Nothing Compares
NORTH CAROLINA

Joint Legislative Oversight Committee
on Health and Human Services, Joint Study of
Justice and Public Safety and Behavioral Health
February 25, 2016

Governor's Task Force on Mental Health and Substance Use

Opening comments

- Chief Justice Mark Martin
- DHHS Secretary Rick Brajer

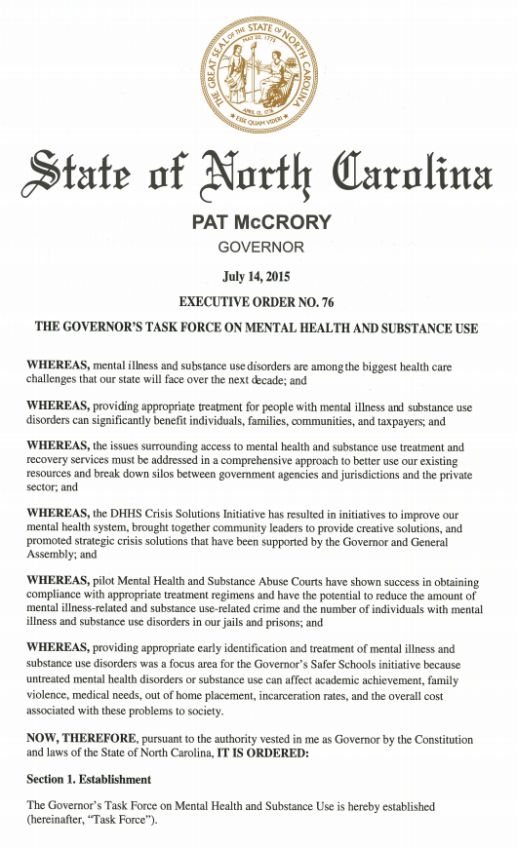
Agenda

- Opening remarks
  - Chief Justice Mark Martin; DHHS Secretary Rick Brajer
- Progress to date and timing of final deliverables
- Workgroup on Adults – Dr. John Santopietro
- Workgroup on Opioid Abuse and Heroin Resurgence – Kurtis Taylor, Jr.
- Workgroup on Children, Youth and Families – William Lassiter
- Next steps
- Closing remarks
  - Chief Justice Mark Martin; DHHS Secretary Rick Brajer
- Q & A

Gov. Pat McCrory's Executive Order No. 76

Task Force on Mental Health and Substance Use

- **Whereas**, mental illness and substance use disorders are among the biggest health care challenges that our state will face over the next decade; and
- **Whereas**, the issues surrounding access to mental health and substance use treatment and recovery services must be addressed in a comprehensive approach to better use our existing resources and break down silos between government agencies and jurisdictions and the private sector



State of North Carolina

PAT McCRORY
GOVERNOR

July 14, 2015

EXECUTIVE ORDER NO. 76

THE GOVERNOR'S TASK FORCE ON MENTAL HEALTH AND SUBSTANCE USE

WHEREAS, mental illness and substance use disorders are among the biggest health care challenges that our state will face over the next decade; and

WHEREAS, providing appropriate treatment for people with mental illness and substance use disorders can significantly benefit individuals, families, communities, and taxpayers; and

WHEREAS, the issues surrounding access to mental health and substance use treatment and recovery services must be addressed in a comprehensive approach to better use our existing resources and break down silos between government agencies and jurisdictions and the private sector; and

WHEREAS, the DHHS Crisis Solutions Initiative has resulted in initiatives to improve our mental health system, brought together community leaders to provide creative solutions, and promoted strategic crisis solutions that have been supported by the Governor and General Assembly; and

WHEREAS, pilot Mental Health and Substance Abuse Courts have shown success in obtaining compliance with appropriate treatment regimens and have the potential to reduce the amount of mental illness-related and substance use-related crime and the number of individuals with mental illness and substance use disorders in our jails and prisons; and

WHEREAS, providing appropriate early identification and treatment of mental illness and substance use disorders was a focus area for the Governor's Safer Schools initiative because untreated mental health disorders or substance use can affect academic achievement, family violence, medical needs, out of home placement, incarceration rates, and the overall cost associated with these problems to society.

