

North Carolina

UNIFORM APPLICATION

FY 2016/2017 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 06/30/2018
(generated on 04/29/2016 9.51.57 AM)

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2016

End Year 2017

State DUNS Number

Number 80-978-536

Expiration Date

I. State Agency to be the Grantee for the Block Grant

Agency Name NC Department of Health and Human Services

Organizational Unit NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Mailing Address 3001 Mail Service Center

City Raleigh

Zip Code 27699-3001

II. Contact Person for the Grantee of the Block Grant

First Name Courtney

Last Name Cantrell

Agency Name DMHDDSAS, NC DHHS

Mailing Address 3001 Mail Service Center

City Raleigh

Zip Code 27699-3001

Telephone 919-733-7013

Fax (919) 508-0951

Email Address courtney.m.cantrell@dhhs.nc.gov

III. Expenditure Period

State Expenditure Period

From

To

IV. Date Submitted

Submission Date 9/1/2015 12:34:04 PM

Revision Date 4/29/2016 9:51:09 AM

V. Contact Person Responsible for Application Submission

First Name DeDe

Last Name Severino

Telephone 919-715-2281

Fax

Email Address dede.severino@dhhs.nc.gov

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2016

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
 Community Mental Health Services Block Grant Program
 as authorized by
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
 and
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Richard O. Brajer

Signature of CEO or Designee¹: _____

Title: Secretary

Date Signed: _____

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

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3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
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I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Richard O. Brajer

Signature of CEO or Designee¹: *Sherry's Brackner for Richard O. Brajer*
Deputy Secretary

Title: Secretary Date Signed: 8/31/15

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

Name	<input type="text" value="Richard O. Brajer"/>
Title	<input type="text" value="Secretary"/>
Organization	<input type="text" value="NC Department of Health and Human Services"/>

Signature: _____ Date: _____

Footnotes:

As an agency of state government, no lobbying activities occur.

Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

B. Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) is the State Mental Health Agency (SMHA) for the Community Mental Health Services (CMHS) Block Grant and the Single State Agency (SSA) for the Substance Abuse Prevention and Treatment (SAPT) Block Grant. The Division falls under the Department of Health and Human Services that, as a state agency of the Executive Branch, is directly under the Governor and Lieutenant Governor. DMH/DD/SAS consists of the Director's Office and four sections, each of which is subdivided into teams based on functions. The organizational structure of the Division as a public service delivery system may best be described as a matrix of integrated functions.

The Community Policy Management (CPM) Section is primarily responsible for the oversight of services delivered by Local Management Entities-Managed Care Organizations (LME-MCOs), the Division's intermediaries at the local level. The CPM Section consists of the Community Mental Health Section and Community Innovations Section, the Local Management Entity Systems Performance Section, the Justice System Innovations Section, the Community Health Integration, Wellness and Prevention Section and the Quality Management Section. Each of the program sections in the section has staff with expertise in each of the populations of focus who are further specialized along the developmental stages of early childhood (0-5), later childhood (6-12), youth (13-17) and adulthood. The Community Mental Health Section houses the Adult Mental Health Services Lead, the Child Mental Health Services Lead and the Housing Services Lead. The CPM section manages the Community Mental Health Services and the Substance Abuse Prevention and Treatment Block Grants.

The Resource and Regulatory Management Section is responsible for fiscal monitoring, accountability and regulatory compliance, support of information technology, and contracts management. It is made up of the Information Systems Team and the Accountability Team.

The Advocacy and Customer Service Section provides consumer advocacy leadership and ensures that state-operated healthcare facilities and community-based systems are in compliance with rights protection for individuals served through the system. It is made up of the Customer Service and Community Rights Team and the Consumer Empowerment Team.

The Operations Support Section is responsible for planning, rule and policy development, media relations, training and communication with external stakeholders. The Planning, Division Affairs, and Communications and Training teams fall under this section.

Mental health and substance use treatment and prevention services were formerly provided directly by service providers employed by area/county programs. With the 2001 Mental Health Reform legislation

passed by the NC General Assembly, the focus of area programs shifted from direct service provision to the management of the local service delivery system by Local Management Entities (LMEs) that contracted with providers for the delivery of services in their catchment areas. Between 2001 and 2010, the number of LMEs was incrementally reduced from 48 to 23. In April 2005, the state piloted the 1915 (b) Freedom of Choice Waiver/(c) Innovations Home and Community Based Services (HCBS) Managed Care Waiver. Under the waivers, Medicaid services are funded through capitated Pre-paid Inpatient Health Plans (PIHP) that allow the MCOs to have more flexibility in service delivery. The success of the pilot project led to the submission of a waiver amendment by DHHS to the Centers for Medicaid and Medicare Services (CMS) in December 2009 for the expansion of the waivers through the state. Numerous mergers among LMEs have occurred since then. As of July 2015, there are 8 LME-MCOs covering the state's 100 counties. DMH/DD/SAS and the Division of Medical Assistance (the state Medicaid agency) jointly administer the MCOs. DMH/DD/SAS holds performance contracts with the LMEs who with the DMH/DD/SAS are responsible for implementing the system of services and supports for eligible children, youth and adults with serious mental health, substance use disorders and/or intellectual and/or developmental disabilities.

The SMHA provides a comprehensive system of care to enable individuals that it serves to live in communities of their choice and avoid inpatient hospitalization and institutionalization to the greatest extent possible. The array of available services includes basic outpatient services (assessment, individual therapy, group therapy, family therapy), enhanced mental health and substance abuse services (community support team, intensive in-home outpatient therapy, comprehensive outpatient therapy, Substance Abuse Intensive Outpatient program, Substance Abuse Comprehensive Outpatient Treatment, Adolescent Day Treatment), opioid/medication assisted therapies, halfway house and supported housing services, Work First services and Treatment Accountability for Safer Communities (TASC) for people who have been in the correction system. In addition, mobile and walk-in crisis services, various levels of detoxification, residential, and inpatient treatment services are available throughout the state.

The continuum of services further includes evidence-based practices that are in the state service definitions (specifications of the services that providers can be paid for with public funds) such as Therapeutic Foster Care, Multi-systemic Therapy, and Family Functional Therapy for children and youth and Assertive Community Treatment, Supported Housing and Supported Employment for adults. Other evidence-based practices are offered under the intensive in-home services definition. For example, an ACT team may implement an integrated dual disorders treatment model to better serve individuals with co-occurring mental illness and addiction.

Seeking Safety or trauma-informed cognitive behavioral therapies may be utilized under the SAIOP or SACOT service definitions for those individuals who have experienced trauma in their lives. Local Management Entities-Managed Care Organizations have also developed and implemented, with DMH/DD/SAS approval, alternate service definitions such as peer and recovery supports, transition services, wellness, and living skills to create a more robust continuum of care. The SMHA further coordinates Crisis Intervention Training programs (CIT) that provide law enforcement officials with skills

that enable them to de-escalate crisis among people with mental illness to divert them from incarceration. Tele-health is currently being utilized in areas that have shortages of therapists and/or psychiatrists. Community Prevention Resources (CPRs), funded through the Substance Abuse Prevention and Treatment Block Grant and the State's 2004 Strategic Prevention Framework/State Incentive Grant, provide additional resources.

DMH/DD/SAS receives funds from the NC General Assembly for crisis services (mobile crisis teams, emergency department length of stay plan, walk-in crisis and psychiatric after-care, and crisis intervention teams) geared towards the reduction of hospitalization, the use of emergency department services, jail diversions among people with mental health and substance use disorders. These services are implemented by the DMH/DD/SAS in coordination with the LME-MCOs and community partners.

In addition to contracting with the eight LME-MCOs for the delivery of the service array from prevention, early intervention, treatment and recovery services and supports, the Division also contracts with several other entities to address needs and gaps within the system. Following are some examples of those contracts:

- *Governor's Institute on Substance Abuse* – The primary objective of this contract is to increase access to and improve the quality of services provided in the state by: (1) expanding the use of evidence-based/best practices through the NC Practice Improvement Collaborative (NC PIC); (2) promoting the integration of behavioral healthcare with primary healthcare in two regions of North Carolina and the rest of the state; (3) improving physician understanding of addictions and mental illnesses; and (4) enhancing the quality of the workforce and provider agencies in the state, with a special emphasis on service members, veterans and their families. Both the Mental Health and Substance Abuse Block Grants support this work.
- *NC State University, Center for Urban Affairs and Community Services* – This contract provides for the management of the web-based Treatment Outcomes Program Performance System (NC TOPPS) which allows Local Management Entities/Managed Care Organizations (LME-MCOs) and their contracted network service providers to submit initial, periodic updates and episode completion interview information for all consumers within specified substance abuse and mental health populations. Data entered into the system is then used in developing accountability measures for both the Mental Health and Substance Abuse Block Grants.
- *University of North Carolina, School of Social Work, Behavioral Healthcare Resource Program* - The primary goal of this contract is to increase access to and improve the quality of building resiliency, prevention, early intervention, treatment and recovery supports and services by: (1) expanding the use of prevention, early intervention, treatment and recovery support services for mental health and substance abuse that demonstrate success in improving outcomes and/or supporting recovery; (2) enhancing the quality of the workforce providing prevention, early intervention, treatment and recovery supports and services; (3) enhancing the ability of provider agencies to determine the ongoing effectiveness of building resiliency, prevention, early intervention, treatment and recovery support services; and (4) planning the implementation of new, expanded or enhanced services within the state. This work is supported by both the Mental Health and Substance Abuse Block Grants.

- Center for Child and Family Health – This Center is a collaborative coalition among the University of North Carolina in Chapel Hill, Duke University, North Carolina Central University and the National Center on Child Traumatic Stress Network.) The goal of this contract is to provide subject matter expertise to promote, inform and train the system in the use of evidenced based services and supports that are developmentally appropriate, address sexually reactive diagnosis and treatment, and trauma-informed care.
- *National Alliance on Mental Illness North Carolina (NAMI NC)* – This contract's purpose is to 1) provide youth, families and adult consumers, providers and community partners the knowledge and skills essential as stakeholders in sustaining an effective recovery oriented system of care; and 2) provide outreach to, promote awareness of, and access to participation in consumer, youth and family driven person centered planning and recovery oriented Mental Health, Intellectual and Developmental Disabilities, and Substance Abuse (MHDDSA) system of care in communities across North Carolina through an array of targeted evidenced informed consumer/family driven best practices for those most seriously in need of services and supports.
- *North Carolina Mental Health Consumer's Organization (NCMHCO)* – The NCMHCO is a statewide consumers' organization run by and for mental health consumers. This contract's purpose is to promote and support a recovery oriented system of care by building effective partnerships in communities and at the state level with informed adult consumers living with serious mental illness. Effective communication strategies and networks engage a membership of over 400 individual consumers and affiliated local consumer support groups regionally located throughout the state. The organization operates a toll free "warm line"; publishes newsletters four times a year; holds an annual statewide recovery oriented leadership conference; and provides training on Wellness Recovery Action Plan (WRAP) as part of person-centered planning and other evidenced based practices, such as risk reduction, suicide prevention such as QPR-Question, Persuade and Refer, stigma reduction, such as Mental Health First Aid training.
- *North Carolina Families United and NC Youth MOVE (Motivating Others through Voices of Experience)* – Mental Health Block Grant funds support NC Families United is to develop parent/family leadership partners to work with State and community partners for the purpose of building a strong system of care for children and youth experiencing mental health challenges and their families. This work includes recruiting, training and supporting Family Partners to work with the LME SOC Coordinators and School Child and Family Team Liaisons; actively promoting policies and procedures that serve the best interests of these children, youth, and their families through work with State and local entities; and actively promoting, modeling and adhering to the values and principles of System of Care, such as Child and Family Team training as part of person-centered planning.
- *NC Youth MOVE (Motivating Others through Voices of Experience)* - Mental Health Block Grant funds support NC Youth MOVE in providing youth leadership development training, mentoring, RENEW and Futures Planning, as part of person-centered planning, with youth/young adults ages 15-21 who have struggled with mental health and substance issues, including trauma-based experiences. The leadership series unites the voices of traditional and non-traditional leaders with lived experiences in various systems including mental health, juvenile justice, education, and child welfare. Youth leaders become engaged as peer to peer supports, participate in panels for outreach, education and to inform policy changes.

- *REAL Crisis Intervention, Inc.* – Mental Health Block Grant funds support the implementation of the NC Suicide Prevention Lifeline, part of the SAMHSA National Suicide Prevention Lifeline network, provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week at **1-800-273-8255**. Staffed by trained professionals, the NC Suicide Prevention Lifeline responds to an average of 3,000 calls a day. On average, 234 referrals are made directly to the Mobile Crisis Teams, a part of the crisis service array implemented by the LME-MCOs statewide. The NC Suicide Prevention Lifeline is recognized nationally for excellence in the efficiency and volume of its call response and serves as one of eight approved VA Crisis Call Centers. Staffs are certified trainers for and provide Applied Suicide Intervention Skills (ASIST), a two-day course that trains community lay help givers – gatekeepers - about the risk for and signs of imminent suicide and how to prevent death by suicide from occurring.

The Division coordinates with the North Carolina National Guard, active duty, and US Veterans Affairs, Tricare, and the Citizen Soldier Support Program, as well as with the NC General Assembly, the Division of Vocational Rehabilitation Services, the Department of Correction, the Department of Public Instruction, the Department of Labor, the Governor’s Institute, Area Health Education Programs, state universities, provider organizations, and faith-based organizations on various initiatives that address active duty military, veterans, National Guard Members, the Reserve, and family members of the military. The NC FOCUS on Service Members, Veterans, and their Families is a collaborative initiative of DMH/DD/SAS involving the state government, Veterans Affairs, the Department of Defense, and other organizations. Its mission is to promote best practices in the service of veterans who served in Operation Enduring Freedom/Operation Iraqi Freedom while creating a referral network of services for post-deployment readjustment assistance. The group developed resource materials for returning veterans with mental health needs, substance abuse disorders, traumatic brain injury, and homeless veterans and family members, including children of military families. Since this collaborative work began in 2008, efforts have spanned from combat veterans to all veterans, active duty as well as reservist and the National Guard.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet services needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data set including, but not limited to, the [National Survey on Drug Use and Health](#) (NSDUH), the [Treatment Episode Data Set](#) (TEDS), the [National Facilities Surveys on Drug Abuse and Mental Health Services](#), the annual [State and National Behavioral Health Barometers](#), and the [Uniform Reporting System](#) (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance abuse prevention, and substance abuse treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase behavioral health services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

[SAMHSA's Behavioral Health Barometer](#) is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the [National Survey of Substance Abuse Treatment Services](#) (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the [Behavioral Health Barometers](#). States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the [Healthy People Initiative](#)¹⁸ HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

¹⁸ <http://www.healthypeople.gov/2020/default.aspx>

Footnotes:

Step 2: Identify the unmet service needs and critical gaps within the current system.

Responses to *Criterion 2: Mental Health System Data Epidemiology (Estimate of Prevalence and Quantitative Targets)* and *Criterion 4 (Targeted Services to Rural and Homeless, and Older populations)* and *Criterion 5: Management Systems* are included in our identification of unmet service needs and critical gaps within the current service system. Our primary data sources are the Uniform Reporting System (URS) tables required for the CMHS Block Grant, our paid claims data base for federal and state funds, the Client Data Warehouse (CDW), and the web-based NC Treatment and Outcomes Performance System (NC TOPPS). Local Management Entities/Managed Care Organizations and service providers provide information on client level demographic characteristics, claims for services, and clinical outcomes to the state data systems cited above.

Estimate of Prevalence and Quantitative Targets. Adults with serious mental illness (SMI) and children and youth with serious mental disorders (SED) constitute the populations of focus of the Community Mental Health Services Block Grant. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) uses prevalence estimates for adults with SMI and children with SED determined by the Federal Government and that are adjusted for state poverty thresholds by the National Research Institute (NRI) of the National Association of State Mental Health Directors (NASMHD) State Data Infrastructure Coordinating Center for the Center of Mental Health Services. About 5.4 percent of the state's adult population and 13.0 percent of children and youth have a diagnosable mental health disorder that meets the Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria accompanied by serious role impairment that has lasted for at least twelve months and puts the individual at risk for out-of-home placement.

With a population estimate of 9,943,964 residents for 2014, North Carolina has the eighth largest population among 50 states, ranking eighth in population change between 2010-2014 (<http://www.census.gov/popest/data/state/totals/2014/index.html>). Adults make up about 75.6 percent (7,517,637) of the total population of which 405,952 have serious mental illness based on the SMI prevalence estimate of 5.4 percent. Children and youth make up close to a quarter (24.4%) of the whole population. Based on the prevalence estimate (13%) for the state, North Carolina had a total of 315,423, children and youth with SED in 2014 (<http://www.census.gov/popest/data/state/asrh/2014/index.html>).

Unmet service needs and critical gaps. The SMHA served a total of 203,196 individuals diagnosed with psychiatric disorders in community-based settings in SFY 2012 (URS Tables, Table 3. Profile of Persons Served in the Community Mental Health Setting, State Psychiatric

Hospitals, and Other Settings (URS Tables. Table 14A. Profile of Persons with SMI/SED Served by Age, Gender, and Race/Ethnicity). Of this number 122,000 met the criteria for SMI and 40,732 met the criteria for SED. Thus, the state treated only 30.7 percent of 397,916 adult North Carolinians estimated to have SMI and only 13.1 percent of the 309,824 NC children and youth estimated to have SED.

Older populations. The U.S. Census Bureau estimates that nearly 23 percent of North Carolina's population will be over age 60 by the year 2030, an increase of more than 26 percent from 2012. Of the state's residents, 31.9 percent are over 50, 18.6 percent are over 60, 8.7 percent are over 70, and 3.3 percent are over 80. The proportion of North Carolina's population that is 60 and older is growing more rapidly than other components of the population.

Older groups are largely underrepresented among adults served through DMHDDSAS, Individuals 65 and over comprise about 13.1 percent of the general adult population (<http://www.census.gov/popest/data/state/asrh/2011/index.html>); however, only 3.3 percent were served through the public mental health system (2012 CMHS Block Grant, URS Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity). DMHDDSAS currently funds 18 Geriatric Adult Mental Health Specialty Teams to increase the ability of people with mental illness to live successfully in their communities. The team consists minimally of a therapist and a registered nurse, both with experience working with the population. The team provides training and consultation to staff working in adult care homes, home health care agencies, and senior centers as well as community organizations and program staff that support older adults with mental illness to remain in their community.

DMHDDSAS and the Division of Aging and Adult Services (DAAS) co-lead the NC Mental Health and Aging Coalition, the mission of which is to focus on the mental health needs and substance use of older adults, build community capacity, and support advocacy and action. In the past year, SAMHSA and the Administration on Aging sponsored a Regional Policy Academy focused on the issues and challenges around behavioral health for older adults. The NC Team that attended the academy consisted of professionals from DMHDDSAS, DAAS, and DMA who together developed a plan to bring awareness and education to community partners to begin conversations to address issues related to suicide, depression/anxiety, alcohol, and prescription and other drug use and misuse among older adults. DMHDDSAS has included a Peer Support Specialist Certificate opportunity to engage older adults in recovery from mental health issues to provide peer support and mentoring to their cohorts.

Rural populations. The Community Mental Health Services Block Grant provides services to adults with serious mental illness and co-occurring disorders and to children with

serious emotional disorders and co-occurring disorders who live in rural areas where close to one-fourth of the state's residents reside. The state has typically served more people with mental health disorders in rural areas. For instance, the State Mental Health Agency (SMHA) delivered mental health services to 344 adults per 10,000 and 304 children or youth per 10,000 residing in rural counties. About 266 adults per 10,000 and 293 children and youth per 10,000 were served in metropolitan areas in the same fiscal year. DMHDDSAS, in collaboration with the Medicaid agency, the Office of Rural Health and Community Care, and the Local Management Entities/Managed Care Organizations, have engaged in several efforts to increase access to mental health and substance abuse services throughout the state. These include the expansion of telepsychiatry services, walk-in centers, and mobile crisis teams. DMHDDSAS further has an ongoing contract with the School of Nursing in the University of North Carolina at Chapel Hill to provide tuition-assistance to psychiatric mental health nurse practitioners graduate students. In return for the funding, the students agree to find employment to serve consumers in underserved areas of the state. Recruitment and training of rural mental health professionals is also being addressed as part of the state's current workforce initiative.

Homeless populations. The NC Coalition to End Homelessness, a statewide non-profit organization, holds a point-in-time count of the homeless over a 24-hour period in the last week of January each year. Results for the 2014 count showed 11,448 people living in sheltered (emergency, seasonal, or transitional) and unsheltered settings, an decrease of 2,154 from the previous year. Of the homeless adults, 2166 had serious mental illness while 2719 had substance use disorder. A total of 469 had been discharged from a mental health hospital or a substance abuse program in the thirty days preceding the point-in-time count.

About 10 percent of homeless adults were veterans. Projects for Assistance in Transition from Homelessness (PATH), a federal grant program administered by the state, provides outreach to individuals who are homeless and who have mental illness or co-occurring mental and substance abuse disorders.

Needs of the military and veterans. In 2008 the Rand Center for Military Health and Policy Research published "Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery" that focused on post-traumatic stress disorder, major depression, and traumatic brain injury as the invisible wounds service men and women incurred because of war. The monograph included a report from a telephone survey of 1,695 individuals who had been previously-deployed in Operations Enduring Freedom and Iraqi Freedom (OEF/OIF) that found mental and cognitive problems in about a third of the respondents with 11.1 percent having a mental health condition only (PTSD or depression, no TBI), 7.3 percent having a mental health condition combined with TBI, and 12.2 percent, having

TBI only. PTSD, depression and TBI have immediate and long-term consequences for the individual, society, and the economy. And yet, close to 60 per cent of those with TBI had not been evaluated for their injury and only about 53 percent of those with PTSD or depression had gone to doctor or clinician for help. Confidentiality, availability of providers, and lack of evidence-based practices were cited as the most common barriers to treatment (http://www.rand.org/content/dam/rand/pubs/monographs/2008/RAND_MG720.pdf).

North Carolina is home to a large number of active military, National Guard and Reserves, veterans, and military families, ranking third in the country on this criterion. In a recent study, the NC Institute of Medicine noted that 35% of North Carolinians have some relationship to the military. The number of reserve component members in the state sum up to 22,000. A total of 116,000 are in the active military, while a total of 766,000 are veterans, and 190,896 are dependents of service members. Forty-three percent of service member families include children and youth. Based on the estimates of 14 percent for PTSD, 14 percent for major depression and 18.5 percent for TBI established in the Rand study cited above, 107,240 would have PTSD, another 107,240 would have major depression and 141,710 would have TBI among the veteran population alone.

DMHDDSAS serves the needs of the military primarily through the NC Focus on Service Members, Veterans, and their Families, a project that it supports. NC Focus promotes evidence-based and best practices in the screening, assessment, and treatment of active duty, National Guard, reservists, and veterans who served in the military and their families.

Race/Ethnic Disparities. Blacks or African Americans are over-represented in the mental health public service delivery system, more so among children and youth than adults. The Hispanic or Latino population currently constitutes 8.9 percent of the total population of North Carolinians. North Carolina has the highest growth rate in Hispanic or Latino population in the nation. The growth of Hispanics or Latinos highlights a need for service providers to examine barriers that residents who are Hispanic may encounter when seeking services. Many area programs are attempting to hire Spanish speaking staff, but others still rely on using interpreters when providing services.

In summary, the CMHS Block Grant will continue to provide services to the populations identified by statute who continue to be in need of services. The grant will focus on serving (a) children and youth with Serious Emotional Disorders (SED) and their families and (b) adults with serious mental illnesses (SMI). It will also continue its focus on priority populations with or at risk for SED and SMI to which it is currently providing services using state and/or federal funds. The state priority groups are the following:

- For mental health
 - those who are deaf and hard of hearing
 - those who are homeless
 - military veterans and their families
- Co-occurring disorders
 - Children and youth with co-occurring disorders
 - Adults with co-occurring disorders

DMHDDSAS has submitted a grant application to SAMHSA for the SOC Expansion Planning Grant that will highlight the needs of American Indians/Alaska Natives, Hispanics or Latinos, military personnel (active, guard, and reserve and their families, LGBT (Lesbian, Gay, Bisexual, and Transgendered) populations and other un- or underserved populations, including the elderly).

DMHDDSAS, Local Management Entities, the NC Mental Health Planning and Advisory Council, Consumer and Family Advisory Committees, the NC Institute of Medicine task forces, and advocacy groups conducted surveys in 2010 to determine unmet service gaps and priorities in the public mental health and substance use service delivery system, the results of which fall into six themes that provided direction to the identification of unmet needs and the prioritization of planning activities. The themes are:

- *Long Term Supports for Independence and Recovery*, including emergency services, affordable medications, primary healthcare, housing, employment, and other supports for community living.
- *Quality and Accountability*, including comprehensive assessments, the use of evidence-based practices, performance tracking, and efficient data systems.
- *Workforce Development*, including provider trainings in core and specialty areas, especially from consumers' and families' perspectives, and residency rotations in mental health, substance abuse and developmental disabilities.
- *Expansion of Services*, particularly for rural areas, trauma-informed care, dual disability services, and community inpatient services.
- *Services for Vulnerable Populations*, including people who are deaf and hard of hearing, people undergoing transitions, very

young children and their families, women and girls, youth who are at high risk, people who are homeless, people with justice system involvement and people with chronic illnesses

- *Leadership and System Management*, including State and local disability-specific specialists, interagency collaboration and cooperation, use of effective funding policies, and support for consumers' participation in policy decisions.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's [NBHQF](#). The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at <http://www.samhsa.gov/data/quality-metrics/block-grant-measures>. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?
4. If not, what changes will the state need to make to be able to collect and report on these measures?

Please indicate areas of technical assistance needed related to this section.

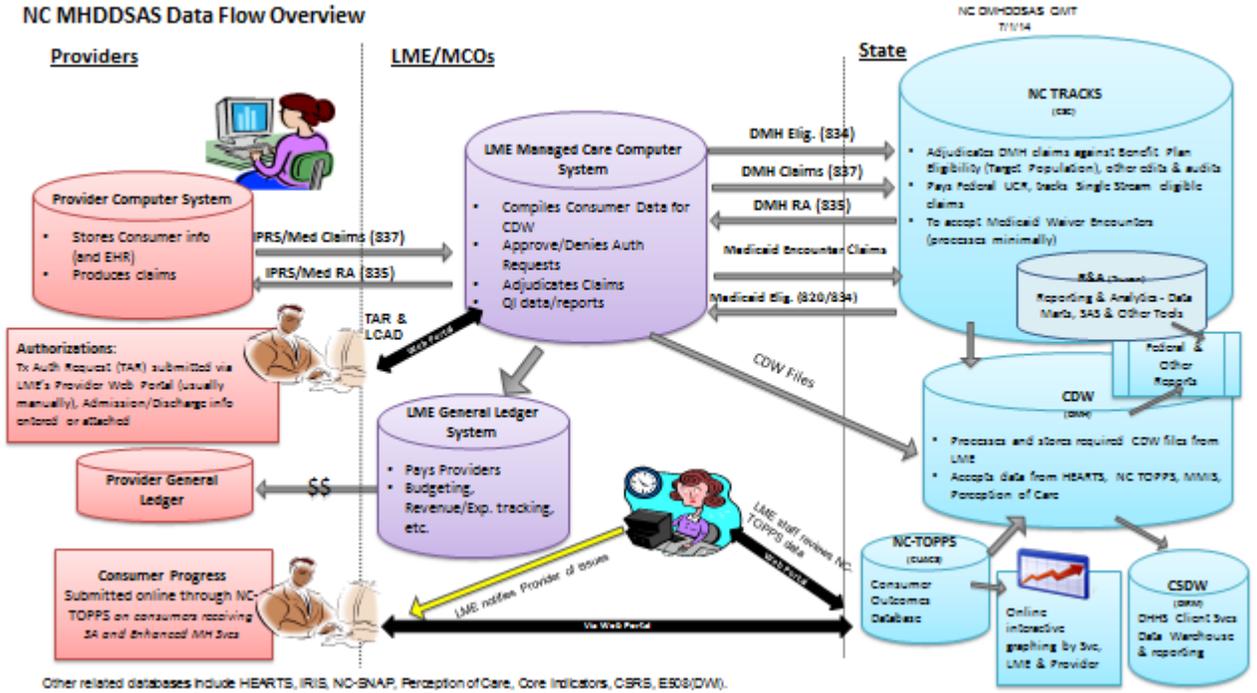
Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

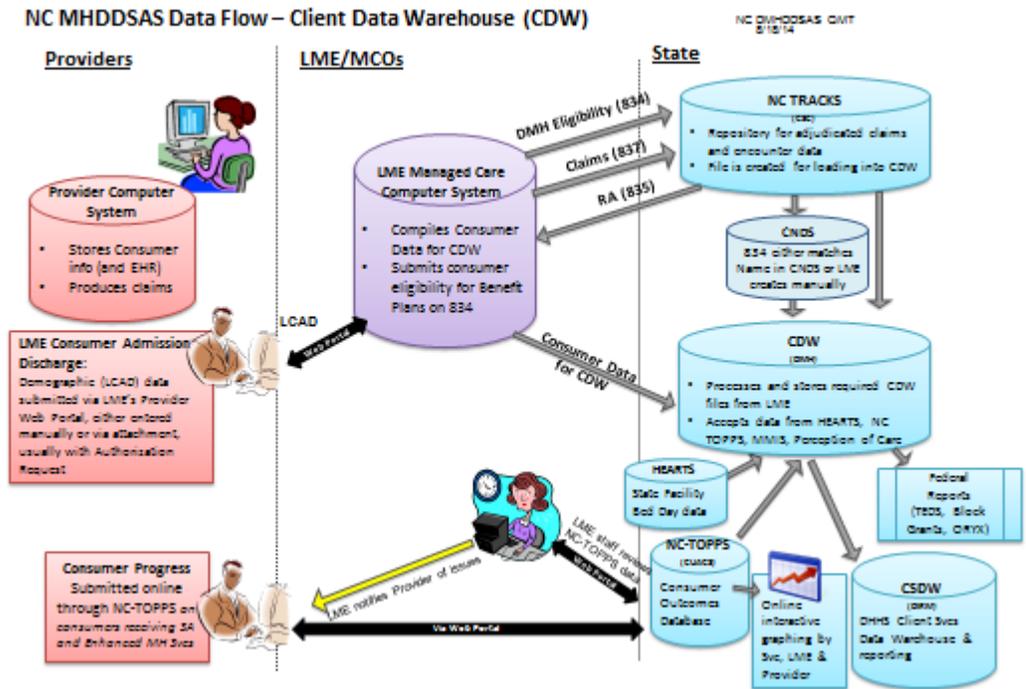
Quality and Data Collection Readiness

1) State's Data and Reporting Process Overview

NC MHDDSAS Data Flow Overview



NC MHDDSAS Data Flow – Client Data Warehouse (CDW)



2) The DMH/DD/SAS current data process is a large combined data system. It includes the populations of mental health services clients and substance abuse consumers, in addition to

providing data on Developmentally Disabled individuals and those suffer from Traumatic Brain Injury.

- 3) The state's current data system is able to collect and report measures at the individual client level, with full protection of client identifying information.
- 4) The state does not need to make any changes to the existing data system at this time to collect information at the individual client level.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1
Priority Area: Community Integration
Priority Type: MHS
Population(s): SMI, SED

Goal of the priority area:

- 1) Increase access to community-based services.
- 2) Reduce need for inpatient care.
- 3) Partner with people with mental health and co-occurring disorders to provide direction to the public service delivery system at the systemic and individual levels and to participate and guide their treatment.

Objective:

Adults with serious mental illness, children and youth with serious emotional disorders, and people with substance use disorders and co-occurring disorders, can develop their full potential if they live with freedom and dignity in the least restrictive setting and in the community of their choice.

Strategies to attain the objective:

- 1) Enhance community based services, strengthen system of care for children with SED and co-occurring disorders and their families, ensure post discharge planning.
- 2) Planning efforts will focus on increasing the representation of consumers and their families in decision making bodies and the participation of consumers and their families in treatment planning.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Number served in the community
Baseline Measurement: 166,000 individuals were served in the community.
First-year target/outcome measurement: 167,000 SMI adults and SED children served (SFY 2014)
Second-year target/outcome measurement: 168,000 SMI adults and SED children served (SFY 2015)

Data Source:

Medicaid, federal, state, and other paid claims

Description of Data:

Payments made to service providers for publicly funded community based mental health services

Data issues/caveats that affect outcome measures::

Managed care organizations are using LOCUS/CALOCUS scales to measure levels of care which would also have an impact on the way that SMI and SED will be defined.

Indicator #: 2
Indicator: Reduced re-admissions to state psychiatric hospitals (30 days)
Baseline Measurement: 13.3 percent were re-admitted to a state psychiatric hospital within 30 days of discharge.
First-year target/outcome measurement: No more than 12.5 percent will be re-admitted to a state psychiatric hospital within 30 days after discharge.
Second-year target/outcome measurement: No more than 12 percent will be re-admitted to a state psychiatric hospital within 30 days of discharge.

Data Source:

State hospital records

Description of Data:

The clinical record held within the state hospital setting will include a running record of hospital usage for an individual.

Data issues/caveats that affect outcome measures::

Indicator #:

3

Indicator:

Reduced re-admissions to state psychiatric hospitals (180 days)

Baseline Measurement:

15.6 percent were re-admitted to a state psychiatric hospital with 180 days after discharge.

First-year target/outcome measurement:

No more than 15 percent will be re-admitted to a state psychiatric hospital within 180 days of discharge.

Second-year target/outcome measurement:

No more than 14.5 percent will be re-admitted to a state psychiatric hospital within 180 days of discharge.

Data Source:

State psychiatric hospital admission records

Description of Data:

State hospitals track admission patterns of each individual that utilizes the facility.

Data issues/caveats that affect outcome measures::

Indicator #:

4

Indicator:

The number/percent of consumers and their families in decision making bodies/advisory committees

Baseline Measurement:

Consumers and parents were represented in 25 decision-making bodies/advisory committees.

First-year target/outcome measurement:

Consumers and parents will be represented in at least 30 decision making bodies/advisory committees

Second-year target/outcome measurement:

Consumers and parents will be represented on at least 40 decision making bodies/advisory committees

Data Source:

Family and youth surveys

Description of Data:

Surveys of family and youth organizations on the State Collaborative

Data issues/caveats that affect outcome measures::

Sample will not be representative; data will be based on self reports.

Priority #:

2

Priority Area:

Recovery Support Services

Priority Type:

MHS

Population(s):

SMI, SED

Goal of the priority area:

North Carolina

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To assist adults who have mental health and/or substance use problems, and children with SED and co-occurring disorders and their families to have a safe and stable home in a safe neighborhood, to have meaningful work, and to be a contributing member of society.

Objective:

Adults with serious mental illness, children and youth with serious emotional disorders, and people with substance use disorders and co-occurring disorders recover from the symptoms of mental illness and/or substance abuse as supported by a strong body of empirical evidence. Recovery support means partnering with people who have mental health and/or substance problems to provide direction to the public delivery system at the systemic and individual levels. SAMHSA has identified four elements- health, home, purpose, and community- that are essential to recovery. To facilitate and sustain recovery, people with mental illness and substance abuse need to have services and supports to be healthy, to have a safe and stable home in a safe neighborhood, to have meaningful work, and to be a contributing member of society.

Strategies to attain the objective:

Strengthening and developing supported employment, supportive housing, peer supports and recovery specialists, transition, maintenance and aftercare services that people with mental health, substance use problems and/or co-occurring disorders need to maintain their recovery and develop resiliency.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Proportion of adults reporting participation in treatment planning
Baseline Measurement: 82% of adults reported participating in their treatment plan
First-year target/outcome measurement: 82% of adults will report participating in their treatment plan
Second-year target/outcome measurement: 85% of adults will report participating in their treatment plan.

