Governor’s Task Force on Mental Health and Substance Use
MEETING MINUTES

Date: March 10, 2016 **Time**: 1:00-5:30pm **Location**: Raleigh Convention Center

MEETING CALLED BY	Governor’s Task Force on Mental Health and Substance Use
TYPE OF MEETING	Task Force meeting
ATTENDEES: 96 total	

COMMITTEE MEMBERS			STATE STAFF ATTENDEES		
NAME	**AFFILIATION**	**PRESENT**	**NAME**	**AFFILIATION**	**PRESENT**
Richard Brajer	Secretary of Health and Human Services	☒	Dale Armstrong, MBA, FACHE	Deputy Secretary, NC Behavioral Health and Developmental Disability Services	☒
Chief Justice Mark Martin	Supreme Court of North Carolina	☒	Sonya Brown	Team Leader, Justice Systems Innovations, NC DMHDDSAS	☒
Commissioner Ronald Beale	Macon County	☒	Brenda Davis	Community Policy Management, NC DMHDDSAS	☒
Sheriff Asa Buck III	Carteret County	☐	Lisa DeCiantis	Community Mental Health, NC DMHDDSAS	☒
Chief District Judge Joseph Buckner	North Carolina District Court 15-B	☐	Ken Edminster	Housing Administrator, NC DMHDDSAS	☒
Bruce Capehart, MD, Medical Director, OEF/OIF Program	Durham VAMC	☒	Kendra Gerlach	Director, NC DHHS Office of Communications	☒
Lisa Cauley, Child Welfare Division Director	Wake County Department of Social Services	☒	Dan Guy	NC DHHS Office of Communications	☒
Karen Ellis, Director	Cleveland County Department of Social Services	☒	Eric Harbour	Child Mental Health, NC DMHDDSAS	☒
Samuel Ervin, IV, Associate Justice	Supreme Court of North Carolina	☒	Dr. Nancy Henley	Chief Medical Officer, NC Division of Medical Assistance	☒
Lorrin Freeman, JD	Attorney	☒	Margaret Herring	Community Mental Health, NC DMHDDSAS	☒
Donald Hall, Chairman	Pender County ABC Board	☒	Jessica Herrmann	Community Policy Management, NC DMHDDSAS	☒
Brian Ingraham, CEO	Smoky Mountain LME/MCO	☒	Dawn Johnson	Community Policy Management, NC DMHDDSAS	☒
Dr. Mike Lancaster	SouthLight, Inc.	☒	Rachel Johnson	Justice Systems Innovations, NC DMHDDSAS	☒
William Lassiter, Deputy Commissioner for Juvenile Justice	North Carolina Department of Public Safety	☒	Dr. Robert Kurtz	Justice Systems Innovations, NC DMHDDSAS	☒
Rep. Susan Martin	8th District	☒	Ken Schuesselin	Consumer Policy Advisor, Office of the Director, NC DMHDDSAS	☒
Benjamin Matthews, PhD, Deputy CFO for Operations	North Carolina Department of Public Instruction	☒	Stacy Smith	Adult Mental Health, NC DMHDDSAS	☒
Greta Metcalf, LPC, COO	Jackson County Psychological Services	☒	Flo Stein	Deputy Director, Community Policy Management, NC DMHDDSAS	☒
Al Mooney, MD	Family Medicine & Willingway Foundation	☒	Debbie Webster	Transition Services, NC DMHDDSAS	☒
Bryant Murphy, MD	UNC-Chapel Hill/NC Medical Society	☐	Martin Woodard	Quality Management, NC DMHDDSAS	☒
Deborrah Newton, JD	Attorney	☒	McKinley Wooten	Deputy Secretary, NC Administrative Office of the Courts	☒
David Passmore, Vice	Boys and Girls Homes of	☒			

President of Residential Services	North Carolina				
Senator Louis Pate	7th District, NC General Assembly	☒			
Ashwin Patkar, MD, Medical Director, Duke Addictions Program	Duke University Medical Center	☒			
Katherine Peppers, CPNP	Growing Child Pediatrics	☒			
Patricia Porter, Ph.D.	Consultant, NC General Assembly	☒			
Jack Register, MSW, Executive Director	National Alliance on Mental Illness – North Carolina	☒			
Dave Richard, Deputy Secretary	NC Department of Health and Human Services	☒			
Dr. John Santopietro	Mecklenburg Co	☐			
Steven Scoggin, MDiv, PsyD, LPC, Assistant Vice President of Faith and Health and Behavioral Health	Wake Forest Baptist Medical Center	☒			
George Solomon, Director of Prisons	NC Department of Public Safety	☒			
Donna Stroud, Associate Judge	NC Court of Appeals	☒			
Kurtis Taylor, Jr., Outreach/Re-entry Coordinator	Oxford House, Inc.	☐			
Senator Tommy Tucker	35th District, NC General Assembly	☒			
Senator Terry Van Duyn	49th District, NC General Assembly	☒			