NOW, THEREFORE, pursuant to the authority vested in me as Governor by the Constitution and laws of the State of North Carolina, **IT IS ORDERED:**

Section 1. Establishment

The Governor's Task Force on Mental Health and Substance Use is hereby established (hereinafter, "Task Force").

Building upon a strong foundation of commitment

The Governor's Task Force on Mental Health and Substance Use builds on work already begun by Governor McCrory, with the launch of the Crisis Solutions Initiative in 2013 and the launch of the Governor's Substance Abuse and Underage Drinking Prevention and Treatment Task Force in 2014.

Governor Pat McCrory signed the executive order that established the Task Force on July 14, 2015

Areas of progress: Crisis Services and Prevention

- **Mental Health First Aid:**
  N.C. has trained nearly 18,000 citizens in Mental Health First Aid and 362 Mental Health First Aid instructors
- **Behavioral Health Urgent Care Centers and Facility-Based Crisis Treatment Options:**
  4 new centers to provide alternatives to emergency departments
- **Crisis Intervention Training:**
  Nearly 8,200 Law Officers Trained
- **EMS Pilot Programs:**
  Enables those in a mental health crisis to access specialized behavioral health and substance use services quickly while allowing emergency departments to focus on caring for patients needing an acute level of medical attention.

Areas of progress: Crisis Services and Prevention

- **Critical Time Intervention:**
  Assists adults with mental illness and no/unstable housing who are transitioning out of jails, hospitals and emergency departments—4 teams and growing.

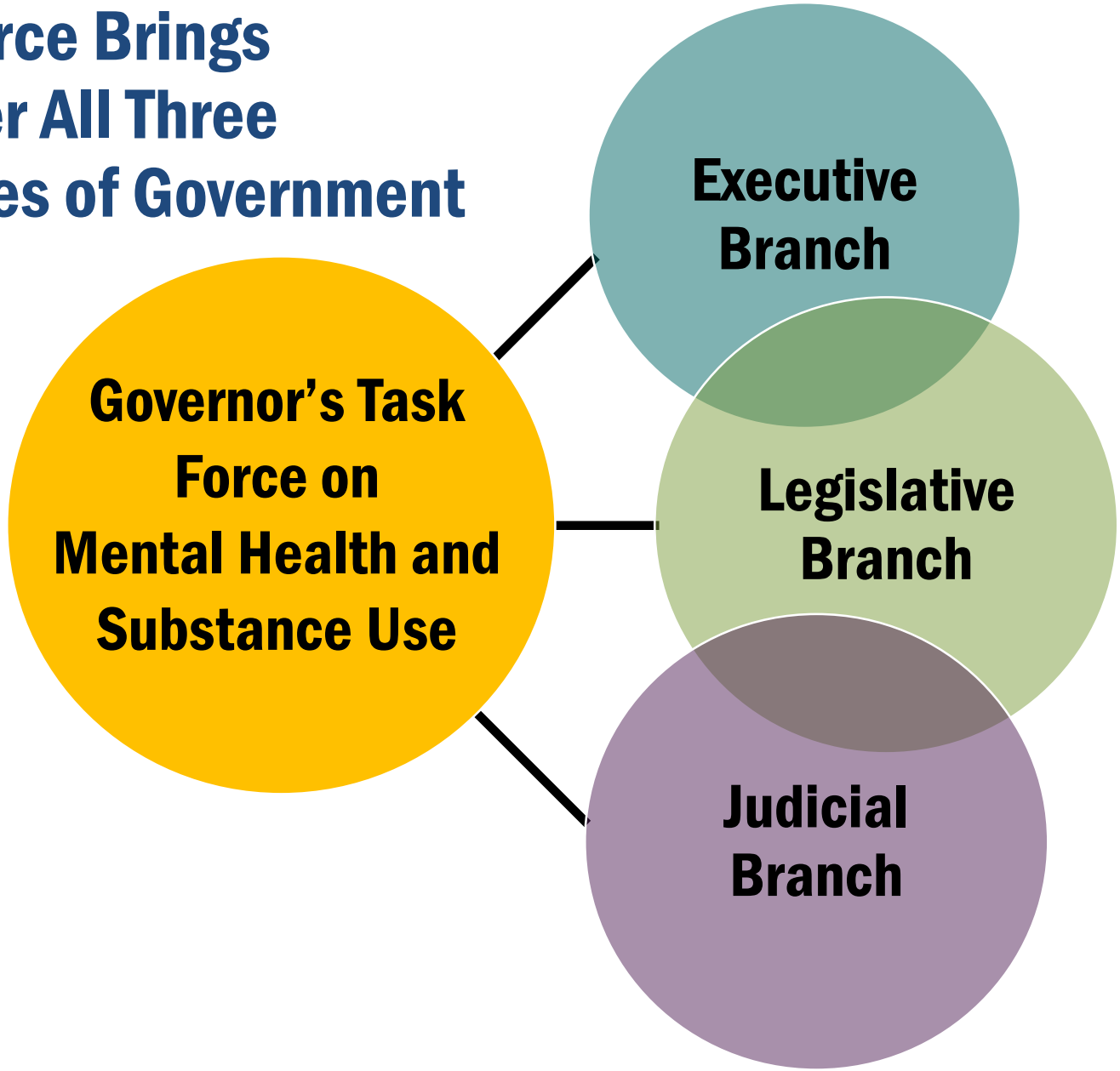
- **Access to Recovery Grant:**
  A $7.8-million Access to Recovery grant from the federal Substance Abuse and Mental Health Services Administration provides vouchers for better access to treatment for individuals in recovery from substance use disorders.