Data Source:

Mental Health Statistics Improvement Program (MHSIP) Perception of Care surveys (consumer satisfaction survey)

Description of Data:

Surveys of family and youth conducted by DMH/DD/SAS

Data issues/caveats that affect outcome measures::

Sample is not representative; data are based on self-reports

Indicator #: 2
Indicator: Proportion of families/guardians reporting participation in their children's treatment
Baseline Measurement: 81% of families/guardians reported participating in their children's treatment plan
First-year target/outcome measurement: At least 82% of families/guardians will report participating in their children's treatment plan.
Second-year target/outcome measurement: At least 85% of families/guardians will report participating in their children's treatment plan.

Data Source:

Mental Health Statistics Improvement Program (MHSIP) Perception of Care surveys (consumer satisfaction survey)

Description of Data:

Surveys of family and youth conducted by DMH/DD/SAS

Data issues/caveats that affect outcome measures::

Sample is not representative; data are based on self reports.

Indicator #: 3
Indicator: Proportion of adult consumers receiving supported employment (long term support,

supported employment group, supported employment individual)

Baseline Measurement: A total of 371 adult consumers received supported employment

First-year target/outcome measurement: At least 400 adult consumers will receive supported employment.

Second-year target/outcome measurement: At least 500 adult consumers will receive supported employment

Data Source:

Medicaid, federal, state and other paid claims

Description of Data:

Payments made to service providers for publicly funded community based mental healths services

Data issues/caveats that affect outcome measures::

Indicator #:

4

Indicator:

Number of adults consumers receiving residential or living supports in the community (family living, group living, home supports, independent living, residential supports).

Baseline Measurement:

A total of 1,224 adult consumers received residential or living supports in the community.

First-year target/outcome measurement:

A total of 1,250 adult consumers will receive residential or living supports

Second-year target/outcome measurement:

At least 1500 adult consumers will receive residential or living supports

Data Source:

Medicaid, federal, state or other paid claims

Description of Data:

Payments made to service providers for publicly funded community based mental health services

Data issues/caveats that affect outcome measures::

Priority #:

3

Priority Area:

Primary and Behavioral Health Integrated Health Care

Priority Type:

MHS

Population(s):

SMI, SED

Goal of the priority area:

To address the primary health care needs of adults with SMI and children with SED.

Objective:

People with mental illness have morbidity rates that are higher than those of the general population. Their lifespan is also considerably shorter. Analyses of the NC Mental Health Statistics Improvement Program (MHSIP) perception of care surveys that now include health questions show higher prevalence of asthma, diabetes, and cardiovascular disorders among individuals with psychiatric and substance use disorders compared to the general populations as measured by the NC Behavioral Risk Factors Surveillance Surveys (NC BRFSS). The focus of planning activities for this priority will be two-pronged:(1) Treatment- where the individuals with mental health and substance use issues are treated for chronic illness and where people with chronic illnesses are treated for mental health and substance use issues; and (2) prevention- where healthy lifestyles are promoted and the effects of medication are monitored for their physical and other side effects.

Strategies to attain the objective:

Support the promotion of health lifestyles and manage chronic conditions common to adults with SMI and children with SED.

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator: Number of adult consumers in wellness education programs
Baseline Measurement: 21 adult consumers received wellness education
First-year target/outcome measurement: At least 50 adult consumers will receive wellness education
Second-year target/outcome measurement: At least 100 adult consumers will receive wellness education

Data Source:

Medicaid, federal, state, and other paid claims

Description of Data:

Payments made to service providers for publicly funded community based mental health services

Data issues/caveats that affect outcome measures::

Managed Care Organizations are using LOCUS/CALOCUS to measure level of care

Indicator #: 2

Indicator: Number of adult consumers with SMI and youth with SED receiving tobacco cessation counseling

Baseline Measurement: A total of 248 adult consumers with SMI and children with SED received tobacco cessation counseling

First-year target/outcome measurement: At least 350 adults with SMI and children with SED will receive tobacco cessation counseling

Second-year target/outcome measurement: At least 500 adults with SMI and children with SED will receive tobacco cessation counseling

Data Source:

Medicaid, federal, state, other paid claims

Description of Data:

Payments made to service providers for publicly funded community based mental health services

Data issues/caveats that affect outcome measures::

Managed Care Organizations are using LOCUS/CALOCUS scales to measure levels of care

Priority #: 4

Priority Area: Mental Health and Substance Use Services for the military and their families.

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

To address the unmet needs of the military and their families through increased education, prevention, outreach, identification, engagement coordination, and delivery of behavioral health services.

Objective:

North Carolina is home to a large number of active military, National Guard and Reserves, veterans, and military families, ranking third in the country on this criterion. In a recent study, the NC Institute of Medicine noted that 35% of North Carolinians have some relationship to the military. The number of reserve component members in the state sum up to 22,000.

A total of 116,000 are in the active military, while a total of 766,000 are veterans, and 190,896 are dependents of service members. Forty-three percent of service member families include children and youth. Based on the estimates of 14 percent for PTSD, 14 percent for major depression and 18.5 percent for TBI established in the Rand study cited earlier, 107,240 would have PTSD, another 107,240 would have major depression and 141,710 would have TBI among the veteran population alone.

Strategies to attain the objective:

Planning will revolve around training, access to care in integrated practices, school settings, and third party payment.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Number of veterans served through DMD/DD/SAS
Baseline Measurement: A total of 2,717 veterans (out of 215,643 individuals with mental illness served through DMH/DD/SAS) received mental health services
First-year target/outcome measurement: At least 2,717 veterans will receive mental health services
Second-year target/outcome measurement: At least 2,717 veterans will receive mental health services

Data Source:

Client Data Warehouse

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 5
Priority Area: Servicesto Juveniles with SED and Adults with SMI who are involved with the Juvenile and Criminal Justice System.
Priority Type: MHS
Population(s): SMI, SED

Goal of the priority area:

Address the needs of people with mental disorders, substance use disorders, co-occurring disorders, or a history of trauma in the criminal and juvenile justice systems.

Objective:

Studies show that youth with SED and adults with SMI and people with SUD or co-occurring disorders are at high risk for involvement with the law. There is a need to increase the availability of, access to, and effectiveness of community-based interventions and treatments for people who are involved with the criminal justice system so that they do not end up in correctional facilities

Strategies to attain the objective:

Continue collaboration and planning activities with the Department of Correction and Administrative Office of the Courts to improve services and maximize the use of resources for justice involved people with substance use and mental health problems.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Numbers of youth and adults involved with the justice system who are served in the community
Baseline Measurement: 16,301 adult individuals involved with the justice system were served in the community by TASC. 3,256 youth involved with the justice system were served in the community through Juvenile Justice Partnerships.
First-year target/outcome measurement: At least 16,400 adults involved in justice system will be served in the community by TASC. At least 3,200 youth involved with the justice system will be served by Juvenile Justice Partnerships.
Second-year target/outcome measurement: At least 16,500 adults involved with the justice system will be served in the community by TASC. At least 3,200 youth involved in the justice system will be served by Juvenile Justice Partnerships.

Data Source:

NC Treatment and Outcomes Program Performance System (NC TOPPS)

Description of Data:

Data issues/caveats that affect outcome measures::

The SMHA and and SSA are currently merging Managed Care Organization which will result in changes to the provider networks serving these consumers.

Priority #: 6
Priority Area: Trauma Informed Care and other Evidence Based Services
Priority Type: MHS
Population(s): SMI, SED

Goal of the priority area:

To increase the use of Evidence Based Practices

Objective:

Trauma is a widespread, harmful, and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war, and other harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of children, youth and adults receiving treatment for mental and substance use disorders. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Research shows that adults with mental illness and substance use or co-occurring disorders and children and youth with SED and co-occurring disorders recover better if evidence-based practices are used in their treatment

Strategies to attain the objective:

Promoting training on trauma specific interventions and other evidence based practices.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Proportion of adult consumers served by ACT
Baseline Measurement: A total of 6,172 adults received ACT services
First-year target/outcome measurement: At least 6,200 adults with SMI will receive ACT services
Second-year target/outcome measurement: At least 6,250 adults with SMI will receive ACT services

Data Source:

Medicaid, federal, state, and other paid claims

Description of Data:

Payments made to service providers for publicly funded community based mental health services

Data issues/caveats that affect outcome measures::

Managed Care Organizations are currently merging and it could impact on submission of claims

Indicator #: 2
Indicator: Proportion of child/youth consumers served with MST
Baseline Measurement: A total of 1,290 children/youth served received MST.
First-year target/outcome measurement: At least 1,290 children/youth with SED will receive MST
Second-year target/outcome measurement: At least 1,300 children/youth with SED will receive MST

Data Source:

Medicaid, federal, state, and other paid claims

Description of Data:

Payments made to service providers for publicly funded community based mental health services

Data issues/caveats that affect outcome measures::

Manged care organizations currently merging which could impact submission of claims.

Indicator #:

3

Indicator:

Proportion of child/youth consumers with Therapeutic Foster Care

Baseline Measurement:

A total of 3,758 children/youth with SED received TFC

First-year target/outcome measurement:

At least 3,800 children/youth with SED will receive TFC

Second-year target/outcome measurement:

At least 3,850 children/youth with SED will receive TFC

Data Source:

Medicaid, federal, state, and other paid claims.

Description of Data:

Payments made to service providers for publicly funded community based mental health services

Data issues/caveats that affect outcome measures::

Managed Care Organizations are currently merging and it could impact submission of claims.

Priority #:

7

Priority Area:

Reduction of health disparities

Priority Type:

MHS

Population(s):

SMI, SED

Goal of the priority area:

Reduce health disparities among people that have been identified as under served by State Data sources and through national studies.

Objective:

Minority groups tend to be more underserved and to have poorer health outcomes compared to other groups. State data sources show the underrepresentation of female children and youth, adult single males, the elderly, and American Indians and Asians among the people served with mental illness and substance use disorder served by the system

Strategies to attain the objective:

Reduce health disparities by gender, sexual orientation, ethnicity, and race.

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

Reduction in disparities on functional and other outcomes by gender and ethnicity

Baseline Measurement:

First-year target/outcome measurement:

To be developed

Second-year target/outcome measurement:

Data Source:

NC Treatment and Outcomes Program Performance System (NC TOPPS)

Description of Data:

Data issues/caveats that affect outcome measures::

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			\$0	\$0	\$0	\$0	\$0
6. Other 24 Hour Care		\$0	\$0	\$0	\$0	\$0	\$0
7. Ambulatory/Community Non-24 Hour Care		\$22,886,267	\$406,010,322	\$0	\$204,323,648	\$0	\$0
8. Mental Health Primary Prevention**		\$796,898	\$0	\$0	\$0	\$0	\$0
9. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)		\$2,861,702	\$0	\$0	\$0	\$0	\$0
10. Administration (Excluding Program and Provider Level)		\$400,000	\$0	\$0	\$914,430	\$0	\$0
11. Total	\$0	\$26,944,867	\$406,010,322	\$0	\$205,238,078	\$0	\$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

These projected figures have been revised, as per our SAMHSA CMHS Project Officer, to reflect the two-year planning period. The amount reflected above in Column B does not include the amount in Table 6b non-direct service activities, in the amount of \$1,672,147. That amount plus the total in this table equals the entire allotment amount of \$28,617,014.

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Expenditures
Healthcare Home/Physical Health	\$461,000
General and specialized outpatient medical services;	
Acute Primary Care;	
General Health Screens, Tests and Immunizations;	
Comprehensive Care Management;	
Care coordination and Health Promotion;	
Comprehensive Transitional Care;	
Individual and Family Support;	
Referral to Community Services;	
Prevention Including Promotion	\$398,449

Screening, Brief Intervention and Referral to Treatment ;	
Brief Motivational Interviews;	
Screening and Brief Intervention for Tobacco Cessation;	
Parent Training;	
Facilitated Referrals;	
Relapse Prevention/Wellness Recovery Support;	
Warm Line;	
Substance Abuse Primary Prevention	\$
Classroom and/or small group sessions (Education);	
Media campaigns (Information Dissemination);	
Systematic Planning/Coalition and Community Team Building(Community Based Process);	
Parenting and family management (Education);	
Education programs for youth groups (Education);	
Community Service Activities (Alternatives);	
Student Assistance Programs (Problem Identification and Referral);	

Employee Assistance programs (Problem Identification and Referral);	
Community Team Building (Community Based Process);	
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);	
Engagement Services	\$345,430
Assessment;	
Specialized Evaluations (Psychological and Neurological);	
Service Planning (including crisis planning);	
Consumer/Family Education;	
Outreach;	
Outpatient Services	\$1,261,365
Individual evidenced based therapies;	
Group Therapy;	
Family Therapy ;	
Multi-family Therapy;	

Consultation to Caregivers;	
Medication Services	\$
Medication Management;	
Pharmacotherapy (including MAT);	
Laboratory services;	
Community Support (Rehabilitative)	\$1,960,646
Parent/Caregiver Support;	
Skill Building (social, daily living, cognitive);	
Case Management;	
Behavior Management;	
Supported Employment;	
Permanent Supported Housing;	
Recovery Housing;	
Therapeutic Mentoring;	
Traditional Healing Services;	

Recovery Supports	\$
Peer Support;	
Recovery Support Coaching;	
Recovery Support Center Services;	
Supports for Self-directed Care;	
Other Supports (Habilitative)	\$36,335
Personal Care;	
Homemaker;	
Respite;	
Supported Education;	
Transportation;	
Assisted Living Services;	
Recreational Services;	
Trained Behavioral Health Interpreters;	

Interactive Communication Technology Devices;	
Intensive Support Services	\$1,905,613
Substance Abuse Intensive Outpatient (IOP);	
Partial Hospital;	
Assertive Community Treatment;	
Intensive Home-based Services;	
Multi-systemic Therapy;	
Intensive Case Management ;	
Out-of-Home Residential Services	\$320,000
Crisis Residential/Stabilization;	
Clinically Managed 24 Hour Care (SA);	
Clinically Managed Medium Intensity Care (SA) ;	
Adult Mental Health Residential ;	
Youth Substance Abuse Residential Services;	
Children's Residential Mental Health Services ;	

Therapeutic Foster Care;	
Acute Intensive Services	\$944,842
Mobile Crisis;	
Peer-based Crisis Services;	
Urgent Care;	
23-hour Observation Bed;	
Medically Monitored Intensive Inpatient (SA);	
24/7 Crisis Hotline Services;	
Other	\$3,458,833
Total	\$11,092,513

Footnotes:

This table includes services that billed both through fee-for-service, as well as through non-unit cost reimbursement. In the Healthcare Home/Physical Health section, this includes services billed through several E&M codes that are available to practitioners to provide screening/assessment for various medical conditions particularly prevalent in individuals with SMI for whom psychotropic medications are prescribed. The Prevention section includes the Suicide Prevention line, as well as funding for family partners. Medication Services are included in the Healthcare Home/Physical Health section. Outpatient Services includes the 5% set aside for FEP. Recovery supports are included in Table 6b. Funding for peer-operated hospital diversion services is included in the Acute Intensive Services section. The "Other" section includes numerous services under the State's Crisis Solutions Initiative including Behavioral Health Urgent Care & Facility Based Crisis centers, Critical Time Intervention, Community Paramedic Mobile Crisis Management, Mental Health First Aid and Group Home

Planning Tables

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Block Grant
MHA Technical Assistance Activities	\$877,366
MHA Planning Council Activities	\$5,000
MHA Administration	
MHA Data Collection/Reporting	\$149,896
MHA Activities Other Than Those Above	\$639,885
Total Non-Direct Services	\$1672147
Comments on Data:	
<div style="border: 1px solid black; padding: 5px;"> SMHA TA Activities: Governor's Institute and UNC Behavioral Healthcare Resource Program contracts SMHA Data Collection/Reporting: NC State Center for Urban Affairs and Community Services contract Other SMHA Activities: NAMI NC contract and consumer directed services. </div>	
Footnotes:	

Environmental Factors and Plan

1. The Health Care System and Integration

Narrative Question:

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.²⁶ Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but “[h]ealth system factors” such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.²⁷ It has been acknowledged that there is a high rate of co-occurring mental illness and substance abuse, with appropriate treatment required for both conditions.²⁸ Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The [Framingham Heart Study](#) produced the idea of “risk factors” and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence-based practices^{29 30} that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.³¹ Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.³² In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.³³ Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.³⁴ Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.³⁵ In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.³⁶

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.³⁷ Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as federally qualified health centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.³⁸ Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, care, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes³⁹ and ACOs⁴⁰ may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.⁴¹ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.⁴²

One key population of concern is persons who are dually eligible for Medicare and Medicaid.⁴³ Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.⁴⁴ SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.⁴⁵ Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.⁴⁶ SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.⁴⁷ It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.⁴⁸

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.⁴⁹ Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, which includes information and resources to help promote health, good outcomes and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.⁵⁰

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.⁵¹ However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment and recovery support for persons with, or at risk of, mental illnesses and substance use disorders.

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be charged with coordinating care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?
6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

10. Indicate tools and strategies used that support efforts to address nicotine cessation.
 - Regular screening with a carbon monoxide (CO) monitor
 - Smoking cessation classes
 - Quit Helplines/Peer supports
 - Others _____
11. The behavioral health providers screen and refer for:
 - Prevention and wellness education;
 - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
 - Recovery supports

Please indicate areas of technical assistance needed related to this section.

²⁶ BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun;49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bulletin of the World Health Organization*, 2013;91:102–123

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Footnotes:

1. The Health Care System and Integration

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?

North Carolina chose not to expand Medicaid coverage for adults at this time following conversations with CMS and also decided to opt for the federally operated health insurance exchange, but will offer plans through the federal exchange. Block grant and state dollars will therefore continue to be used for people who are uninsured. These funds will also be used to pay for services that are not covered by insurance and Medicaid. Screening and brief interventions for alcohol and drug misuse and depression screening are currently covered if provided by physicians and other medical practitioners in primary care clinics.

2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?

DMH/DD/SAS has a system for monitoring access to mental health and substance use services that is based on payments made by state, Medicaid and other federal sources of funding for appropriate services. DMH and DMA have performance contracts with LME-MCOs. Performance data is shared twice per month with the Secretary of DHHHS. Measures include access to care, timeliness, and transition from hospitals to the community and consumer satisfaction. The Division also plans to expand its role to monitor QHPs in the exchange, including access to care, actual benefit plans and adherence to parity requirements.

3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.

Currently, the Division of Medical Assistance and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services are jointly responsible for monitoring the Local Management Entities-Managed Care Organizations. Each LME-MCO submits data to DMH/DD/SAS on a quarterly basis that measures timely access to services, based on the urgency of the need (emergent, urgent or routine). Any future plans that will be offered through the federal exchange will be monitored by DMH/DD/SAS.

4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations of MHPAEA?

As North Carolina will offer plans through the federal exchange, the Division will work with the federal government to ensure that we have a role in reviewing complaints. DMHDDSAS will collaborate with the Office of the Insurance Commissioners to review complaints. The Consumer Services Section of DMHDDSAS offers telephone and face to face support for consumers and families and will monitor complaints related to MHPEA. Provider organizations have hosted training with Carol McDaid regarding final parity rules and conducted planning to monitor implementation. The NC Institute of Medicine recently hosted a presentation by NCBCBS/Magellan regarding their implementation of the new rules.

5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

The essential health benefit is a basic benefit; therefore North Carolina will continue to pay for services not covered that are believed to be essential to the overall stabilization and recovery of individuals, such as recovery support services. The MH service array offered by the state Medicaid plan is robust and exceeds services required in the essential benefit

6. Is the SSA/SMHA involved in the various coordinated care initiatives in the state?

Primary care and behavioral health care integration activities in DMH/DD/SAS have revolved around collaboration between the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS) and Local Management Entity-Managed Care Organizations (LME-MCOs) in cooperation with Community Care of North Carolina (CCNC). CCNC is at the center of a vibrant partnership between the NC Department of Health and Human Services (DHHS) and 14 independent medical care networks consisting of 4,500 physicians in 1,360 primary care practices. CCNC currently provides a health home for approximately 1.27 million Medicaid patients in North Carolina.

CCNC and LME-MCOs meet regularly at the local level to collaborate on care coordination for individuals with severe mental health and substance use disorders and other chronic medical conditions.

DMH/DD/SAS has been successful in being awarded a five year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) for the design and implementation of a state-level SBIRT (Screening, Brief Intervention, and Referral to Treatment) program to address alcohol and substance use concerns of patients at primary care sites affiliated with CCNC. This project is a collaboration of DMH/DD/SAS, the Governor's Institute on Substance Abuse and CCNC. Over the course of the project, NC plans to serve over 37,000 adults across 13 counties, with the subsequent intent to expand to all 14 CCNC networks. In these locations, patients who are identified with a potential alcohol or substance use disorder are administered alcohol and drug screening tools, are also assessed for depression and other mental health disorders, and as appropriate are provided education, intervention, or referral to treatment provided by licensed behavioral health clinicians on-site (at the primary care practice), or are referred for behavioral health treatment at specialty provider agencies.

DMH/DD/SAS, in cooperation with the Division of Medical Assistance, has a CMS approved plan to offer services through primary care health homes that coordinate behavioral health care through the LME-MCOs. The Kate B. Reynolds foundation funds demonstration projects to explore models of integrated care in MH provider agencies and funds the Center for Excellence for Integrated Care to provide technical assistance for behavioral health providers seeking to improve integration. Performance contracts with LME-MCOs and providers include the requirement to monitor annual visits with a primary care providers.

Additionally, Dr. Courtney Cantrell, Director of the Division of MH/DD/SAS is the designated lead staff for integrated care initiatives across all divisions within the NC Department of Health and Human Services. She chairs various workgroups to assure coordination of integrated care strategies, as well as to establish common performance indicators and measures specific to integrated care.

7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices and the publicly funded behavioral health providers?

In 2011, DMH/DD/SAS was awarded a five-year \$8.33 million grant from SAMHSA for funding to design and implement a state-level SBIRT (screening, brief intervention, referral and treatment) program in NC.

This project is a collaboration of DMH/DD/SAS, the Local Management Entities-Managed Care Organizations of CenterPoint Human Services and Sandhills, the Governor's Institute on Substance Abuse, Community Care Network of North Carolina, and several providers including Daymark Recovery Services, Insight and Robeson Health Care Corporation. Five primary care practices affiliated with CCNC and three sites of Robeson Health Care Corporation, a Federally Qualified Health Center, are currently implementing SBIRT. Each site has an onsite clinician providing brief intervention, brief treatment, and referral to treatment. At the end of its fourth year, NC SBIRT provided more than 25,000 screening on alcohol and drug use, delivered on-site interventions and referrals to about 1,000 patients with substance use and co-occurring disorders. Outcomes have been consistently positive. Rates for alcohol use and drug use have decreased, the changes being statistically significant. Psychological well-being has improved; the number of days when participants felt depressed or anxious have gone down as shown by follow-up interviews for the sixth month follow-up and discharge samples. Participants have also reported decreases in trauma-related symptoms such as nightmares, situation avoidance, numbness and detachment between baseline and follow-up interviews. The number of ER visits also declined significantly.

8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?

Yes, the Division has been actively working with the Division of State Operated Health Facilities (DSOHF) and the Division of Public Health to support an increase in nicotine dependence treatment in state facilities (psychiatric hospitals, developmental centers, alcohol and drug abuse treatment centers), as well as in other public and private treatment facilities. DSOHF, in collaboration with the University of North Carolina at Chapel Hill, received a grant in 2011 from the Pfizer Medical Group to implement a Quality Improvement Project with two treatment facilities to integrate nicotine dependence treatment into their systems. With support from DPH, an online Tobacco Dependence Training Program was created that addresses tobacco use treatment integration into chemical dependence services; assessment diagnosis and pharmacotherapy; behavioral interventions; treatment planning and practical applications. The Division will work with DPH to disseminate this training to providers across the state.

Additionally, in 2011, NC became one of SAMHSA's Leadership Academies for Wellness and Smoking Cessation. Through this effort, a diverse group of stakeholders including treatment providers came together to create an action plan for reducing the prevalence of tobacco use among behavioral health consumers. The partners adopted the target to reduce smoking prevalence among the general population to 16%; adult mental health clients to 39%; and adult substance abuse clients to 39%, each by end of year 2016. This initiative named Breathe Easy NC is working on the following strategies: 1) Facilities, 2) Provider Education and Quitline, 3) Consumers and Community, 4) Policy Systems Performance Measures and Outcomes and 5) Sustainability. Each strategy group is working on specific tasks to be completed over the next year. The stakeholders meet annually in September to assess progress in achieving its established targets. The Facilities and Provider Education/Quitline committees have been working to offer nicotine dependence training and 5 A's Training for providers. They also have presented on tobacco dependence treatment in conferences such as the Addiction Professionals of NC and webinars. The SSA has also been routinely promoting the use of the Quitline NC to providers across the state not only to assist their clients with quitting their tobacco use, but for their staff as well.

9. What agency/system regularly screens, accesses, and addresses smoking among persons served by the behavioral health system?

In addition to the above, NC DHHS also provides routine screening and assessment, and provides treatment options for smoking cessation and for other unhealthy behaviors for patients at state operated psychiatric and addictions treatment facilities.

10. Indicate tools and strategies used that support efforts to address nicotine cessation.

- Regular screening with a carbon monoxide (CO) monitor
- Smoking cessation classes
- Quit Helplines/Peer supports
- Others _____

11. The behavioral health providers screen and refer for:

- Prevention and wellness education
- Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
- Recovery supports

The Division of Medical Assistance requires through Clinical Coverage Policy 8-C, that all comprehensive clinical assessments include information on an individual's chronological general and medical health history and current issues, as well as current medications for physical conditions. These assessment requirements are applicable for all consumers and adherence is reviewed and monitored annually through block grant monitoring reviews.

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)⁵², [Healthy People, 2020](#)⁵³, [National Stakeholder Strategy for Achieving Health Equity](#)⁵⁴, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, and people living with HIV/AIDS or other chronic diseases/impairments) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).⁵⁵

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The top Secretarial priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."⁵⁶

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.⁵⁷ This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations.⁵⁸ In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the population they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

Please indicate areas of technical assistance needed related to this section.

⁵²http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵³<http://www.healthypeople.gov/2020/default.aspx>

⁵⁴<http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf>

⁵⁵<http://www.ThinkCulturalHealth.hhs.gov>

⁵⁶http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵⁷<http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208>

⁵⁸http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

2. Health Disparities

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?

The North Carolina Division of MH/DD/SAS currently tracks access to or enrollment in services and types of services received by race, ethnicity, gender and age through the Uniform Reporting System tables that are required by the CMHS Block Grant. We do not currently have a mechanism for tracking language services and LGBTQ and will seek technical assistance for adding these fields in our data collection system.

2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.

The Cultural Competency Plan is a process to help further develop and oversee a culturally responsive and sensitive community behavioral health system. Its goal is to provide objectives and actions as well as provide guidance on implementation of the objectives and actions. The DMH/DD/SAS system is one where effective treatment and appropriate services are provided to those served in a culturally competent manner while maintaining the highest level of clinical competency required. We believe that increased cultural competency sensitivity will help to increase the level of clinical competency in the state behavioral health system.

The intention of the Cultural Competency Plan is to ensure the diverse cultural and linguistic needs of those we serve are met and systems policies and procedures reflect those same diverse needs. The plan will offer guidance to the Division by making a series of recommendations that will positively impact the people we serve and further supporting the overall success of the Division. It is believed that this plan will motivate the System in integrating cultural factors into clinical care and assist mental health, developmental disability and substance use disease professionals with broadening their awareness of culture and embracing and respecting diversity.

3. Are linguistic disparities/language barriers identified, monitored, and addressed?

The LME-MCOs capture data specific to English language proficiency as well as primary language designation. Additionally, there is data collected that attempts to determine how well the person served was able to understand their interaction with providers. These data points can be analyzed and evaluated to further determine how well linguistic differences are being addressed. They can also be used to determine gaps and whether there are any required next steps.

4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.

The LME-MOCs translate many of their documents and website materials to ensure that non-English speaking clients are able to access and understand the publicly funded behavioral health system and also make an effort to have bilingual staff available to assist with communication. Each LME-MCO operates a 24-7-365 call center and each is required to have interpreting services available for any calls that come in from individuals who do not speak English. All of the LME-MCOs contract with language interpreting service providers that offer a vast number of languages and that are available within a few seconds after the LME-MCO call center receives a call and identifies a need for an interpreter. In

addition, all LME-MCOs must offer TTY or other similar type services for individuals who are deaf or hard of hearing. LME-MCOs further have responsibility that the linguistic and cultural needs of populations within their catchment areas are met through contractual agreements with behavioral health providers who are competent in identified languages and cultures.

5. Is there state support for cultural and linguistic competency training for providers?

In its contract/performance agreement with all LME-MCOs, the Division of MH/DD/SA Services requires that each LME-MCO annually complete an assessments of community need, provider capacity, gaps in services and strategic plans to identified address gaps. As per the contract, “The LME-MCO shall conduct a community need and provider capacity assessment during the first quarter of this contract, using a standardized process and reporting format defined by the Secretary. The assessment shall take into consideration the population in the catchment area, identified gaps in the service array, including gaps for underserved populations, perceived barriers to service access, and the number and variety of age-disability providers for each service. The assessment shall include input from consumers, families, community stakeholders, and CFAC. In evaluating the adequacy of the provider community the LME-MCO shall consider issues such as the cultural and linguistic competency of existing providers and provisions of evidence based practices and treatments and the availability of community services to address housing and employment issues.”

Under the terms of this Contract, the DHHS delegates the authority to develop and manage a qualified provider community in accordance with community needs including enrollment, disenrollment, and certification of providers including assessment of qualifications and competencies in accordance with applicable state and federal rules, standards and the provider qualifications established by the LME-MCO and deemed necessary for the effective provision of quality services. The Division of MH/DD/SA Services, in collaboration with the Division of Medical Assistance, reviews the gaps analyses completed by the LME-MCOs and provides feedback, recommendations and approval of their plans to address identified needs. Each LME-MCO receives both administrative and direct services funding. Administrative funds are often utilized by the LME-MCOs to facilitate and provide training to their contracted behavioral health providers in areas and topics necessary to assure the needs of the populations are met. This can include training in linguistic and cultural competence.

Environmental Factors and Plan

3. Use of Evidence in Purchasing Decisions

Narrative Question:

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including mental health and substance abuse services. Over the past several years, SAMHSA has received many requests from CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance abuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states use of the block grants for this purpose. The NQF and the Institute of Medicine (IOM) recommend that evidence play a critical role in designing health and behavioral health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP⁵⁹ is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with (SED). The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General⁶⁰, The New Freedom Commission on Mental Health⁶¹, the IOM⁶², and the NQF.⁶³ The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."⁶⁴ SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocols (TIPs)⁶⁵ are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)⁶⁶ was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding mental health and substance abuse services.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
 - a. Leadership support, including investment of human and financial resources.
 - b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
 - c. Use of financial incentives to drive quality.

- d. Provider involvement in planning value-based purchasing.
- e. Gained consensus on the use of accurate and reliable measures of quality.
- f. Quality measures focus on consumer outcomes rather than care processes.
- g. Development of strategies to educate consumers and empower them to select quality services.
- h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.
- i. The state has an evaluation plan to assess the impact of its purchasing decisions.

Please indicate areas of technical assistance needed related to this section.

⁵⁹ [Ibid, 47, p. 41](#)

⁶⁰ United States Public Health Service Office of the Surgeon General (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

⁶¹ The President's New Freedom Commission on Mental Health (July 2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

⁶² Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*. Washington, DC: National Academies Press.

⁶³ National Quality Forum (2007). *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*. Washington, DC: National Quality Forum.

⁶⁴ <http://psychiatryonline.org/>

⁶⁵ <http://store.samhsa.gov>

⁶⁶ <http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

3. Use of Evidence in Purchasing Decisions

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.

The Division of MH/DD/SAS established the North Carolina Practice Improvement Collaborative (NC PIC) in 2005 to review evidence-based or promising practices and assess their applicability to the system of care in North Carolina. NC PIC is composed of state agency personnel, academicians and providers specializing in the fields of mental health, developmental disabilities and substance use disorders. The Deputy Director of Community Policy Management, DMH/DD/SAS, was integral to the creation of this professional collaborative and continues to function as the Project Manager.

In 2013, the Adult Mental Health (AMH) section within the Division was expanded to include the hiring of three evidence based practice specialists. The AMH team was able to add an additional four staff in the fall of 2014. Two of these staff serve as subject matter experts on ACT, and are trained as lead TMACT (Tool for the Measurement of Assertive Community Treatment) evaluators. Two other staff are identified as subject matter experts on Individual Placement Support-Supported Employment, and are trained as lead IPS-SE fidelity reviewers. One staff is both an ACT and IPS-SE subject matter expert. The remaining two staff provide data support, technical assistance and assistance with the development of trainings and learning collaboratives for providers, LME-MCO staff and individuals/family members.

Additionally, all lead subject matter experts are also knowledgeable in other evidence based practices, including: Seeking Safety, Motivational Interviewing, Cognitive Behavioral Therapy, Wellness Recovery Action Planning, Wellness Management and Recovery and eCPR. The AMH team regularly identifies ways to improve the service delivery system by identifying evidence based and promising practices that can enhance and strengthen the adult mental health service array.

Finally, the AMH team is responsible for completing and tracking fidelity trends specific to ACT (TMACT) and IPS-SE (IPS Fidelity Tool.) Current policy requires any agency providing these services to complete regular fidelity reviews and engage in quality improvement planning.

2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?

The Division of MH/DD/SAS reviews information regarding evidence-based or promising practices in purchasing or policy decisions. The Division uses information from the literature or from the NREPP and other SAMHSA websites supporting the EBP or promising practice. EBP developers or proponents and subject matter experts are invited to present to the NC PIC on the EBP or practice.

DMH/DD/SAS uses multiple sources of information to guide its recommendations. There is no singular source referenced for EBP selection due to the nature and complexity of the practice protocols and intended outcomes for targeted behavioral health populations, especially those in most serious need who live with complex behavioral health challenges. To date the NC PIC process has worked well, especially when implementation science informs both practice selection and implementation processes.

North Carolina's ACT policy was revised in 2013 (and is under current revision) to ensure it identifies and aligns with best practices. A certification process has been created based on TMACT fidelity scores which identifies a certification cut off point of any score below a 3.0 as not being certified. This is believed to be a first step towards North Carolina's vision to ensure that high fidelity ACT providers are easily found and accessible throughout the state.

Identifying and financially supporting the North Carolina Assertive Community Treatment Technical Assistance Center (NC ACT TAC) has been extremely helpful in both completion of TMACTs on all ACT providers in the state, which is currently more than 80, bringing in subject matter experts for trainings and technical assistance and developing a technical assistance plan that partners NC DMH/DD/SAS AMH section staff with NC ACT TAC staff to ensure that ACT providers focused on quality improvement have access to the supports and assistance they need.

3. **Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?**

The state has used information regarding evidence-based practices to develop guidance for LME-MCOs in their choices of EBPs for people that they serve. An example is the release of the manual ***Developing Effective, High-Quality Community Mental Health and Substance Abuse Services: A Guide for Local Management Entities*** (<http://www.ncpic.net>). In addition, publications from the North Carolina Institute of Medicine (NCIOM) Task Force include the Plan on Suicide Prevention for the Division of MH/DD/SAS populations served, as well as the NCIOM Task Force Report on Growing Well on early social, emotional and mental health needs of very young children provide comprehensive guide to EBPs and implementation strategies and challenges (www.nciom.org). The more recent NCIOM Task Force on Essentials for Childhood published ***Safe, Stable and Nurturing Relationships and Environments to Prevent Child Maltreatment*** in 2015. This group, which included staff from the Division of MH/DD/SAS, was tasked with studying and developing a collaborative, evidence-based, systems-oriented, public health-grounded strategic plan to reduce child maltreatment and secure family well-being in North Carolina. This report summarizes the findings of the Task Force and the Task Force recommendations. Taken together, the recommendations of the Task Force will ensure North Carolina has a comprehensive, coordinated system to support child and family well-being.