GUEST			GUEST	
NAME	**AFFILIATION**		**NAME**	**AFFILIATION**
Jasmine Akalasny	Roxie Detox, Fayetteville		Doc Holliday	Recovery Communities of NC
Chris Austin	NC State University		Robin Huffman	NC Psychiatric Association
Dr. Eric Beeson	Family Institute, Northwestern University		Genta Hughes	Carelink Solutions
Jesse Bennett	NC State University		Trish Hussey	Freedom House Recovery Center
Jennifer Bills	Disability Rights - NC		Victoria Johanningsmeier	Governor's Institute on Substance Abuse
Dean Blackburn	Student Wellness, UNC - CH		Dr. Burt Johnson	Trillium Health Resources
Dawn Blagrove	Carolina Justice Policy Center		Ed Johnson	Southeast ATTC
Amanda Blue	Healing Transitions, Wake County		Eric Johnson	Alliance Behavioral Healthcare
Belinda Booker	Psychiatry, UNC Medical Center		Marcy Joyner	Gaston County Public Health
Elizabeth Borntrager	Psychiatric Nurse Practitioner		Tonia Joyner	Alliance Behavioral Healthcare
Tammy Brunelle	Coastal Horizons Center		Nicholle Karim	NAMI NC
Chris Budnick	Healing Transitions		Pam Kilpatrick	OSBM
Cynthia Cabaniss	Family Service of the Piedmont		Nicole King	Duke University School of Nursing
Christopher Campau	NC State University		Karen Kranbuehl	ACT for Recovery, NC
Yeshica Carerra	City Substance Abuse		Dr. Tobias LaGrone	Conduct Intelligence Group
Paul Evans	Cone Behavioral Health		Warren Margulies	Fellowship Hall
Kay Castillo	NASW-NC		Anthony Marino	Clinical Community Solutions
Kimberly Chansen	Durham Wellness Center		Donald McDonald	RCNC

Karen Chapple	Coastal Horizons		Dr. Sara McEwen	Governor's Institute on Substance Abuse
Kayla Chatterton	Fellowship Health Resources		Anthony McLeod	Governor's Institute on Substance Abuse
James Cioe	Governor's Institute on Substance Abuse		Connie Mele	Mecklenburg County Health Department
Tad Clodfelter	SouthLight Healthcare		Brian Mingia	Old Vineyard Behavioral Health
Laurel Cooney	Roxie Detox, Fayetteville		Parker Morris	
Starlett Davis	Alliance Behavioral Healthcare		David Mountcastle	Clean Slate
Dr. Joshua Dittmer	Carolina Performance		Steve Owen	Fiscal Research, NC General Assembly
Jennifer Evans	Wake County		Yancee Perez	Alliance Behavioral Healthcare
Paul Evans	Cone Behavioral Health		Dr. Gregory Perkins	Fayetteville State University
Mark Ezzell			Shane Phillips	Healing Transitions
Dr. Wei Li Fang	Governor's Institute on Substance Abuse		Pamela Shipman	Monarch
Amanda Gilmore	SUNY – Empire State College		James Simmons	Eastpointe
Gail Goode			Bebe Smith	UNC School of Social Work
Anthony Greenidge	Counseling Services, NC A&T State University		Donna Kay Smith	Accessible Minds/Voices Action Network
Shirley Hart	Tia Hart Community Recovery Program		Susan Vebber	NC Nurses Association
Lyssa Haynes	Old Vineyard Behavioral Health		Leza Wainwright	Trillium Health Resources
Drew Heath	OSBM		Andrew Walsh	Partners Behavioral Health Management
Jennifer Hillman	Legislative Research, NC General Assembly		Wayne Williams	OSBM
Dr. Kristina Hobby	CCNC		Berkeley Yorkery	NC Institute of Medicine

1. Agenda topic: Recovery Perspective **Presenter(s):** Chris Budnick, Donald McDonald, Karen Kranbuehl, and Jesse Bennett

Discussion

- Members of the recovery community presented nine recommendations that they would like to have included in the Task Force report to the Governor (for more information, see their input document posted on the website for the March 10, 2016 meeting):