Areas of progress: Behavioral Health in Justice System

- Invested $12 million over two years for mental health beds and treatment in prisons in 2015 budget.
- All Juvenile Court Counselors have been trained on Mental Health First Aid.
- Implemented the Justice Reinvestment Act which includes investments in behavioral health treatment.
- Received Federal Second Chance Act Grant to enhance case planning process for juveniles.

How did we arrive to where we are today?

Task Force Brings Together All Three Branches of Government



Established 3 workgroups

Adults

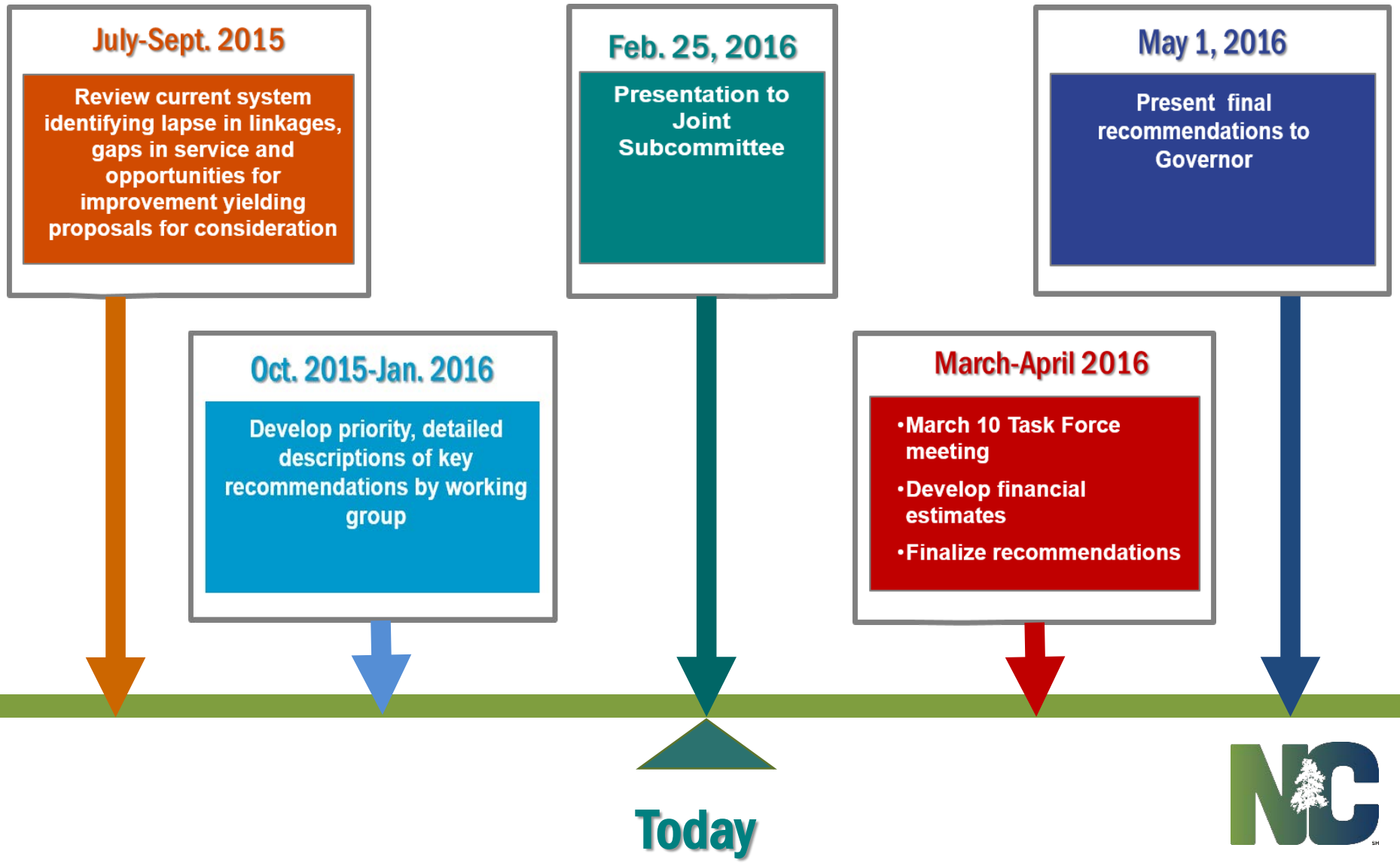
Opioid Abuse and Heroin Resurgence

Children, Youth and Families

Focus areas

- Transitions
- Adult & juvenile offenders
- Transitions into prisons and jails
- Transitions out of prisons and jails
- Foster care
- Too many people seeking emergency help in community hospital Emergency Rooms
- Silos remain
- Available natural supports

Where we are today



Workgroup on Adults: Dr. John Santopietro

Challenges to address

- Appropriate, Affordable & Available Housing
- Coordination of care for veterans
- Integrated Behavioral & Physical Healthcare
- Efficiency, transparency & innovation
- Diversion to treatment from criminal justice when appropriate
- Trauma informed systems of care
- Behavioral health payment system

Current capacity

- State Operated Healthcare Facilities:
  - Mental health disorders: Broughton Hospital, Cherry Hospital, & Central Regional Hospital
  - Substance use disorders: RJ Blackley ADATC, JF Keith ADATC, & Walter B Jones ADATC
- 8 Local Management Entities-Managed Care Organizations (LME-MCOs)
- 382 addiction treatment centers
- 23 maternal & perinatal substance abuse programs
- 307 licensed mental health facilities; 10 licensed private psychiatric facilities; 412 licensed nursing facilities
- Approximately 30 Assertive Community Treatment Teams
- Integration of behavioral health care services into primary care:
  - Co-location in the 14 Community Care of NC networks
  - County Health Departments
- Therapeutic Courts: 8 Family, 18 Adult, 4 Youth, 7 DWI, 6 Mental Health, 2 Veterans & 1 Tribal
- 203 halfway houses and 207 Oxford Houses