DMH/DD/SAS collaborates closely with the Division of Medical Assistance (DMA) around policy revisions and fidelity scores. All fidelity reports for ACT are reviewed by key, identified DMA staff prior to dissemination to the ACT provider. DMH regularly informs DMA staff of providers that are out of compliance with current policy standards as well as providers that exceed policy expectations. Likewise, DMH/DD/SAS has included DMA in the state services IPS-SE service definition, even though it currently is not a Medicaid funded service at this time (it is currently funded through Medicaid b3 funds).

The DMH/DD/SAS AMH team regularly communicates with LME-MCOs around fidelity scores, how to support high fidelity services in their network and has facilitated meetings to allow LME-MCO staff to ask questions about upcoming policy changes.

Recently, the NC ACT TAC developed and facilitated a two day training on High Fidelity ACT Practices for middle to upper management staff at LME-MCOs, provider agencies and DMA/DMH/DD/SAS staff. The training focused on providing information about high fidelity ACT practices, anticipated outcomes from high fidelity ACT providers, and how they can support their teams in improving their ACT services. This

training also included a provider panel, featuring staff from two provider agencies that have exceptional ACT teams in the state.

In addition, the Division of MH/DD/SAS has been more than pleased with the outcomes of the NC ACT TAC. The quality of work they have completed since 2013 and their ability to engage ACT providers across the state shows that it is a solid investment. They have recently broadened their scope to include oversight and management of the Dartmouth IPS-SE Trainer position, and they have developed working relationships with Case Western University (Richard Kruszynski) to support the implementation of Integrated Dual Disorders Treatment, are sending a staff to become certified by the Motivational Interviewing Network of Trainers and have subject matter expertise in recovery and psychiatric rehabilitation. As we fully fund the NC ACT TAC, they are able to offer their trainings and technical assistance free of charge an overwhelming majority of the time. This ensures that provider staff, LME-MCO staff and state-level staff are able to access evidence based, recovery oriented, and person-centered trainings regardless of potential funding barriers. This is an initiative the Division shall continue to fund at full level to ensure DMH/DD/SAS is able to continue its close collaboration with the NC ACT TAC and focus on ensuring individuals across the state with MH/SU have access to recovery oriented, evidence based, person centered services.

4. Does the state use a rigorous evaluation process to assess emerging and promising practices?

As stated earlier, the Division established the North Carolina Practice Improvement Collaborative (NC PIC) in 2005 to review evidence-based or promising practices and assess their applicability to the behavioral health system in North Carolina. NC PIC is composed of state agency personnel, academicians and providers specializing in the fields of mental health, developmental disabilities and substance use disorders. The Deputy Director of Community Policy Management, DMH/DD/SAS was integral to the creation of this professional collaborative and continues to function as the Project Manager.

5. Which value based purchasing strategies do you use in your state?

The Division of MH/DD/SA Services utilizes the following:

- a. **Leadership support, including investment of human and financial resources:** As stated above, the Adult Mental health Team is involved in various ways and levels to assure that specific services meet fidelity measures. LME-MCOs are able to and have been supported in offering enhanced rates to providers of quality, evidence-based and fidelity services.
- b. **Use of available and credible data to identify better quality and monitor the impact of quality improvement interventions:** Each LME-MCO is required, as part of its national accreditation and external quality review processes to have a quality assurance plan and identify quality improvement projects. Often these quality improvement projects are identified through a needs and gaps analysis or through regular collection and reporting on data elements required by the Division.

- c. **Use of financial incentives to drive quality:** As stated above, the Division is supportive of the LME-MCOs efforts to offer enhanced rates to providers of quality, evidence-based and fidelity services.
- d. **Provider involvement in planning value-based purchasing:**
- e. **Gained consensus on the use of accurate and reliable measures of quality:** The majority of the measures of quality utilized by the Division are based on nationally accepted models/data, primarily HEDIS. These measures have been used for a number of years and the LME-MCOs are able to provide input on parameters and methodology through several mechanisms, such as monthly conference calls and/or meetings with the Quality Management Directors (each LME-MCO must have a QM department).
- f. **Quality measures focus on consumer outcomes rather than care processes:** As stated above, most of the Division's measures are HEDIS. Some are outcomes-focused, such as readmission rates to inpatient settings 30-days post discharge and 180-days post discharge.

Environmental Factors and Plan

4. Prevention for Serious Mental Illness

Narrative Question:

SIMs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.⁶⁷ The "Prodromal Period" is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.⁶⁸ In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.⁶⁹ The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.^{70 71} This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

****It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Please indicate areas of technical assistance needed related to this section.

⁶⁷ Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

⁶⁸ Fusar-Poli, P., Bonoldi, I., Yung, A.R., Borgwardt, S., Kempton, M.J., Valmaggia, L., Barale, F., Caverzasi, E., & McGuire, P. (2012). Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk. Arch Gen Psychiatry. 2012 March 69(3):220-229.

⁶⁹ Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

⁷⁰ van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D.H., Yung, A.R., McGorry, P., & Cuijpers, P. (2013). Preventing a first episode of psychosis: meta-analysis of randomized controlled prevention trials of 12-month and longer-term follow-ups. Schizophr Res. Sep;149(1-3):56-62.

⁷¹ McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

Please use the box below to indicate areas of technical assistance needed related to this section:

Technical assistance needs include the following:

- Effective screening, assessment and interventions for early signs of the prodromal phase of psychoses.
- Effective strategies in health care and system integration for this population to sustain engagement and reduce transition rates to psychosis.
- Effective strategies to inform and engage families and other child, health and human service providers and school personnel in early identification and supporting engagement in treatment to improve youth outcomes.
- Funding mechanisms to support non-billable services necessary for EBP model implementation, especially in rural communities.
- Implement prevention and wellness messaging to effectively make connections between use of cannabis and higher clinical risk for psychoses, as well as effective use of health supplements such as Vitamin D and N-Acetyl Cysteine (NAC) in prevention and early intervention of early signs of psychosis in parallel to early findings for those with FEP.
- Effective ways to address and mediate effects of ACEs (adverse childhood events), especially trauma in early childhood that correlates with

higher clinical risk for psychoses.

Footnotes:

4. Prevention for Serious Mental Illness

The North Carolina DHHS and the SMHA appreciate the importance of early identification and intervention among children, youth and young adults as there is a high cost associated with delayed treatment for individuals, families, the community at large, health care systems and the state's public mental health system. It is the intention of the SMHA to implement early identification, early intervention and treatment of youth and young adults at high clinical risk, or in the early stages of mental disorders with psychosis.

Addressing the mental health needs of children, youth and transition age young adults is one of the seven priorities identified in the Division of MH/DD/SAS's three year plan that is currently being developed. This plan spans 2015-2018; it identifies goals, objectives, strategies and outcome indicators for each of the priority areas.

With the SMHA's implementation of the Coordinated Specialty Care model for First Episode Psychosis (FEP) 5% MHBG set aside, it is anticipated that as the training and technical assistance plan is implemented statewide, earlier identification and referral of those with high clinical risk or those in the early stages of mental disorders with psychosis will increase. The opportunity for engagement and earlier treatment is correlated with a reduction in the transition rate to psychosis over time (Fusar-Poli, P., et al, 2012). Clinically attuned workforce development will be critical to effectively address population needs statewide.

The LME-MCOs and provider networks implement screening, triage and referral (STR) in order to initiate early identification of youth with serious emotional disturbance (SED) and young adults with serious mental illness (SMI), including those youth displaying sub-threshold or early signs of psychosis during adolescence and transition to adulthood or Prodromal Period in which youth often experience attenuated and nonspecific thought, mood and perceptual disturbances accompanied by poor psychosocial functioning. Treatment services for those who meet medical necessity include comprehensive clinical assessment, outpatient treatment, intensive in-home services, multi-systemic therapy (MST), therapeutic foster care and child and adolescent day treatment for mental health and/or substance use disorders. Telehealth and telepsychiatry are increasingly more available across the state to improve timely access to developmentally appropriate assessment, treatment and psychiatric consultation. The current array of services and supports are supported in communities and managed by the LME-MCOs. Both state and federal block grant funds as well as Medicaid and SCHIP (in NC Health Choice) and other third party insurers support early identification and intervention. Adequate resources in parallel to the more clinically attuned workforce will be needed as referrals increase.

Technical assistance needs include the following:

- Effective screening, assessment and interventions for early signs of the prodromal phase of psychoses.
- Effective strategies in health care and system integration for this population to sustain engagement and reduce transition rates to psychosis.

- Effective strategies to inform and engage families and other child, health and human service providers and school personnel in early identification and supporting engagement in treatment to improve youth outcomes.
- Funding mechanisms to support non-billable services necessary for EBP model implementation, especially in rural communities.
- Implement prevention and wellness messaging to effectively make connections between use of cannabis and higher clinical risk for psychoses, as well as effective use of health supplements such as Vitamin D and N-Acetyl Cysteine (NAC) in prevention and early intervention of early signs of psychosis in parallel to early findings for those with FEP.
- Effective ways to address and mediate effects of ACEs (adverse childhood events), especially trauma in early childhood that correlates with higher clinical risk for psychoses.

Environmental Factors and Plan

5. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)

Narrative Question:

The Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress through its FY 2016 Omnibus bill, Public Law 114-113, to set aside 10 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based programs that provide treatment for those with early serious mental illness (SMI) and a first episode psychosis (FEP) – an increase from the previous 5% set aside. This additional 5 percent increase to the set-aside is over the FY 2015 level. The appropriation bill specifically requires the 10 percent set-aside to fund only those evidence-based programs that target FEP. The law specifically stated:

"...the funds from set-aside are only used for programs showing strong evidence of effectiveness and targets the first episode psychosis. SAMHSA shall not expand the use of the set-aside to programs outside of those that address first episode psychosis".

Previous appropriation language (P.L. 113-76 and P.L. 113-235) allowed the use of set aside funds for individuals with early SMI, including those without psychosis. However, the new language specifically requires states to focus their efforts only on FEP.

States that are currently utilizing FY 2016 set-aside funds for early SMI other than psychosis must now refocus their efforts to service only those with FEP. SAMHSA will allow states that already signed a contract or allocated money to their providers using the FY 2016 funds to complete these initiatives through the end of their contract or by the end of September 30, 2016, whichever comes first. States may continue to support these efforts using the general MHBG funds; however, the set-aside allocation must be used for efforts that address FEP. Nothing precludes states from utilizing its non-set-aside MHBG funds for services for individuals with early SMI.

If states have other investments for people at high risk of SMI, they are encouraged to coordinate those programs with early intervention programs supported by the MHBG. This coordination will help ensure high risk individuals are swiftly identified and engaged in evidence-based services should they develop into diagnosable SMI. Please note that the MHBG funds cannot be used for primary prevention or preventive intervention for those at high risk of SMI.

States can implement models which have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state should be able to begin to move their system toward earlier intervention, or enhance the early intervention services already being implemented.

SAMHSA and NIMH in conjunction with National Association of State Mental Health Program Directors (NASMHPD) will continue to ensure that technical assistance and technical resources are available to states as they develop and implement their plan.

States will be required to revise their two-year plan to propose how they will utilize the 10 percent set-aside funding to support appropriate evidence-based programs for individuals with FEP. Upon submission, SAMHSA will review the revised proposals and consult with NIMH to make sure they are complete and responsive. If a state chooses to submit a plan to utilize the set-aside for evidence-based services other than Coordinated Specialty Care (CSC) approach developed via the RAISE initiative, SAMHSA will review the plan with the state to assure that the approach proposed meets the understanding of an evidence-based approach. With consultation with NIMH as needed, the proposals will be either accepted, or requests for modifications to the plan will be discussed and negotiated with the State. SAMHSA will notify each State once the revised proposals are approved.

This initiative also includes a plan for program evaluation and data collection related to demonstrating program effectiveness. SAMHSA is also required within six months of the appropriations statute enactment to provide a detailed table showing at a minimum each State's allotment, name of the program being implemented, and a short term description of the program. Additional technical assistance and guidance on the expectations for evaluation, data collection and reporting will follow.

States must submit their plan revision request proposal into the FY 2016-2017 Block Grant Application under the following section:

Section III. Behavioral Health Assessment and Plan, C. Environmental Factors and Plan, #5. Evidence-Based Practices for First Episode Psychosis.

The state must revise the following for the 10 percent set-aside for first episode psychosis:

1. An updated description of the states chosen evidence-based practice for the 10 percent set-aside initiative.
2. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
3. A budget showing how the set-aside and additional state or other supported funds, if any, will be utilized for this purpose.
4. The states provision for collecting and reporting data, demonstrating the impact of this initiative.
5. Any foreseen challenges.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

North Carolina Revised Proposal for the FY2016-2017 Block Grant Application

10% Set Aside for First Episode Psychosis

Description of the Chosen Evidence Based Practice

North Carolina will continue to fund programs that are based on the empirically supported RAISE-ETP (aka NAVIGATE) core model of Coordinated Specialty Care but will allow flexible use of block grant funds to pay for currently non-reimbursable services and innovative approaches to non-core interventions such as peer support services.

Description of Our Current Plan

Trillium Health Resources LME/MCO: Trillium Health Resources contracted with RHA Services, Inc. for the development of a CSC program in New Hanover County, North Carolina. This is a rural area of the state. The CSC team was fully staffed and operational as of March 1, 2015. A total of 33 clients have been served. The target population is adolescents and young adults, typically age 15-30 who have experienced a first episode of psychosis.

Alliance Behavioral Health Care LME/MCO: Alliance Behavioral Health Care contracted with the University of North Carolina, (UNC) Center for Excellence in Community Mental Health. The contract is for two projects:

1. Expansion of services at a current site located in Carrboro, North Carolina. The UNC OASIS program began in 2005 and was part of the RAISE project. Funding was provided to bring their model to fidelity with CSC by hiring additional staff (Supported Employment Specialist). Staff at the Carrboro OASIS site are also responsible for providing technical assistance and consultation services to RHA and any additional site(s) funded with FEP set aside funds as well as on a broader basis to agencies and group practices with an interest in serving individuals who have experienced a first episode of psychosis. In addition, funding was provided for the development of a database that will guide clinical practice and ensure quality assurance from all funded programs, as well as collect specific data elements related to these projects.
2. Implementation of a second CSC site in Wake County, North Carolina. The CSC team in Wake County, which is located in Raleigh, was fully staffed and operational as of April 15, 2015. They are currently serving 22 clients. The target population is adolescents and young adults, typically age 15-30 who have experienced a first episode of psychosis.

Planned Activities for 2016-2017

Priorities/Goals/ Objectives

1. Continue two sites currently operated through Trillium/RHA and Alliance/UNC. There will be some expansion of services at both sites:
 - Trillium/RHA – a part-time family therapist will be part of the team. Currently the lead therapist is providing individual and family work. Given the current caseload it was recommended that additional staff be hired to focus specifically on family work.

- Alliance/Wake – The OASIS Technical Assistance Program has developed a pilot model for Peer Support Programming which goes beyond integration of a Certified Peer Support Specialist on the clinical team, and addresses both person-centered treatment engagement and social recovery from a first episode of psychosis. While placement of a peer support specialist on a CSC clinical team is a valuable and desirable service role, due to limited funding and feedback OASIS has received from active program participants, OASIS proposes the use of a peer support specialist to instead facilitate same-age peer-to-peer recovery mentoring and mutual support. Under this model one part-time clinician would serve to coordinate and support two part-time Certified Peer Support Specialists per CSC team, whose collective objectives would include recruiting, training, and matching active CSC program participants in established recovery as “recovery partners”, along with volunteer community members as “recovery allies”, to engage with CSC program participants with less established recovery. These “recovery partners” and “recovery allies” would be supported by the Certified Peer Support Specialists to engage with participants to develop adaptive peer relationships encouraging routine in-person contact, health and recovery education and support, and routine engagement in developmentally-appropriate social community activity involvement.
 - UNC OASIS will continue to operate a CSC program in Carrboro, North Carolina. However, as of SFY2017 they will not use MHBG set-aside funds for this program. This program is primarily supported through insurance billing and other funds available through the UNC Health Care System. The UNC OASIS program and the UNC Wake site are in close geographical proximity and will share FTEs for Peer Support and Supported Employment until the caseload size at the Wake site reaches capacity for these positions to be full-time. The salary and benefits for these positions will be moved from the UNC OASIS technical assistance and consultation budget to the Wake site budget.
2. Continue the contract with UNC OASIS to provide technical assistance and consultation to all funded programs. OASIS technical assistance program has primary responsibility for coordinating and disseminating state-wide community education about identifying First Episode Psychosis and about the availability of CSC programming in order to support client outreach and recruitment.
 3. Implementation of 2 additional CSC sites
 4. Fully implement the Quality Assurance Database developed by the UNC OASIS technical assistance program to be utilized by all FEP sites funded under this initiative
 5. Improved coordination of LME/MCO staff and CSC sites staff to ensure that the following staff at the LME/MCO are informed of CSC sites in their catchment area and how to access/refer for services:
 - 24 hour service access/call centers
 - Care Coordination
 - Utilization Management
 - Hospital Liaisons
 - Jail Liaisons
 - Consumer Rights/Client Advocacy
 6. Education on FEP and service access will be provided to the following agencies/groups in each CSC catchment area:
 - Hospital EDs

- Crisis Service Providers
 - Psychiatric Hospitals
 - NAMI
 - Institutions of Higher Learning
 - Local Education Administration
 - Law Enforcement
 - Primary Care Providers
7. The OASIS Technical Assistance Program will coordinate with other research initiatives focused on FEP in order to continue to provide technical assistance and consultation on new best practices that are developed as a result of research.

Implementation Strategies

- Issue an *Invitation to Apply/ Readiness Survey* to the remaining six (6) LMEs/MCOs.
- Provide training materials, including SAMHSA webinars, technical assistance and consultation on the implementation of a CSC model of care to new CSC sites.
- On-going work with LMEs/MCOs, site providers and staff to ensure compliance with contracts and deliverables.
- On-going work with UNC regarding technical assistance and consultation to ensure consistency and fidelity among programs and to ensure that the activities of the CSC programs meet SAMHSA requirements and also meet the requirements and expectations of DMH/DD/SAS and the LMEs/MCOs.
- Facilitate workgroups with all stakeholders regarding billing and financial sustainability including review of finance approaches outlined by SAMHSA.
- Develop site specific and state-wide education materials for professionals in diverse settings on the early warning signs of psychosis and early engagement and links to treatment services.
- Conduct regional education and outreach events specifically addressing FEP.
- Conduct/facilitate cross site phone conferences for clinical consultation and programmatic/quality management across all service sites.
- On-site technical assistance and cross site program visits.
- Include FEP education in other education and professional development events provided through existing networks to include NC Collaborative for Children, Youth and Families Crisis Solutions, Families United, NC Council of Community Programs, AHEC Regional Training events, NC Pediatric Society, NAMI conferences, NC Practice Improvement Collaborative, etc.

Budgets

Current Programs

UNC OASIS Technical Assistance and Consultation

Description	Funding Amount
Personnel: <ul style="list-style-type: none"> • .25 Clinic Director Consultant • .20 Clinic Manager Consultant • .05 Operations Director Consultant 	260,071.31

<ul style="list-style-type: none"> .10 Psychologist Consultant Program Coordinator Data base Coordinator Vocational Specialist (to be moved to the Wake Site budget effective July 1, 2016) 	
Consulting Expenses	5,400.00
Supplies/ Equipment/Operating costs	38,019.69
Database development and website	10,000.00
FFY15 Funds	213,904.00
FFY16 Funds	99,587.00
TOTAL	\$313,491.00

UNC OASIS Wake Site

Description	Funding Amount
Personnel: <ul style="list-style-type: none"> .05 Medical Director .1 Clinic Director (UNC OASIS Carrboro site) .50 Physician Clinic Director Wake site Clinician Administrative Assistant Medical Assistant .15 Business Services Coordinator	331,892.00
Supplies/Equipment/Operating costs	72,093.00
FFY15 Funds	213,904.00
FFY16 Funds	190,081.00
TOTAL	\$403,985.00

Trillium/RHA

Description	Funding Amount
Personnel: <ul style="list-style-type: none"> Team Leader/Individual Therapist .5 Family Therapist IPS Supported Employment Specialist .5 Recovery Case Manager/Referral Specialist .5 Peer Support Specialist .30 Psychiatrist .20 RN .03 Clinical Director .05 Program Director .05 Business Manager .40 Administrative Assistant 	348,344.00

Supplies/equipment/operating costs	70,514.00
FFY15 Funds	213,904.00
FFY16 Funds	204,954.00
TOTAL	\$418,858.00

Proposed Services/Programs

Wake OASIS Peer Support Pilot

Description	Funding Amount
Personnel	70,000.00
Supplies/Equipment/Operating Costs	35,000.00
FFY16 Funds TOTAL	\$105,000.00

Additional CSC sites

Description	Funding Amount
Personnel: <ul style="list-style-type: none"> • Clinician/Team Lead • Clinician/Case Manager • .5 Psychiatrist • IPS Supported Employment Specialist • Peer Support Specialist • .5 RN/Medical Assistant • Administrative Assistant • % of Business staff required for operations 	340,000.00
Supplies/equipment/operating costs	70,000.00
TOTAL	410,000.00
FFY16 Funding TOTAL --- 2 Sites	\$820,000.00

Budget Summary

- **Total FFY15 funds currently allocated - \$641,712.00**
- **Total FFY16 funds currently allocated -\$494,622.00**
- **Total FFY16 funds to be allocated for 2 additional sites and the Wake Oasis Peer Support Model -\$925,000.00**
- **Total FFY16 funds for current and proposed services - \$1,419.622.00**

Performance Measures/Data Collections and Reporting

With ongoing funding for Quality Assurance monitoring, the OASIS Technical Assistance Program will be able to monitor, through the established Quality Assurance data collection protocol, targeted changes in program outcomes at the state and local levels including:

- Patient treatment adherence and treatment drop out
- Family engagement in treatment
- Positive and negative psychotic symptoms
- Visits to emergency and crisis services
- Psychiatric hospital admissions and nights admitted
- Employment status
- School enrollment status
- Criminal justice involvement
- Health insurance status
- Patient program satisfaction
- Patient domains of living satisfaction

The OASIS CSC Quality Assurance Database currently collects a broad, but targeted, spectrum of participant and provider-level data at routine clinical contact intervals in order to achieve the level of outcome monitoring required for a team-based clinical program. With program sites routinely submitting this quality assurance data for combined measurement and analysis of outcomes and fidelity ratings, the OASIS Program proposes that a high quality of CSC care can be established, maintained and continuously improved throughout the state. Ongoing funding will support the existence and maintenance of this database, and additional funding would allow for enhanced software development, to allow administrators, clinicians, and participants to interact with this data more intuitively.

5. Evidenced-Based Practices for Early Intervention (5% set-aside)

1. An updated description of the state's chosen evidenced-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.

We have implemented the CSC (Coordinated Specialty Care Model) for intervention and treatment of early/first episode psychosis.

2. An updated description of the plan's implementation status, accomplishments and any changes in the plan.

North Carolina Division of MH/DD/SAS issued an *Invitation to Apply/Organizational Readiness Survey* on August 18th, 2014 to all of our LME-MCOs for the implementation of services based on the Coordinated Specialty Care (CSC) model. We selected two applicants for funding.

Trillium Health Resources LME/MCO: Trillium Health Resources contracted with RHA Services, Inc. for the development of a CSC program in New Hanover County, North Carolina. This is a rural area of the state. The CSC team was fully staffed and operational as of March 1, 2015. A total of 30 clients have been served. They are currently serving 21 clients. Their target population is adolescents and young adults, typically age 16-25 who have experienced a first episode of psychosis.

Alliance Behavioral Health Care LME/MCO: Alliance Behavioral Health Care contracted with the University of North Carolina, the Center for Excellence in Community Mental Health. The contract is for two projects:

1. Expansion of services at a current site located in Carrboro, North Carolina. The UNC OASIS program began in 2005 and was part of the RAISE project. Funding was provided to bring their model to fidelity with CSC by hiring additional staff (Supported Employment Specialist). Staff at the Carrboro OASIS site are also responsible for providing technical assistance and consultation services to RHA staff, as well as on a broader basis to agencies and group practices with an interest in serving individuals who have experienced a first episode of psychosis. In addition, funding was provided for the development of a database that will guide clinical practice and ensure quality assurance from all funded programs.
 - Database – The database is in the process of being tested and finalized. The target date for completion is 12/31/15. Feedback has been gathered from clinicians and consumers. The system is designed for access through a web portal with an option for real time data reports at an individual patient level and aggregate reports for stakeholder use. Technical issues are being addressed in regards to firewall and confidentiality issues. A webinar was conducted with RHA staff in October, 2015 with an overview of the clinical tools and data elements.
 - Technical assistance – OASIS staff and RHA staff have determined that they will have periodic on-site visits at each site and routine technical assistance conference calls. Visits and routine phone calls are in the process of being scheduled.
 - Additional staff needed to bring the model to fidelity have been hired.
2. Implementation of an additional CSC site in Wake County, North Carolina. The CSC team in Wake County was fully staffed and operational as of April 15, 2015. They have evaluated 16 clients and are currently serving 13 clients. The target population is adolescents and young adults, typically age 16-25 who have experienced a first episode of psychosis.

Additional Accomplishments in North Carolina

The State Mental Health Association in collaboration and funding from DMH/DD/SAS, convened the North Carolina Practice Improvement Collaborative (NC PIC) on November 7, 2014 in Raleigh, NC entitled, **Early Identification and Treatment of First Episode Psychosis** with three leading experts in the field, as well as a subject matter expert panel including a family member and provider panel. Presentations from the meeting included:

Recovery After an Initial Schizophrenia Episode (RAISE) and the North American Prodrome Longitudinal Study –
Presented by Robert Heinssen, PH.D, Scientific Executive and Director of the Division of Services and Intervention Research at the National Institute of Mental Health

Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care and Overview of SAMHSA/CMHS Block Grant and 5% FEP Set-Aside – Presented by Cathy Abshire, Acting Director of the Center of Mental Health Services, Division of State and Community Systems Development, Substance Abuse and Mental Health Services Administration

Early Intervention in Psychosis: Why and How – Presented by Diana Perkins, MD, Professor of Psychiatry at the University of North Carolina School of Medicine and Medical Director of the UNC OASIS program.

3. The planned activities for 2016 and 2017 including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.

Priorities/Goals/Objectives

- a. Continue funding for 3 CSC sites;
- b. Explore options for on-going sustainability of current programs and potential expansion sites
- c. Fully implement the data collection system through the QA database at the UNC-OASIS site in Carrboro.
- d. Implement the data collection system at the Wake and New Hanover sites after successful implementation at the UNC-OASIS site in Carrboro;
- e. Explore options to partially support additional site(s) based on LME-MCO expressed interest;
- f. Contracted provider will continue to perform education, consultation, and technical assistance to interested areas across the state.
- g. Outreach and education to potential consumers;
- h. Develop working relationships with other providers including EDs, psychiatric hospitals, crisis services and routine mental health providers
- i. Regional education and outreach events that include information on FEP practice model
- j. On-going outreach, education and professional development events will be provided through existing networks among those to include NC Collaborative for Children, Youth and Families Crisis Solutions Initiative, NC Council of Community Programs, AHEC regional training events, NC Pediatric Society, Community Care of NC as well as statewide and/or regional conferences hosted by NAMI among others.

Implementation Strategies

- Designated staff at the DMH/DD/SAS will directly monitor providers, as well as the two LME-MCOs involved with these specific programs to assure program priorities, goals and objectives are met. Monitoring activities include on-site visits and participation in status update conference calls.
- Cross –site phone conferences for clinical consultation and programmatic/quality management across the three service sites
- On-site technical assistance and cross-site program visits to further inform implementation of CSC practice in diverse settings with the goal of improving overall CSC program implementation by identifying common effective and innovative strategies employed in response to culturally and geographically diverse settings.
- OASIS to disseminate a training manual, online curriculum and program implementation manual
- Statewide Suicide Prevention Plan implementation – specific strategies implemented for Zero Suicide through CSC for FEP
- DMH/DD/SAS Child Mental Health Team – early identification and referral for FEP through the System of Care Framework and school based, health, child welfare and juvenile justice initiatives

Performance indicators

Key performance indicators include number served, percentage of publicly insured clients, retention in the program, reduction in symptoms, housing status, employment status/school attendance and percentage of unplanned psychiatric hospital readmissions.

4. A budget showing how the set-aside and additional state or other supported funds, if any for this purpose.

Trillium/RHA was allocated \$330,000 from FFY 14 funds in SFY15. Budget line items included the following:

- Team Leader/Family Therapist
- IPS Supported Employment Specialist
- Recovery Case Manager
- Peer Support Specialist
- Psychiatrist
- RN
- Administrative Assistant
- Office Support Overhead
- Travel for community outreach
- Office supplies
- Communications/marketing
- Program supports for clients

Total Trillium/RHA expenditures for the time period July 1, 2014-September 30, 2015 - \$261,347.21

Alliance/OASIS was allocated \$643,491.00 from FFY14 and FFY15 funds.

Budget line items for the Technical Assistance/Carrboro site including the following:

- QA Database manager
- .35 FTE Medical Director
- .20 FTE Clinic Director
- Supported Employment Specialist
- Database Administrator
- .10 FTE psychologist
- Database/website development
- Computer equipment
- Technology
- Office Supplies
- Marketing
- Travel

Budget line items for the Wake site included the following:

- .5 FTE Psychiatrist
- Clinician
- .5 FTE Education and employment specialist
- Program administrator/clinician
- Outreach and marketing
- Office supplies
- Travel
-

Total Alliance/UNC expenditures for the time period July 1, 2015-September 30, 2015:

FFY14- \$382,143.79

FFY 15 - \$85,878.72

Total - \$468,022.51

5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

The state will use the QA database and indicators to monitor impact of programs. Programs will be regularly submitting QA reports to the designated DMH/DD/SAS staff for review.

Environmental Factors and Plan

6. Participant Directed Care

Narrative Question:

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them through the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

North Carolina is not utilizing a voucher system at this time, other than through its Access to Recovery discretionary grant.

Environmental Factors and Plan

7. Program Integrity

Narrative Question:

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 USC § 300x- 55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance abuse programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include:(1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?
2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
 - a. Budget review;
 - b. Claims/payment adjudication;
 - c. Expenditure report analysis;
 - d. Compliance reviews;
 - e. Client level encounter/use/performance analysis data; and
 - f. Audits.
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How does the state ensure block grant funds and state dollars are used for the four purposes?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

7. Program Integrity

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?

Yes, please see the attached *Service System Integrity Plan*.

2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?

Procedures for assuring that the federal program requirements are conveyed to intermediaries and providers are through contractual agreements. A performance contract held between NC DMH/DD/SAS and each LME-MCO clearly outlines the policies, procedures and practices required for all funding, including state funding, and specifically, SABG and MHBG funding received. NC DMH/DD/SAS assists providers in adopting practices that promote compliance with program requirements, including quality and safety standards through a combination of means including contractual requirements, training, monitoring and independent peer review. Technical assistance and support are provided to the LME-MCOs, the provider networks and consumers in communities by designated subject matter experts. The Compliance Reviews that are conducted by the Audit Team include plans of correction, when necessary, that address exceptions with the required program elements.

3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:

- a. **Budget review;**
- b. **Claims payment/adjudication;**
- c. **Expenditure report analysis**
- d. **Compliance reviews;**
- e. **Client level encounter/use/performance analysis data; and,**
- f. **Audits**

The program integrity activities that NC DMH/DD/SAS employs for monitoring the appropriate use of block grant funds and oversight practices include program and budget staff who are responsible for budget review, planning and allocation decisions; reviewing, monitoring and updating claims/payment adjudication; completing a thorough expenditure report analysis and encounter/utilization/performance analysis; implementing compliance reviews and audits. State and local compliance reviews and subrecipient monitoring are completed by designated administrative and programmatic staff. Compliance reviews and subrecipient monitoring are completed by designated administrative and programmatic staff. State level monitoring of the LME-MCOs is completed, documented and reported monthly. The same is true for other subrecipient relationships. The LME-MCOs are required by their performance contract and business plan with NC DMH/DD/SAS to comply with all subrecipient monitoring requirements.

4. Describe payment methods used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.

To ensure that payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of service delivered, NC DMH/DD/SAS convenes a State Services workgroup comprised of staff from finance, audit and policy, program managers, quality management and clinical staff. This group reviews state and block grant funded services, proposed alternative services, determines appropriateness of the service or support and corresponding rate structures (cost, provider

credentials, medical necessity, intensity, frequency and duration). These services are then implemented and paid through the NCTracks system.

5. Does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

NC DMH/DD/SAS assists providers in adopting practices that promote compliance with program requirements, including quality and safety standards through a combination of means including contractual requirements, training, monitoring and independent peer review. The Compliance Reviews by the Audit Team include plans of correction that address exceptions with the required program elements. Included are elements that relate to consumer safety, such as TB testing and HIV/Early Intervention services. Each LME-MCO has staff designated as the Substance Abuse Point of Contact for their agency. Monthly conference calls are conducted by the Program Managers with the SA Points of Contact to provide technical assistance, updates and trainings on specific or requested topics. Compliance checks are also conducted by staff. For example, Prevention and Early Intervention team staff conduct site visits to review for fidelity to best practices for Project T&D and All Stars. CPM staff also provide training at conferences such as the Summer and Winter Schools for Alcohol and Drug Studies.