1. **Use State monies to fund recovery support services.**
   a. **Provide funding for the development of Recovery Community Organizations.**
      - Recovery Community Organizations are comprised of individuals in recovery, their families, friends, and allies and exist to enhance the quantity and quality of recovery supports available to people seeking recovery and those who are sustaining recovery.
   b. **Recovery Community Organizations can operate Recovery Community Centers.**
      - Recovery community centers can provide emotional, informational, instrumental and affiliational support.
      - Recovery community centers can include addiction recovery peer support specialists.
      - Addiction recovery peer support specialists are familiar with local resources and are skilled in assertive linkage to treatment, recovery, social, occupational, educational, and housing resources.
      - Addiction recovery peer support specialists can work with individuals in a social setting detox and recovery initiation center.
      - They also draw upon volunteers from the larger recovery community.
      - Governor McCrory and the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) have demonstrated a financial commitment to Recovery Community Organizations as evidenced by the recent Invitation to Apply for Recovery Community Center funding.
      - These recovery community centers could be strategically located next to social setting detox/recovery initiation centers
   c. **Addiction Recovery Peer Support Specialists**
      - Recovery Communities of North Carolina (RCNC) is presently implementing a directive from DMHDDSAS to create an addiction specialty for peer support specialists.

- Addiction Recovery Peer Support Specialists can do outreach during critical opportunities for recovery initiation:
  - Post-Naloxone overdose reversal
  - At emergency departments
  - Through law enforcement interactions (i.e., The Gloucester Angel Program)
- Addiction Recovery Peer Support Specialists can do outreach during critical opportunities for recovery maintenance:
  - Following discharge from ADATC and other treatment programs
  - Recovery-check ups
  - To assist with overcoming barriers to housing, employment, and citizenship

State monies are more effective than funding through the Federal Block Grant for implementing recovery support services through new recovery community organizations.

2. **Build a network of social setting (non-medical) detox/recovery initiation centers.**
   - They provide easy access to a lower level of care that can serve individuals who are intoxicated, individuals who are in withdrawal, and individuals who are at high risk for a return to substance use.
   - They can serve to help people initiate recovery.
   - They serve as an entry point into a larger continuum of care, without being the most expensive option in the continuum. These settings can serve to divert many people from higher levels of care (emergency departments) and from the wrong level of care (jail) and can serve as an entry point into an addiction treatment/recovery continuum of care.
   - They provide resources for diversion for law enforcement and EMS.
   - Social setting detox centers can work well with the previous recommendation.
3. **Provide long-term, recovery-supportive systems of care.**
   - Model addiction treatment services after the Physician Health Programs, which include sustained monitoring, support, and re-engagement when needed.
4. **Leaders at every level must fight stigma.**
   - Have a statewide campaign led by Governor McCrory, identifying himself as a Recovery Ally and highlighting the lived reality of recovery as an expectation, not an exception.
   - Implement changes in written and oral language that dispose of stigmatizing language and replace it with recovery-centered language (see input document online). This must happen in every agency at every level with consistency.
5. **Mandate registration and utilization of the Controlled Substance Reporting System (CSRS).**
   - Mandate 100% registration and utilization of the CSRS by all DEA licensed physicians and pharmacists; providers have already been “encouraged” to participate and that tactic has proven ineffective. This is one aspect of solving the problem, but it is a crucial aspect that is within state control.
6. **Increase access to Naloxone.**
   - Pair Naloxone with all opioid prescriptions regardless of amount or duration. This sends a clear message regarding the potential lethality of opioids (patient education) without the need to profile patients.
7. **Drug Treatment Courts**
   - The Task Force’s mission specifically includes making recommendations regarding the justice system. As the Governor said at the January 19, 2016 Task Force meeting, the recommendations must be specific and action-oriented in order to be viable. These recommendations are crucial for the future effectiveness of the Drug Treatment Courts (DTCs):
     - Reinstate funding for DTCs.
       - Allocate funds sufficient to make DTC available to individuals in all districts.
       - Legislative defunding in 2011 nearly eliminated juvenile DTCs, closed some adult DTCs, and leaves the remaining DTCs inadequately funded.
       - Cost / benefit analyses show a significant return on investment through savings in incarceration, reduced crime, community health, and other savings.
     - Clarify that Medication Assisted Treatment (MAT) is an option for DTC participants pursuant to the existing standard of care in the treatment field.
       - For issues regarding application of the standard of care, the counselor on the DTC core team should make a treatment-based recommendation.
       - Where MAT is approved but proper use is at issue, courts should not summarily deny MAT, but should use methods suggested by the National Association of Drug Court Professionals for increasing proper use.

