who have co-occurring substance abuse problems, and who have been incarcerated for lengthy periods of time.

Recommendation 10.8. It is the recommendation of the Task Force that prison and probation should communicate with each other about offenders with mental illness and their prison treatment needs and experiences (use of services, medications) prior to release and post-release.

Recommendation 10.9. It is the recommendation of the Task Force that housing providers should be incentivized to house offenders with mental illness who are reentering their communities. The Task Force recognizes that this recommendation goes beyond the scope of the DAC but is a critical issue that must be addressed if any long-term success at reintegration of the mentally ill is accomplished. Moreover, the Task Force recommends that the DAC establish contracts with vendors to establish transitional care facilities for sex offenders and offenders with mental illness in 10 locations across the state. These facilities and their effectiveness toward facilitating successful community reentry and reducing recidivism should be evaluated using indicators of effectiveness, length of stay, recidivism rates, etc.

Recommendation 10.10. It is the recommendation of the Task Force to consider piloting Critical Time Intervention (CTI) for offenders with severe mental illness who are returning to their communities. These programs are typically designed and implemented by community mental health centers. Where expansion of the mental health specialty probation officer program (see below) is not feasible, or when probation caseloads are too large to meet their mentally ill probationer's needs, development of a Critical Time Intervention (CTI) initiative should be considered. CTI is a nine-month long intervention strategy designed to help persons transitioning from homeless shelters and psychiatric institutions to the community by providing intensive support, particularly in the first several months, to help engage transitioning persons to services and supports in the community. CTI may also assist releasing inmates with mental illness to successfully transition back to the community.

Recommendation 10.11. It is the recommendation of the Task Force that the DAC develop a collaborative relationship with state vocational rehabilitation and work more closely with local vocational rehabilitation offices. Prison social work staff should meet with and receive training from the state Department of Vocational Rehabilitation (DVR) regarding eligibility requirements and processes for applying for DVR assistance, as this may help them to better guide their releasing inmates in applying for DVR services. This training could include a presentation about the Client Assistance Program - a federally-funded agency charged with providing advocacy, assistance and advice to people with disabilities, including disabled ex-offenders who are seeking DVR services. Developing relationships with staff in local DVR offices may help the prison social workers to better understand and influence local DVR polices, thereby easing the application process. Also, establishing relationships with the state's DVR staff may help assure better state-wide consistency in DVR's provision of support to releasing inmates with disabilities.

Recommendation 10.12. It is the recommendation of the Task Force that the DOP consider developing a standardized prerelease programs unique to offenders with mental illness – particularly those with lengthy incarceration histories – to help them begin to readjust to community life. The program should be implemented prior to and following release and should include all relevant supports.. Offenders with mental illness completing a lengthy prison sentence will need help learning new ways of relating to others. They may need assistance in understanding how prison life has changed them, and help understanding how to respond to people outside of

prison. Programs aimed at educating these offenders about this adjustment process may better prepare these offenders for their release. In addition, family members and loved ones supporting the offender may need help understanding the ways in which he or she has changed, and how to best support the inmate's readjustment to life outside of prison.

Recommendation 10.13. Improve the employability of offenders with mental illness who may be able to work by providing them training in job skills and supports to maintain employment. Gainful employment is a crucial ingredient for successful post-release adjustment and recovery – especially for offenders with a mental illness and substance use disorders. In addition to income, work provides structure and a sense of purpose to individuals lives. Research has demonstrated that individuals with serious mental illness are capable of working competitively in the community. Whenever possible, offenders with mental illness should be considered for job training programs, including within Correction Enterprises, with a focus on learning job skills that are in demand in the community. In addition, opportunities for these offenders to learn "soft skills" such as getting along with fellow employees, avoiding conflict, and cooperative work relations, should be provided. Upon their release supportive employment programs be made available for offenders with mental illness to assist them in obtaining and maintaining employment, through DVR and community mental health programs. This will require coordination with community corrections.

Recommendation 10.14. Increase opportunities for LME-MCOs and community providers to learn more about evidence-based and best practices in supporting justice-involved persons with mental illness in the community. Efforts should be made to develop mental health professionals' ability to support persons with mental illness who are involved with the criminal justice system. Although community providers are often well-versed in the provision of evidence-based treatments for mental illness, few of them are aware of evidence-based practices for reducing criminal justice recidivism.

Although beyond the scope of DAC, community-based mental health staff who manage the care and those who provide direct services to offenders in our public mental health system need to know how to work with mentally ill offenders in the community to reduce their likelihood of returning to prison. They need to be aware of the evidence-based practices for effective interventions with offenders, including the risk-need-responsivity principles, and on ways to address the central risk factors for criminal justice recidivism. Trainings on working effectively with a mentally ill criminal justice-involved population could be provided through workshops at professional conferences, through adjustments to curricula taught in professional schools, and through targeted efforts to cross train mental health professionals, community corrections and prison staff.

Recommendation 10.15. Expand the mental health specialty probation officer program. A specialty mental health probation officer program is currently being piloted in two North Carolina counties (Sampson and Wake). Research conducted in other states has found such programs effective in reducing criminal justice recidivism among probationers with mental illness. Once the evaluation of the North Carolina mental health probation officer pilot program determines its effectiveness and refines this model, it should be expanded statewide, with priority given to offenders with severe mental illness who have experienced long periods of incarceration. Such offenders may be in great need of support to transition successfully to the community. Although there may be pressure to expand the caseloads of mental health probation officers, these must remain low to enable the probation officer to provide services at a level of intensity and frequency sufficient to meet the offender's needs.

Recommendation 10.16. The Task Force recommends the Administrative Office of the Courts review methods of diverting low level offenders prior to their confinement to DAC. We further recommend that (1) mental health courts be expanded and that (2) outcomes data collection for mental health courts is standardized.

Recommendation 10.17. It is recognized that the collection and aggregation of specific data is essential to determine effectiveness and efficiency, it is recommended that DAC enter into initial discussion with NC Government Data Analytics Center to develop appropriate performance indicators for the treatment and housing of mentally ill offenders.

1[illegible]. General Policy and Culture

N.C. Department of Health and Human Services

Participating Agencies

- Division of Adult Correction and Juvenile Justice, Department of Public Safety
- Division of Medical Assistance, DHHS
- Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, DHHS
- Division of Social Services, DHHS
- Division of State Operated Healthcare Facilities, DHHS

N.C. Department of Health and Human Services

Information Collected

- Service Name
- Population Served
- Funding Source
- Penetration Rates
- Setting in which Service Delivered
- Authority
- Capacity
- Entrance & Exit Criteria

NC Mental Health and Substance Use Service Array Survey

Table 1

Service Name	Service Population/Eligibility	Funding	Penetration	Setting	Oversight Agency	Authority/Rule	Funding Source and Capacity	Entrance/Exit
• *Include any subcategories of service on a separate line* • *In Table 2, please add service description and key terms*	*Age group, source, justice involvement, etc. What makes you eligible?*	*List the fund source*	*% = receiving / needed + eligible*	*Community (home, office, school), facility/type, correctional setting (jail, YOC, detention, prison)*	*State Division/Department*	*Cite the applicable statute or rule*	*Entitled, limited to available funding *add annual expenditure for each*	• *How do you get into service (medical necessity, referred by courts, self-ref., sentenced, LME-MCO)* • *How are you discharged (medical. nec., goals met, complete sentence, time-limit, complete course*

Table 2

Service (and 2-3 sentence description)	
Key Terms (and definition)	