6. How does the state ensure block grant funds and state dollars are used for the four purposes?

NC DMH/DD/SAS ensures that block grant funds and state dollars are used for the four purposes by monitoring that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid through an integrated claims adjudication system. This system (NCTracks) regularly scans for claims where Medicaid eligibility applies and re-adjudicates and reverses payments made with Block Grant funds. The state monitors to ensure that LME-MCOs include State/Block Grant services in their Coordination of Benefit (COB) Policies and Procedures and are sampling State/Block Grant services when they monitor Providers. This will occur as a part of the quarterly fiscal monitoring and annual settlement. The quarterly fiscal monitoring review serves the purpose of observing and understanding the LME-MCO's operations and providing technical assistance. And the annual settlement ensures compliance of the following:

- i. Compliance with the requirements of the DMHDDSAS contract;
 - ii. G.S. 159 (Fiscal Control Act)
 - iii. The LME-MCOs compliance with G.S. 122C
 - iv. OMB circulars A-87, A-122, and A-133
 - v. Compliance with requirements and restrictions of the SAPTBG, CMHSBG, SSBG, CASP dollars and their accompanying state MOE requirements, the PATH Program federal formula grant, SPF-SIG, SDFSCA, and other federally funded or designated projects.
 - vi. Compliance with all state and federal laws and regulations.
- a) NC DMH/DD/SAS funds those priority treatment and support services not covered by Medicaid, Medicare or private insurance for low-income individuals and that demonstrates success in improving outcomes and/or supporting recovery. The LME-MCOs adopt and publish the benefit plan for target population consumers that define the services that individuals in each target

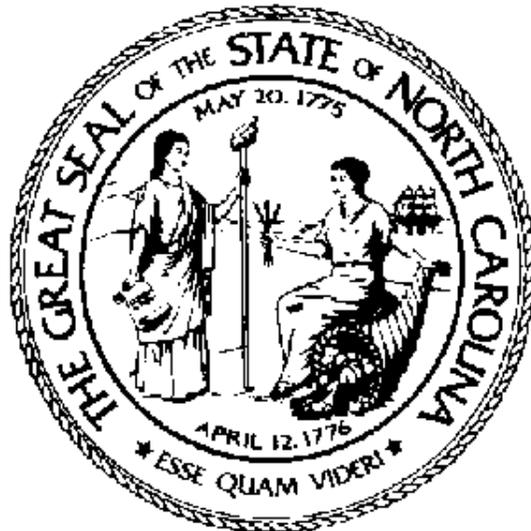
population may expect to receive. The benefit plan shall be flexible to maximize the services and promote the expected outcomes that consumers may receive while ensuring the LME-MCO delivers services within available funding shall ensure that non-Medicaid funds are utilized for DMHDDSAS specified priority populations. The priority population areas are as follows:

- i. Individuals who are at risk of harming self or others
- ii. High Risk individuals (for adults with over three (3) crisis and/or inpatient events in the past 12 months, or for children and adolescents with over two (2) crisis and/or inpatient events in the past 12 months)
- iii. Individuals with a Mental Illness or Substance Use Disorders who are transitioning from an inpatient, facility-based crisis, detoxification or withdrawal management service, or residential care service setting to the community
- iv. Youth and young adults (ages 16 to 25) who experience a first episode psychosis
- v. Individuals with Severe and Persistent Mental Illness, who are not stable
- vi. Individuals with Co-occurring MI/SU or MI/DD
- vii. Individuals who are Homeless or At Risk of Homelessness
- viii. Individuals with Traumatic Brain Injury (TBI)
- ix. Individuals who are Criminal or Juvenile Justice System involved
- x. Individuals who are Deaf or Hard of Hearing
- xi. Veterans, military service members and their families
- xii. Individuals with complex medical disorders
- xiii. Individuals with Department of Justice (DOJ) settlement agreement involvement
- xiv. Department of Social Services (DSS) involved adults
- xv. Individuals assessed with an American Society of Addiction Medicine (ASAM) level indicating the need for Residential or Inpatient level (Level 3.1 to 4.0) including detoxification or Withdrawal Management (Level 3.2TWM to 4.0 WM)
- xvi. Management (Level 3.2TWM to 4.0 WM)
- xvii. Individuals who inject drugs
- xviii. Pregnant women who use alcohol and/or other drugs
- xix. Individuals with Communicable Disease Risk/HIV
- xx. Children and adolescents with a mental health disorder and who are living with an adult with a MI or SUD
- xxi. Individuals with I/DD who are at risk of abuse, neglect or exploitation
- xxii. Individuals with I/DD who are transitioning from institutions and residential placements
- xxiii. Individuals with I/DD who are transitional age youth who are moving from school to employment and/or other community involvement
- xxiv. DSS involved adults include individuals receiving Work First cash assistance, individuals who are involved with Child Protective Services or individuals who have been convicted of a Class H or I controlled substance felony in NC and who are applicants for or recipients of Food Stamps.

LME-MCOs are responsible for both ensuring continuity of care for individuals in service, and availability of services throughout the year for priority population consumers and applicants for services. Changes to the LME-MCO Benefit Plan shall be submitted to the Division 30 days prior to publication for Division's State Services committee approval.

- b) NC DMH/DD/SAS provides SABG funds for primary prevention: universal, selective, and indicated prevention activities and services for persons not identified as needing treatment. The LME-MCOs provide leadership, technical assistance, and participation in community wide prevention and early intervention strategies, coalitions and other initiatives to discourage inappropriate access, misuse, and abuse of legal and illegal substances (alcohol, tobacco, and other drugs) by minors and adults and to improve the emotional health and well-being of individuals in their catchment area.
- c) NC DMH/DD/SAS collects performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment and recovery support services and to plan the implementation of new services. The North Carolina - Treatment Outcomes and Program Performance System (NC-TOPPS) is a web based program by which DMH/DD/SAS measures the quality of substance abuse and mental health services and the impact on individuals' lives. By capturing key information on an individual's service needs and life situation during a current episode of care, NC-TOPPS aids in developing meaningful treatment plans and evaluating the impact of services on an individual's life, as well as, the effectiveness of the service system.

North Carolina Department of Health and Human Services



Service System Integrity Plan SFY: 2015-2016

for

The Division of Mental Health, Developmental Disabilities
and Substance Abuse Services

Revised
July 2015

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Mission

It is the mission of the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) programs to, ***provide people with, or at risk of, mental illness, developmental disabilities, and substance use problems and their families the necessary prevention, intervention, treatment services and supports they need to live successfully in communities of their choice.***

Plan Purpose

It is the purpose of the Service System Integrity Plan to support compliance, proper expenditure and accountability within NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) programs by ensuring that State and Block Grant dollars are utilized appropriately, in accordance with statutory and regulatory framework, and in support of programmatic goals.

Plan Guiding Principles

This Service System Integrity Plan will promote the following principles:

1. Promote a cost efficient and effective behavioral health care system.
2. Ensure adherence to statutory and regulatory standards and practices.
3. Develop and monitor communication methods, training and technical assistance regarding service system integrity.
4. Support appropriate strategies and approaches to carrying out effective Service System Integrity efforts.
5. Proactively recognize areas of risk that may adversely affect Service System Integrity and proactively address vulnerabilities.
6. Fair and reasonable enforcement of system integrity monitoring. Failure to comply with system integrity efforts may result in technical assistance, plans of correction or other actions.

Responsible Staff

Audit/Policy Team - responsible for coordination of System Integrity Plan activities; monitoring/auditing LME-MCOs for compliance with State and Federal Block Grant rules and regulations; development of the DMH/DD/SAS subrecipient monitoring plan and oversight of its implementation.

Block Grant Coordinators - responsible for keeping abreast of Block Grant regulations and requirements, communication with DHHS staff and LME-MCOs and coordination of planning goals and strategies relevant to the Block Grant within DMH/DD/SAS.

Chief of Addictions and Management Operations - responsible for programmatic leadership and policies regarding utilization of State and Block Grant funds.

Contract Managers - responsible for administering the performance contract with Division contractors and monitoring compliance with the terms of the contract.

Financial Operations Section - responsible for budget management of State and Block Grant funds and supervision of staff that conduct the State and Federal NonUCR Settlement, performing audits of financial status reports submitted by non-profits; chairing the Center of Excellence contract review committee.

LME Performance Team - responsible for administering the performance contract with LME-MCOs and monitoring LME-MCO compliance with the terms of the contract.

Program Managers - responsible for monitoring specific programs and initiatives; ensuring compliance with project objectives and funding requirements.

Quality Management Section - responsible for developing and monitoring performance measures and communicating areas of concern to designated teams and management.

State Services Committee - responsible for ensuring the Service System Integrity Plan for State and Block Grant funds is carried out; ensuring State and Block Grant funds are used in compliance with state and federal requirements and policies.

Plan

1. **Budget Review**

- a) The NC DMH/DD/SAS contracts with the LME-MCOs to administer and oversee State funds and Federal Block Grant funds for the provision of prevention and treatment services for mental health and substance use disorders.
 - i) NC DMH/DD/SAS allocates State and Block Grant funds to LME-MCOs annually. The Financial Operations Section sends annual Continuation Allocation letters to the LME-MCOs and tracks all revisions to the initial continuation allocation through subsequent allocation letters.
 - ii) Federal Block grant funds are awarded by federal fiscal year and tracked by cost centers specific to the award year. The accounts are also separate for Unit Cost Reimbursement (UCR) and expenditure-based (Non-UCR) subcontracting. The Financial Operations Section ensures that Block Grant funds allocated to LME-MCOs are in accordance with the approved block grant plan), and revises LME-MCO allocations to reflect changes in Federal allocations as necessary based on utilization and changes in availability. LME-MCOs may request a realignment of Federal funds from one account to another; the LME-MCO must make a request in writing and justify the request. These realignments are reviewed by the Financial Operations Section in coordination with program staff, and when necessary, by the State Services Committee for compliance with funding regulations and Block Grant Plan goals, by the Financial Operations Section for fund availability, by the DHHS Budget and Analysis Office and approved by the Office of State Budget and Management.
 - iii) State service funds are allocated to the LME-MCOs once state General Assembly approves an annual budget, and these allocation are communicated to the LME-MCOs via the continuation allocation letter and subsequent allocation letters. The majority of these state funds are allocated into the single stream funds account, however, there are additional specific accounts for funds whose expenditures are subject to specific reporting requirements. These funds are deemed "special categorical" funds. Single stream funds are allocated as non-UCR funds, but LME-MCOs are required to submit claims for services rendered and the value of these claims will be considered in settlement of the single stream funding account. Since the single stream funds are flexible in nature, LME-MCOs do not have to request a realignment of these funds, however for special categorical funds any request to change their designation has to be requested in writing and be considered by the Division.
- b) Direct contracts that utilize State and/or Block Grant funds are managed by Program Managers in the program sections of NC DMH/DD/SAS. The Program Managers ensure that the subcontractors fulfill requirements of the Federal government and the approved application for Federal funds. These contracts are reimbursed on an expenditure basis within a contract maximum and are monitored by the Contract Managers according to Subrecipient Monitoring procedures. The Financial Operations Section tracks the subrecipient monitoring that is completed by program managers to assure compliance with the requirements and cost principles of the Federal Office of Management and Budget and the requirements set within the contracts (A-87, A-122, Omni-circular). The Financial Operations Section reports and

follows up on the findings as required to the DHHS Office of Internal Auditors, the Controller's office and the State Auditor

- c) The Financial Operations Section manages the administrative portion of State and Federal Block Grant funds through specific cost centers in the State budget for NC DMH/DD/SAS. The annual Cost Allocation Plan determines which administrative expenses are allocated to Federal grants. Financial Operations works with the responsible staff members to ensure that the correct methodology is utilized. Financial Operations staff ensures that expenditures are restricted to budgetary limits as allowable under the block grant plan throughout the fiscal year.

2. Claims Payment and Adjudication

- a) Claims for Block Grant and State funded UCR services are adjudicated locally by the LME-MCO. The LME-MCO then submits these claims to the State's claims vendor for secondary adjudication for reimbursement. The LME-MCOs have a choice of paying the service provider based on their local adjudication or waiting until the State level adjudication occurs. LME-MCOs have adjudication audits/edits in place to ensure at a minimum, that the provider has a valid contract, the service is not duplicated, the fields contain valid values, the service was authorized by the LME-MCO and the rate is at or below the contract maximum for that service. LME-MCOs also have systems to check that both the consumer and provider are eligible to receive funding for services.
- b) The State claims system adjudication includes similar edits that are determined by the State Services Committee. The State claims vendor also adjudicates for diagnostic match with the Benefit Plan eligibility, as well as compliance with other service definition requirements, such as same day exclusions for certain procedure codes. The LME-MCO must also designate in the State's claims adjudication system which of their subcontractors are eligible to earn Federal Block Grant funds.
- c) Budget Criteria are established annually by the State Services Committee and published on the NC DMH/DD/SAS website, which designate the criteria for payment from each Federal Block Grant account. For example, certain accounts are limited to specific clinical Benefit Plans and procedure codes. Benefit Plans are specific to Block Grant funding categories, such as "Injecting Drug User/Communicable Disease Risk" and "Adult Substance Abuse Women". Services that meet the Budget Criteria, but are adjudicated after the LME-MCO has pulled down their Federal allocation, count toward justification for the State funds allocation.

Periodically, a transfer or adjustment between accounts or grant award periods may occur after the claim was first adjudicated. LME-MCOs also have the capacity to correct errors on a paid claim.

3. Expenditure Analysis

- a) Non-UCR Block Grant and State funds are managed by the LME-MCOs. They subcontract with providers who carry out the Block Grant treatment and prevention goals required by the Federal government and specified in the approved NC Block Grant Assessment and Plan, along with services funded by the NC General Assembly according to policies set by NC DMH/DD/SAS. Each LME-MCO is responsible for monitoring Non-UCR Block Grant expenditures throughout the fiscal year, both fiscally and programmatically. The State

Services Committee, reviews the NonUCR Expenditure Overview report, which summarizes expenditures by LME-MCO and Account, periodically for overall and LME-MCO specific earnings year-to-date relative to budgets. Financial Operations also tracks these expenditures regularly for utilization review.

- b) UCR Block Grant expenditures are monitored periodically by the NC DMH/DD/SAS State Services Committee. The committee reviews a summary report which shows YTD expenditures by Block Grant UCR account. This report displays the earnings relative to the budget for each LME-MCO and for each account as a whole. The Committee identifies earnings issues and recommends transfers of funds as appropriate. Each LME-MCO is expected to monitor Block Grant earnings on at least a monthly basis and take remedial actions at the local level to ensure funds are drawn down appropriately throughout the fiscal year.

4. Compliance Reviews

- a) Substance Abuse Block Grant prevention and treatment services and Mental Health Block Grant services are monitored by LME-MCOs. Program and individual monitoring is conducted annually by the Financial Operations Section Audit Team. The Audit Team has the lead role in the Division for the standardization of local monitoring to be completed by the LME-MCOs. The monitoring tools are posted on the NC DMH/DD/SAS website and are specific to the Block Grant program requirements (e.g., prevention, Women's Set-Aside, IV Drug Users, etc.). The Block Grant Steering Committee selects a sample of providers and individuals whose services were reimbursed with Federal Block Grant funds from claims reimbursed with Federal Block Grant funds. The Audit Team produces a monitoring report for each LME-MCO.
- b) In accordance with the NC DMH/DD/SAS Policy and Procedure for the Review, Approval and Follow-Up of Plan(s) of Correction, if systemic compliance issues are found, a plan of correction is required. Any contractor must submit a plan of correction within 15 days from receipt of their monitoring report to submit the plan of correction, which is reviewed by the subject matter experts within the NC DMH/DD/SAS. Additionally, within 60 days after the approval of the plan of correction, the Audit Team coordinates across the Division from issuance to point of resolution for non-compliant findings from LME-MCOs or non-profit entities which DMH/SS/SAS contracts.
- c) Semi-Annual Compliance Reports are submitted by each LME-MCO to the Block Grant Coordinator within the CPM Section. These Compliance Reports serve as a mechanism to ensure that the LME-MCOs are adhering to the broad categorical requirements of the Substance Abuse Prevention and Treatment Block Grant; i.e., assuring priority admission for specific populations, providing outreach services for certain populations, as well as reporting specific prevention activities. These reports are reviewed by the Block Grant Coordinator and program managers for accuracy and content and feedback is provided to the LME-MCOs by the Block Grant Coordinator.
- d) Independent Peer Reviews (IPR) are conducted annually by a third party under contract with the DMH/DD/SAS for the treatment component of both the Substance Abuse and Mental Health Block Grants. The purpose of IPR is to assess the quality, appropriateness and efficacy of treatment services funded with block grant monies, and to ensure that at least five percent of contracted block grant providers are reviewed. Specific services are selected each fiscal year for review, with the goal of ensuring a representative sample of providers, across

all regions of the state that work with a diversity of consumers in a variety of settings. The following criteria are considered in the selection process: (1) total amount of UCR funds paid during the fiscal year; (2) location/region; (3) treatment program modality and size/census; (4) service areas/facility licensure type; (5) availability for review; (6) accreditation status. Reviewers are volunteers, selected based on clinical experience and expertise in the service area being reviewed, appropriate certifications/licensure, cultural sensitivity, interest in the process and completion of the IPR training. Reviewers complete and submit individual reports to DMH/DD/SAS, as well as to the agencies reviewed. In addition, feedback surveys are completed by the reviewers, as well as the participating sites.

5. Utilization/Performance Analysis

- a) The Quality Management Section tracks and monitors LME-MCO system performance through a set of contractual indicators and service utilization measures. Measures are selected to support priorities of the DMH/DD/SAS and, where possible, are based on nationally recognized behavioral health measures. Performance standards are set annually based on the previous year's state average to encourage incremental improvements. When an LME-MCO is found to be performing below standards on performance measures, the LME-MCO Monitoring and Technical Assistance Procedure is followed to improve the performance of the LME-MCO. The LME Performance Team also uses the monthly NC DHHS LME-MCO Performance Summary Report to review with the LME-MCOs their performance standards that do not meet the expected measures. The LME Performance Team member indicates a plan of action needed on the subrecipient monitoring tool and follow-up as needed.
- b) The Clinical Quality Committee reviews identified outliers and significant service trends, contingent on the availability of data, to determine if there is concern that service delivery might be out of compliance with the service definition, rules or statutes. Where appropriate, these outliers, trends or compliance concerns will be monitored according to the Targeted Services Monitoring Procedure by the Audit Team, once approved and implemented.
- c) In cases where the utilization of Federal Block Grant funds is determined to be out of compliance and a payback required, the Financial Operations Section ensures that those funds are utilized within the period of availability for that block grant award. If the availability period for the returned funds has ended, the DHHS Controllers Office refunds the funds to the Federal government.

6. Financial and Year-End Activities

- a) Each LME-MCO's state and block grant non-UCR funds are financially monitored quarterly and settled annually by field staff from the Financial Operations Section with assistance from the LME Performance Team (see procedures Preparation of Tentative Settlement Report and LME-MCO Settlement Guidelines). These procedures review expenses related to the LME-MCO service delivery to ensure that they are allowable under state and federal guidelines and are supported with the appropriate documentation. If the LME-MCO has disallowed costs and a payback is required, funds that are received are processed by the Financial Operations Section according to State policy. Based on findings from the quarterly fiscal monitoring or annual settlement and LME-MCO may be required to enter into a Plan of Correction (POC) to remediate systemic or material findings (please see NC DMH/DD/SAS

Policy for the Review, Approval and Follow-Up of Plan(s) of Correction. LME-MCOs have 15 days from receipt of their monitoring report to submit the plan of correction, which is reviewed by the subject matter experts within the NC DMH/DD/SAS.

- b) The Office of the State Auditor audits the NC DMH/DD/SAS' monitoring procedures for the Federal Block Grants on an annual basis for compliance with federal regulations. The Audit Team and Financial Operations Section respond with a plan of correction to any findings and recommendations issued by the State Auditor.

7. Disbursement of Funds

- a) NC DMH/DD/SAS checks that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered. This is accomplished in two ways. For Non-UCR (expenditure based allocations) the LME-MCOs are responsible for local management of the funds. The LME-MCO designates a staff person to oversee the Federal CMHBG and SAPTBG funds, who oversees program development, budgets, contracts and reimbursement. The Non-UCR Settlement process conducted by the Financial Operations Section and LME Performance Team checks that Federal cost principles and regulations are followed. The state has established state wide default rates for most services, and rates that are substantially higher than other established rates for that service are reviewed and approved/denied by the Financial Operations Section in consultation with Program Managers.

8. Promotion of Compliance Practices

- a) NC DMH/DD/SAS assists providers in adopting practices that promote compliance with program requirements, including quality and safety standards through a combination of means including contractual requirements, training, monitoring and independent peer review (as noted in number 4 above). The Compliance Reviews by the Audit Team include plans of correction that address exceptions with the required program elements. Included are elements that relate to consumer safety, such as TB testing and HIV/Early Intervention services. Each LME-MCO has staff designated as the Substance Abuse Point of Contact for their agency. Monthly conference calls are conducted by the Program Managers with the SA Points of Contact to provide technical assistance, updates and trainings on specific or requested topics. Compliance checks are also conducted by staff. For example, Prevention and Early Intervention team staff conduct site visits to review for fidelity to best practices for Project T&D and All Stars. Program staff also provide training at conferences such as the Summer and Winter Schools for Alcohol and Drug Studies.

9. Funds Utilized for SAMHSA's Four Purposes

- a) NC DMH/DD/SAS monitors that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid through an integrated claims adjudication system. This system (NCTracks) regularly scans for claims where retro-active Medicaid eligibility applies and re-adjudicates and reverses payments made with Block Grant funds. The state monitors to ensure that LME-MCOs include State/Block Grant services in their Coordination of Benefit (COB) Policies and Procedures and are sampling State/Block Grant services when they monitor Providers. This will occur as a part of the quarterly fiscal monitoring and annual settlement. The quarterly fiscal monitoring review serves the purpose of observing and understanding

the LME-MCO's operations and providing technical assistance. And the annual settlement ensures compliance of the following:

- i. Compliance with the requirements of the DMHDDSAS contract;
 - ii. G.S. 159 (Fiscal Control Act)
 - iii. The LME-MCOs compliance with G.S. 122C
 - iv. OMB circulars A-87, A-122, and A-133
 - v. Compliance with requirements and restrictions of the SAPTBG, CMHSBG, SSBG, CASP dollars and their accompanying state MOE requirements, the PATH Program federal formula grant, SPF-SIG, SDFSCA, and other federally funded or designated projects.
 - vi. Compliance with all state and federal laws and regulations.
- b) NC DMH/DD/SAS fund those priority treatment and support services not covered by Medicaid, Medicare, or private insurance for low-income individuals and that demonstrate success in improving outcomes and/or supporting recovery. The LME-MCOs adopt and publish the benefit plan for target population consumers that define the services that individuals in each target population may expect to receive. The benefit plan shall be flexible to maximize the services and promote the expected outcomes that consumers may receive while ensuring the LME-MCO delivers services within available funding shall ensure that non-Medicaid funds are utilized for DMHDDSAS specified priority populations. The priority population areas are as follows:
- i. Individuals who are at risk of harming self or others
 - ii. High Risk individuals (for adults with over three (3) crisis and/or inpatient events in the past 12 months, or for children and adolescents with over two (2) crisis and/or inpatient events in the past 12 months)
 - iii. Individuals with a Mental Illness or Substance Use Disorders who are transitioning from an inpatient, facility-based crisis, detoxification or withdrawal management service, or residential care service setting to the community
 - iv. Youth and young adults (ages 16 to 25) who experience a first episode psychosis
 - v. Individuals with Severe and Persistent Mental Illness, who are not stable
 - vi. Individuals with Co-occurring MI/SU or MI/DD
 - vii. Individuals who are Homeless or At Risk of Homelessness
 - viii. Individuals with Traumatic Brain Injury (TBI)
 - ix. Individuals who are Criminal or Juvenile Justice System involved
 - x. Individuals who are Deaf or Hard of Hearing
 - xi. Veterans, military service members and their families
 - xii. Individuals with complex medical disorders
 - xiii. Individuals with Department of Justice (DOJ) settlement agreement involvement
 - xiv. Department of Social Services (DSS) involved adults
 - xv. Individuals assessed with an American Society of Addiction Medicine (ASAM) level indicating the need for Residential or Inpatient level (Level 3.1 to 4.0) including detoxification or Withdrawal Management (Level 3.2TWM to 4.0 WM)
 - xvi. Individuals who inject drugs
 - xviii. Pregnant women who use alcohol and/or other drugs
 - xix. Individuals with Communicable Disease Risk/HIV

- xx. Children and adolescents with a mental health disorder and who are living with an adult with a MI or SUD
- xxi. Individuals with I/DD who are at risk of abuse, neglect or exploitation
- xxii. Individuals with I/DD who are transitioning from institutions and residential placements
- xxiii. Individuals with I/DD who are transitional age youth who are moving from school to employment and/or other community involvement
- xxiv. DSS involved adults include individuals receiving Work First cash assistance, individuals who are involved with Child Protective Services or individuals who have been convicted of a Class H or I controlled substance felony in NC and who are applicants for or recipients of Food Stamps.

LME-MCOs are responsible for both ensuring continuity of care for individuals in service, and availability of services throughout the year for priority population consumers and applicants for services. Changes to the LME-MCO Benefit Plan shall be submitted to the Division 30 days prior to publication for Division's State Services committee approval.

- c) NC DMH/DD/SAS provides SABG funds for primary prevention: universal, selective, and indicated prevention activities and services for persons not identified as needing treatment. The LME-MCOs provide leadership, technical assistance, and participation in community wide prevention and early intervention strategies, coalitions and other initiatives to discourage inappropriate access, misuse, and abuse of legal and illegal substances (alcohol, tobacco, and other drugs) by minors and adults and to improve the emotional health and well-being of individuals in their catchment area.
- d) NC DMH/DD/SAS collects performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment and recovery support services and to plan the implementation of new services. The North Carolina - Treatment Outcomes and Program Performance System (NC-TOPPS) is a web based program by which DMH/DD/SAS measures the quality of substance abuse and mental health services and the impact on individuals' lives. By capturing key information on an individual's service needs and life situation during a current episode of care, NC-TOPPS aids in developing meaningful treatment plans and evaluating the impact of services on an individual's life, as well as, the effectiveness of the service system.

Environmental Factors and Plan

8. Tribes

Narrative Question:

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#)⁷⁴ to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.
2. Describe current activities between the state, tribes and tribal populations.

Please indicate areas of technical assistance needed related to this section.

⁷⁴ <http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

8. Tribes

1. **Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.**
2. **Describe current activities between the state, tribes and tribal populations.**

According to the 2000 census, North Carolina has one of the largest American Indian populations east of the Mississippi and the eighth largest population in the nation exceeding 120,000 for eight state recognized tribes (Coharie, Eastern Band of Cherokee (also federally recognized), Haliwa-Saponi, Lumbee, Meherrin, Ocaneechi Band of Saponi, Sappony and Waccamaw Siouan) and four urban American Indian organizations (Association for Indian People, Guilford Native American Association, Metrolina Native American Association and Triangle Native American Society). American Indian population growth exceeds that of many other ethnic groups in the state. The Lumbee, who number close to 70,000, is the largest of the state tribes.

The DMH/DD/SAS has a 25-year partnership with the NC Commission on Indian Affairs. Both agencies collaborate with each other to engage the eight tribes and four urban associations in determining needs, planning and capacity building, implementation and evaluation of mental health and substance use disorder services for Native Americans in North Carolina. The Commission on Indian Affairs has participated in the advisory board for prevention services, the Cooperative Agreement Advisory Board (CAAB) and the statewide Fetal Alcohol Syndrome Disorders Coalition.

Although gambling has been an important and multi-functional element in Cherokee culture, current issues regarding problem gambling as it impacts families and the community are of interest to tribal agencies and leaders. The North Carolina Department of Health and Human Services (NC DHHS) is funding a needs assessment that will assist and inform agencies serving tribal members and their community. Through this grant, the Center for Native Health is working closely with Analenisgi, the tribe's behavioral health program to develop programmatic strategies to benefit the Eastern Band of Cherokee Indians (EBCI). DHHS has provided training for EBCI members in the Stacked Deck curriculum, which is listed on SAMHSA's NREPP website. Stacked Deck is offered to students in grades 7-12, as well as youth being served at the substance abuse treatment center, Unity Healing Center, in Cherokee, NC.

The NC Screening, Brief Intervention, and Referral to Treatment (SBIRT) grant project is working with the Lumbee, the Coharie and the Waccamaw Siouan Tribes of North Carolina on issues related to mental health and substance use. The tribes have identified traditional practices that may be effective in addressing these issues and have held "Talking Circles" and drumming events with the support of grant funds. In addition, during its first year, the NC Access to Recovery IV (NC ATR IV) grant project has identified two counties (Robeson and Sampson) in which to develop recovery support services with a focus on the Lumbee, Coharie and Waccamaw-Siouan tribes. Services, which are primarily provided by tribal members, include spiritual counseling, Native American Healing and other traditional practices as types of recovery services that can be reimbursed by NC ATR IV. Additionally, staff are working with tribal administrators to develop a more robust recovery-oriented system of care.

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

Narrative Question:

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- Education builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- Alternatives provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- Problem Identification and Referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.
- Community-based Process provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning
- Environmental Strategies establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- Universal: The general public or a whole population group that has not been identified based on individual risk.
- Selective: Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data-driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or

an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse- related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

Please consider the following items as a guide when preparing the description of the state's system:

1. Please indicate if the state has an active SEOW. If so, please describe:
 - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
 - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
 - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).
2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
 - a. A statewide licensing or certification program for the substance abuse prevention workforce;
 - b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
 - c. A formal mechanism to assess community readiness to implement prevention strategies.
5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.
8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Not applicable to the MHBG.

Environmental Factors and Plan

10. Quality Improvement Plan

Narrative Question:

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

In an attachment to this application, states should submit a CQI plan for FY 2016-FY 2017.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

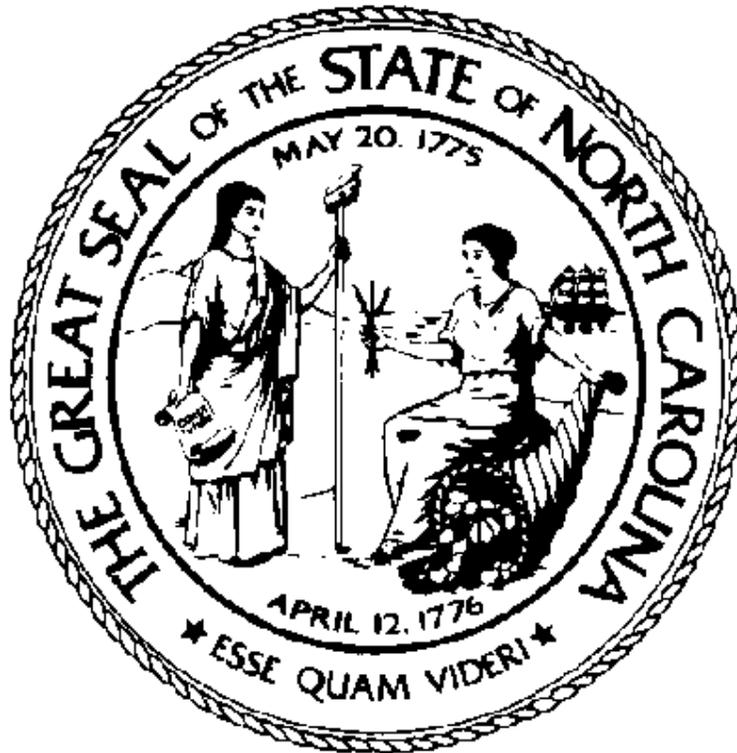
Footnotes:

10. Quality Improvement Plan

In an attachment to this application, states should submit a CQI plan for FY2016-FY2017.

Please see the attached ***Quality Management Plan for SFY15-16 for the Division of Mental Health, Developmental Disabilities and Substance Abuse Services.***

Quality Management Plan SFY: 2015 - 2016
for
The Division of Mental Health, Developmental Disabilities
And Substance Abuse Services



Revised & Approved:
April 28, 2015

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Values and Guiding Principles of the Quality Management Program

The [Division of Mental Health, Developmental Disabilities and Substance Abuse Services](#) (DMH/DD/SAS or Division) Quality Management Plan weaves together the mission and vision of the NC Department of Health and Human Services and DMH/DD/SAS and with the National Behavioral Health Quality Framework(NBFQF), the Federal Centers for Medicare and Medicaid Services Quality Framework and a Total Quality Management philosophy to formulate a structure and a process to achieving a high quality MH/DD/SA service system.

The mission of the [NC Department of Health and Human Services](#) (NC DHHS) is, ***in collaboration with its partners, to protect the health and safety of all North Carolinians and to provide essential services.*** This mission is driven by a vision that all ***North Carolinians will enjoy optimal health and well-being.***

It is the mission of the Division to, ***provide people with, or at risk of, mental illness, developmental disabilities, and substance abuse problems and their families the necessary prevention, intervention, treatment services and supports they need to live successfully in communities of their choice.***

In 2009 NC DHHS launched a management and organizational vision to ensure better quality of care, customer service, efficiency and responsibility through being:

- ❖ **Customer service focused.** North Carolinians are the center of our service design and delivery, and allocation of human and fiscal resources.
- ❖ **Anticipatory.** DHHS actively monitors changes in the needs of its customers and the impact of its services and applies new and innovative approaches in a timely, targeted and effective manner.
- ❖ **Collaborative.** DHHS values internal and external partnerships.
- ❖ **Transparent.** DHHS shares information, planning and decision-making processes and communicates openly with its customers and partners.
- ❖ **Results-oriented.** DHHS emphasizes accountability and measures its work by the highest standards.

The Division's Quality Management plan outlines the Division's Quality Management Program, its values and guiding principles, approach, structure, responsibilities, and improvement initiatives.

Customer Service

North Carolina's Service System

The Division's organizational structure is designed to implement North Carolina's public mental health, developmental disability and substance use service system. Our programs are governed by rules created by the MH/DD/SA Commission and we are advised by the State Consumer and Family Advisory Committee. MH/DD/SAS services are managed by Local Management Entities-Managed Care Organizations (LME-MCO) that oversee comprehensive provider networks that *provide the necessary MH/DD/SA services and supports that North Carolinian's need to live successfully in communities of their choice* (See Appendix A: Local Management Entities Map).

Quality Management Infrastructure

Keeping those we serve at the center of service design and delivery the Division's Quality Management structure provides the focus for ongoing attention to the clinical quality and effectiveness of the service system. The Division's Steering Committee brings together staff from across the Division to plan, monitor and evaluate initiatives to improve the clinical quality of the service system and the effective use of state and federal funds (See Appendix B: Division Quality Management Infrastructure).

A Culture of Quality

Customer focused quality management is championed at the Division by Executive Operations team to promote a collaborative, accountable and results-based organization. Through this the Division created a workforce development model that includes:

- ❖ Quality Improvement as part of job descriptions, employee training and evaluation
- ❖ Standards for internal customer service
- ❖ A Code for Ethical Conduct for staff
- ❖ Guidelines designed to promote teamwork
- ❖ Focus on establishing an effective work culture in the midst of change

Fiscal Resources

It is the Division's responsibility to provide a cost efficient publicly funded behavioral health care system while supporting quality service delivery. The Division will monitor compliance, efficiency and accountability within NC DMH/DD/SAS programs by detecting and preventing fraud, waste, program abuse, and by ensuring that State and Block Grant dollars are utilized appropriately, in accordance with laws and regulations, and in support of programmatic goals through the DMH/DD/SAS Service System Integrity Plan.

Anticipatory

Performance Monitoring

To ensure the needs of those we serve are being met the Division monitors key indicators to help assure that the system is working as intended, opportunities for improvement area identified and acted upon, desired improvements are recognized and efforts to sustain successful practices are implemented and monitored to maintain achievements, as priorities change.

A process for periodic monitoring of key indicators is coordinated by the Steering Committee. Monitoring of indicators will include:

- ❖ Reviewing valid and reliable performance and outcome data
- ❖ Determining significance of trends and patterns
- ❖ Implementing improvement initiatives
- ❖ Evaluating improvement initiatives
- ❖ Raising the bar on measures when appropriate
- ❖ Evaluating and revising the Quality Management plan annually

Quality Management and Performance Expectations for LME-MCOs are established per contract. Routine monitoring against performance targets or standards provides information on how the system is doing. The Division supports a statewide Incident Response Improvement System for reporting and documenting responses to emergency and critical incidents with a focus on future prevention. Contract requirements address reporting and resolution requirements related to complaints and grievances and establishes standards for resolution timeframe.

Regular and ongoing feedback within the Division and to Local Management Entities-Managed Care Organizations and system stakeholders is a key to ensuring and sustaining improvements in quality. The guidelines for critical outcomes and performance measures are described in the North Carolina LME-MCO Performance Measurement and Reporting Guide. Measurement is based on valid and reliable data, consistent with the NBHQF and describe the health and functioning of the MH/DD/SA system.

The Division evaluates the overall performance of the Local Management Entities-Managed Care Organization and their network through the review of each management function, compliance with reporting requirements, through statewide measures of service quality, input from stakeholders via surveys and outcome measurement systems, analysis of emergency and critical incidents, and review and follow-up of complaints and grievances.

In December 2013, The Department of Health and Human Services announced the Local Management Entities-Managed Care Organizations Consolidation Plan. As this transition occurs over the next several years the Division and system stakeholders will anticipate and manage the impact of the system transition on MH/DD/SA services and supports.