- Rename DTCs as Recovery Courts
  - Align North Carolina with leaders in a national trend of identifying the courts as Recovery Courts, which places the focus on goals rather than on problems.

8. Collegiate Recovery and High School Recovery Clubs

- Recovery communities include individuals in recovery as well as allies. At the collegiate and high school levels, allies include students who have parents in recovery or active addiction, as well as students who just choose not to drink or use. Recovery communities in colleges and high schools provide a supportive environment and safe haven for students on campuses that universally feature frequent and heavy drinking. Therefore, we recommend that North Carolina:
  - Establish high school recovery programs and develop more Collegiate Recovery Communities (CRCs).
  - Allow CRCs to associate with, assist, and sponsor local high schools with recovery supports, including recovery clubs. This will help students recover in high school and as they transition from high school to college.
  - The Governor and Task Force members can reduce stigma in educational institutions and among young people by identifying as recovery allies.

9. Needle and Syringe Exchange Programs (SEPs)

- North Carolina should join twenty states that explicitly authorize SEPs, including Kentucky, Indiana, and Nebraska, as well as major cities in Georgia and West Virginia. The following reasons are listed below:
  - SEPs can prevent HIV and Hepatitis C.
    - North Carolina's Medicaid costs for patients with chronic hepatitis C rose from around $8 million in 2013 to over $50 million in 2014.
    - The lifetime treatment cost for a person with HIV is estimated to be between $385,200 and $618,900, while hepatitis C costs $100,000-$500,000 to treat.
    - Prevention is inexpensive, with individual needles and syringes costing less than 50 cents each.
  - SEPs can be a gateway to treatment.
    - SEP participants are five times more likely to enter drug treatment than non-participants. SEPs connect participants to resources and assist in application processes.
  - SEPs can decrease crime.
    - SEPs connect participants to drug treatment, housing, food pantries, and other social services, alleviating the impetus for many crimes.
    - In one study, Baltimore neighborhoods with SEPs experienced an 11% decrease in crime compared to those without, which saw an 8% increase in criminal activity.

- It was announced that the Senate passed the Comprehensive Addiction and Recovery Act (CARA) by a vote of 94 to 1. If passed by the House, CARA will help more people stay in recovery and live to their greatest potential. Judge Martin said that CARA also will help combat opioid epidemic.
- Dr. Capehart brought up the need to address cultural fit. Veterans currently comprise 13% of the state's population. Healthcare professionals need to figure out how to keep them in treatment, which will improve their chances for remaining substance free. While prescribing Naloxone with an opioid prescription is a great tool, pairing the person with a specialized peer support specialist with lived experience may be more beneficial.
- Ms. Kranbuehl highlighted the need to develop stronger alternatives (e.g., treatment facilities, programs, drug treatment courts) so that young people will have different options. Having a clinician or peer support specialist work with the consumer helps them figure out ways to identify viable solutions to the many barriers.
- What is missing is transitioning from an acute model to management of a chronic illness. NC needs to increase access to treatment and recovery support and collaborate with stakeholders (e.g., APNC, NCHRC, SUD Federation).

Conclusions

- NC needs to go to a recovery oriented system of care where addiction is viewed and treated as a chronic illness.
- NC needs to increase access to evidence-based treatment interventions and recovery support services throughout the State.

Action Items	Person(s) Responsible	Deadline
• Include recommendations as a part of the report from the Opioid Abuse and Heroin Resurgence Workgroup of the Task Force that will be submitted to the Governor.	Brian Ingraham and Sheriff Asa Buck	April 7, 2016

2. Agenda topic: Workgroup on Prescription Opioid Abuse, Heroin Resurgence, and Special Topics **Presenter(s):** Brian Ingraham

<table>
<tr><td>Discussion</td><td>

Mr. Ingraham identified the following challenges to address:

Stigma, both associated with those suffering from addiction and related to Medication Assisted Treatment.
Insufficient knowledge generally regarding addiction as a brain disease.
Insufficient prevention & early intervention activities.
Insufficient information regarding effectiveness of opioids for treating pain especially long term use.
Inadequate funding for treatment, especially for uninsured & underinsured.
Resistance to changing prescribing habits and mandatory checks of the CSRS.