Workgroup on Adults: current priority considerations

Changes that Directly Improve Consumer's Lives

1. **Appropriate, Affordable & Available Housing**
2. **Expand Case Management / Recovery Services**
3. Expand Employment Opportunities
4. Develop Behavioral Health Workforce
5. Psychiatric Advanced Directives
6. Coordination of Care for Veterans
7. Better Use of Inpatient Care & Alternatives

Cross-Systems

8. **Diversion to Treatment from Criminal Justice whenever appropriate**
9. Well-integrated Behavioral & Physical Healthcare
10. Collect Data & Use to Guide Actions, including Funding Decisions
11. Develop Public-Private Partnerships that foster Efficiency, Transparency & Innovation

MHSU System Improvements

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

Workgroup on Adults

Current priority considerations

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

Workgroup on Adults

Current priority considerations

2. Expand Case Management / Recovery Services

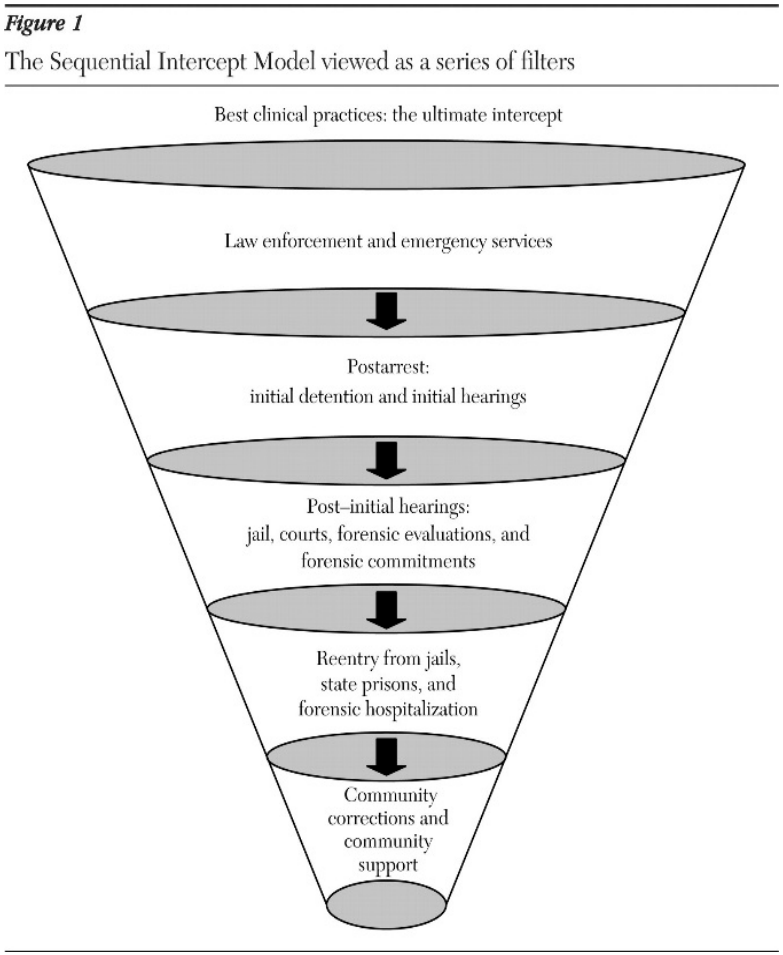
a. Independent, Stand-alone Case Management Service Definition
b. Promote Assertive Community Treatment Teams (ACTT):
c. Incentivize ACTT where it does not exist with start-up funds
d. Develop forensic ACTT (or FACT) in areas of highest need
e. Create “step-down” lower intensity case management service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

Workgroup on Adults

Current priority considerations

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

- Sequential Intercept Model
  - Intercept 1: Law enforcement & emergency services
  - Intercept 2: Post-arrest - initial hearings & initial detention
  - Intercept 3: Post-initial hearings - jails, courts, forensic evaluations & commitments
  - Intercept 4: Reentry from jails, state prisons & forensic hospitalization
  - Intercept 5: Community corrections & community support
- Best Clinical Practices at all points is the ultimate intercept