Collaborative

Involvement of Stakeholders

Success of our service system is dependent on the collaboration between the Division, Local Management Entities-Managed Care Organizations, direct service providers, consumers and families and other community stakeholders. The Executive Operations Team will ensure coordination with standing advisory and stakeholder committees with responsibilities for quality of the service system including:

- ❖ DMH/DD/SAS External Advisory Team
- ❖ State Consumer & Family Advisory Committee
- ❖ DHHS LME-MCO Director Meetings
- ❖ DHHS LME-MCO Clinical Director Meetings
- ❖ DHHS LME-MCO Medical Director Meetings
- ❖ DHHS LME-MCO Quality Management Directors Forum
- ❖ Joint Clinical Policy Collaborative
- ❖ Block Grant Planning Council
- ❖ Departmental Waiver Advisory Committee
- ❖ Service Advocacy Organizations

The Executive Operations Team continues to ensure regular communication and feedback through communication bulletins, websites, forums, trainings and conference participation.

Division Leadership will foster collaborative efforts with the [Division of Medical Assistance](#) to ensure coordinated oversight of the 1915 b/c Medicaid Waiver, Partnership for Healthy North Carolina, and the Division of Medical Assistance Quality Strategy for the North Carolina Behavioral Health Prepaid Inpatient Healthcare Plans. Division staff will be a part of the Intra-departmental monitoring teams responsible for the monitoring the operations and services related to the waivers, block grants and state funded services.

Transparent

Communication

Communication is critical to the success of any quality improvement effort. The Division's Leadership will communicate priorities, a directional vision and goals for the MH/DD/SA service system. The Steering Committee will monitor and communicate progress and performance related to Division initiatives and quality improvement projects in relation to the priorities and goals.

The Division's Leadership will support a culture conducive to open communication, information sharing and champion data driven decision making at the State and local levels. Report results and highlights will be communicated on the Division website, in memos and other communiqués so that together as a system we can learn from each other. Sharing information and data will encourage innovation and enable replication of successful practices.

Results Oriented

Performance Measurement & Sustainability

The Steering Committee is charged with the overall implementation and success of the Division's quality management plan. It oversees all quality management committees and monitors Division initiatives. The Steering Committee is responsible for promoting excellence and assisting with identifying potential issues and opportunities for improvement and ensuring that they are referred to and addressed at the appropriate level.

Reports will be based on consistent and credible data and will be examined to determine if changes have produced the desired results, or if further adjustments are needed to achieve success. On an annual basis, the Steering Committee will oversee the review of reporting requirements, data sources and reporting formats to ensure that reporting elements remain relevant and support the desired system outcomes.

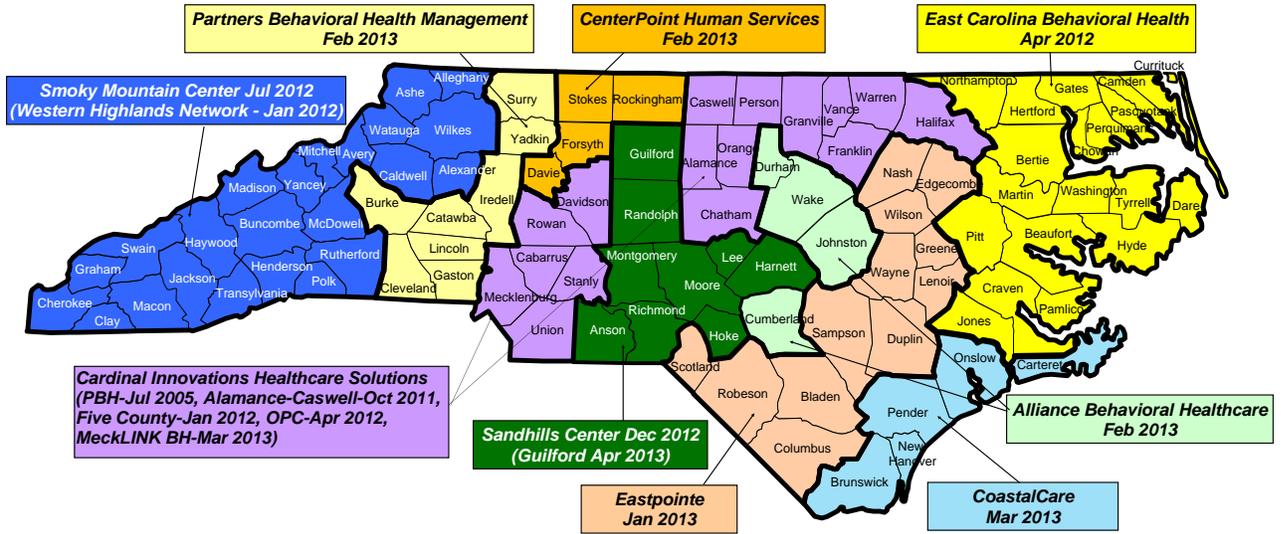
The Steering Committee ensures improvement actions and quality initiatives are followed-up for successful resolution and sustainability. The Steering Committee champion information sharing when change actions result in demonstrable improvements; those actions will be recognized and spot-lighted. Additionally, communication on system performance will occur throughout the quality improvement process using the Centers for Medicare and Medicaid Services Quality Framework to promote strategic and solution focused initiatives. (See Appendix C: Quality Framework)

Appendix A

Local Management Entity Map

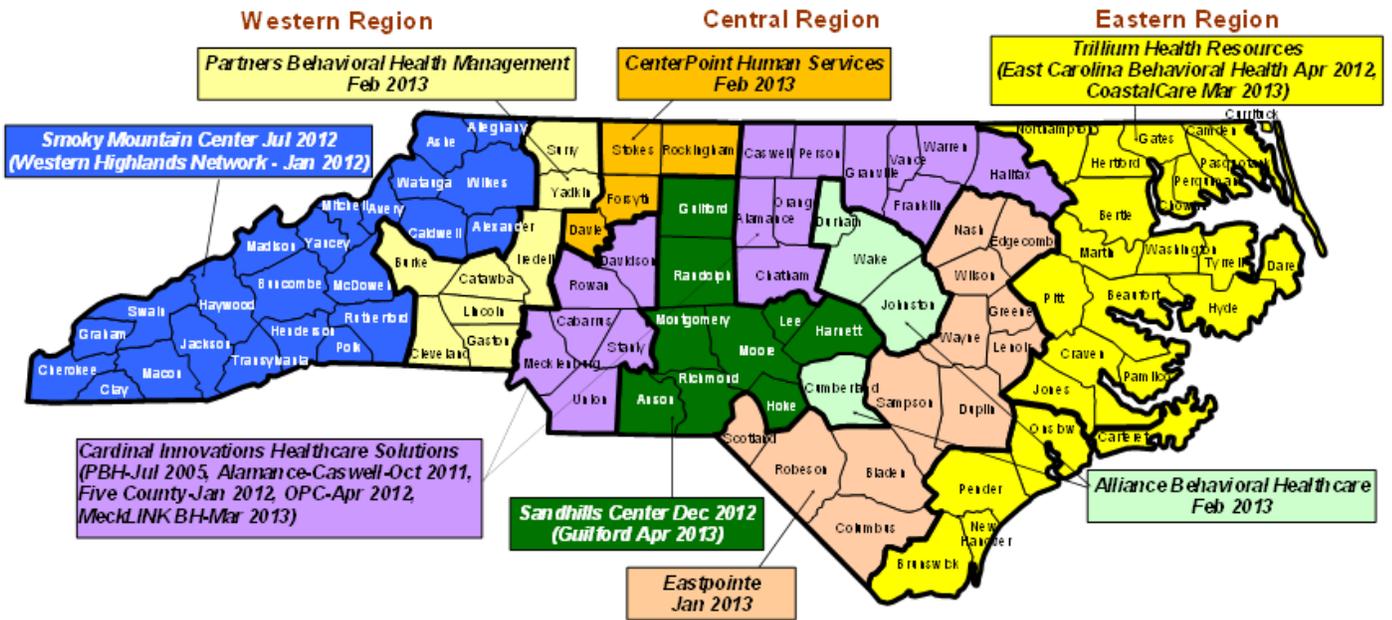
SFY 14-15 Configuration

Local Management Entity - Managed Care Organizations (LME-MCOs) and 1915 b/c Medicaid Waiver Implementation Dates



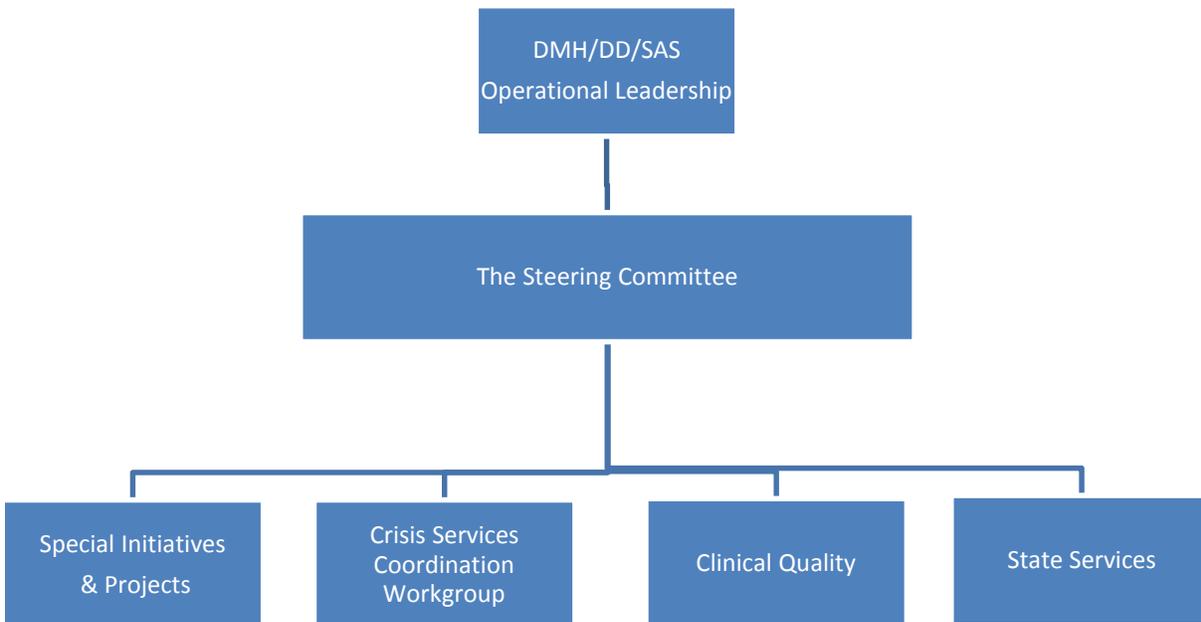
- Reflects LME-MCOs as of 4/1/14.
- Western Highlands Network operating under a management agreement 10/1/13, merger date 7/1/14.

Configuration July 2015



Appendix B

Division Quality Management Infrastructure



The Steering Committee

Ultimate responsibility for a comprehensive and sustainable quality management program at the Division is delegated to the Division's Steering Committee. The Steering Committee is charged with the overall success of the Division's quality management activities. It oversees all quality management responsibilities in the Division and serves as the hub receiving reports and recommendations from the Quality Cross-Functional Committees and Special Initiatives/Projects, and it serves as the link to other DHHS quality initiatives.

On an annual basis, the Steering Committee reviews and approves the QM Plan and Steering Committee membership for the upcoming year. The Steering Committee membership will comprise the Cross-Functional Committee chairs, the LME-MCO liaisons, the project management supervisor, the medical director, key quality management and finance staff, the deputy directors and chaired by the Division Director.

The Steering Committee meets at least monthly and is responsible for promoting excellence and for identifying potential problems and opportunities for improvement and ensuring that they are referred to and addressed at the appropriate level within the organization. The Steering Committee ensures that corrective action and quality initiatives are followed-up on for successful resolution and keep the Executive Operations Team informed.

The Steering Committee's Responsibilities Include:

1. Development of the Division's Quality Management Plan, which will be reviewed and updated annually. The Quality Management Plan will identify performance measures and procedures for monitoring state established waivers, block grants and Division priorities.
2. Oversight of the Quality Cross-Functional Committees Analysis of reports related to LME-MCO operations to gain broader perspective of statewide service system and performance. LME-MCO Reports include:
 - Local Business Plan
 - Gap Analysis and Community Needs Assessment
 - Performance Improvement Projects
 - Intra-departmental Monitoring Reviews
 - Monthly Monitoring Reports
 - DMA & DMH Performance Measures
 - Performance Contract Reports/Data Requirements
 - Stakeholder Satisfaction Surveys
 - Reports regarding emergencies, critical incidents, complaints and grievances
3. Review reports and recommendations from the Cross Functional Committees including Clinical Quality, State Services and Crisis Services Coordination Workgroup for service system impacts.
4. Review Special Initiative/Project progress, trends and monitor for impact on other parts of the service system.
5. Identify the need for special studies, initiatives or technical assistance and refer to the appropriate committee or team for implementation and monitoring.
6. Identify methods for communicating service system performance and improvement initiatives with Division staff and external advisory and stakeholder committees who share responsibility for the quality of the service system.
7. Ensure annual review of Division required LME-MCO reporting tools and requirements, to ensure reporting requirements accurately assess service system performance and that data is used to support decision making and performance monitoring; and to ensure that required data reporting is reviewed and communicated in a timely manner with system stakeholders.

Quality Cross-Functional Committees

The Steering Committee delegates priority quality improvement initiatives to specialized Quality Cross-Functional Committees with expertise in clinical quality, data analytics and state service implementation. Committees may also have workgroups that address specific topics within the purview of the Committee. Each committee regularly reports to the Steering Committee its activities, any areas of concern and success it has identified, and provides recommendations for action to improve the service system. Each

committee monitors the results of corrective action and quality initiatives within its purview to ensure successful resolution and keeps the Steering Committee and Executive Operations Team informed.

Cross Functional Committees Responsibilities Include:

1. Responsible for monitoring and providing oversight of specific areas within its charge and identifying potential problems or opportunities for improvement.
2. Committee determines most effective way to provide technical assistance or implement improvement actions and provides ongoing monitoring.

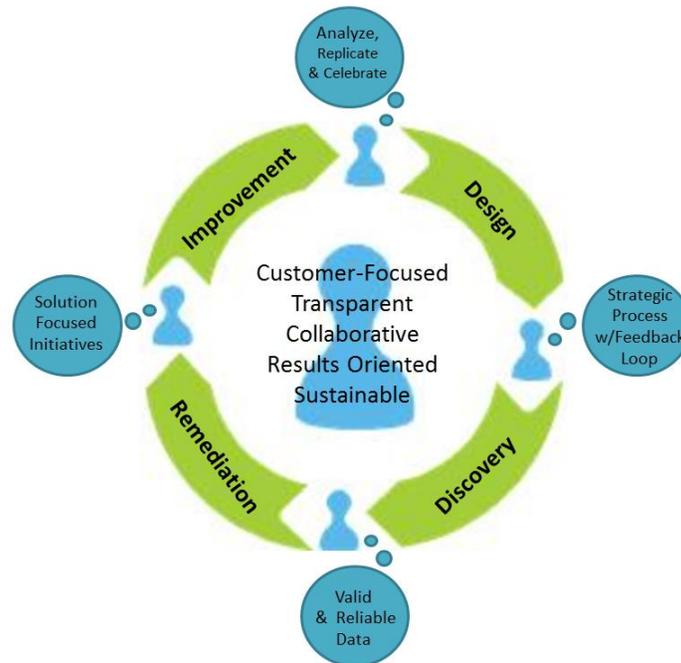
Time Limited Workgroups & Special Initiatives/Projects

Time-limited workgroups and special initiatives/projects will be established as needed to address a specific issue, formulate a recommendation for an appropriate course of action, or implement a particular initiative. Membership will be drawn from staff with relevant experience and skills. Each group will have a charge that specifies a facilitator, responsible staff persons, deliverables, timelines and routes of communication. Workgroups and Special Initiative/Projects will regularly report to a Cross-Functional Committee or to the Steering Committee on activities, any areas of concern and success identified, and provides recommendations for improvement actions.

Appendix C

Quality Framework

The Federal Centers for Medicare and Medicaid Services promote a comprehensive framework for managing waiver plans. The Division has adopted and promoted this framework since 2003; it consists of four distinct, but related, activities that form a continuous, interdependent process. The framework is applied to clinical and performance outcome measures to assist with communicating and monitoring quality improvement initiatives.



Design: The design function refers to strategies for building quality assurance and quality improvement into the conception and design of the system. It includes mechanisms such as effective information systems, communication channels, feedback loops.

Discovery: The discovery function refers to the collection, analysis and reporting of information to make certain that people, processes and products are meeting basic requirements of quality and to evaluating progress toward goals. It includes compliance monitoring and audit activities, collection and analysis of trend data on services, consumer perceptions and outcomes, recurring management reports and dashboards and targeted evaluation studies.

Remediation: Remediation refers to strategies used to identify, analyze and correct problems quickly and effectively. Mechanisms vary based on the situation and can include consultation and technical assistance, training, development of new initiatives, plans of correction, repayment of funds, loss of certification and redirection of resources.

Improvement: Improvement refers to systematic strategies to make incremental enhancements to operations and procedures that move the system toward achieving specified goals.

Total Quality Management Framework

The Division's long-term success will be achieved through a Total Quality Management approach that promotes a customer-focused atmosphere that involves all employees in continual improvement efforts. Our customers include persons receiving services and their families, our funders, all DHHS divisions, Local Management Entities-Managed Care Organizations and their provider networks, State and local Consumer and Family Advisory Committees (CFACs) and other state and local stakeholders. A culture of quality requires DMH/DD/SAS to effectively communicate and champion service delivery and project improvement initiatives.

To be effective, quality management requires integrated structures and processes that permeate all levels of every organization within the service system and works toward the objectives of:

- ❖ **Safeguarding** the health, safety and rights of persons served
- ❖ **Improving customer services** through collaboration with or input from persons served and family involvement
- ❖ Ensuring **fair and easy access** to services
- ❖ Supporting the achievement of desired **outcomes and satisfaction** for persons served
- ❖ Ensuring the **integrity, effectiveness and continuous quality improvement** of services through review of consistent and credible data
- ❖ Ensuring **compliance** and guiding improvements of the services provided under state and federal funding and Medicaid waivers
- ❖ **Cultural competence**
- ❖ **Collaboration with other agencies**

Total Quality Management will be achieved through implementing a culture, approach and agency structure that provides a collaborative approach to enable persons served to live successfully in their communities.

Environmental Factors and Plan

11. Trauma

Narrative Question:

Trauma⁷⁵ is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems⁷⁶. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed approach consistent with “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach”.⁷⁷ This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma⁷⁸ paper.

Please consider the following items as a guide when preparing the description of the state’s system:

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state’s policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

Please indicate areas of technical assistance needed related to this section.

⁷⁵ Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.*

⁷⁶ <http://www.samhsa.gov/trauma-violence/types>

⁷⁷ <http://store.samhsa.gov/product/SMA14-4884>

⁷⁸ *Ibid*

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

11. Trauma

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?

The state's standardized screening/triage/referral process (STR) which is required for admission into the service delivery system includes questions on trauma history. In addition, the state's web-based data collection – the NC Treatment and Outcomes Program Performance System – that is completed by service providers includes questions on trauma.

2. Describe the state's policies that promote the provision of trauma-informed care.

Although the state currently does not have specific policies designed to connect individuals with trauma histories to trauma-focused therapy, there are a number of initiatives underway that support pilot efforts where results will inform future policy direction and enhance the ongoing awareness, education, delivery, and monitoring around provision of trauma-informed care. See more detail in Question/Answer #3 below.

3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?

NC Child Treatment Program: In 2013, the North Carolina General Assembly (NCGA) granted a \$1.8 million annually-recurring appropriation to the North Carolina Child Treatment Program (NC CTP), a program of the Center for Child and Family Health (CCFH), to support program infrastructure, activities, and expansion of the child mental health service array.

Specifically, over the course of SFY 2015, the scope of training provided by NC CTP increased from one (1) to five (5) evidence-based child trauma treatment models for children from birth to 18 years of age, including:

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) -- TF-CBT is designed to help youth ages 3 to 18 experiencing posttraumatic stress in returning to a healthy state of functioning after a traumatic event.
- Parent-Child Interaction Therapy (PCIT) -- PCIT is a treatment for young children ages 2 to 7 with emotional and behavioral disorders emphasizing improvement of the quality of the parent-child relationship and changing parent-child interactions.
- Child-Parent Psychotherapy (CPP) -- CPP is an intervention for children from birth through age 5 who have experienced at least one traumatic event and who are experiencing behavioral, attachment, and/or mental health problems as a result.
- Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) -- SPARCS is a 16-session group intervention designed to address the mental health needs of chronically traumatized adolescents who may still be living with ongoing stress and may be experiencing problems in several areas of functioning.

- Attachment and Biobehavioral Catch-up (ABC) -- ABC is a 10-session intervention aimed at helping caregivers provide nurturing care to young children ages six months to two years who have experienced early maltreatments and/or disruptions in care.

In addition to the annually-recurring operation budget, the NCGA allocated \$500,000 to be used over a period of two years (2013-2015) to support development of the NC CTP data exchange tool, *NC Performance and Outcomes Platform (NC POP)*.

Project Broadcast: The NC Division of Social Services (NCDSS) has been awarded grant funding for *Project Broadcast: Disseminating Trauma-Informed Practices to Children in the North Carolina Child Welfare System*. NCDSS is collaborating with NC DMH/DD/SAS in the nine pilot counties. NC DMH/DD/SAS is engaging its LME-MCOs and their providers in establishing local task forces for implementation, and training providers in trauma informed EBTs to serve children and their families in the local child welfare systems. Project Broadcast:

- Provides training and professional development for resource parents (i.e., foster, adoptive, kinship) using the National Child Traumatic Stress Network's (NCTSN) Resource Parent Curriculum; child welfare professionals will also use the NCTSN's Child Welfare Toolkit
- Increases access to trauma-informed, evidence-based treatments for children and youth by training more clinicians in these interventions:
 - Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
 - Attachment and Bio behavioral Catch-up (ABC)
 - Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
 - Parent-Child Interaction Therapy (PCIT)
- Creates systemic changes so that the training and interventions offered to the nine demonstration counties can eventually be expanded to all 100 North Carolina counties.

4. Does the state provide trainings to increase the capacity of providers to deliver trauma-specific interventions?

In addition to the project noted above, affordable trainings are offered by Local Management Entities-Managed Care Organizations, the Area Health Education Centers (AHECs), hospital systems, provider organizations, and universities to increase the capacity of providers to deliver trauma-specific interventions.

Environmental Factors and Plan

12. Criminal and Juvenile Justice

Narrative Question:

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one third meet criteria for having co-occurring substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.⁷⁹

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.^{80 81} Rottman described the therapeutic value of problem-solving courts: "Specialized courts provide a forum in which the adversarial process can be relaxed and problem-solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs." Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.⁸²

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

Please consider the following items as a guide when preparing the description of the state's system:

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?
4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

Please indicate areas of technical assistance needed related to this section.

⁷⁹ <http://csqjusticecenter.org/mental-health/>

⁸⁰ The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman, 2000.

⁸¹ A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs, U.S. Department of Justice, Renee L. Bender, 2001.

⁸² Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNeil, Dale E., and Renée L. Binder. [OJJDP Model Programs Guide](#)

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

12. Criminal and Juvenile Justice

1. **Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as part of coverage expansions?**

This is not applicable to North Carolina. The state government has decided not to expand Medicaid coverage for adults. It has also decided that it will not set up a health insurance exchange.

2. **Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?**

Yes, an array of services, which include screening, triage, referral, assessment, treatment and crisis prevention and recovery planning for those who are/may become involved with the justice and court system are provided across the state prior to adjudication and/or sentencing for individuals with mental health and/or substance use disorders. Some of these services and processes for access to services and/or diversion are highlighted below:

- Throughout North Carolina, law enforcement, mental health professionals and advocates are joining in partnership to establish Crisis Intervention Teams (CIT). CIT programs provide law enforcement the knowledge and skills they need to de-escalate persons in crisis and emphasize treatment rather than jail time for persons displaying symptoms of mental illness. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (MH/DD/SAS) coordinates this statewide initiative through its Justice Systems Team.
- Persons charged with Driving While Impaired (DWI) may obtain an assessment from a network of more than 400 authorized substance abuse service provider agencies prior to their initial court appearance.
- Drug Education Schools (DES) are a diversion opportunity for first-time offenders per NC General Statute 90-96 in cooperation with District Attorneys' offices. The NC Justice Reinvestment Act of 2011 expanded eligibility criteria regarding felony charges in NC General Statute 90-96 and required that the option be made available to all first-time felony drug possession offenders. Previous law only allowed for felony possession of less than one gram of cocaine and it was at the prosecutor's discretion whether to defer prosecution on any drug offense. The Division of MH/DD/SAS coordinates this statewide initiative through its Justice Systems Team by approving programs to provide DES as well as ensuring the training and certification of DES Instructors.
- Juvenile Justice Substance Abuse Mental Health Partnerships emphasize checking eligibility for and enrolling eligible clients in programs, such as Medicaid and Health Choice (SCHIP in NC), so that SABG and MHBG funds may be used to provide services, supports and other needs that have no other funding source. Juvenile Justice Substance Abuse Mental Health Partnerships serve youth that have been adjudicated delinquent, adjudicated undisciplined or on diversion contracts and are pre-adjudication (see description in #3). The LME-MCO representative on the local team is often a member of the System of Care, Care Coordination, or Community Relations section of that LME-MCO. Operating under System of Care principles and using Child and Family Teams, the Partnerships are particularly designed to address coordination of care, including transitioning youth from Detention and Youth Development Centers back to the community.

3. Do the SMHA and the SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?

The Division of MH/DD/SAS is a signatory of a Memorandum of Agreement with the Division of Adult Correction and Juvenile Justice and the Administrative Office of the Courts. This MOA, initiated in 2000 and recently re-signed, guides local operations and articulates the state's commitment to evidence based treatment and correctional practices.

- Treatment Accountability for Safer Communities (TASC) bridges justice and treatment systems by linking treatment and justice goals of reduced drug use and criminal activity. Objectively balancing public safety and public health, the TASC care management model reduces recidivism and improves justice, treatment and individual outcomes. TASC is organized into four regions which reflect the state's four judicial divisions, consistent with the unified court and statewide probation systems, and is available in all 100 North Carolina counties. Services include: screening and assessment of an offender's need for substance abuse or mental health services; treatment matching to ensure that the offender receives the correct level and type of care; referral and placement with appropriate service providers; and care management through individualized service planning, coordination and monitoring to ensure compliance with criminal justice conditions, progress in treatment and recovery supports.

While the majority of adult justice-involved offenders are not Medicaid eligible, the TASC Standard Operating Procedures outline in the Placement Activities chapter the responsibilities for considering potential funding sources. TASC assists offenders in accessing services through authorization and coordination of services with the LME-MCO and treatment provider requirements. In an effort to maximize treatment resources, all available treatment programs are considered, including those funded by the Department of Public Safety. Through the navigation of services, supports and resources, TASC assists probationers, parolees and post-releases for a healthy and safe return to their communities.

- The Division of MH/DD/SAS has a long-standing partnership with the Judicial Branch and the NC Division of Adult Correction in the development, implementation and on-going support of North Carolina's Drug Treatment Courts. DMH/DD/SAS was an original partner in the development of the program and serves as a legislatively mandated member of the State Advisory Committee and is a signatory to the State Memorandum of Agreement regarding the operation of Drug Treatment Courts. TASC provides the care management for most of the adult treatment courts.
- At the request of the Department of Public Safety, DMH/DD/SAS is participating in a task force to address issues related prison inmates with mental illness. Recommendations are being developed in the areas of: evidence-based correctional mental health treatment practices, the use of restricted housing, re-entry practices related to community-based treatment, safe transportation practices, disciplinary procedures, the use of restraints, training for custody staff

- Driving While Impaired (DWI) Services are specialized services that ensure individuals with DWI convictions complete a clinical substance use assessment, and either substance abuse intervention or treatment before their license may be considered for reinstatement. The services offered include the following levels of care: ASAM Level .05 (early intervention), ASAM Level I (outpatient), ASAM Levels II.1 and II.5 (intensive outpatient and comprehensive outpatient) and various ASAM Level III services (residential and inpatient). DMH/DD/SAS administration of these services includes: policy development; technical assistance; training; oversight of DWI-related evidence-based practices, laws and rules; and authorization and monitoring of DWI-specific service providers. The DWI Services office coordinates with the Division of Motor Vehicles (DMV), NC Department of Transportation, to ensure substance abuse services are verified and communicated to DMV as required for DWI offenses and DWI-related Driving While License Revoked offenses. An automated process for directly entering information regarding treatment compliance into the individual's motor vehicle record at DMV is used.
- DMH/DD/SAS works collaboratively with the Department of Public Safety, Division of Adult Correction and Juvenile Justice (DACJJ), to manage the Juvenile Justice Substance Abuse Mental Health Partnerships. The Partnerships are local teams lead by LME/MCO and JJ staff working together with providers to deliver effective, family-centered services and supports for juvenile justice- involved youth with substance use issues or co-occurring substance use and mental health problems. The Partnerships operate under System of Care principles and ensure the completion of comprehensive substance use and mental health screening and assessments; the provision of evidence-based treatment options; the use of Child and Family Teams; and the involvement of JJ's Juvenile Crime Prevention Councils to support a recovery-oriented system of care. Partnerships are active in 72 out of 100 counties and serve youth that have been adjudicated delinquent, adjudicated undisciplined or on diversion contracts and are pre-adjudication.

4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

Yes, interagency and cross-trainings are provided for behavioral health providers and criminal/justice to support and expand our collaborative work, increase awareness and skills in working across systems and with those who live with serious mental illness and/or mental health challenges, and/or substance use disorders.

- CIT trainings are conducted in all LME/MCOs in North Carolina. Since its inception, as of January 2015:
 - 7,004 law enforcement officers are CIT certified;
 - 352 law enforcement agencies participate in CIT;
 - 755 telecommunicators (dispatchers) have received CIT training; and,
 - 399 emergency medical technicians, paramedics and fire fighter have completed CIT training.

- This past calendar year (2014), an additional 1,094 officers became CIT certified, resulting in 19% more CIT certified officers than existed in 2013. Currently, approximately 33% of all law enforcement officers in North Carolina have completed CIT training. Also, an additional 21 law enforcement agencies began participating in a CIT program in North Carolina in 2014, representing a 6% increase from the previous year in the number of law enforcement agencies participating in a CIT program. In addition, 2014 saw an additional 73 telecommunicators trained in CIT, an 11% increase from the previous year.
- Regional meetings are held one to two (1-2) times per fiscal year which address training needs for behavioral health and juvenile justice. The meetings are held with the local teams of the Juvenile Justice Substance Abuse Mental Health Partnerships. The regional meetings are held to model collaboration at the state level and encourage collaboration at the local level. Training offered through these meetings is determined by the local team's requests and needs and has included topics such as the role of Young Adult Advocates, Increasing Family Engagement, Creating an Effective System of Care for Juvenile Justice-Involved Youth, Care Coordination, Collecting and Using Data to Inform Local Decision Making, and Responsible Information Sharing. Through this juvenile justice initiative, a variety of other trainings are provided to promote the use of evidence-based practices and treatments across the systems, such as the Global Appraisal of Individual Needs, Trauma-Informed Care, Seven Challenges and Brief Challenges. Additional training can be requested by local teams via the technical assistance and training program.
- Through TASC, no-cost online trainings, webinars and face-to-face are available to treatment providers and criminal justice professionals – particularly the Department of Public Safety on topics such as Training for Community Corrections Officers on People with Cognitive Disabilities, Tools of the Trade: Incorporating Science into Practice, Treatment Planning, Trauma-Informed Improves Case Management for Criminal Justice-Involved Clients, Co-Occurring Disorders, Confidentiality and Mental Health First Aid.

DMH/DD/SAS and TASC assisted the Division of Adult Correction in the development of statewide training for probation officers on mental illness. The modules included:

- Module 1 - Using the Risk Need Assessment (RNA) flags to determine the need for a Mental Health referral: reviews Mental Health flag on the RNA, explains why certain questions are asked and explains what the questions mean. Gives suggestions for follow up questions, ways to initiate a conversation with an offender about their answers, how to interpret answers & what steps to take for referrals to TASC & other providers.
- Module 2- Severe & Persistent Mental Illness: explains the term, "Severe and Persistent Mental Illness" or SPMI. Reviews major disorders & their symptoms. Briefly discusses how substance abuse can co-occur with mental illness.
- Module 3- Helping Offenders with Mental Illness Adhere to Medications: discusses the reasons people may not take their medications as prescribed. Gives suggestions for how to talk with offenders about medications & help offenders better adhere to their medication regimens. Provides a medication chart which lists the major psychiatric medicines and their uses and side effects.

- Module 4- Other MH Disorders: explains personality disorders & focuses more specifically on borderline & antisocial personality disorders. Discusses PTSD & traumatic brain injury.
 - Module 5- Crisis Response: explains what it means for a person to be in crisis, how to tell if someone is in crisis, & how to talk to a person in crisis. Discusses referrals that officers can make when an offender is having a MH crisis & provides web links to resources in their county.
 - Module 6- Recognizing and reducing the negative effects of job-related stress: discusses burnout & vicarious traumatization that probation officers may experience. Describes how to recognize the symptoms & gives suggestions for preventing & addressing burnout & vicarious trauma. Officers are provided with Employee Assistance Program referral information.
- For DWI Services at the ASAM .05 level of care, Prime for Life, an evidence-based curriculum was adopted for individuals who are not diagnosed with a substance use disorder but have been convicted of a single DWI offense. DMH/DD/SAS trains providers in this curriculum. DMH/DD/SAS DWI Services staff provide training through a variety of existing training venues as well.

Environmental Factors and Plan

13. State Parity Efforts

Narrative Question:

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.⁸³

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.⁸⁴

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. SMHAs and SSAs should collaborate with their state's Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Please consider the following items as a guide when preparing the description of the state's system:

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

Please indicate areas of technical assistance needed related to this section.

⁸³ <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>

⁸⁴ Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. *Psychiatric Services*. 60(12) 1589-1594

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

13. State Parity Efforts

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?

A specific financial amount has not been earmarked, but efforts have been made to host training events for providers and stakeholders to educate them about The Affordable Care Act, Parity, and the changing health care environment.

2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?

Yes - the Alcohol and Drug Council of North Carolina received a CMS Navigator grant targeting individuals with mental health and substance use disorders for enrollment. North Carolina had one of the highest number of enrollments of the uninsured in the nation.

3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

Yes – the state has provided resources to provider and consumer organizations to assist them in understanding health insurance options and the requirements of parity.

Environmental Factors and Plan

14. Medication Assisted Treatment

Narrative Question:

There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 40⁸⁵, 43⁸⁶, 45⁸⁷, and 49⁸⁸. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

Please indicate areas of technical assistance needed related to this section.

⁸⁵ <http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939>

⁸⁶ <http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214>

⁸⁷ <http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131>

⁸⁸ <http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Not applicable to the MHBG.

Environmental Factors and Plan

15. Crisis Services

Narrative Question:

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](#)⁸⁹,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports being used to address crisis response include the following:

Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)
- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

Please indicate areas of technical assistance needed related to this section.

⁸⁹Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

15. Crisis Services

Please indicate areas of technical assistance needed related to this section.

The state has made significant progress in understanding the need for ongoing development of a continuum of crisis intervention services, and has established the NC Crisis Solutions Initiative in order to manage the related work. Please see www.nccrisissolutions.org for specific details. The state is also grateful for a recently approved technical assistance request for consultation around the development of peer operated hospital diversion services. It is in the area of the use of peers throughout the crisis intervention continuum where the state could most use continued outside expertise and consultation.

