Governor’s Task Force on Mental Health and Substance Use
Workgroup on Adults

www.ncdhhs.gov/mhsu
### Proportion of Adults with Substance Use & Mental Health Disorders

<table>
<thead>
<tr>
<th></th>
<th>General Public</th>
<th>Probation &amp; Parole</th>
<th>State Prison</th>
<th>Jail</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Substance Use Disorder</strong></td>
<td>16%</td>
<td>40% &amp; 35%</td>
<td>53%</td>
<td>68%</td>
</tr>
<tr>
<td><strong>Serious Mental Illness - w/ Co-occurring SUD</strong></td>
<td>5.4%</td>
<td>7-9%</td>
<td>16%</td>
<td>17%</td>
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<tr>
<td></td>
<td>25%</td>
<td>49%</td>
<td>59%</td>
<td>72%</td>
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*Adults with Behavioral Health Needs Under Correctional Supervision, Council of State Governments, 2012*
### Number of North Carolinians with Substance Use & Mental Health Disorders

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td><strong>Substance Use Disorder</strong></td>
<td>1,225,096</td>
<td>35,870 &amp; 4440</td>
<td>19,926</td>
<td>12,430</td>
</tr>
<tr>
<td><strong>Serious Mental Illness w/ Co-occurring SUD</strong></td>
<td>413,470</td>
<td>7165-9212</td>
<td>6015</td>
<td>3108</td>
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<tr>
<td></td>
<td>103,368</td>
<td>3511-4514</td>
<td>3549</td>
<td>2238</td>
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</tbody>
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*Adults with Behavioral Health Needs Under Correctional Supervision, Council of State Governments, 2012*

*2014 US Census Population on 11.30.2015, DACJJ, NCDPS*

*Average Daily Population Jan-Dec 2013, BJS*
Current Capacity

- State Operated Healthcare Facilities:
  - Mental health disorders: Broughton Hospital, Cherry Hospital, & Central Regional Hospital
  - Substance use disorders: RJ Blackley ADATC, JF Keith ADATC, & Walter B Jones ADATC

- 8 Local Management Entities-Managed Care Organizations (LME-MCOs)

- 382 addiction treatment centers

- 23 maternal & perinatal substance abuse programs

- 307 licensed mental health facilities; 10 licensed private psychiatric facilities; 412 licensed nursing facilities

- Approximately 30 Assertive Community Treatment Teams

- Integration of behavioral health care services into primary care:
  - Co-location in the 14 Community Care of NC networks
  - County Health Departments

- NC is behind national average in nearly all MH/SUD professions

- Therapeutic Courts: 8 Family, 18 Adult, 4 Youth, 7 DWI, 6 Mental Health, 4 Veterans & 1 Tribal

- 203 halfway houses and 207 Oxford Houses
Recommendations

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

Cross-Systems
5. Well-integrated Behavioral & Physical Healthcare
6. Collect Data & Use to Guide Actions, including Funding Decisions
7. Develop Public-Private Partnerships that foster Efficiency, Transparency & Innovation
8. Consumers should be Diverted from Criminal Justice to Treatment whenever possible*

MHSU System Improvements
9. Care should be Easy to Access; “No Wrong Door”
10. Trauma-informed Systems of Care
11. Improve Behavioral Health Payment System
12. Promote Leadership on MH & SU Issues at all Levels
1. **Appropriate, Affordable & Available Housing**
   - Develop therapeutic housing where individuals can develop a sense of community
   - Establish partnerships with builders
   - Promote development of half-way houses that can provide comprehensive services
   - Tiny Homes Community Collaborative