Workgroup on Adults

Current priority considerations

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

- DHHS should continue to educate police chiefs, sheriffs, LME-MCOs, fire & rescue, EMS, dispatchers, & other local entities about CIT & provide technical assistance
- Effective CIT requires additional resources for Behavioral Health Urgent Care Centers that can provide law enforcement a quick hand off; Rural communities may require other options (e.g., more robust mobile crisis, in home stabilization, increased consultation for EDs serving as the intercept CIT drop-off site)
- Other solutions may include crisis "navigators" – including peers – assigned at crisis/intercept points to assist officers, families and the consumer navigate the system in order to get the individual engaged in services.
- DHHS should continue to support Mental Health First Aid; Special emphasis should be made to train criminal justice professionals
- Enhance therapeutic courts (mental health, drug, recovery, veterans)
  - Identify goals to include in therapeutic courts that reduce recidivism
  - Where specialized courts are not feasible, judicial districts should consider using special dockets

Workgroup on Opioid Abuse and Heroin Resurgence: Kurtis Taylor, Jr.

Challenges to address

- Awareness of the dangers of prescription opioid misuse growing health hazard
- Resurgence of heroin use
- Stigma and awareness of Medication Assisted Therapy
- Limited availability of Naloxone
- Adequate recovery related services

Workgroup on Opioid Abuse and Heroin Resurgence

Current Capacity

- **51** Opioid Treatment Programs (OTPs) in North Carolina
- **432** physicians in the state can prescribe Buprenorphine
- **1,354** community heroin overdose reversals using Naloxone from August 1, 2013 to November 16, 2015
- **33** NC law enforcement departments have set up Naloxone programs, with 24 rescues thus far. Nearly all the law enforcement departments began the program in 2015
- **27,457** cumulative registered dispensers and prescribers participating in NC Controlled Substance Reporting System as of November 9, 2015 (8,402 dispensers and 19,055 prescribers)
- **6,809,298** opiate prescriptions dispensed from January 1 – September 30, 2015

Workgroup on Opioid Abuse and Heroin Resurgence

Current priority considerations

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

Workgroup on Opioid Abuse and Heroin Resurgence

Current priority considerations

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

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

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

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

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

Workgroup on Opioid Abuse and Heroin Resurgence

Current priority considerations

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

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

b. Increase availability of Naloxone throughout the state.

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

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

Workgroup on Opioid Abuse and Heroin Resurgence

Current priority considerations

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

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

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

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

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

Workgroup on Opioid Abuse and Heroin Resurgence

Current priority considerations

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

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

Workgroup on Opioid Abuse and Heroin Resurgence

Current priority considerations

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

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

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

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

Workgroup on Children, Youth and Families: William Lassiter

Challenges to address

- Access and work force development
- Stigma
- Trauma-informed care
- Foster care
- Juvenile Justice

Workgroup on Children, Youth and Families

Current priority considerations

1. Standardization / Accountability
2. Increase access and workforce development
3. Education/Stigma Reduction/Primary Prevention
4. Data and Technology
5. Trauma-Informed State

Workgroup on Children, Youth and Families

Current priority considerations

1. Standardization and Accountability

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

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

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

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

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

Workgroup on Children, Youth and Families

Current priority considerations

2. Increase access

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

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

Workgroup on Children, Youth and Families

Current priority considerations

3. Stigma, Education and Primary Prevention

Mental Health First Aid

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

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

Workgroup on Children, Youth and Families

Current priority considerations

4. Data and technology

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

b. Data Investigative Council (MOUs regarding data sharing)

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

Workgroup on Children, Youth and Families

Current priority considerations

5. Trauma-informed state

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

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

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

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

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

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

Workgroup on Children, Youth and Families

Current priority considerations

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

Next steps

March-April 2016

- March 10 Task Force meeting
- Develop financial estimates
- Finalize recommendations

May 1, 2016

Present final recommendations to Governor

Concluding Remarks

- Chief Justice Mark Martin
- DHHS Secretary Rick Brajer