Environmental Factors and Plan

16. Recovery

Narrative Question:

The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- | | | |
|--------------------------------------------|-------------------------------------------------------|------------------------------------------------------------------|
| • Drop-in centers | • Family navigators/parent support partners/providers | • Mutual aid groups for individuals with MH/SA Disorders or CODs |
| • Peer-delivered motivational interviewing | • Peer health navigators | • Peer-run respite services |
| • Peer specialist/Promotoras | • Peer wellness coaching | • Person-centered planning |
| • Clubhouses | • Recovery coaching | • Self-care and wellness approaches |
| • Self-directed care | • Shared decision making | • Peer-run crisis diversion services |
| • Supportive housing models | • Telephone recovery checkups | • Wellness-based community campaign |
| • Recovery community centers | • Warm lines | |
| • WRAP | • Whole Health Action Management (WHAM) | |
| • Evidenced-based supported | | |

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Recovery is based on the involvement of consumers/peers and their family members. States should work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

Please consider the following items as a guideline when preparing the description of the state's system:

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

16. Recovery

- 1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?**

The state has adopted the SAMHSA definition of recovery and its ten guiding principles. The Recovery Summit held in March 2013 gathered people in recovery and other stakeholders to discuss recovery and make recommendations for recovery integration (mental health and substance use), recovery in practice (clinical services, consumer-operated services) and recovery in policy (managed care, state level). In planning this Summit, the state received technical assistance from SAMHSA's BRSS TACS initiative. The state currently has an Access to Recovery IV (ATR IV) grant project that is being implemented in partnership with Recovery Communities of North Carolina (a non-profit organization that is run wholly by people in recovery).

Additionally, the US DOJ Settlement Agreement calls for ensuring that the state develops a Recovery-Oriented System of Care. It states *"Individuals have access to the array and intensity of services and supports they need to successfully transition to and live in community settings, including supported housing. Such services and support shall: be evidence-based, recovery-focused and community-based."*

Since the inception of the Person-Centered Plan (PCP) in 2006, the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services has supported and encouraged the utilization of person-centered planning and the professional development and growth of all people engaged in the process. Through ongoing evaluation of the PCP, the Division of MH/DD/SAS has monitored the achievement of objectives using quantifiable measures, assessed the effectiveness of particular interventions and policies, as well as monitored public opinion. Subsequently, the PCP format has been redeveloped over the last five years, taking into careful consideration legislative requirements, new priorities that have emerged, innovative approaches that are available and evaluative information that has provided new direction for the planning process.

The Person-Centered planning process supports strengths and recovery and applies to everyone supported and served in the North Carolina mental health, developmental disabilities and substance use disorder system. Person-centered planning provides for the individual with, or the family of a person with, a disability, assuming an informed and in-command role for life planning, service, support and treatment options. The person with a disability, and his/her family, or the legally responsible person directs the process and shares authority and responsibility with system professionals about decisions made.

The policy of the NC Division of MH/DD/SAS is that the Person-Centered Plan (PCP) is the umbrella under which all planning for treatment, services and supports occurs. Person-centered planning begins with the identification of the reason the individual/family is requesting assistance. The plan focuses on the identification of the individual's/family's needs and desired life outcomes. This is not just a request for a specific service(s). The Qualified Professional responsible for the development of the PCP must

assure that the plan captures all goals and objectives and outlines each team member's responsibilities within the plan. This plan is based on what is most important to and for the individual/family as identified by the person/family to whom the plan belongs and the people who know and care about the person. This planning approach therefore supports good action and crisis planning. The plan captures long term and short term outcomes, goals and objectives, including detailed information regarding justification for continuation, modification or termination of a goal and it outlines each team members' responsibilities within the plan.

Person centered planning is based on a variety of approaches, values, principles or "tools" to organize and guide community change and life planning with people with disabilities, their families and friends. All approaches or "tools" have distinct practices, but share common beliefs. The NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services strongly believes that the key values and principles listed below must be evident in the planning process.

- 2. How are treatment and recovery support services coordinated for any individual served by block grant funds?**
- 3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations and families/significant others?**

A statewide Peer Support Services policy has been developed to ensure there is consistent across the state and it is recovery-focused and evidence-based. The stakeholder workgroup includes Certified Peer Support Specialists, peer support providers and other advocates.

As of 08/21/2015 there are a total of **1883** Certified Peer Support Specialists. See the attached chart following this section for specific demographics.

Peer Supports have been added to the Medicaid State Plan Amendment and are now included as a Medicaid 1915 (b)(3) service. In addition, as part of the Settlement Agreement with the U.S. Department of Justice, Peer Supports have been included in a variety of new functions. Certified Peer Support Specialists have been hired as "In Reach" specialists for assertive engagement of individuals living in adult care homes and hospitals. They are required staff for ACT teams. They will be hired in Supported Employment programs as "Employment Peer Mentors" and as "Tenancy Support Specialists" to help people gain and maintain independent living skills in order to better assure community integration.

- 4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program or standards for peer-run services?**

The state provides and supports training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers through the Consumer and Empowerment Team and through training contracts with consumer and family organizations, universities, and Area Health Education Centers.

This is also supported through the Division's contract with the Governor's Institute on Substance Abuse and is operationalized through trainings offered on recovery-oriented systems of care through the Behavioral Healthcare Resource Program, UNC School of Social Work.

5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches and services within the state's behavioral health system?

To facilitate guidance in determining the future evidence-based services and supports that will be provided through North Carolina's public system, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services developed the North Carolina Practice Improvement Collaborative (NC PIC). The NC PIC is comprised of representatives of all three disabilities and meets thrice yearly to review and discuss current and emerging best practices for adoption and implementation across the State.

The mission for the NC PIC is to ensure that all North Carolinians will receive excellent care that is consistent with scientific understanding of what works whenever they come into contact with the DMH/DD/SAS system. Research has found that even some of the most popular and well disseminated programs are not evidence based and in fact can be counterproductive. The provision of quality services and supports involve fidelity to proven intervention models.

Through its contract with the Division, NC PIC conducts literature reviews and provides critical thinking and analysis to specific questions regarding trends, best practices and implementation of services in the publicly funded system. They are tasked with building on on-going research, providing analysis and promoting information that will aid North Carolina providers in implementing high-fidelity, evidence-based and best practices. They have a specific focus on the development of a state-wide systems of care related to recovery supports and services and trauma-focused care.

PIC meetings must be conducted regularly on topics endorsed by the Division. These conferences must focus on implementation and fidelity monitoring strategies. Examples of recent trainings include: ***Addressing the Needs of Our Military Families in North Carolina, The Future of Crisis Response in North Carolina***, and ***Early Identification and Treatment of First-Episode Psychosis***.

6. Describe how individuals in recovery and family members are involved in the planning, delivery and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).

7. Does the state support, strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks and recovery-oriented services?

In 2001, the General Assembly enacted Mental Health System Reform legislation that also required the state to develop a state plan. The first guiding principle of the 2001 State Plan reads “Treatment, services, and supports to consumers and their families shall be appropriate to needs, accessible and timely, consumer-driven, outcome-oriented, culturally- and age-appropriate, built on consumer’s strengths, cost-effective, and reflective best practices.”

The State provides funding and supports for existing consumer, family, and youth organizations to expand self-advocacy, self-help programs, support networks and recovery oriented services. Peer Support is included in at least three of the State’s reimbursable service definitions: Assertive Community Treatment Team, Community Support Team, and Social Support Detoxification. In addition, several Local Management Entities-Managed Care Organizations have promoted recovery-oriented services and are reimbursing for these services through alternative service definitions and through PATH funds.

In 2006, the State developed and implemented the NC Certified Peer Support Specialist program (NCCPSS) to train and certify peer specialists. Currently, there are over 1800 Peer Support Specialists (CPSS) in the state. Peer specialists have been hired by providers and LME-MCOs to provide peer support and assist in various projects to promote advocacy and empowerment of consumers and family members. The state has also developed a web-based course designed to assist managers and supervisors wishing to enhance their skills supervising NC Certified Peer Support Specialists. All approved courses under this program are guided by recovery principles, national research and best practice reports (e.g. Pillars of Peer Support), and the evidence-based practice delineated in SAMHSA’s consumer-operated services toolkit.

In August 2012, the state signed a Settlement Agreement with the U.S. Department of Justice to develop and implement effective measures to prevent inappropriate institutionalization of individuals with SMI/SPMI. This includes the development of (1) permanent supportive housing, (2) transition protocols that include new “Transition Coordinators” and “In-Reach” staff providing engagement and linkage, and (3) community wrap-around supports and services such ACT, Peer Support, Supported Employment, and Tenancy Supports. The state is engaged in workgroups with stakeholders, including consumers and families, to receive input in the planning process and ensure services are recovery-focused and evidence-based. Peer Supports have been included in a variety of new functions as a result of the settlement implementation plan. Certified Peer Support Specialists will be hired as “In Reach” specialists for assertive engagement of individuals living in adult care homes and hospitals. They are required staff for ACT teams. They will be hired in Supported Employment programs as “Employment Peer Mentors” and as “Tenancy Support Specialists” to help people gain and maintain independent living skills in housing.

Peer Supports have been added to the Medicaid State Plan Amendment and are now included as a Medicaid 1915(b)(3) service. Previously, Peer Support services were being paid mainly through alternative service definitions with limited state funds. Peer Supports are paid through Medicaid funding across all LME-MCOs as they expand managed care.

Additionally, the US DOJ Settlement Agreement calls for ensuring the state develops a Recovery-Oriented System of Care. It states “Individuals have access to the array and intensity of services and supports they need to successfully transition to and live in community settings, including supported

housing. Such services and support shall: be evidence-based, recovery-focused, and community-based.” becomes a shared value of individuals we serve, service providers and administrators.

It is important to note that transition age youth do not always relate to the idea of “recovery”. The system and premise North Carolina embraces for children, youth and families is that of building resilience; some youth better identify with ‘pre-recovery.’ To this end, the State has provided funding to North Carolina Families United (NCFU), the statewide family organization, to produce a training curriculum for families and service providers on how to implement system of care and how to choose service providers for families with SED and their families. With support from the block grant, NCFU has funded and trained Family Support Partners and specialists. NCFU works with NAMI in NC as well as community mental health associations and Family Support Network organizations in an effort to unify and strengthen work in this arena. Each of these entities along with other community and state organizations and agencies participate in the NC Collaborative for Children, Youth and Families, and statewide interagency forum for promoting the tenants and practices that further strengthen an effective System of Care in North Carolina. Partnerships with families and youth leaders and those in transition is vital to the success and sustainability of an SOC that promotes strengths and builds resilient children, youth and families, especially those living with or at risk for experience behavioral health challenges.

In addition, the State has legislation requiring consumer and family participation at the state and local level. NC General Statute 122C-1701 State Consumer and Family Advisory Committee (SCFAC), enacted in 2006 requires consumer and family member participation at the state and local level. The SCFAC functions as a consumer advisory board to DMH/DD/SAS. A local Consumer and Family Advisory Committee (CFAC) is similarly required at each LME-MCO to review, comment on and monitor the implementation of the local business plan; identify service gaps and underserved populations; make recommendations regarding the service array and monitor the development of additional services; review and comment on the LME-MCO programs budget, participate in quality improvement measures and performance indicators; and submit to the State CFAC findings and recommendations regarding ways to improve the service delivery system.

The CMHS Block Grant has a legislatively-mandated MH Planning Council (half of which consist of consumer and family representatives) that assists in formulating the CMHS Block Grant plan, including determining targets for the block grant indicators. The Council also reviews State plans and provides advice and recommendations to the State on service delivery issues. Many of the Planning Council’s consumer and family representatives also sit on the SCFAC and LME-MCO CFACs.

The state has supported the development and growth of Person Centered Thinking (PCT) and Person Centered Plans (PCP). All treatment plans must include a completed PCP for each individual receiving care. Consumers and family members are entitled to participate in their own individual plan of care. Advocacy and Customer Service staff has educated consumers and family members of their rights and opportunities to advocate for services.

LME-MCOs have policies on Cultural Competence and educate their providers, consumers, family members and LME-MCO staff on the importance of being culturally competent.

The state has provided technical assistance to LME-MCOs so that they can conduct Crisis Intervention Training (CIT) in their local communities in order to educate law enforcement officers. In addition, local CFAC members participate on the CIT panel presenting information relevant to dealing/living with persons with disabilities.

The State sponsors meetings that identify individual and family members' issues and needs regarding the behavior health system and developed a process for addressing these concerns. DMH/DD/SAS developed policy DO 112 Consumer and Family Member Volunteer Appointment to DMH/DD/SAS workgroups and committees. This policy was developed so that all interested individuals have an equal opportunity to participate in the policy and decision making bodies of the system. Notices of all volunteer opportunities are posted on the Division website and also sent out to a mass mailing of all local CFACs, SCFAC and other grass root organizations. Members of the Consumer Empowerment Team (CET) of the Division attend all local CFAC meetings and have developed connections with individuals and local advocacy organizations in each of the catchment areas. CET members routinely inform their individual contacts about opportunities for inclusion and participation in the ongoing development and monitoring of mental health, developmental disability, and substance use service system.

Information on local support groups, advocacy organizations at the state and federal level, and various self-help options are posted on the website. DHHS and DMH staff meet monthly with advocates to discuss ongoing issues across the state. The State has provided funding for Recovery Education Centers (REC) that focus on evidence-based practice curriculums designed to build recovery skills or wellness recovery practices. The Division has funded two consumer-run organizations which teach advocacy skills and provide ongoing support to their members: The NC Mental Health Consumers Organization and the NC Association of Self Advocates. Some LME-MCOs use state dollars to provide funding and support to local NAMI Chapters and NC First in Families to provide ongoing education and support to their members. Some LME-MCOs also provide meeting space and other types of support for 12-step programs and other peer support groups. The Consumer Empowerment Team has begun to present information to local community groups on how to access services in their local communities. The Consumer Empowerment Team will further continue to expand their contact beyond LME-MCO CFACs to grass roots organizations, faith based organizations and other community groups to develop a large network of advocates across the state.

- 8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.**
- 9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity and other co-morbid health conditions.**

The Division has promoted integrated care efforts of behavioral health providers for several years. It has also promoted the use of "Evaluation and Management" procedural codes that call for the provision of health screening and risk assessments for obesity, high blood pressure and other conditions often associated with long-term use of medications frequently prescribed for serious mental illnesses.

The Division of Medical Assistance has recently clarified the inclusion of tobacco cessation programs by LME-MCOs and can be billed by physicians and physician extenders. Physicians, nurse practitioners and physician assistants can use codes 99406 and 99407 for this purpose.

The NC DHHS screens, assesses and provides treatment options for smoking and other unhealthy behaviors at all three state psychiatric facilities. In 2011, NC became one of SAMHSA's Leadership Academies for Wellness and Smoking Cessation. Through this effort, a diverse group of stakeholders including treatment providers came together to create an action plan for reducing the prevalence of tobacco use among behavioral health consumers. The partners adopted the target to reduce smoking prevalence among the general population to 16%; adult mental health clients to 39%; and adult substance abuse clients to 39%, each by end of year 2016. This initiative, named *Breathe Easy NC*, is working on the following strategies: 1) Facilities, 2) Provider Education and Quitline, 3) Consumers and Community, 4) Policy Systems Performance Measures and Outcomes and 5) Sustainability. Each strategy group is working on specific tasks to be completed over the next year. The stakeholders meet annually in September to assess progress in achieving its established targets. The Facilities and Provider Education/Quitline committees have been working to offer nicotine dependence training and 5 A's Training for providers. They also have presented on tobacco dependence treatment in conferences such as the Addiction Professionals of NC and webinars. The Division has also been routinely promoting the use of the Quitline NC to providers across the state not only to assist their clients with quitting their tobacco use, but for their staff as well.

The Division has been actively working with the Division of State Operated Health Facilities (DSOHF) and the Division of Public Health to support an increase in nicotine dependence treatment in state facilities (psychiatric hospitals, developmental centers, alcohol and drug abuse treatment centers), as well as in other public and private treatment facilities. DSOHF, in collaboration with the University of North Carolina at Chapel Hill, received a grant in 2011 from the Pfizer Medical Group to implement a Quality Improvement Project with two treatment facilities to integrate nicotine dependence treatment into their systems. With support from DPH, an online Tobacco Dependence Training Program was created that addresses tobacco use treatment integration into chemical dependence services; assessment diagnosis and pharmacotherapy; behavioral interventions; treatment planning and practical applications.

10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?

The State Mental Health Agency has a housing plan to address the housing needs of persons with serious mental illness so that they live in the least restrictive setting possible. The Best Practices Team of Community Policy Management of DMH/DD/SAS has two housing specialists on its staff, one of whom is a housing coordinator who works full-time on finding and increasing housing opportunities for people with mental health and/or substance use disorders and/or who are in need of developmental disability services. In addition, each LME-MCO has its own full-time housing coordinator working on the same tasks. DMH/DD/SAS participates in housing programs of the state such as the State Department of Housing and Community Development, the State Housing Finance Agency, and Local Housing Authorities. The State Housing Trust Fund, funded with \$9.6 million in recurring funds by the NC General Assembly, provides support for supportive housing, home ownership, construction, rental apartments, new construction, and rehabilitation. It also participates in a variety of federal housing programs such as those funded by the US Department of Housing and Urban Development. The state is

currently engaged in a project to transition people with mental illness living in adult care homes to more appropriate settings where they will receive better services and supports.

The State of North Carolina entered into a settlement agreement with the United States Department of Justice (USDOJ) on August 23, 2012. The purpose of this agreement is to assure that persons with mental illness are allowed to reside in their communities in the least restrictive settings of their choice. This Agreement is intended to ensure the state will meet the requirements of the ADA, the Rehab Act, and the Olmstead decision, which require that services offered to individuals with disabilities shall be provided in the most integrated setting appropriate to meet their needs. While this settlement agreement was designed to address specific Olmstead issues, it is the desire of the Division that this will provide the infrastructure for a more comprehensive housing response and plan. An integral component of the agreement includes the utilization of peers as "In Reach" Specialists who provide in reach services to individuals residing in adult care homes who may desire more independent housing options. These In Reach Specialists, typically either directly employed by the LME-MCOs or under contract through a provider agency, will play a vital role in transitioning individuals to less restrictive settings.

For the past several years, each LME-MCO has had a contractual requirement to have at least one FTE designated as the Housing Specialist for their catchment area. The responsibilities of the Housing Specialist, which encompass all disability groups, include the following broad categories:

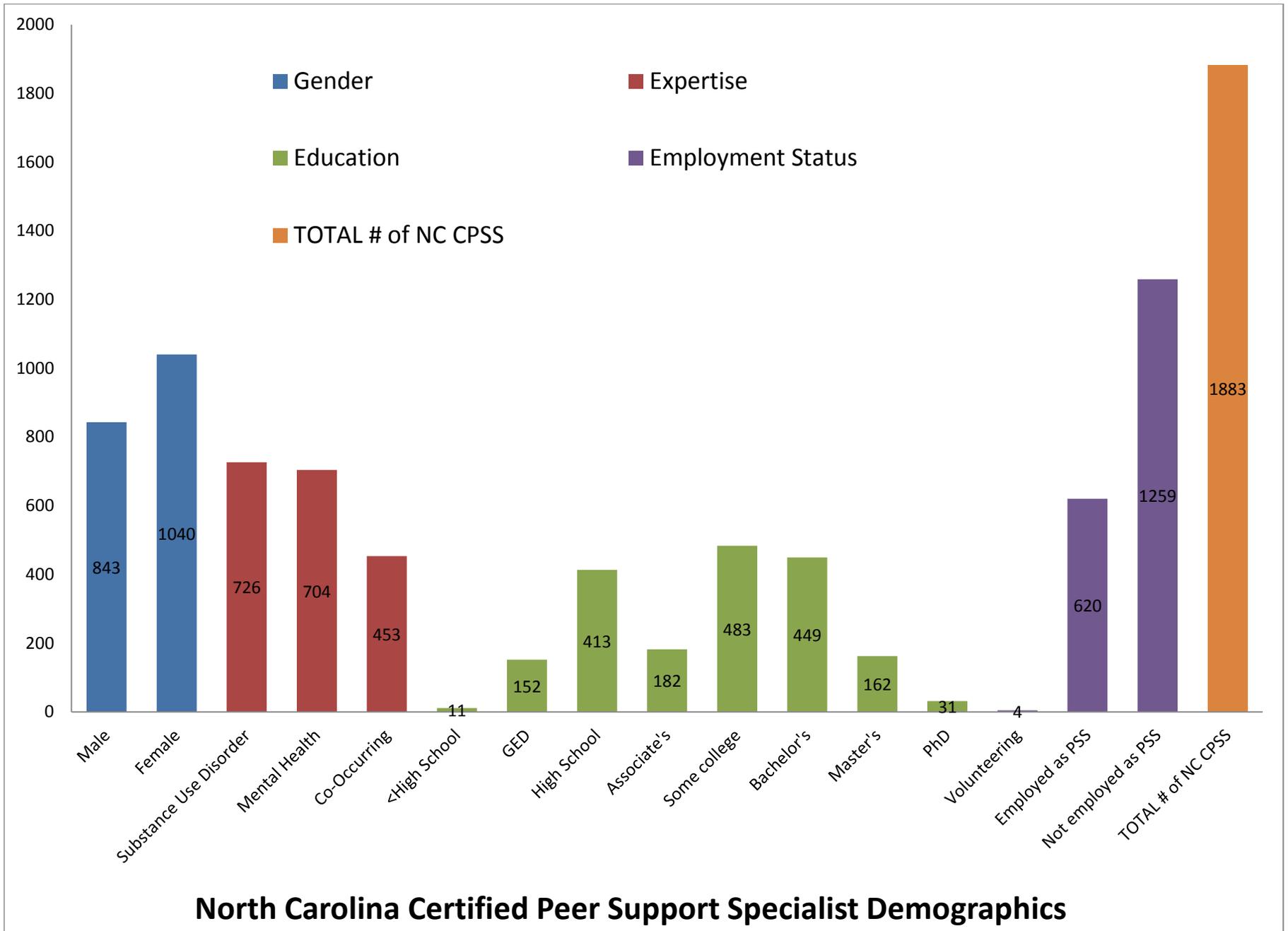
- Serve as Lead Agency for the Targeting Program and the Housing 400 Initiative to ensure DMH/DD/SAS tenants have the support services they need in addition to affordable housing;
- Actively participate in the local Continuum of Care (US Department of Housing and Urban Development housing programs that provide units for DMH/DD/SAS consumers who are homeless) by engaging in activities that support the expansion of housing opportunities to ensure DMH/DD/SAS consumers have access to Continuum of Care housing units;
- Develop and annually update a Strategic Housing Plan that includes an inventory of local, existing housing for DMH/DD/SAS consumers; the housing needs of DMH/DD/SAS consumers; strategies for filling the gap between existing housing and housing needs; barriers to implementing those strategies; and means for assessing implementation of the Strategic Housing Plan;
- Participate in the quarterly meetings for Housing Specialists that are offered by DMH/DD/SAS;
- Educate and be a resource for MH/DD/SAS professionals, advocates, consumers, families and service providers in identifying, accessing and maintaining affordable housing, regarding the NC Landlord-Tenant and Fair Housing laws and on negotiating reasonable accommodations;
- Develop a positive working relationship with local public housing authorities and HUD Section 8/Housing Choice Voucher administrating agencies to improve access and increase the supply of these resources;
- Establish partnerships with other local, affordable housing and MH/DD/SAS advocates to improve access and increase the supply of resources for MH/DD/SAS consumers;

- Develop and maintain an internal wait list for consumer referrals to housing resources that have referral relationships with the LME/MCO; and
- Work with other agencies to identify and secure housing and support services funding opportunities from private, city, county, state and federal sources.

Many of the above responsibilities speak to systemic progression. In addition, each LME-MCO has the capacity to develop alternative service definitions to better meet specific needs of their geographic areas. For example, some LME-MCOs have developed service definitions that provide a reimbursement mechanism for contracted providers to maintain contact and provide supportive services to individuals (that do not meet medical necessity criteria for higher levels of care) in independent housing settings. This helps assure that individuals have the necessary supports in place to remain in less-restrictive settings.

11. Describe how the state is supporting the employment and educational needs of individuals served.

North Carolina has supported the Individual Placement Support- Supported Employment (IPS-SE) Evidence Based Practice for adults with severe mental illness and co-occurring mental health and substance use disorders since 2013. There are currently 34 teams providing the service across the state, and DMH/DD/SAS continues to partner with LME-MCOs to identify gaps in services and possible solutions to ensure individuals across the state can access this service. DMH/DD/SAS staff are primarily responsible for completing fidelity reviews on all teams, developing fidelity action plans, and providing training and technical assistance to support providers in implementing this model. DMH/DD/SAS actively partners with the Division of Medical Assistance and the Division of Vocational Rehabilitation to ensure that fidelity based practice is supported by all divisions. DMH/DD/SAS also partners with stakeholder groups, including: NAMI, NC ACT TA Center and Employment First NC to increase awareness of IPS-SE across the state, and ensure that these stakeholder groups have information to advocate for this service. Finally, North Carolina is a member of the Dartmouth IPS Learning Collaborative, which provides technical assistance and support not only from other states and countries implementing this service, it provides a direct means of communication with the organization that developed and researched this model.



Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead

Narrative Question:

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in [Olmstead v. L.C., 527 U.S. 581 \(1999\)](#), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to Section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office of Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

17. Community Living and the Implementation of Olmstead

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services and employment services.

North Carolina's Olmstead plan includes a comprehensive supportive community based housing initiative. Through a housing first approach, individuals that would like to live in the community with supports, and placed in homes without the requirement to demonstrate "readiness". We have worked with our partners at the LME-MCO level and their contracted providers to meet individuals 'where they are at' and assist them with skills necessary to living outside of an institutional setting. Full participation with a harm reduction model is essential as many individuals are coping with substance use in addition to mental health needs.

North Carolina has a few projects identified to assist individuals with the expense of living in the community. In addition to utilizing other existing subsidized housing programs such as Housing Choice Vouchers, Shelter Plus Care, and SHP programs; North Carolina offers the Targeting Unit program. This is a tax incentive program, where in exchange for a tax adjustment developers of new housing units dedicate at least 10% of their project to low income individuals. This is the project on which the HUD 811 project was based. Individuals can also receive rental assistance through the Keys program funded through the NC Housing Finance Agency. A new program call Transitions to Community Living as assists an identified population with leaving state hospitals or adult care homes (ACH), and transitioning back into the community.

Key to the success of an individual remaining in the community is the type of supports provided. These are identified with the individual through the Personal Care Plan process. North Carolina sets up services to individuals by way of our LME-MCO system. Each LME-MCO is responsible for a specific catchment area and contracting with providers to meet the presenting need. For supportive housing some key services include ACT, Community Support Teams, and Peer Supports. ACT services are currently being reviewed to make sure they meet fidelity. This is being done by reviewing them in the Team ACT standards. Peer specialists are certified through an intensive program developed by the state and university partners. In addition to support services, individuals are assisted with community living by supported employment. These programs are also being review for fidelity on the Dartmouth model.

2. How are individuals transitioned from hospital to community settings?

Individuals are transitioned out of hospitals through an In Reach and Transition model. Each LME-MCO has received state funding to provide staff to first identify individuals that want to live in a more independent situation in the community. Once those individuals are identified, then the Transition Coordinator meets with the individual to begin the planning process. Everything from housing selection, to services, to furnishing is reviewed and set up in the individual's plan. Transition coordinators are trained in the process to assist individuals out of the institutional setting and have a full knowledge of housing options available.

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead decision of 1999?

To assist with meeting the Olmstead decision, North Carolina is working on a state wide housing plan. This will encompass all aspects of supportive housing. A special focus will be on developing new and additional housing resources. In a state that is well over 60 percent rural, housing options that meet Federal level inspections can be difficult to identify. Through partnering with the Housing Finance Agency, efforts are being review to see how to encourage more property owners to participate with stipend type programs. Efforts are being put in place to see if incentives can be identified to correct inspection issues in exchange for an agreed upon lease period. Lastly, discussions on how to assist those individuals with credit or criminal backgrounds move beyond that barrier are taking place.

In addition to state level plan, each LME-MCO is funded by state dollars to operate a Housing Specialist in their organization. Those housing staff will be required to build off the state plan and develop a housing plan that reflects the issues in their catchment area. It should include how the housing staff will assist in developing housing opportunities. This includes participation on and in their local CoCs, networking with local housing authorities, and being a contact person for their local Targeting Unit program.

4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved.

North Carolina is involved with a settlement with DOJ over adults with SMI residing in adult care homes. The settlement was reached in the fall of 2012. It is an eight year plan to move a total of 3000 individuals into supportive community based housing. At this time the state is entering the fourth year of the eight year settlement.

The overall plan is to assist two thousand individuals out of ACHs and an additional thousand individuals who are residing in state facility without appropriate housing and are at risk of entering an adult care home. In both the adult care home and hospital setting, LME-MCO staff start by providing In Reach to the systems. Here certified peer specialists meet with individuals and explore what type of living situation they would be interested in. If an individual requests assistance with moving back to the community, In Reach then activates the individual in the Transitions to Community Living (TCL) project and the Transition Coordinator leads a team to support the move back to the community.

Through extensive planning that includes housing, services, and benefits; plans are identified and individuals are moved to the community. In order to make the housing affordable, the state has implemented its own voucher program and the individual will only pay 30% of their income towards housing.

LME-MCO are currently working with the state to make sure contracted providers for ACT and Supported Employment are operating programs that meet fidelity for that service model. Any individual participating can refuse services, however, everyone will receive at least Tenancy Supports as a means of providing well-being checks in the community.

Environmental Factors and Plan

18. Children and Adolescents Behavioral Health Services

Narrative Question:

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.⁹⁰ Most mental health disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.⁹¹ For youth between the ages of 10 and 24, suicide is the third leading cause of death.⁹²

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.⁹³ Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with more than 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.⁹⁴

According to data from the [National Evaluation of the Children's Mental Health Initiative](#) (2011), systems of care⁹⁵:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance

use, and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?
6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

Please indicate areas of technical assistance needed related to this section.

⁹⁰ Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

⁹¹ Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

⁹² Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

⁹³ The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁹⁴ Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010>.

⁹⁵ Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf>.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

18. Children and Adolescents Behavioral Health Services

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental health and substance use disorders?

North Carolina's response to the Willie M. lawsuit in 1979 originated the national System of Care model. The Willie M. lawsuit was a class action lawsuit on behalf of several adolescents who had been adjudicated delinquent, had a history of assaultive behaviors and demonstrated significant psychiatric problems. The class action suit stated that they were not receiving the behavioral health, educational, or community-based services they needed in order to succeed in at home, in school and in the community. The settlement stipulated that children meeting the class criteria had the right to individualized treatment in the least restrictive setting possible (NC DHHS, 1999). The resulting Willie M. program taught administrators, policymakers, researchers, practitioners a number of lessons upon which System of Care is founded:

- Importance of child-serving systems owning the children that the nobody else wanted
- Creating a new approach to treatment
- Creating seminal concepts in service delivery
- Focusing on measurable goals
- Changing the way scholars theorized about child psychopathology
- Establishing an innovative cost-accounting system
- Developing new community-based services for children
- Understanding the critical role of training.
- Demonstrating the crucial value of human relationships in mental health treatment

By 1999, the number of youth under this class action had grown to 1,650 and North Carolina was spending over \$100 M annually on this group, at an average of \$51,000 per child per year. (Willie M.: A Legacy of Legal, Social and Policy Change on Behalf of Children – Kenneth A. Dodge, Ph.D., Janis B. Kupersmidt, Ph.D., Reid Griffith Fontaine, J.D., M.S.)

When the lawsuit ended in 1999, North Carolina remained committed to the System of Care concept. Access to the Willie M. funding expanded to a broader population of children/youth with mental health needs, hoping to mitigate an increase in the numbers of young consumers with high/complex needs beyond what the existing continuum of care could meet. In addition, from 1995 to 2007, North Carolina won a series of SAMHSA Child Mental Health Initiative (CMHI) grants that initiated the development of local systems of care in 30 counties in North Carolina. Through both the Willie M. program and the CMHI grants, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) which is also the State Mental Health Authority and the Single State Agency for substance use, learned that the following SOC elements were necessary to achieve positive outcomes:

- Family/Youth co-leadership in the development of a local SOC;
- Strength-based approach to working with children and families;
- A full service array to meet the range of child/youth mental health needs;
- Necessity to partner with other child-serving systems and coordinate service supports in order to meet the mental health needs of children;

- A system of accountability at work at the individual child/family level, the local level and state level;
- Importance of growing and training a diverse workforce that can deliver effective treatment; and,
- Identification and measurement of treatment outcomes.

North Carolina adopted the System of Care approach as the framework for the organization and the delivery of all child-serving systems in 2001. Since then North Carolina has established the following SOC infrastructure components:

- **State/Local Collaboratives** – The NC Collaborative on Children, Youth and Families -- a state-level interagency body that includes senior staff from all the public state child-serving agencies, family representatives and child and family advocates -- was established in 2000. The purpose of the State Collaborative is to identify shared goals for an overlapping population of children/youth with complex, multi-agency- involved challenges and to find solutions for those challenges.

In addition, local collaboratives (comprised of local public agency decision-makers, family representatives and child/family advocates) were established in the catchment areas of the local mental health entities. These collaboratives are to identify and negotiate barriers through an examination of local policies and administrative processes which undergird the local service delivery system and to support effective child and family teaming.

Whether at the state or local level, Collaboratives were designed as forums for cross-systems discussions and strategy development representatives to tackle barriers to effective service delivery at either the local and/or state level to create change that would result in improved outcomes for children and families. At both the local and state level, collaborative participants are charged with coordinating services, funding, training and local reporting requirements to eliminate service duplication, improve system responsiveness to children and their families, and to increase the available array and range of services/resources.

The State Collaborative now generates its own funding through an online SOC training for providers that it developed through the collaboration of agencies and family and youth.

Going Forward: The next developmental phase for the State Collaborative is to become an entity that shares responsibility and accountability at the state level regarding how agencies and families work together to produce better outcomes for children and families. More specifically, the State Collaborative will move into examining opportunities to maximize incentives, analyzing the state's current financing of child and family services, and identifying opportunities to align practice with program and system goals statewide.

Lastly, the State Collaborative's leadership role will be strengthened by creating a two-way communication channel with local collaboratives for the purposes of 1) to convey clear expectations regarding outcome accountability to Community Collaboratives 2) for the State Collaborative to hear from the Community Collaboratives about local progress (or not) and the resulting impact on child and family outcomes and 3) for Community Collaboratives to provide

feedback about policies, funding constraints and other administrative barriers that impede positive outcomes at the local level

- **Family/Youth Leadership at all levels of the North Carolina System of Care:** North Carolina Families United (NCFU) is the statewide family network and the state chapter of the National Federation of Families. A statewide agency was established in 1997 as part of the first CMHI grant. NCFU became a nonprofit 501 (c)(3) organization (<http://www.ncfamiliesunited.org>) in 2000. It is a family support and advocacy organization that links families to State and community partners to improve the lives of children and youth with serious emotional disorders and their families; to educate and advise policymakers and other stakeholders on the unique strengths and needs of children with severe emotional disturbance; and to actively promote philosophy and guiding principles of SOC. It has nearly 500 family leaders/supporters/advocates across the state, including at least 40 who have received the national certification as family partners in SOC.