2. **Expand Employment Opportunities**
   - Work with state Vocational Rehabilitation to implement “place & train” models
   - Greater use of peers (e.g., TROSA model)
   - Promote coaching for job success
   - Request Dept. of Commerce to evaluate programs & services for consumers; report findings & develop recommendations to expand employment opportunities
3. **Expand Case Management / Recovery Navigation Services***
   - Independent, Standalone Case Management Service Definition
   - Promote Assertive Community Treatment Teams (ACTT):
     - Incentivize ACTT where it does not exist with start-up funds
     - Develop forensic ACTT (or FACT), in areas of highest need
     - Create “step-down” lower intensity case management service definition for periodic ongoing support to prevent decompensation, following ACTT
   - Critical Time Intervention statewide for consumers who would benefit from this time-limited, intensive service (e.g., discharge from state hospital, release from incarceration)
   - Develop “navigator” case management service to assist consumers less disabled by MI &/or SUDs but need occasional assistance

4. **Develop Behavioral Health Workforce**
   - Expand role of Peer Support
   - Professional Case Managers are necessary
   - Community Colleges offer AA degrees for Certified Case Managers
5. **Well-integrated Behavioral & Physical Healthcare**
   - In behavioral healthcare settings, consumers should be routinely screened for physical health conditions, like diabetes & high blood pressure
   - In primary care settings, patients should be routinely screened for common behavioral health problems, like depression, substance use & suicide risk
   - Care should be convenient for consumers & families
   - “Health homes” that address both physical & behavioral health concerns should be established for people with complex, co-occurring behavioral health & physical health challenges.
   - The role of public county health departments should be expanded to include screening & referring individuals for MH & SU treatment, with greater coordination with LME-MCOs, including co-location

6. **Collect Data & Use to Guide Actions, including Funding Decisions**
   - Establish high-level quality improvement workgroups that include NC Sheriffs’ Association, AOC, NC Association of County Commissioners, DHHS, DPS, existing MH & SUCoalitions, etc. for data driven cross-system problem-solving.
7. Develop Public-Private Partnerships that foster Efficiency, Transparency & Innovation

- State/Local partnerships with private & teaching hospitals & the Hospital Association to develop bed board registries
- State/Local partnerships with private agencies to provide tele-psychiatry in rural & other underserved areas
- State/Local partnerships with private nursing homes that have excess capacity to study the feasibility of converting to therapeutic/supportive housing options
- Engage with private Trusts/Foundations/Endowments for seed funding to promote innovative practices. Examples: construction of “tiny homes” & mobile behavioral health clinics
8. Consumers should be diverted from the criminal justice system to treatment whenever possible*

*Sequential Intercept Model*

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

Best Clinical Practices at all points is the ultimate intercept.
8. Consumers should be diverted from the criminal justice system to treatment whenever possible* (continued)

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

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

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

- DHHS should continue to support Mental Health First Aid; Special emphasis should be made to train criminal justice professionals
9. Care should be Easy to Access; “No Wrong Door”
   • Each LME-MCO submits a plan to assure that care is easy to access & there is “no wrong door”
   • Conduct a “No Wrong Door” campaign
   • Expand on existing communication systems, such as 911/211

10. Trauma-informed Systems of Care
   • Dept of Veterans Affairs offers evidence-based care for PTSD that has demonstrated excellent clinical outcomes. Specific interventions for psychotherapies & pharmacotherapy are published at www.ptsd.va.gov
   • Substance use disorder treatment programs can decrease the rates of motor vehicle crashes & occupational injury, which in turn will decrease the risk for new cases of PTSD.
   • Coordination with the State Committee on Trauma to begin building a relationship with the MH-SUD community
11. Improve Behavioral Health Payment System
   • Enable greater flexibility in providing services needed, when needed
   • Place providers at risk via capitation contracts that incentivize care that is cost &
     clinically effective, reward creative solutions while assuring greater accountability

12. Promote Leadership on MH & SU Issues at all Levels
   • Raise awareness & reduce stigma through public education campaigns (e.g.,
     Mental Health First Aid)
   • Encourage local/multi-county MH & SU task forces/coalitions. Include consumers,
     families, providers, first responders (EMS & law enforcement), LME-MCOs, County
     Commissioners, advocates & others
   • Encourage counties to participate in the Stepping Up Initiative, a national effort to
     divert people with mental illness from jail to treatment https://stepuptogether.org/
   • Encourage counties to use the Sequential Intercept Model to address concerns
     about the criminalization of people with MI & SUDs