Mr. Ingraham reiterated that positive trends are occurring but that opioid addiction is an enormous problem, which requires interventions at many different levels. The Workgroup identified five recommendations:

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

Workgroup members were invited to expand on the recommendations. Dr. Patkar said that improving the use of the CSRS and that changing prescribing and dispensing practices is achievable. However, attention needs to be paid to heroin treatment since it is well known that when the opioid prescriptions decrease, heroin addiction increases.
Justice Ervin said that a substantial number of those involved in the justice system have a substance use disorder (SUD). We need to make an intentional effort to address the underlying problem of SUD.
Dr. Lancaster asked whether the Medical Board was involved in the discussion of recommendations that will go forward. At the January meeting, there was a representative from the Board who went over the pros and cons and provided the Board's perspective. If changes are mandated, issues of the required number of continuing education credits, enforcement, and consequences will need to be addressed. Also mentioned was the suggestion to match every prescription of an opiate with a prescription for Naloxone. Dr. Capehart said that the VA has a national mandate for Naloxone, where the nurses in chronic pain clinics and SUDs clinic have taken on the initiative. Eventually primary care clinics will be ensuring that Veterans who receive an opiate prescription also receive a prescription for Naloxone. Nurses are providing training on the spot so Veterans pick up Naloxone when they go to the pharmacist.
Rep. Martin asked whether the Workgroup would consider renaming drug treatment courts as recovery courts. It seems like it would be an easy change to make.
Ms. Freeman asked if there are currently any high school recovery programs. Wake County has one but has run into the problem of sending the student back into same environment with no ongoing support. Perhaps a high school-college recovery program could be developed since many NC residents want to attend college in the State.
Dr. Mooney has been working with a Recovery Community Organization in another state and found that students in recovery had a GPA of 3.7 vs. other students who had a GPA of 2.7. In addition, 94% of the recovery students graduate (vs. 50%). Forty percent of recovery students go on for graduate work.
The availability of medication assisted treatment along with psychotherapy was discussed. Many rural counties don't have resources. Affordability is also an issue, especially for the uninsured or for those not on Medicaid.

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<tr><td>Conclusions</td><td>

Stigma is perceived as a barrier to accessing needed opioid treatment.
Education, prevention, and early intervention are critical in stopping the opioid epidemic.
Changing opiate prescribing and dispensing practices is viewed as possible.
Affordable medication assisted treatment and psychotherapy need to be available across the State.

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Action Items	Person(s)	Deadline

	Responsible	
• Work with the General Assembly to pass legislation mandating the prescription of Naloxone with each prescription of an opiate. • Rename drug treatment courts to recovery courts. • Consider developing a pilot in which a recovery community is established at a high school in concert with a public four-year college.		

3. Agenda topic: Workgroup on Children, Youth, and Families **Presenter(s):** William Lassiter and Katherine Peppers

Discussion	• Mr. Lassiter identified the following challenges to address: ○ Access and Workforce Development: Access is an issue when youth spend an average of 29 days in detention waiting for a placement. A deterrent to access is the need for trained professionals to work with youth. Sixty counties don't even have a licensed psychologist so access in these counties is difficult. ○ Stigma reduction: Children who are different are often bullied, depressed, or have other mental illness and will face lifelong challenges. ○ Trauma-informed care: Almost 90% of those committed to Youth Detention Centers have been diagnosed with PTSD because of domestic violence; verbal, psychological, physical, or sexual abuse; or bullying. ○ Foster care: Youth must be assured of getting the services that they need while in foster care. ○ Juvenile justice system: Youth involved with the juvenile justice system must have access to evidence-based mental health services. • Recommendations were in five areas: ○ Standardization and accountability: There should be consistent credentialing so that when a provider is credentialed, it means that all LME/MCOs have credentialed that person. Providers need to be monitored for fidelity to evidence-based interventions so that measurable outcomes result, and LME/MCO's can make informed decisions. In addition, dollars should follow the consumer, not the LME/MCO. A consumer should be able to receive the needed services regardless of the county where it if offered. ○ Increase access and workforce development: NC is committed to unification of families. This means the integration and coordination of care across the board. ○ Stigma reduction, education, and primary prevention programming: One way to reduce stigma is through the Mental Health First Aid (MHFA) course. One focus is to train school and college personnel and counselors. Block grant money could be reallocated to support MHFA. ○ Data and technology: All agencies should submit their data to the Government Data Analytics Center (GDAC) so that baseline data on risks and needs and outcomes of individuals can be tracked. The GDAC would enable agencies to communicate with each other and reduce duplication of data. ○ Trauma-informed state: Statewide training for staff at public safety agencies, law enforcement, and the courts is needed so that youth are not re-traumatized as they go through the public system. It was suggested that a state advisory council be appointed to oversee this initiative. • The Workgroup strongly recommended that the age for juvenile jurisdiction be raised from 16 to 18 years. Adolescents' records should not prevent them from being awarded scholarships, attending college, or getting a job. Being diverted into a teen court was offered as one potential option. • Questions were asked about kids who did not receive services because they were not eligible to Medicaid; whether kids could be fast tracked in order to avoid spending the night at the office with a staff member or in the ER; and whether kids in foster care or juvenile justice could be considered a priority since those situations were not necessarily safe nor stable.
Conclusions	• Youth are not being adequately served by the present public system. • Kids in foster care or in the juvenile justice system need access to the behavioral health services that they need. • Standardization of credentialing and services is needed. • Personnel in public schools and higher education should receive MHFA training. • Dollars should follow the consumer. • The age for juvenile jurisdiction should be raised from 16 to 18 years.