As the statewide chapter of Youth M.O.V.E (Motivating Others through Voices of Experience), NCFU also assists young adults and agency partners with bringing youth leadership to their area; offers individual youth membership to young adults interested in transforming systems; improves youth involvement on decision-making boards at the local and state levels; unites the voices of young adults through youth leadership development and expands local chapters of Youth M.O.V.E.; and creates opportunities for peer-to-peer mentoring. The first NCFU President co-chaired the State Collaborative with a Duke Child and Family Policy researcher for the first few years. NCFU staff and members continue to be active participants in the State Collaborative as it evolves. NCFU staff also provide technical assistance to local collaboratives and family groups to encourage family participation in local SOC planning, training, supports in local child and family teams, etc. There are 47 youth leaders around the state.

Going Forward: With the state family/youth leadership component well-established (if not fully stabilized), the focus now is on identifying financing opportunities that will allow the local communities to recruit and expand the family and youth voices involved in the local system of care development. North Carolina has sent a team of family members, youth and administrators to participate in the *Growing the Youth and Parent-Peer Support Movement: Working Strategically to Support Implementation (Peer Support)* in July 2015.

- One of the first decisions of the State Collaborative was to use the **Child and Family Team as the organizing principle for service delivery** for all children receiving public funding services. Through the Willie M. Program and the early CMHI demonstration grants, North Carolina learned the concept of individualized treatment planning for children/youth with mental health needs within a “wraparound” approach. In Wraparound, a team of people (including people from formal and informal agencies and natural family/community supports) help the family to coordinate existing resources, supports and services into an individualized plan for the identified child/youth. The preferences and choices of the child/youth and his/her family leads the development and implementation of the plan. Although the other child-serving systems (i.e. child welfare, juvenile justice, education, etc.) have individual histories, guiding philosophies, and

best practice models, the CFT process has become the common basis of operation in North Carolina.

Going Forward: The challenge today is that there are multiple child and family teams, with multiple purposes, definitions and processes. Families who are multi-agency involved find themselves subjected to many meetings with uncoordinated objectives and multiple plans for which they are held accountable. The primary objective now is to look for ways that a single CFT process can be used to accomplish key goals within each system and to coordinate across systems, so the child and family's access to services for which they are eligible is maximized (and not duplicated); and the number of meetings and paperwork is streamlined.

Various local communities have looked at the issue of ensuring that the current CFTs are operating with fidelity. DMH/DD/SAS has shared resources with LME-MCOS for monitoring CFT processes. However, through the High Fidelity Wraparound component of the SOC Expansion grant, DMH/DD/SAS intends to work with the State Collaborative to identify/develop a tool that can be used statewide to set standards for all CFT meetings (regardless of the service delivery system) and to measure the team's fidelity to those set standards.

- **Establishing a workforce of local SOC Coordinators** specifically charged to support/facilitate local system of care development across the state. Based on the success of the three CMHI SOC demonstration projects (from 1995-2007), DMH/DD/SAS obtained \$2 M per year in recurring state funds to establish SOC coordinator positions at the state and local levels. These coordinators are responsible for performing specific required SOC functions to ensure the ongoing local SOC development throughout the state. The demonstration grants initiated system of care development in 30 counties and established several essential state infrastructural components. This particular workforce segment has been critical to NC's efforts to take SOC to scale. These SOC coordinators collaborate with local child and family advocates, local child-serving public agencies, private providers and a host of community-based agencies to keep growing and spreading SOC.

Going Forward: One component critical to maintaining the depth of SOC development and continued expansion is a training and technical assistance system. North Carolina does not have this infrastructure component in place. As will be discussed in Question #4, DMH/DD/SAS has found a way to provide support for the evidence-based program development aspect of SOC. However, North Carolina has not been able to create a sustainable training and technical assistance system that supports ongoing child and family team practice development, collaborative development, family and agency leadership development and strategic planning necessary. The Division has been able to plant seeds of support at universities (e.g. UNC-Chapel Hill BHRP, UNC-Greensboro Child, Youth, and Family Partnership, Duke University Child and Family Policy, etc.) through contracts to support various aspects. However, this is fragmented and incomplete. The goal is to develop a comprehensive training and technical assistance that will address all of the components needed to implement SOC within each local community and across the state.

The other challenge facing the SOC implementation goals in North Carolina is the profound change that the behavioral health system has undergone in the past 15 years. In October 2001, a substantial change to the public behavioral health system in North Carolina. House Bill 381 (S.L. 2001-437) known as the Mental Health System Reform Act transformed area programs that directly employed individuals to provide services to Local management Entities (LMEs) who managed services by contracting with providers for the delivery of services in their respective catchment areas, effectively separating management from delivery functions. Between 2001 and 2010 the number of LMEs was reduced from 41 to 23.

In 2001, the state contracted with a private for-profit company to conduct utilization reviews to determine the medical necessity of mental health and substance abuse services for Medicaid recipients as a means of controlling costs. This was the state's first foray into managed care for the public behavioral system.

The change over to the LME system had a substantial impact and some unintended consequences on state agencies, providers, and the people served through the public service delivery system. One unintended consequence was the explosion of private provider agencies in the state. This changed the nature of the workforce through a dramatic volume increase as well as an extreme diversity in the range of skills, level of expertise, and philosophical commitment of the individuals in the field.

In 2005, the state designated a Local Management Entity – Piedmont Behavioral Health – to pilot Section 1915 (b) Managed Care/Freedom of Choice Waiver and (c) the Home and Community-based Services Waiver that allowed the pilot LME greater flexibility in authorizing, budgeting, managing, and delivering innovative mental health and substance use services under a Managed Care environment where it received a set amount of funding from the state based on a capitated amount for each Medicaid-eligible person served in its catchment area. Under the waivers, Piedmont Behavioral Health established the Comprehensive Community Model that established criteria for staffing and services in the selection of the mental health and substance use agencies for the closed network of providers in the catchment area. The waiver program was expanded to other sites beginning in 2011. As of July, North Carolina is composed of nine sites currently operating as Managed Care Organizations. [Note: All entities still retain their LME responsibilities as well.]

During this time DMH/DD/SAS merged branches in its organizational structure that served age or disability-specific populations into sections composed of teams formed along function and content expertise lines.

Further changes are anticipated based on current legislative debates underway. Eventually there may be 4 regional accountability entities. The NC Expansion grant participating sites were chosen based on their geographic presence in the potential regional catchment areas to ensure SOC development would be fully incorporated in NC's managed care evolution.

Wrestling to integrate the SOC development with the managed care evolution may be the biggest challenge for local system of care development throughout NC. This change is presenting an opportunity and incentive to become more creative about filling the gaps in the child behavioral health service array. Hospitalization and residential treatment are the biggest expenditures in the North Carolina child behavioral health system. MCOs are developing alternative service and in lieu of definitions based on evidence based programs and local best practices. MCOs are also paying enhanced rates for specialized evidence-based therapies (e.g. trauma-focused cognitive behavioral therapy and parent-child interaction therapy).

Another unintended side effect of the reform is that as the local Area programs morph into LME-MCOs that cover larger geographic service areas than before and struggle to absorb new high level management responsibilities, leadership can lose sight of local community efforts that are necessary in order for a system of care approach to function well. To that end, Division staff have been diligent each year in ensuring that System of Care functions and milestones are part of the Performance Agreement established between DHHS and these local LME-MCO. DMH continues to track the local SOC development work through SOC reports that are compiled by the SOC Coordinators, through each LME-MCOs progress on the Community Progress Indicator Report that is published quarterly, and the NCTOPPS (NC Treatment and Outcomes Program Performance System) reports. QM Team disseminates reports and provides Dashboard summaries through the DMH/DD/SAS website. The Division's audit process is evolving to take into account system of care objectives as well.

- **Data system:** The Willie M. Program and the CMHI demonstration grants taught state policy makers and administrators the importance of measuring treatment outcomes and identifying indicators of progress. DMH developed a web-based system (NCTOPPS) for collecting data (based on mental health indicators derived from the demonstration grants) and a system for analyzing the impact on mental health consumers. LME-MCOs are required to use this instrument as part of their Quality Management responsibilities. The performance agreement dictates that LME-MCOs require their service providers to train and collect data using this instrument. NCTOPPS data is now supplemented by another web-based substance abuse data collection tool.

Going Forward: (See question #5 for further discussion of the State's continued development of the overall management information system.) Local collaboratives are encouraged to gather data/information directly from families and youth who use the child service delivery systems, as well as, to use data from various grants and pilot projects. Such data combined with risk and need, utilization, cost, and outcomes data from each of the systems is helpful to each community for identifying strengths and challenges, formulating critical system concerns and for promoting policy and funding recommendations.

This year, through a joint endeavor, NC DMH/DD/SAS, the NC Division of Social Services and the Jordan Institute of UNC-Chapel Hill School of Social Work provided training to six local collaboratives on *Effective Cross-agency Continuous Quality Improvement (CQI)*. The project goals were for the collaborative members to 1) learn the 4 step CQI process for improving

outcomes; 2) understand the role of readiness in CQI and 3) prepare to address readiness issues within the collaborative. The overall purpose is to help all partners in the collaborative to learn to use a standard model to analyze data and develop goals and action steps that will lead to improved outcomes. The training project included face-to-face training for LME-MCO Quality Improvement staff who became the local facilitators for the CQI process, a two part webinars for the CQI teams, and a one hour facilitator conference call. Six collaboratives were selected through a competitive application process. Each collaborative chosen designated a CQI team of 4-6 people. Each team selected a readiness priority and/or a child outcome to address. Each team began the progress of collecting baseline data through review of local, shared data and making hypotheses and goals. After the collection of baseline data and the development of hypotheses, each team will develop an action plan that uses shared data to track progress and make improvements to their projects. The first reports are to be presented in November 2015. Based on the progress of this CQI pilot, DMH/DD/SAS will develop a plan of training and technical support for the remainder of Community Collaboratives in the use of a continuous quality improvement process in the development and tracking of priorities.

- **Enhancement of the continuum of care/service array.** The establishment of a Child Mental Health Plan in 2003 established the service array that is necessary to support children/youth with moderate and severe mental health needs. Division staff have continued to work with DMA to create both Medicaid and state funded service definitions to support the development and expansion of those services. Additionally, when DMH received a three-year grant for Adolescent Treatment and Coordination Grant in 2005, North Carolina continued to enhance the existing service array by expanding the treatment needs focus of the continuum of care to include the substance use disorder needs as well. The current strategic plan for statewide SOC development includes identification of evidence-based programs to be added to the service. More recently, DMH is now layering on the concept of developing a trauma-informed care environment in which all the public child-serving delivery systems will operate.

Going Forward: The NC SOC Expansion grant will work with the North Carolina Child Treatment Program (CTP or Effective Mental Health Treatment for Children, Adolescents, and Families Coping with Traumatic Stress, Loss, and Parenting Difficulties) and other experts on trauma as members of planning collaboratives to develop a plan for infusing the system with trauma-informed care. A consortium of faculty and staff from the Center for Child and Family Health-NC, Duke University Evidence-Based Practice (EBP) Implementation Center (that includes staff from SAMHSA's national Center for Child Traumatic Stress and the School of Medicine at the University of North Carolina at Chapel Hill) is responsible for the CTP. Their collaboration and that of others will lead to a plan focused on the identification of key Evidence-based Programs and other strategies (e.g., Trauma-focused Cognitive Behavioral Therapy, decreasing multiple child placements) and a plan for sustainable education and training, emphasizing cultural and linguistic competency, recovery, standardized assessment, clinical competency, clinical supervision, model fidelity, and implementation strategies. The Expansion grant will also include the development of comprehensive primary prevention plan in order to reach a broader population of children and youth to promote their healthy socio-emotional development. Furthermore, early intervention and recovery support services will be enhanced to promote stability and avert crises.

Additionally, the service array development will continue to emphasize the linkages with primary care providers.

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance use and co-occurring disorders?

Since 2006, the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) has supported and encouraged the utilization of person-centered planning and the professional development and growth of all people engaged in the process. Through ongoing evaluation of the Person-Centered Plan (PCP), DMH/DD/SAS has monitored the achievement of objectives using quantifiable measures, assessed the effectiveness of particular interventions and policies, as well as, monitored public opinion. Subsequently, the PCP format was redeveloped in 2010, taking into careful consideration legislative requirements, new priorities that have emerged, innovative approaches, and evaluative information.

As stated previously, Child and Family team planning and the concept of the development of a unique plan for every child/youth served by the system were critical elements of the Willie M. Program. These elements were solidified in the North Carolina System of Care that emerged from the federal CMHI grants. As North Carolina began the overall reform of the mental health system, DMH/DD/SAS moved towards Person-Centered Planning as one of the key aspects of the system overhaul. The DMH/DD/SAS Child Mental Health Team, in the process of creating a vision for the child/youth and family behavioral system with the SOC approach as the foundational organizational principle of that vision, compared the SOC CFT process to Person-Centered Planning. The SOC CFT process was shown to hold the same values as the person-centered planning process. A technical assistance document created in 2004 to help local communities see the overlap between CFT and PCP stated that “primarily, the child and family team planning process is designed to achieve a set of outcomes that reflect the voice and choices of the child and family”. Fidelity to the child and family team process would mean that the process must include the following elements:

- Individualized service planning driven by strengths and needs
- Needs and preferences of the child and family dictate the types and mix of services provided.
- Family participation in ALL aspects of planning, service delivery and evaluation.
- Prevention, early identification and intervention.
- Planning and service coordination or case management of comprehensive, integrated services across the child-serving systems and into the adult service system.
- Nondiscrimination in access to services. No rejection, no ejection from services.
- Services provided in the least restrictive environment
- SOC should be community-based, with the focus of the services, management and decision-making responsibility resting at the community level.
- Human rights protection and advocacy.
- Culturally competent and responsive to the cultural, racial and ethnic differences of the population served.

The SOC CFT process was formally recommended by DMH/DD/SAS as the best practice process to be used for children/youth with a mental health or substance use disorder and for children/youth with both disorders. Although the PCP process continues to be modified as new issues are identified -- for example, the PCP process was further enhanced by new guidelines for the development of the companion comprehensive crisis plan in 2014 -- the CFT planning process continues to be the recommended approach for children/youth with behavioral needs.

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?

Aside from continuing to staff the North Carolina Collaborative on Children, Youth and Families (i.e. the State Collaborative), DMH/DD/SAS collaborates with other child-and-youth-serving agencies on initiatives where the population of focus is children with severe emotional disturbance who are generally involved with multiple agencies.

One interagency collaborative effort that has been instrumental in local system of care development has been an initiative under the Department of Public Safety/Division of Adult Correction and Juvenile Justice. This initiative is the *North Carolina Reclaiming Futures Initiative*. It is designed to help improve the work among juvenile courts, probation, adolescent substance abuse and mental health treatment, and the community to reclaim youth. The model embodies three major elements: improvement in treatment services for mental health and drug and alcohol use; a comprehensive system of care that coordinates services, and the involvement of the community in creating new opportunities for the youth. In 2011, a statewide office was established to support the implementation. This is a public-private partnership that includes the Kate B. Reynolds Charitable Trust and The Duke Endowment. DMDDSAS participates in oversight through an advisory group. The Initiative is underway in 29 counties.

DMH/DD/SAS also collaborates with the Department of Public Instruction on a SAMHSA-funded Bullying and Suicide Prevention Program; with the Division of Public Health on Project Launch (early intervention); with Division of Social Services on a SAMHSA-funded trauma-focused grant for children and youth in foster care; and with the Divisions of Public Health, Medical Assistance and Child Development and Early Education and the NC Interagency Coordinating Council for Children with Disabilities on early childhood mental health. (See also discussion in question #5 related to a new Department of Public Instruction Mental Health Stakeholders Group.)

4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?

In 2009, DMH/DD/SAS provided seed funding from the MHBG and state mental health trust fund for a project that would help to increase access to evidenced based treatment.- The seed money was able to leverage Duke Endowment and other regional funding sources. The result was the creation of a public-private partnership that established The NC Child Treatment Program through the Center for Child and Family Health. NCCTP trains clinicians in evidence-based interventions through Learning Collaboratives. NCCTP trains, supervises and coaches practitioners in a year-long learning community experience. The clinicians who successfully complete the training, maintain fidelity to the model and can demonstrate positive outcomes are included in a roster system managed by NCCTP. NCCTP facilitates access of children and families who need access to these specialized trauma therapies. NCCTP trains the following

evidence-based practices: trauma focused cognitive behavioral therapy, parent-child interaction therapy, child parent psychotherapy, and structured psychotherapy for adolescents responding to chronic stress.

The NCCTP has been able to train clinicians from around the state. As of this date, there are 445 in-training or graduated practitioners affiliated with the NCCTP, including 347 TF-CBT rostered clinicians. Additionally, NCCTP has developed a secure database that tracks individual and aggregate level fidelity and outcome data with interface capability to work with existing networks within state agencies.

DMH/DD/SAS developed the North Carolina Practice Improvement (NCPIC) to facilitate the identification of current and future evidence-based services and supports that will be incorporated in North Carolina's public behavioral health system. The NCPIC is comprised of representatives of the DMH/DD/SAS disability areas and meets three times a year to review and discuss current and emerging best practices for adoptions and implementation across the State. Applications may be submitted for evaluation at these meetings. The members look to confirm the completeness of the evidence base. Annually, the group presents a report of prioritized program recommendations to the Division Director at a public forum. This forum features brief educational descriptions of the practices being recommended by the NC PIC in its report. NCPIC is hosted by the Governor's Institute on Substance Abuse.

The Division provides training through Area Health Education Centers, family advocacy and support agencies, the State Collaborative, and through universities using state or MH Block grant funds. LME-MCOs also provides practice skill development training to their provider networks. Additionally the North Carolina Council of Community Programs provides a range of training to both provider and LME-MCO staff from around the state. This is an area in the SOC infrastructure development that the Division would like to see significantly enhanced in order to ensure that there is consistent, quality, and in depth training/coaching of both policy and practice around the state to develop the broad, diverse, well-informed workforce required to achieve a comprehensive service array.

5. How will the state monitor and track service utilization, costs, and outcomes for children and youth with mental, substance use and co-occurring disorders?

The State collects performance indicators information through the Client Data Warehouse (CDW) from LME-MCOs and client level data through the web-based NC TOPPS.

Through data infrastructure grants, the Division developed database structure and definitions in its two client data warehouses, the DMH Client Data Warehouse (CDW), which is the Division level production database, and the Client Services Data Warehouse (CSDW) which is the enterprise level web-based decision support database. Currently, the system has the capability of web-based reporting, utilizing data from the Perception of Care surveys, Medicaid, State funded services, the client information systems of LME-MCOs, the billing and information system of the Health Enterprise Accounts Receivable and Tracking System for State Facilities (HEARTS) and archived data. Reports based on databases are produced through corporate or ad-hoc queries and are disseminated to end-users. The Division produces the LME-MCO Performance Measurement Report based on Medicaid and state and county claims data, LME-MCO reported data, access data, and state hospital data including the alcohol and addiction treatment centers from the CDW and LME-MCO reports. This report monitors the LME-MCO's performance on the critical performance measures (timely initiation and engagement in service, timely

follow-up after inpatient care, etc.) against statewide averages for services to persons in need by age and disability.

North Carolina Treatment Outcome and Program Performance System (NC-TOPPS), Initial, Update, and Episode completion interview information for all consumers within specified substance abuse and mental health populations. NC-TOPPS information provides one method for the collection of the Division's consumer functional outcomes data. Consumer functional outcomes data are the DHHS source of information utilized to monitor the impact of services.

In December 2008 the North Carolina Department of Health and Human Services (DHHS) awarded a contract to Computer Sciences Corporation (CSC) to develop and implement a Replacement Medicaid Management Information System (NCMMIS+) in support of healthcare administration for multiple DHHS agencies. NCTracks, the Replacement NCMMIS+, is used by the Division of Medical Assistance (DMA), the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), the Division of Public Health (DPH), the Migrant Program for the Office of Rural Health and Community Care (ORHCC) and the Division of Health Service Regulation (DHSR). NCTracks processes health care claims for enrolled DHHS providers who serve the citizens of North Carolina.

NCTracks is a multi-payer system that facilitate provider enrollment and consolidate claims processing activities for multiple DHHS health plans. By having a multi-payer system the Divisions within DHHS have the ability to analyze and interpret data reported through NCTracks regarding State and Federally funded behavioral health and Medicaid related physical health and pharmacy claims.

The Division's data system described above will provide data for consumers six years and older. To know about the utilization and costs for the early childhood population, the Division will have to partner with other child-serving systems where children under six years of age are more likely to be identified for early intervention behavioral health services (e.g. school systems, social services, early childhood education programs). For consumers three years and younger, the Division will need to work with the Child Developmental Service Agencies (CDSAs) or through private providers who are working on fee for service basis.

DMH is starting to develop data sharing agreements with other divisions and Departments in order to track at both the child-level and systems level service utilization and cost rates for children/youth with behavioral health needs. At this point, the only analysis available to the Division is based on the paid claims for services submitted by providers.

Keeping those we serve at the center of service design and delivery the Division's Quality Management structure provides the focus for ongoing attention to the clinical quality and effectiveness of the service system. The Division's Quality Management Steering Committee brings together staff from across the Division to plan, monitor and evaluate initiatives to improve the clinical quality of the service system and the effective use of state and federal funds.

To ensure the needs of those we serve are being met the Division monitors key indicators to help assure that the system is working as intended, opportunities for improvement area identified and acted upon, desired improvements are recognized and efforts to sustain successful practices are implemented and monitored to maintain achievements, as priorities change.

A process for periodic monitoring of key indicators is coordinated by the Steering Committee. Monitoring of indicators will include:

- ❖ Reviewing valid and reliable performance and outcome data
- ❖ Determining significance of trends and patterns
- ❖ Implementing improvement initiatives
- ❖ Evaluating improvement initiatives
- ❖ Raising the bar on measures when appropriate
- ❖ Evaluating and revising the Quality Management plan annually

Quality Management and Performance Expectations for LME-MCOs are established per contract. Routine monitoring against performance targets or standards provides information on how the system is doing. The Division supports a statewide Incident Response Improvement System for reporting and documenting responses to emergency and critical incidents with a focus on future prevention. Contract requirements address reporting and resolution requirements related to complaints and grievances and establishes standards for resolution timeframe.

Regular and ongoing feedback within the Division and to Local Management Entities-Managed Care Organizations and system stakeholders is a key to ensuring and sustaining improvements in quality. The guidelines for critical outcomes and performance measures are described in the North Carolina LME-MCO Performance Measurement and Reporting Guide. Measurement is based on valid and reliable data, consistent with the NBHQF and describe the health and functioning of the MH/DD/SA system.

The Division evaluates the overall performance of the Local Management Entities-Managed Care Organization and their network through the review of each management function, compliance with reporting requirements, through statewide measures of service quality, input from stakeholders via surveys and outcome measurement systems, analysis of emergency and critical incidents, and review and follow-up of complaints and grievances.

6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?

The Department of Health and Human Services has not currently identified a liaison to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services.

The closest North Carolina has come to establishing behavioral health liaisons to support school systems was through the Child and Family Support Team (CFST) initiative. The CFST initiative was originally authorized and funded in the 2005 session of the NC General Assembly. The budget provided \$11.0 M for teams of school nurses and school social workers to be placed in 100 schools,

in 21 local education agencies (LEAs). These teams were assigned to work with a target population of children/youth who were at risk of drop out based on socio-economic needs, poor academic scores, suspension rates and behavioral health needs. To assist those teams, the General Assembly funded a recurring allocation of approximately \$944,000 to hire 1 LME Care Coordinator and DSS team facilitators in the LME catchment area of the CFST LEAs. These LME staff were called school care coordinators and were assigned to provide training to school staff, to participate with school staff in service planning for identified students and to assist students with accessing mental health and substance abuse services. In the 2011 Appropriations Act, the General Assembly eliminated the funding for the DSS Facilitator and LME Care Coordinator positions but continued to ask the LME to appoint specific staff members to continue serving in the same capacities. This resulted in reduced access to the behavioral health system for the CFST schools (January 2013 Legislative Report to the Office of the Governor and Legislative Committees/Subcommittees by the North Carolina Child and Family Leadership Council.)

As North Carolina moved into a behavioral health managed care environment, LME-MCOs took on care coordination responsibilities within the service area for which they are responsible. Under the 1915 (b)/(c) waivers, this form of care coordination is a risk-management and quality-management function that is designed to proactively intervene and manage care for Special Needs Populations. Children/Youth who are hospitalized, have had a certain number of crisis episodes, or are in Level III group homes or PRTFs are designated special needs populations. Some LME-MCOs have identified specific care coordinators to serve the child/youth special needs population. These care coordinators find themselves working with school systems especially when coordinating discharge planning from a residential setting back to the child's home community. Otherwise, schools may be able to find some general guidance with the local behavioral health system through the Community Relations component of an LME-MCO from either a SOC Coordinator or another staff.

However, there has been a long history (going back to the establishment of the Willie M. Program) of dialogue, joint planning and implementation between the state public mental health system and the state education system. In June 2015, the Department of Public Instruction's Exceptional Children's Director invited a representative group of stakeholders involved in mental health services to children across the state to participate in a daylong Mental Health Stakeholder meeting. The purpose of this Stakeholder group is to forge a consensus around the most relevant issues and the development of a strategic plan. The intent is use the jointly developed strategic plan to develop legislation and/or policy to create school-based mental health programming. The expectation is that the Stakeholder Group will lead to a series of smaller meetings throughout the year to address the specific concerns that are identified.

The current issues identified through the Stakeholder Group include:

- Lack of consistent availability of a comprehensive range of mental health and substance abuse services across the state;
- Non-Medicaid students (even with private insurance) having less access to specialized therapies and/or enhanced services to which Medicaid students have more access;
- As public behavioral system shifts to Managed Care orientation, the increased complexity in getting onsite services in school systems;

- Lack of coordination between school systems and behavioral health providers when students are placed in residential programs outside of their home communities;
- Meeting the behavioral health needs of students who are not identified as Exceptional Children (i.e. special education).

7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

In North Carolina, the cut-off age for receiving public behavioral health services in the child/adolescent system is 18 or up to 22 years of age if the youth has Medicaid. There is not a state-designed transition process for individuals aging out of the child/youth behavioral health system into the adult system.

This area is noted by several LME-MCOs as a major community needs and gaps issue. Local communities are testing a variety of strategies to find ways to support youth through the transition. One LME-MCO received permission from the Division of Medical Assistance (DMA) in SFY 14-15 to use an Alternative Medicaid Service Definition to use Medicaid funding to support a transitional living program for consumers aged 16-25. The provider – Youth Villages – has been providing a specific transitional living program for youth aging out the foster care and juvenile justice systems --around the county for several years. This program – now called YVLifeSet – has trained specialists who work with eight youths at a time. The specialists provide assessments and partner with the youth to develop an individualized treatment plan across education, career, housing, financial, relationship and health domains. The plan takes into account the particular needs and goals of each young person. The youth meet with specialists on a weekly basis to set goals and plan how they will navigate their transition to adulthood. The program provides intensive, individualized, and clinically focused case management, support, and services. The program also provides limited financial support to help with specific objectives in the plan (e.g. apartment application fee, money to buy clothes for a job interview, materials for school). A University of Chicago study of the YVLifeSet program in Tennessee (funded by multiple foundations) has provided the following key findings after a one-year follow-up:

- The program boosted earnings by 17 percent, increased housing stability and economic well-being (including a 22 percent decrease in the likelihood of experiencing homelessness), and improved some of the primary outcomes related to health and safety (including improvements in mental health and a decrease in intimate partner violence). However, it did not significantly improve outcomes in the areas of education, social support, or criminal involvement.
- The program was found to be equally effective across different subgroups of youth, including youth with and without histories of juvenile justice custody.

Youth Villages currently has a proposal before the state legislature proposing a statewide implementation of this transitional living program. Depending on its legislative success, this could become a cornerstone of an integrated approach to supporting the transition of youth to adulthood in multiple service systems.

Alliance Behavioral Healthcare LME-MCO is midway through a SAMHSA grant that targets high-risk 16-21 year olds in Durham County who have mental health challenges and have become disconnected from services and supports that would normally assist them in transitioning to adulthood. Through partnerships within the community, BECOMING connects these youth with literacy support services, coordination of clinical care, employment services, positive recreational opportunities and leadership training, with a goal of helping make these transitions more successful.

Since 2008, NC DMH/DD/SAS has contracted with NCFU to improve the quality and outcomes of community based services for transition-aged youth in accordance with the Community Mental Health Services Block Grant. NCFU has been able to leverage MHBG funding to raise additional funding to expand the services and supports to emerging young adults. The program offered is called *Transition Mentoring Services*. NCFU provides intensive coaching and mentoring to at least 8 transitioning youth (annually) who have been identified as having the most difficulty transitioning out of high school to engage them in the process of becoming successful adult members of their communities. NCFU also reaches youth not yet identified as needing treatment to seek and find services enhancing positive mental health and behavioral health outcomes. The Rehabilitation for Empowerment, Natural Supports, Education and Work (RENEW) model will continue to be the process used.

RENEW Secondary Transition Model core activities include providing 1-3 hours (per week) of intensive mentoring with our Program Director and engaging the young adult in a youth-directed planning process called Futures Planning. Futures Planning is a person-centered planning process developed by the young adult through a supportive youth driven process which identifies priorities, goals, and strategies such that the role of the youth/young adult and those with a role in supporting achievement are clearly identified. The Program Director then partners with the youth to prepare and co-lead in developing an individualized team to assist them with reaching their goals.

In addition to the use of RENEW, Transition Mentoring also involves the youth and their families in transition-related learning opportunities and expands their peer to peer networks through involvement Youth M.O.V.E.'s Youth Leadership Series (YLS). NCFU runs the seven-session series designed to encourage adolescents and young adults with mental and behavioral health concerns to participate on relevant advisory boards at the local, state and national levels. Participants in the NC YLS are encouraged to join Youth M.O.V.E. NC, housed within NCFU, serving as the statewide youth partners for the family-run organization. The YLS creates a culture of unconditional care and serves as a pathway for adolescents and emerging young adults in transition to become advocates for self and others and engage in leadership roles. Since 2008, 62 transition age-youth have received the intensive coaching and mentoring services.

NCFU partnered with the Department of Psychology UNC-Charlotte and the Department of Maternal and Child Health at the UNC School of Public Health to identify successes of transition-related services as well as challenges and barriers that young adults continue to experience as a result of systemic challenges and/or lack of available /responsive systems equipped to address the nature of issues encountered by this population. The data collected and analyzed were derived from qualitative techniques that included focus groups, interviews appreciative inquiry, and a photovoice project. A total of 53 past and present young adults participated. Some of the participants were in restrictive settings.

The evaluation report documented the following youth-reported successes after engagement in the program for 9 months:

Relatively high levels of confidence in their self-determination and mental health coping abilities and that they 'sometimes' or 'almost always' acted in a self-determined way;:

- Improved optimism about adult role functioning (e.g., obtaining a good job, completing school);
- Improved progress toward goals was directly linked to support from mentors and work settings;
- Improvement of certain types of support, including informed decision-making for best outcomes and support in crises;
- Improvement of certain types of support, including informed decision-making for best outcomes and support in crises;
- Improvement in perceptions of self-determined behavior, and smaller, statistically marginal improvements in feelings of self-determination and support self-determination at home;
- Improvements in perceptions of safety at home and at school.

The following barriers/challenges for transition-age youth were summarized from a series of interviews with randomly selected young adults who had participated in RENEW (n=6):

Employment:

- Finding stable employment was the most frequently identified barrier experienced in meeting plan goals because:
 - prescribed medications limited the youth's ability to perform certain tasks.
 - juvenile justice/criminal court records supposedly expunged, still showed up in background checks.
- Difficulty finding housing because:
 - meager resources with disability.
 - long delays proved discouraging and depressing.
 - lack of variety of housing options
- Lack of effective mentors:
 - Mentors not able to connect with youth's life experience
 - Short lived mentoring that ends before youth has accomplished critical goals
 - Insufficient communication with mentors.
- Behavioral Health problems creating a barrier:
 - Difficulty getting the right medication and/or appropriate services
 - Difficulty finding a strengths-based treatment environment
 - Difficulty finding a physician or psychiatrist willing to listen to their story, symptoms, challenges and who can give accurate diagnoses based on the youth's lived experience.

(Jackson-Diop, D., and Fadumo Abdi, UNC-Chapel Hill graduate student and public health intern, *NCFU Brief on Youth Transition Support Services*, 2014.)

The NC Collaborative on Children, Youth and Families has been working on a Strategic Plan for the upcoming sfy 15-16 year. Transition Age Youth issues has been designated as a top priority on which agencies need to collaborate. The current legislative session includes bills that will impact this age group including a juvenile justice bill to change the current policy of 16 and 17 year olds automatically being

tried in the adult criminal court system, regardless of alleged infraction and the *Fostering Success* bill that would extend the provision of foster care services to the age of nineteen and provide for the extension of guardianship services through age 19. The North Carolina Institute of Medicine just started a Taskforce to focus on the needs of the transition age youth in June 2015. Based on the **2012 Kids Count Data Center**, there are 1,347,888 in the transition age group (15 – 24 years old). Recommendations from this group are expected in 2016.

Environmental Factors and Plan

19. Pregnant Women and Women with Dependent Children

Narrative Question:

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant ([Title XIX, Part B, Subpart II, Sec.1922 \(c\)](#)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at <http://www.samhsa.gov/women-children-families>: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges*.

Please consider the following items as a guide when preparing the description of the state's system:

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
 - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
 - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
 - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
 - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Not applicable to the MHBG.

Environmental Factors and Plan

20. Suicide Prevention

Narrative Question:

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised [National Strategy for Suicide Prevention \(2012\)](#).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#).⁹⁶

Please indicate areas of technical assistance needed related to this section.

⁹⁶ http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

Please use the box below to indicate areas of technical assistance needed related to this section:

Technical assistance needs include the following:

1. Effective suicide prevention strategies with working age and older males, especially in rural communities.
2. Effective suicide prevention strategies, connecting trauma informed practices, with young girls and women to reduce non-fatal self-injuries and suicide attempts.
3. Effective strategies in lethal means restrictions in military communities.
4. Effective uniform strategies in suicide risk screening across child-serving settings.
5. Setting effective measures in a managed care environment.
6. Effective strategies and EBPs to build coping skills and address anxiety in school age children and youth.

Footnotes:

20. Suicide Prevention

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised NSSP 2012.

The North Carolina State Suicide Prevention Plan (NC DHHS, 2015) can be found in the attachment section of this plan (electronic version). The Executive Summary of the plan follows directly at the end of this section. The plan can also be accessed at

<http://www.injuryfreenc.ncdhhs.gov/preventionResources/docs/2015-NC-SuicidePreventionPlan-2015-0505-FINAL.pdf>

2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.

3. Include a new plan (as attachment to the block grant app) that delineates the progress of the state suicide plan since the FY 2014-2105 Plan. Please follow the format outlined in the new SAMHSA Guidance for State Suicide Prevention Leadership and Plans.

Below is a description of the planning process and the way in which NC's State Suicide Prevention Plan was created to mirror the format, core components and strategies as outlined in the NSSP (2012).

In addition, the planning process engaged as well as the plan explicitly includes all individuals, in particular those populations most at risk for suicide attempts or death by suicide, those living of all ages with SED, SMI and/or co-occurring disorders (including SUD, IDD/DD, chronic pain or terminal illness). These populations are the same as those supported through the MHBG funds.

The NC DHHS, Divisions of Public Health and Mental Health, Developmental Disabilities and Substance Abuse Services (MH/DD/SAS) facilitated stakeholders through a process to develop [*Saving Tomorrow's Today, North Carolina's Plan to Prevent Youth Suicide*](#) to align with six goals from the *2001 National Strategy for Suicide Prevention (NSSP)*.

In late 2012, the Substance Abuse and Mental Health Services Administration (SAMHSA) released its second [*National Strategy for Suicide Prevention*](#), outlining 13 goals and 60 objectives, organized by four strategic directions: 1) *Healthy and Empowered Individuals, Families, and Communities*; 2) *Clinical and Community Preventive Services*; 3) *Treatment and Support Services*; and 4) *Surveillance, Research, and Evaluation*. To coincide with its release, SAMHSA encouraged states to develop suicide prevention plans across the lifespan.

Concurrent with the 2012 NSSP, the N.C. Department of Health and Human Services (DHHS) Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) worked with the North Carolina Institute of Medicine (NCIOM) to develop a mental health treatment focused [*Suicide Prevention and Intervention Plan*](#), which concentrates on the role of health care and

community based providers to reduce suicide contemplations, attempts, and deaths in the state of North Carolina.

In late 2013, the NC DHHS, through coordinated leadership of the Divisions of Public Health and Mental Health, Developmental Disabilities and Substance Abuse Services (MH/DD/SAS) initiated a 16-month process to develop a statewide *2015 N.C. Suicide Prevention Plan*. **The development of a new plan, seen as a complement to the DMH/DD/SAS plan, provided an opportunity to bring together a group of approximately 180 diverse suicide prevention stakeholders to contribute to its creation.**

The primary purpose of the *2015 N.C. Suicide Prevention Plan* is to empower all North Carolinians with knowledge and to highlight examples of the actions they can take to reduce suicide. Funds and resources available to support coordinated suicide prevention efforts are limited. As such, the plan development process focused on developing a road map for stakeholder groups in North Carolina to address the burden of suicide. The road map approach aligns with current efforts across the state that can leverage partnerships and resources to prevent suicide. Using this plan, practitioners from a variety of disciplines at the state, regional, and local level can align their efforts to plan, implement, and evaluate suicide prevention efforts. Moreover, those individuals with lived experience, survivors, attempters, and those touched by suicide are critical partners and catalysts at the community, regional and state levels. **As an example**, the platform Miss Statesville 2015 chose was “Mental Illness, Change the Story.” She openly discussed her lived experience in high school and college with mental illness, suicide attempts, treatment, recovery and successful outcomes as a college graduate, working in her profession. Effective strategies that span life transitions, opportunities and events through lived experience are core to community impact and drivers for change. Those with FEP are at particularly high risk and are included in this plan, as well as is safety planning in the Coordinated Specialty Care model implementation through the MHBG 5% set aside funding.

In reviewing and using the *2015 N.C. Suicide Prevention Plan* in its entirety, for ease of reference, hyperlinks are provided to allow readers to quickly advance to various sections of the plan, including lists of examples of how each of the following 10 stakeholder groups can contribute to suicide prevention in North Carolina: 1) Governmental Agencies/Departments (Federal, State, Local); 2) **Tribal Governments**; 3) **Health Care Systems, Insurers and Clinicians**; 4) Businesses, Employers and Professional Associations; 5) Primary and Secondary Schools; 6) Colleges and Universities; 7) Nonprofit, Community and Faith-based Organizations; 8) Research Organizations (including universities); 9) **Individuals, Families, Consumers and Concerned Citizens**; and 10) **Military Entities**.

Significant progress and accomplishments since the 2014-15 MHBG Plan:

- The state now has a suicide prevention plan, released in January 2015.
- The plan and process followed the recommended *SAMHSA Guidance for State Suicide Prevention Leadership and Plans*. This spring focused on highlighting the plan and making connections with existing work in communities to prevent suicides.
- A combined *DHHS/DMH/DD/SAS Crisis Solutions Initiative and NC Practice Improvement Collaborative Forum* was held in January 2015 with a focus on preventing suicides and implementing effective crisis services and supports in communities and ways to better utilize

the *National Suicide Prevention Lifeline* through North Carolina's call center, REAL Crisis Intervention, Inc., and the LME-MCO 1-800 Access Screening, Triage and Referral (STR) lines.

- *Crisis Intervention Training (CIT) Conference* in February 2015, highlighted those with lived experience, those who attempted and those receiving supportive intervention from CIT trained police officers and school resource officers.
- A *Suicide Prevention Summit* was held in May 2015, to promote use of the plan among stakeholders and strategies outlined.
- A *Mental Health First Aid Instructors Institute* was held in May 2015, to facilitate essential connections between MHFA and suicide prevention and special populations impacted across our state, including schools, faith communities, health care and law enforcement.
- *Breaking the Silence: Telling Our Stories* was a primary track of the NC Parent Resource Center Conference, May 2015, to engage prevention providers and community stakeholders in implementing the suicide prevention plan through the courage and core leadership of those with lived experience and in recovery.
- Collaborative efforts to create and submit a *SAMHSA Cooperative Agreement for State-Sponsored Youth Suicide Prevention and Early Intervention*, June 2015; when funded, suicide prevention strategies will be implemented in the eastern most counties of our state with targeted focus on those youth 16-25 most at risk who are LGBTQ, American Indians and military/veterans.

Technical assistance needs include the following:

- Effective suicide prevention strategies with working age and older males, especially in rural communities.
- Effective suicide prevention strategies, connecting trauma informed practices, with young girls and women to reduce non-fatal self-injuries and suicide attempts.
- Effective strategies in lethal means restrictions in military communities.
- Effective uniform strategies in suicide risk screening across child-serving settings.
- Setting effective measures in a managed care environment.
- Effective strategies and EBPs to build coping skills and address anxiety in school age children and youth.



**Injury and Violence Prevention (IVP) Branch
N.C. Chronic Disease and Injury Section
N.C. Division of Public Health**



**Policy Development/Prevention and Early Intervention Team
N.C. Division of Mental Health, Developmental Disabilities,
and Substance Abuse Services
N.C. Department of Health and Human Services**



**The University of North Carolina Gillings School of Global Public Health
Department of Health Behavior**

EXECUTIVE SUMMARY

A. Section 1 - Introduction

The North Carolina Injury and Violence Prevention (IVP) Branch is located in the Chronic Disease and Injury (CDI) Section, within the N.C. Division of Public Health (DPH), which has been designated by the N.C. General Assembly as the lead agency for injury prevention in North Carolina. The IVP Branch's programs provide funding, training, and technical assistance to public health professionals working across North Carolina. The Branch works to promote the use of research and data to ensure local communities are implementing initiatives that are effective. In 2004, the IVP Branch led stakeholders through a process to develop [Saving Tomorrow's Today, North Carolina's Plan to Prevent Youth Suicide](#) to align with six goals from the *2001 National Strategy for Suicide Prevention (NSSP)*.

In late 2012, the Substance Abuse and Mental Health Services Administration (SAMHSA) released its second [National Strategy for Suicide Prevention](#), outlining 13 goals and 60 objectives, organized by four strategic directions: 1) *Healthy and Empowered Individuals, Families, and Communities*; 2) *Clinical and Community Preventive Services*; 3) *Treatment and Support Services*; and 4) *Surveillance, Research, and Evaluation*. To coincide with its release, SAMHSA encouraged states to develop suicide prevention plans across the lifespan. Concurrent with the *2012 NSSP*, the N.C. Department of Health and Human Services (DHHS) Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) worked with the North Carolina Institute of Medicine (NCIOM) to develop a mental health treatment-focused [Suicide Prevention and Intervention Plan](#), which concentrates on the role of multiple medical care facilities to reduce suicide contemplations, attempts, and deaths in the state of North Carolina.

In late 2013, the IVP Branch initiated a 16-month process to develop a statewide *2015 N.C. Suicide Prevention Plan*. The development of a new plan, seen as a complement to the DMH/DD/SAS plan, provided an opportunity to bring together a group of approximately 180 diverse suicide prevention stakeholders to contribute to its creation.

The primary purpose of the *2015 N.C. Suicide Prevention Plan* is to empower all North Carolinians with knowledge and to highlight examples of the actions they can take to reduce suicide. Funds and resources available to support coordinated suicide prevention efforts are limited. As such, the plan development process focused on developing a road map for stakeholder groups in North Carolina to address the burden of suicide. The road map approach aligns with current efforts across the state that leverage partnerships and resources to prevent suicide. Using this plan, practitioners from a variety of disciplines at the state, regional, and local level can align their efforts to plan, implement, and evaluate suicide prevention efforts.

Those interested in preventing suicide in North Carolina are encouraged to review the *2015 N.C. Suicide Prevention Plan* in its entirety. However, hyperlinks are provided to allow readers to quickly advance to various sections of the plan, including lists of examples of how each of the following 10 stakeholder groups can contribute to suicide prevention in North Carolina: 1) Governmental Agencies/Departments (Federal, State, Local); 2) Tribal Governments; 3) Health Care Systems, Insurers, and Clinicians; 4) Businesses, Employers, and Professional Associations; 5) Primary and Secondary Schools; 6) Colleges and Universities; 7) Nonprofit, Community, and Faith-based Organizations; 8) Research Organizations (including universities); 9) Individuals, Families, and Concerned Citizens; and 10) Military Entities.

B. Section 2 - How the 2015 N.C. Suicide Prevention Plan Was Developed

From September 2013 through December 2014, a planning team comprised of staff from the IVP Branch, the DMH/DD/SAS, Community Policy Management Section, and the University of North Carolina at Chapel Hill Gillings School of Global Public Health, Department of Health Behavior, led the plan development process. They engaged the assistance of more than 180 suicide prevention stakeholders, representing 10 stakeholder groups, from across the state. Stakeholders worked in either a Working Group or a Consulting Group. Members of both groups: a) completed an online survey to assess alignment of North Carolina activities and needs with the *2012 NSSP*; b) identified examples of what stakeholders in North Carolina are doing to address suicide; c) provided feedback on drafts of individual plan sections; and d) submitted endorsements of the plan.

Working Group members also attended two in-person meetings (April 30 and June 24, 2014). At the first in-person working group meeting participants worked in small groups to: a) determine how 2012 NSSP objectives should remain for consideration in the North Carolina plan; and b) identify examples describing what stakeholder groups could be or are already doing to prevent suicide in North Carolina. Following the meeting, Working and Consulting Group members completed an online exercise to collect over 500 additional examples of what stakeholders are doing or could be doing to address suicide in North Carolina. At the second in-person meeting, Working Group members participated in small group activities to prioritize goals and objectives by importance (e.g., reduces the burden of suicide in North Carolina, uses a comprehensive approach that targets multiple levels, uses interventions that are cost-effective) and feasibility (high, medium, low) for emphasis in the plan.

Following a formal review by the N.C. Department of Health and Human Services Office of Communications, the final version of the 2015 N.C. Suicide Prevention Plan was completed and uploaded to the [N.C. Injury and Violence Prevention Branch's website](#). Additional marketing materials were developed by IVP Branch staff as part of a separate communication and dissemination plan for the 2015 N.C. Suicide Prevention Plan.

C. Section 3 - How Can You Use the 2015 N.C. Suicide Prevention Plan?

The plan was developed to provide stakeholders with a greater understanding of how everyone can contribute to the prevention of suicide and suicidal behaviors in our state, including the following examples:

Identify examples of what you can do. This plan was specifically created to allow anyone to pick it up and identify different ways that they can work to address suicide prevention in North Carolina.

Example: A business owner, distressed over the recent suicide of one of her staff members, refers to the plan to gather ideas on how to better promote mental health wellness and offer support for her employees.

Identify resources. Increase your knowledge about the local and national resources available to people who are in crisis, so that you are able to provide information about those resources to those who might benefit.

Example: A university staff member familiarizes himself with the resources listed in Section 7 of the plan; subsequently, he posts and distributes information to students about the National Suicide Prevention Lifeline, the Trevor Project, and other resources.

Advocate for suicide prevention. Contact local and state policymakers to express concern about the burden of suicide and suicidal behaviors within North Carolina, and to promote the development of strong suicide prevention practices and supportive resources for suicide loss and suicide attempt survivors statewide.

Example: An individual writes her legislator to advocate for easier accessibility to low- or no-cost mental health treatment resources within her community, utilizing the data about suicide in North Carolina within the plan to illustrate the burden of the problem within the state.

Get involved/get trained. Promote accessibility of suicide intervention skills training for all, and utilize the resources described in this plan to complete training yourself, if you have not already done so.

Example: Upon reading about it in the plan, a health care provider enrolls in a Question, Persuade, Refer (QPR) training so that she can better understand and respond to patients who demonstrate warning signs of suicidal ideation and behavior.

Leverage this information for funding opportunities. Use the data and information within this plan as supporting evidence to apply for funding for suicide prevention or mental health promotion programs, or research.

Example: The development director of a nonprofit organization applies for grant funding to support his organization's suicide prevention activities. He references the plan in the application to showcase the significant amount of interest in and concern about the problem of suicide in N.C. and to demonstrate the need for increased funding by highlighting data about its impact.

Readers are encouraged to consider these ideas as a springboard to action and the overall plan as a guide for their efforts, as well as to share this plan with others in their communities. Suicide prevention efforts in North Carolina will be stronger,

more sustainable, and have greater impacts if each of us develops a comprehensive understanding of the problem and is prepared to act, together.

D. Section 4 - What Does the Problem of Suicide Look Like in North Carolina?

Six data sources (five statewide and one national) were used to provide a broad, population-based overview of suicide and self-inflicted injury in North Carolina. Understanding the burden of suicide and self-inflicted injury in North Carolina is essential to developing and implementing effective prevention and intervention strategies:

- In 2012, suicide became the leading cause of injury death in North Carolina and remained so in 2013.
- Non-fatal self-inflicted injuries resulting in hospitalization or an Emergency Department (ED) visit are more common than suicide deaths.
- Firearms are the most common method of suicide in North Carolina.
- Males are more likely to die as a result of suicide than females. Females are more likely to be hospitalized or visit an ED for a self-inflicted injury than males.
- Youth and young adults have the highest rates of self-inflicted injury hospitalizations and ED visits of all age groups in North Carolina.
- In addition to sex and age, suicide related disparities in North Carolina have been identified by race, sexual orientation, and veteran status.

The [Burden of Suicide in North Carolina 2013](#)¹ and the [State of North Carolina Coordinated Chronic Disease, Injury, and Health Promotion State Plan 2013](#)² have additional information on the burden of suicide in North Carolina.

E. Section 5 - In What Direction Should N.C. Be Heading?

The 2015 N.C. Suicide Prevention Plan aligns closely with the [2012 National Strategy for Suicide Prevention \(NSSP\)](#)³. As a result, the goals and objectives in the 2015 N.C. Suicide Prevention Plan are organized according to the four strategic directions (SD) included in the 2012 NSSP. These strategic directions outline a comprehensive strategy for suicide prevention through the continued support of effective approaches and the identification of areas in need of greater development or resources. The 2012 NSSP included 13 Goals that describe more information about the strategic directions. Developers of the 2015 N.C. Suicide Prevention Plan adopted all 13 Goals (Table ES-1). Color-shading is used throughout the plan to indicate the four strategic directions.

Table ES-1. N.C. Goals (n=13) by Strategic Direction.

#1 - Healthy and Empowered Individuals, Families, and Communities

GOAL 1. Integrate and coordinate suicide prevention activities across multiple sectors and settings.

GOAL 2. Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.

GOAL 3. Increase knowledge of the factors that offer protection from suicidal behaviors or promote wellness and recovery.

GOAL 4. Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.

#2 - Clinical and Community Preventive Services

GOAL 5. Develop, implement, monitor effective programs that promote wellness and prevent suicide and related behaviors.

GOAL 6. Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.

GOAL 7. Provide training to community and clinical service providers on the prevention of suicide and related behaviors.

#3 - Treatment and Support Services

GOAL 8. Promote suicide prevention as a core component of health care services.

GOAL 9. Promote and implement effective clinical and professional practices for assessing and treating those identified as

¹ North Carolina Department of Health and Human Services, Division of Public Health, Chronic Disease and Injury Section, Injury and Violence Prevention Branch (N.C. DPH), 2013a

² N.C. DPH, 2013b

³ U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention (DHHS), 2012

Table ES-1. N.C. Goals (n=13) by Strategic Direction.

being at risk for suicidal behaviors. GOAL 10. Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.
#4 - Surveillance, Research, and Evaluation
GOAL 11. Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action. GOAL 12. Promote and support research on suicide prevention. GOAL 13. Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.

For the 61 objectives developed for the 2015 N.C. Suicide Prevention Plan, stakeholders in North Carolina identified **32 prioritized objectives** (ordered by importance and feasibility) for emphasis in the 2015 N.C. Suicide Prevention Plan. Table ES-2 lists the 32 prioritized objectives in rank order, based on weighted scoring of importance and feasibility. For each objective, the level of feasibility (high or medium) is noted following the wording of the objective.

Table ES-2. Rank-Ordered Objectives Prioritized by Importance and High/Medium Feasibility (N=32).

Rank	Obj	Objective Wording and Feasibility Level (shown in italics)
1	5.2	Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors. <i>High</i>
2	7.1	Develop training on suicide prevention to community groups. <i>High</i>
3	11.3	Improve and expand state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions. <i>Medium</i>
4	9.1	Adopt, disseminate, and implement guidelines for the assessment of suicide risk among people receiving care in all settings. <i>High</i>
5	8.3	Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide. <i>Medium</i>
6	1.1	Integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs with a role to support suicide prevention activities. <i>High</i>
7	8.2	Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings. <i>High</i>
8	6.1	Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means. <i>High</i>
9	11.2	Improve the usefulness and quality of suicide-related data. <i>High</i>
10	13.3	Examine how suicide prevention efforts are implemented in different communities, demographic groups to identify the types of delivery structures that may be most efficient and effective. <i>High/Medium</i>
11	4.1	Accurate data and resources readily available and accessible for pick up use by media and other. <i>Medium</i>
12	7.3	Develop and promote core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education. <i>Medium</i>
13	3.1	Promote effective programs/practices that increase protection from suicide risk. <i>High</i>
14	9.2	Disseminate and implement guidelines for clinical practice and continuity of care for providers working with people with suicide risk. <i>Medium</i>
15	10.3	Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups. <i>Medium</i>
16	13.6	Establish resources/guides to gain access to impact/effectiveness data (e.g. toolkit, resource centers). <i>High</i>
17	5.1	Strengthen the coordination, implementation, and evaluation of comprehensive state/territorial/tribal/local suicide prevention programming. <i>Medium</i>
18	5.3	Strengthen efforts to increase access to/delivery of effective programs and services for mental health/substance use disorders. <i>High</i>

Table ES-2. Rank-Ordered Objectives Prioritized by Importance and High/Medium Feasibility (N=32).

Rank	Obj	Objective Wording and Feasibility Level (shown in italics)
19	10.1	Develop guidelines for effective comprehensive support programs for individuals bereaved by suicide and promote the full implementation of these guidelines at the state/territorial, tribal, and community levels. <i>Medium</i>
20	2.4	Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care. <i>High</i>
21	1.5	Integrate suicide prevention into all relevant health care reform efforts. <i>Medium</i>
22	10.5	Provide health care providers, first responders, others with care/support when a patient under their care dies by suicide. <i>High</i>
23	8.8	Develop collaborations between emergency departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow-up after discharge. <i>Medium</i>
24	2.1	Develop, implement, and evaluate communication efforts designed to reach defined segments of the population. <i>High</i>
25	2.2	Reach policymakers with dedicated communication efforts. <i>Medium</i>
26	7.5	Develop and implement protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk. <i>High</i>
27	9.5	Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among people receiving care for mental health/substance use disorders. <i>Medium</i>
28	7.2	Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk. <i>High</i>
29	9.3	Promote the safe disclosure of suicidal thoughts and behaviors by all. <i>Medium</i>
30	3.2	Reduce the prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders. <i>Medium</i>
31	3.3	Promote the understanding that recovery from mental and substance use disorders are real and possible for all. <i>Medium</i>
32	9.4	Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for people with suicide risk. <i>Medium</i>

F. Section 6 - What Can We (Stakeholders) Do to Address Suicide in N.C.?

Planning process participants identified over 500 examples of what various stakeholder groups, collectively and individually, can do to address suicide in North Carolina.

Section 6 includes lists of stakeholder suicide prevention examples organized by strategic direction, with bolded objectives and examples representing prioritized objectives (i.e., high importance and high/medium feasibility). Examples are presented by stakeholder group in ascending order with three numerical references (i.e., #.#.#): the first number represents the goal number; the second represents the objective number; and the third represents the example number (i.e., 5.2.6 label refers to goal 5, objective 2, and example 6). Detailed information about examples identified is included in [Appendix D](#) of the plan. Some of the examples identified may be the same or similar for multiple objectives. In addition, some examples were identified as being relevant for more than one stakeholder group, and when so, are cross-listed. It is possible that some examples may also be relevant for additional stakeholder groups, but were not identified as such. The complete list of examples, presented by the stakeholder group(s) for which the example was identified, is included in Appendix E.

The examples identified through the planning process may or may not be inclusive of: a) all known evidence-based strategies; b) all types of interventions occurring in North Carolina c) examples relevant for all target audiences; or d) opportunities to address high risk-populations that available data indicate are disproportionately affected by suicide. Some examples may be more or less effective, as the plan development process did not require that all examples listed have

evidence of effectiveness. For some examples, it may be important to tailor the activity for specific target populations at increased risk of suicide (e.g., people with disabilities, LGBTQ citizens, and military or veterans).

G. Section 7 - Where Can I Go to Learn More about Suicide Prevention?

The *2015 N.C. Suicide Prevention Plan* provides information and hyperlinks for additional resources about suicide prevention, at the state and national level, for the following categories: a) Suicide Prevention; b) Mental Health; c) Suicide Disparities ; d) Evidence Based-Practices; e) Advocacy and Awareness; and f) Data and Surveillance.

H. Section 8 - Endorsements

A total of 46 entities and organizations have provided a formal endorsement of the *2015 N.C. Suicide Prevention Plan*.

Environmental Factors and Plan

21. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please consider the following items as a guide when preparing the description of the state's system:

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

21. Support of State Partners

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.

The NCDHHS and the NC Division of MH/DD/SAS have strong intra-agency and interagency alliances that work to achieve common goals and outcomes through shared strategies for universal and targeted populations across the state. A few of the larger current collaborations are highlighted below.

The Division relies heavily on strategic partnerships within the NC Department of Health and Human Services (DHHS), with other state government agencies and the State university system, as well as local government entities, advocacy organizations, consumer organizations, professional organizations and other stakeholder groups.

Specifically, the Division works collaboratively with other divisions and offices of the NC DHHS, including:

- The Division of State Operated Healthcare Facilities
- The Division of Vocational Rehabilitation
- The Division of Public Health
- The Division of Aging and Adult Services
- The Division of Services for the Blind
- The Division of Services for the Deaf and Hard of Hearing
- The Division of Child Development and Early Learning
- The Division of Health Services Regulation
- The Division of Medical Assistance (Medicaid and Medicare)
- The Office of Rural Health and Community Care
- The Division of Social Services (Child and Adult Welfare)
- Office of Medicaid Management Information Systems

The largest initiatives in which the Division is currently involved include the statewide implementation of the 1915 (b)/(c) Medicaid Waiver and integration of behavioral health specialty care and physical health care. These result in particularly close working relationships between every section of the Division of MH/DD/SAS and the Division of Medical Assistance and the Office of Rural Health and Community Care with its Community Care of North Carolina.

The Division's Justice Systems Team is a best practice team responsible for addressing policies and practices regarding adult and child mental health, developmental disabilities and substance abuse needs relative to criminal and juvenile justice systems, including Drug Control and Driving While Impaired services. The team provides leadership regarding evidence-based, best and promising practices related to services and supports for individuals, systems performance, and multi-system coordination. Collaboration occurs with law enforcement (federal, state, county and local) and community and

institutional corrections systems (detention centers, youth development centers, jails, prisons, adult and juvenile courts, probation, parole and post-release supervision). Activities are intended to inform and operationalize public policy, identify areas of need, test models and strategically plan with other agencies, such as:

- Department of Correction (DOC)
- Division of Community Corrections (DCC)
- Division of Alcoholism & Chemical Dependency Programs (DACDP)
- Division of Prisons (DOP)
- Administrative Office of the Courts (AOC)
- Department of Public Safety (DPS – includes Juvenile Justice, Violence Prevention, School Safety, jails, detention, prisons, law enforcement, emergency disaster response)
- Department of Public Instruction (DPI – public schools, local education agencies - LEAs)
- Governor’s Crime Commission (GCC)
- Division of Motor Vehicles (DMV)
- Office of the Attorney General
- State Bureau of Investigation (SBI)
- Drug Enforcement Agency (DEA)
- Local Law Enforcement Agencies
- Sheriffs' Association

There are numerous other interagency initiatives and collaborative efforts across departments of public instruction, public safety, administrative office of the courts, higher education public academic liaisons, primary care and other providers, consumers, youth, and families in which the NC Division of MH/DD/SAS is engaged in order to achieve common goals and outcomes through shared strategies for universal and targeted populations across the state. A number of these have been highlighted throughout this plan in prior sections. Areas in which there is targeted focus include early childhood and family development, school age prevention and early intervention initiatives, youth in transition, adolescent health, suicide prevention, positive parenting, homeless and housing, employment and education, military children and families, and transitions to community living among others. Each of these collaborative initiatives plays a role in building resilience and promoting recovery in North Carolina.

As Technical Assistance needs continue to be identified, we will draw upon these collaborative relationships in order to strengthen our collective efforts to improve outcomes for those children, youth and adults with serious mental health needs and the system that supports and serves individuals in North Carolina.

- 2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.**

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).⁹⁷

Additionally, [Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. 300x-51\)](#) applicable to the SABG and the MHBG, requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC: States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

*Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.*⁹⁸

⁹⁷<http://beta.samhsa.gov/grants/block-grants/resources>

⁹⁸There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health Block Grant Application

1. How was the Council actively involved in the state plan? Attach supporting documentation.

Please see the attached letter of support documenting the Council's participation and review of the plan.

2. What mechanism does the state use to plan and implement substance abuse services?

The Substance Use Disorder Federation functions as the advisory body for the Substance Abuse Block Grant.

3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns and activities into its work?

4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

North Carolina's Mental Health Planning and Advisory Council members carefully review the reports, data and trends. In accordance with the federal law (PL102-321 in 1992 as amended) planning council to: 1) review the Mental Health Block Grant Plan and to make recommendations; 2) serve as an advocate for adults with a serious mental illness, children with a serious emotional disturbance, and other individuals with mental illnesses; and 3) monitor, review and evaluate, annually, not less than once each year, the allocation and adequacy of mental health services within the State.

Council members recently completed an inventory of their spheres of influence, wherein in more than 50+ different arenas, each are engaged locally, regionally, or at the state or national level as advocate, advisors to communities, groups, entities or initiatives. Through the diverse range of opportunities to engage with a broad set of stakeholders and advocates, members gather meaningful input for the plan development and implementation strategies. Through the year, members are fully engaged, consulted and represented in plan implementation and DHHS/DMH/DD/SAS initiatives which are coordinated and align for common vision and outcomes, including the Crisis Solutions Initiative, Recovery and Integrated Care Initiatives, Consumer and Family Advisory Councils (CFACs), the MHDDSAS Rules Commission, the NC Practice Improvement Collaborative (e.g., EBPs for the MHBG 5% set aside for First Episode Psychosis, crisis services array), System of Care Steering and Advisory Committees, as well as other forums and task forces in which consumer-directed care, peer support certification

revisions, homeless, housing and employment initiatives, family partner and youth partner standards of practice, and system of care expansion planning and implementation, among others. To maximize time during Council meetings, often plan and report development include making recommendations and setting priorities for the next plan year. For example, as a result of drafting and reviewing this plan, members agreed and made recommendations that will be considered for inclusion in the SFY16-17 Plan.

The Council has members who self-identify having lived experience personally or as a family member with co-occurring disorders, i.e. MH/SU and MH/IDD. The Council is presented and reviews data and trends that include co-occurring disorders and programs/services that include substance use prevention and/or treatment and recovery. The Council receives reports on services and supports; funds expended; reviews data and trends; requests additional information and makes recommendations. The Council members participate as advocates; i.e., for those who are older adults and aging, for those who need employment, housing or education supports, for those who need a health home, are engaged in community or system transitions, diversion practices (CIT), and access to EBPs that support recovery and wellness, such as Critical Time Intervention (CTI), ACTT, certified peer supports or family partners.

For the most part, the membership of the Council represents many of those served or who provide services and supports. As member terms rotate, diverse representation is and will be intentionally sought. A candidate referral form is completed by interested individuals for identified positions on the Council, including regions of the state (east, west, north south); ethnic and cultural diversity, including American Indian, military/veteran, Hispanic, African American; families of children and youth with SED; adults with parents with SMI or parents with adult children with SMI; and transition age youth with SED/SMI and adults with SMI.

Public Comments:

North Carolina provides opportunities for the public to comment on the State's FY 2016-17 application during the development of the plan and after submission of the plan.

DMH/DD/SAS sought comments and input on the plan during the planning process from December 2014 through August 2015.

DMH/DD/SAS sought the feedback and input from the NC Collaborative for Children, Youth and Families by incorporating the MHBG and SOC Implementation Plan into a larger planning discussion regarding priorities and strategies during the Collaborative's 2-day December 2014 Strategic Planning Meeting and at large during SOC Implementation meetings with stakeholders during January through August 2015.

DMH/DD/SAS sought feedback and input from the State Consumers and Family Advisory Committee (SCFAC) by distributing the draft plan priorities in advance and making a presentation at the August 12, 2015 meeting.

DMH/DD/SAS sought the feedback and input from the Commission on Children with Special Health Care Needs (advisory to the Governor on children's health care and insurance, especially Health Choice – NC's SCHIP) by distributing the draft plan priorities in advance and making a presentation on August 12, 2015.

DMH/DD/SAS sought the feedback and input of the Mental Health Planning and Advisory Council and of the North Carolina Substance Abuse Federation by working on drafting components of the plan; reviewing services data, trends and expenditure reports; and identifying plan priorities, strategies and targets. All were distributed in advance and input provided at the Council's respective meetings from June through August 2015.

The MH Planning and Advisory Council will further assist in the review of the plan and comments submitted to date along with plan elements and priorities determined during Council meetings.

DMH/DD/SAS will publish the final plan on the Division's website to facilitate comments from any person (including federal or other public agencies) after the submission of the plan to SAMHSA in September 2015. Instructions for submitting comments will be given on the web.

North Carolina Mental Health Planning and Advisory Council

August 20, 2015

Dr. Courtney Cantrell
Director of MH/DD/SAS
3001 Mail Center
Raleigh, NC 27699-3001

Dear Dr. Cantrell:

We support an effective coordinated recovery oriented system of care of services and supports for children with serious emotional disturbance and adults with serious mental illness delivered efficiently, using limited resources to meet the growing needs in our communities.

During the Council's recent meetings, the North Carolina Mental Health Planning and Advisory Council has reviewed the SFY14-15 report and current year data and trends for services provided to children with serious emotional disturbance and adults with serious mental illness for whom the Community Mental Health Services Block Grant is intended to serve in North Carolina. We have reviewed plan components and identified priorities for this SFY16-18 two year plan. We recommended modifications to the measures, indicators and targets which are now reflected in the plan. The Council decisions and recommendations were based on the data reviewed, the gaps and needs identified by the Local Management Entities-Managed Care Organizations (LME-MCOs) and provider networks that were reported to the Division and in turn to the Council.

We also considered the varied experiences and expertise we bring to the Council, our work and life in communities is extensive. Many of us are involved in the statewide and community initiatives and in the related advisory groups. These efforts are intended to ensure services and supports are effective and appropriate in meeting the gaps and needs identified as well as build on strengths as we make progress toward meeting outcomes and targets. There is much to be done to meet the unmet needs in North Carolina.

By this letter, we endorse this SFY16-18 plan and affirm that we have provided recommendations that have been incorporated in the plan and in the upcoming report. The Council appreciates the opportunity to participate in the development of the plan and monitoring and reporting outcomes of its implementation.

Sincerely,


Mary Edwards, Chair

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year:
 End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Vicki Smith	Others (Not State employees or providers)	Disability Rights NC		vsmith@disabilityrightsn.org
Lucy Dorsey	Others (Not State employees or providers)	Sandhills Center		Lucy.dorsey@sandhillscenter.org
Terri Shelton	Others (Not State employees or providers)	UNC-Greensboro		
Martin Pharr	State Employees	NC Department of Public Safety/Division of Juvenile Justice		martin.pharr@ncdps.gov
Mary Edwards	State Employees	NC Division of Aging and Adults Services		mary.edwards@dhhs.nc.gov
Gina Price	State Employees	NC Division of Vocational Rehabilitation		Gina.price@dhhs.nc.gov
Wes Rider	State Employees	NC Division of MHDDSAS		wes.rider@dhhs.nc.gov
Danielle Mcconaga	State Employees	NC Division of Social Services		Danielle.mcconaga@dhhs.nc.gov
Kaye Holder	State Employees	NC DHHS		Kaye.Holder@dhhs.nc.gov
Joe Simmons	State Employees	NC DPI		jsimmons@dpi.state.nc.us
Gwen Bercaldi	State Employees	NC Housing & Finance Agency		Gbercaldi@nchfa.com
Catharine Goldsmith	State Employees	NC Division of Medical Assistance		catharine.goldsmith@dhhs.nc.gov
Laura Yates	State Employees	NC Department of Public Safety/Division of Corrections		Mly02@doc.state.nc.us
Dan Brown	Providers	Monarch		rbrunstetter3@triad.rr.com
Jinnie Lowery	Providers	Community Health Services		Jinnie_lowery@rhcc1.co
Marc Jacques	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Recovery Inc		jacques.1111@hotmail.com
Dorothy Best	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	NC Mental Health Consumer Organization		dbestmomentum@earthlink.net
Kent Earnhardt	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	NAMI NC		EarnhardtKent@aol.com

Cheryl Judd	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	NC Mental Health Consumer Organization	cjudd@ncmho.org
Brad Biggerstaff	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	NC Youth MOVE	
Jennifer Rothman	Family Members of Individuals in Recovery (to include family members of adults with SMI)	NAMI NC	jrothman@naminc.org
Patricia Harris	Family Members of Individuals in Recovery (to include family members of adults with SMI)	NAMI NC	pharris@aol.com
Vendia Currie	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Mental Health Association in North Carolina	vcurrie@upscaleenterprises.com
TBD vacant	Parents of children with SED	NC Families United, NCFFCMH, Inc.	
Mary Lloyd	Parents of children with SED	NC Families United, NCFFCMH, Inc.	lloymary@smokymountaincenter.com
Damie Diop-Jackson	Parents of children with SED	NC Families United	djackson@gmail.com
TBD vacant	Parents of children with SED		
Gail Cormier	Parents of children with SED	NC Families United, NCFFCMH, Inc.	gcormier@triad.rr.com

Footnotes:

Membership as of June 2015.

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	30	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	5	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED*	5	
Vacancies (Individuals and Family Members)	<input type="text" value="2"/>	
Others (Not State employees or providers)	3	
Total Individuals in Recovery, Family Members & Others	18	60%
State Employees	10	
Providers	2	
Federally Recognized Tribe Representatives	0	
Vacancies	<input type="text" value="0"/>	
Total State Employees & Providers	12	40%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="6"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="2"/>	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	8	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text" value="4"/>	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

During the SFY14-15 recent meetings, the NCMHPAC was involved in reviewing the SFY14-15 data and trends. In so doing, they then reviewed the plan components and identified priorities for this SFY16-17 two year plan, setting and modifying targets. The Council informed decisions and recommendations based on the data reviewed, the gaps and needs identified by the LME-MCOs and provider networks and through their varied experience and expertise in the communities and statewide initiatives in which they are involved that relate to ensuring services and supports are effective and appropriate to meet needs and gaps identified, as well as build on strengths and progress in meeting outcomes and targets.