Action Items	**Person(s) Responsible**	**Deadline**
• Look into reallocating the block grant to cover MHFA training. • Work with the General Assembly to pass legislation to raise the age of		

juvenile jurisdiction from 16 to 18 years.		

4. Agenda topic: Workgroup on Adults **Presenter(s):** Director George Solomon and Dr. Bruce Capehart

Discussion	• Director Solomon identified the following challenges to address:
	  ○ Appropriate, affordable, and available housing
	  ○ Coordination of care for Veterans
	  ○ Integrated behavioral and physical healthcare
	  ○ Efficiency, transparency, and innovation
	  ○ Diversion to treatment from criminal justice
	  ○ Trauma-informed system of care
	  ○ Behavioral health payment system
	• Priorities fell under three broad areas: changes that directly improve consumers' lives; cross-system collaboration; and MHSU system improvements. The Workgroup recently identified two additional concerns—promoting the use of psychiatric advance directives and taking care of our Veterans. The importance of *no wrong door* and developing a trauma-informed system of care were reiterated. Providers need to understand the consumers' environment, what they have been through, what keeps them going, and how to help them. Also important is the need to promote leadership at all levels and to employ quality behavioral health professionals in the justice system. Of particular concern is the insufficient number of inpatient beds and the lack of therapeutic housing and supportive housing.
	• Dr. Capehart spoke of the need for case management and recovery services for Veterans. Evidence-based practices such as critical time intervention, assertive community treatment teams, and forensic ACT teams need to be expanded. We need to help Veterans get what they want out of their lives and keep them out of inpatient facilities. Psychiatric advance directives allow Veterans to have an informed discussion with their treatment team about their end-of-life wishes.
	• Director Solomon said it is imperative to keep people out of the justice system through diversion, post-arrest, and post-jail, and it would be ideal to keep from them entering the system at all. According to the Sequential Intercept Model, diversion is best at intercepts 1 through 3; it is more economical and more effective than hospitalization, detention, and incarceration. At intercepts 4-5, it is re-entry from incarceration and hospitals and integration through community corrections and support. We need to provide measurable, evidence- based interventions.
	• Law enforcement has been doing crisis intervention for years, but it needs to be expanded. Crisis intervention team (CIT) training has improved communication skills in de-escalating situations and improved outcomes.
	• While therapeutic courts may not feasible in every district, special dockets could be instituted instead.
	• Since 13% of the state has served in the military, it is important that primary care and behavioral health clinicians take a course in military culture so that the services they provide are culturally sensitive. Veterans want to be understood and accepted and receive acknowledgement of their accomplishments. The Workgroup encouraged Secretary Brajer to meet with Ilario Pantano, Director of Military and Veterans Affairs and Dan Hoffmann, Director of VISN 6 to discuss respective priorities in terms of meeting the needs of Veterans in the State. In addition to information sharing, a statewide electronic health record would be ideal. The VA and DoD currently share an electronic record system.
	• There is an insufficient number of inpatient beds, with both civilian and VA EDs jammed with patients unable to progress to inpatient. A high percentage of beds is consumed by forensic patients who are incapable to proceed to trial so are held indefinitely in the beds. In January, this percentage was 60%; it is usually 35%. A sufficient number of crisis beds and housing in community settings is needed, with adequate treatment and resources to support each facility. The Workgroup encouraged DHHS to work with other agencies to look at boarding and determine an effective solution.
	• Collaboration with the four teaching hospitals was encouraged. Each medical school wrote a letter answering question, what are problems across NC and how to solve them? These letters have been submitted for review by the Task Force co-chairs.

Conclusions	• No wrong door and the development and implementation of a trauma-informed system of care are critical.

	• We need to take care of our Veterans, starting with healthcare and behavioral health professionals learning about military culture. Case management and recovery services are needed as well as evidence-based interventions (e.g., CTI, ACT, FACT). • Crisis intervention team training should be expanded. • Therapeutic courts or special dockets should be available. • A sufficient number of crisis beds and housing in community settings is needed, with adequate treatment and resources to support each facility.

Action Items	**Person(s) Responsible**	**Deadline**
• Encourage primary care and behavioral health professionals to take a course on military culture. • Provide professional and public education on psychiatric advance directives. • Encourage the Secretaries of DHHS & DVMA to work together on behavioral health issues related to Veterans. • Expand crisis intervention team training. • Determine how to increase the number of crisis and inpatient beds. • Collaborate with teaching hospitals, NCHA, etc.		

5. Agenda topic: Legislators' Comments **Presenter(s):** Rep. Susan Martin, Sen. Tommy Tucker, and Sen. Terry Van Duyn

Discussion	• Rep. Martin thanked the members of the Task Force and the public to come together on mental health and substance use in NC and stated, "We are all recovery allies." She encouraged the Task Force to stay connected to what will help and that some of the work can be accomplished through state agencies. Fleshing out the recommendations, coming up with options, and determining the cost of each option will help decide where legislators are needed (e.g., recovery courts). She also suggested that the Task Force look at what an investment of preventive cost means. The focus should be on evidence-based treatment and coming up with a workable plan where the recommendations fit together. • Sen. Tucker also thanked everyone for getting involved as it is a daunting task that lies before the Task Force. He recognized that the treatment courts are not properly funded even though they are beneficial. He noted that more physicians need to register and use the CSRS. He said that the Task Force must direct the LMEs/MCOs as to what is needed. • Sen Terry Van Duyn echoed what the other legislators said. She said that the testimony will inform her work as the issues are not partisan.
Conclusions	• Task Force has tackled an enormous problem, which required commitment and time on the part of its members. • Legislators are appreciative of the work of the Task Force and look forward to the final recommendations.

Action Items	**Person(s) Responsible**	**Deadline**
• Determine which recommendations should be addressed by State agencies vs. the General Assembly. • Determine different options and assign a dollar figure to each.	Staff of NC DHHS	April 7, 2016

6. Agenda topic: Timing and Funding **Presenter(s):** Flo Stein

Discussion	• Ms. Stein discussed the timeline for the recommendations. The DHHS staff from each workgroup will take the recommendations and identify which agency is responsible between March 11-25. Working with agency staff, DHHS staff will put a cost figure and determine phasing by March 28-30. DHHS will review this document for cost and phasing, with a draft to the Task Force by March 31 so that they can see if it embodies what they did. At the April 7 meeting, the Task Force as a whole will review the draft document. On April 15, Task Force Co-Chairs will present the recommendations to the Governor. • The workgroups are not staffed to determine budgets or phasing so will rely on the resources of DHHS. • Pam Kilpatrick, OSBM, stated that the Governor is working now to assess priorities for the short session and has reserved a placeholder in his budget. He plans to work closely with

	the Department on this initiative and is expecting recommendations as to where key investments will be made as result of this work. Budget development is in gear now and will be completed by end of April.
Conclusions	• Task Force recommendations will go to the Governor by April 15, with cost estimates and phasing. • DHHS will be responsible for developing cost estimates and timelines.

Action Items	**Person(s) Responsible**	**Deadline**
• Determine which agencies are involved in each recommendation and whether each recommendation goes to an agency or legislature. • Determine cost estimates and phasing for recommendations. • Complete draft of recommendations prior to April 7 Task Force meeting.	Staff of NC DHHS	April 7, 2016

7. Agenda topic: Public Comments **Moderator:** Chief Justice Mark Martin

Discussion	• Dr. Burt Johnson said that ED boarding is a policy goal for the NC Psychiatric Association. ED boarding is when patients stay in the ER due to a lack of beds in which to put them. This practice affects both rural and urban hospital beds. The Association regards ED boarding as unethical and inhumane to individuals. People with behavioral health disorders are treated so much differently from other specialties. For other chronic conditions, if you need a bed, you get one, but psychiatric patients can languish in the ER for over 24 hours. NC has been working on diverting these patients for the past 10 years, but not much has happened. Skilled behavioral health clinicians and case managers are needed in diversion, but too few are available. Telepsychiatry can help, but there are not very many resources. Community and state hospital beds could be increased, but this is a short-term solution. Meanwhile, the average wait time for a state hospital bed continues to rise. It also does not seem like anyone is responsible for managing this system, let alone making changes to the system. • Susan Vedder, a family psychiatric nurse practitioner, sees children in her practice and wanted to reinforce what the CYF Workgroup was recommending. The lack of resources in rural counties and the lack of standardization of services across counties make it challenging to serve children appropriately. She supports the proposed General Assembly bills that allow nurse practitioners to prescribe pharmacologic and non-pharmacologic therapies. • Connie Mele, Assistant Health Director for Mecklenburg County proposed a behavioral health licensed clinician in each law enforcement office. When SUD treatment program is offered in jail, the recidivism rate is 39% as opposed to the national average of 50%). Last year, they achieved a recidivism rate of 36%. Sheriff Irwin Carmichael of Mecklenburg County has a robust jail diversion program that also looks at housing and food. Most are ineligible for Medicaid funding. If there is a decrease in the block grant, then counties will have to pick up the costs. Prevention is critical. • Anthony Marino is the advocacy chair of NC Clinical Community Solutions. He noted the inequity related to service availability by county and encouraged the incentivization of ACT teams where they currently do not exist. Dr. Capehart said that incentivizing means providing “pioneering funding” to support adequate funding for LME/MCOs to offer ACTT services in their areas. • Dr. Tad Clodfelter, CEO, SouthLight, emphasized the science of addiction and that addiction should be viewed and treated as a chronic disease. The longer people stay in treatment the greater the possibility of long sustained recovery. Mandatory treatment gets just as good outcomes as voluntary treatment. • Donna Kay Smith, is a mental health professional but also has a son with mental illness. She recounted her son’s story and how very little has changed from 2005 when they moved to another state to 2015 when they returned. NC needs to develop a trauma-informed system of care and offer case management services and evidence-based interventions. What they have received is nothing beyond immediate transient care. Because of her experience and expertise, she was finally able to get him into treatment and her son is now doing well. Service providers are acting as gatekeepers instead of providing the basic necessary care to make gains and to sustain the gains after discharge. They do this knowing that the care will not be sufficient. Lack of adequate funding is one of the culprits. • Jack Register, NAMI, appreciated Smith’s story because she presented a clear and cogent

	picture of what she has gone through.
Conclusions	• ED boarding is a problem that must be solved through the funding of a sufficient number of crisis and hospital beds and the training and hiring of skilled behavioral health clinicians and case managers. • Treatment and recovery services need to be adequately funded and standardized across the State. • Incarcerated consumers need access to evidence-based treatment and recovery supports.

Action Items	**Person(s) Responsible**	**Deadline**
• Investigate the funding of additional crisis and hospital beds. • Determine how services can be standardized across LME/MCOs. • Determine funding requirements associated with evidence-based treatment and recovery services. • Determine the cost of providing incarcerated consumers with evidence-based treatment and recovery services.	Staff of NC DHHS	April 7, 2016

8. Agenda topic: Thinking Ahead to Implementation **Presenter(s):** Secretary Rick Brajer

Discussion	• Secretary Brajer stated that even though the Task Force has strong legislative support, it is unlikely that they will be able to address all recommendations in the short session. He reiterated the timeline.
	  ○ Identify potential resources and proposed timelines for potential implementation (between March 10 and April 7).
	  ○ The full Task Force incorporates the timing and funding into the final recommendations for the Governor (between April 7 and 14).
	  ○ Continue working on the implementation plan for each recommendation (begin after May 1).
	  ○ How does the Task Force remain engaged (up until the long session in 2017)? What is the Task Force willing to do after May 1 until April of next year?
	• Members of the Task Force expressed a willingness to continue the coalition together. There are multiple coalitions working across state that we should access and mobilize them under the Task Force umbrella (e.g., Crisis Solutions, NAMI, SUDs Federation). Having the three branches of government involved facilitates more meaningful outcomes. Evaluation and accountability were viewed as key. The possibility of funding a pilot project was proposed. What was emphasized was the need to provide a realistic plan that encompassed prevention, education, therapeutic diversion, treatment, and recovery services and supports.
	• Secretary Brajer said it was a resounding yes to stay engaged and to maintain networks as well as engage other groups. The turnout from the public emphasizes that our work is important. He thanked everyone for their participation, especially the recovery community.

Conclusions	• The Governor's Task Force on Mental Health and Substance Use will continue to meet.

Meeting Adjourned: 5:30 pm
Next Meeting: April 7, 2016