North Carolina Mental Health Planning and Advisory Council (NCMHPAC)
Meeting Minutes of April 6, 2018 - Approved
Meeting location: 3724 National Drive, Suite 100, Raleigh, NC 1-888-251-2909; 5814639#

Present: Dave Wickstrom, Vice Chair, Vicki Smith, Mary Edwards, Tammie Theall Deppe, Gail Cormier, Seth Maid, Janice Shirley, Wes Rider, Terri Shelton, Nina Leger, Victoria Jeffries, Vicki Smith, Jim Swain
Phone: Mary Lloyd, Bert Bennett, Terri Shelton, Wes Ryder, Damie Jackson-Diop, Chair
Staff: Ken Edminster, Susan Robinson, Karen Feasel, Walt Caison
Guests: Kathy Nichols, Ted Johnson (phone), Lacy Flintall,

	Agenda Item/Presenter Discussion	MHBG Relevance Resources/Data Sources	Action
1	**Meeting Convened/Introductions** Damie Jackson-Diop, Chair, convened the meeting, welcome and introductions were completed. New member candidates received affirmative Council votes and are recommended to the DHHS Secretary for appointment per the by-laws.	**NCMHPAC Bylaws** **NCMHPAC Role:** https://www.ncdhhs.gov/divisions/mhddsas/councils-commissions Meet and review the MHBG Plan not less than once each year; make recommendations to the state mental health agency (SMHA - NC Division of MHDDSAS); advocate for priority populations and others with emotional and mental health needs.	✓ New candidates were welcomed including: o Nina Leger o Victoria Jeffries o Janice Shirley o Juan Santos o Keith Poston
2	**Approval of Minutes/ Review of Agenda** **Discussion:** The new meeting minute format was reviewed; members appreciated the change and will try for the next few meetings. The agenda was reviewed with minor adjustments for time.	NCMHPAC Bylaws	✓ The agenda was adjusted for time. ✓ Minutes of 2/2/17 were unanimously approved after a motion to approve for posting by Dave Wickstrom, second by Mary Edwards.
		Relevance of Topics to the MHBG	
3	**Public Comments** - Members of the public can address the Council. Limit of three minutes.	**NCMHPAC Bylaws** **SMHA Plan requirement: Seek public comments on the plan. Follow these links for the plan and to provide written comments.** https://files.nc.gov/ncdhhs/MHBG%20Plan%20SFY18-19_0.pdf https://www.ncdhhs.gov/divisions/mhddsas/grants/mental-health-block-grant	✓ Billie Deppe: "I am a youth, a young adult, Tammie's daughter. I live in Wake county. I have lived with mental health challenges. I know what

		MHBG Domain Criteria, Priority Areas & Outcomes (NOMs): Understand Implications for the MHBG Priority Populations, especially those who are uninsured, underinsured, non-Medicaid eligible, diverse ethnic, cultural & linguistic needs; for impact to the MHBG requirements and criteria on access, comprehensive system, and Council priorities of adult, family and youth peer supports, non-traditional services and supports. Billie Deppe's candidate nomination form was disseminated to the Council.	help others by working on this council so I applied to be a member of this council. Thank you for considering my application."
4	**Public Comments** - Members of the public can address the Council. Limit of three minutes.	**MHBG Requirement:** The State Mental Health Agency (SMHA – Division of MHDDSAS) will seek and consider public comments on the Community Mental Health Services Block Grant (MHBG) Plan.	None
5	**Leadership Fellows Academy for Consumer & Family Run Non-profits – Overview of Scope of Work (SOW) and outcomes.** **Dr. Richard Clerkin, NCSU Institute for Nonprofits & Lyn Legere (video message)** **Discussion:** Dr. Clerkin provided an overview of the Leadership Fellows Academy, the goal & experience with NSCU Institute for Non-profits, current organizational priorities; scope of work priorities supported by the Division of MHDDSAS contract through MHBG funding; past progress to date; graduates; and next steps for recruiting a new cohort of participants for SFY18-19. Funding: $195,000 in SFY18.	**MHBG Domain Criteria, Priority Areas & Outcomes (NOMs):** ▪ Recovery Supports ▪ Consumer and Family Services ▪ Support and promote access to services – especially consumer & family run organizations ▪ Sustain successful engagement ▪ Provide information to those who work with consumers and families. ▪ Reduction in health disparities. **Resources/Data Sources:** NSCU Leadership Fellows Academy: https://nonprofit.chass.ncsu.edu/education/lfa.php	✓ NCSU and Ken Scheusslin, DMH, agreed to continue to provide updates on a regular basis.

	The Leadership Fellows Academy is a program developed through a partnership between the Institute for Nonprofits at NC State, the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services, and the UNC – Chapel Hill, School of Social Work's Jordan Institute for Families. Its goal is to develop leadership capacity for executive directors, owners and board chairs of consumer operated nonprofit organizations across the state.		
6	**DMHDDSAS Director's Update** **Kathy Nichols, Assistant Director** **Discussion:** **Kathy summarized the following:** · Her role over programs for mental health, substance use, intellectual/developmental disabilities, and prevention & wellness. · Waiver applications in process: o A new waiver on Substance Use Disorders (SUD) applying the national ASAM criteria and standards pf practice and levels of care, including addiction withdrawal criteria o The TBI waiver is addresses inpatient services for individuals with TBI cognitive issues; pending CMS final approval. o CMS is motivated to approve the waivers. o The SUD waiver application will be posted for 45 days for public comments, these will be reviewed prior to submission.	· **DMHDDSAS is the State MH Authority (SMHA) -** organizational responsibilities, comprehensive system for MH services & supports**; MHPC adviser to DMH on the implementation of the MHBG plan.** **MHBG Domain Criteria, Priority Areas & Outcomes (NOMs):** Understand Implications for the MHBG Priority Populations, especially those who are uninsured, underinsured, non-Medicaid eligible, diverse ethnic, cultural & linguistic needs; for impact to the MHBG requirements and criteria on access, comprehensive system, and Council priorities of adult, family and youth peer supports, non-traditional services and supports.	✓ Ken & Walt will send a copy of the waiver and plans for review when prepared in preparation for a future conversation.

	○ Peer supports are being considered. · **Institute for Mental Disease was outlined.** 16 beds severe and persistent mental illness and substance use disorder · **DHSR – Division of Health Services Regulation:** Working with DHSR to update and improve regulations for facilities licensed to provide services. · **Must revise and update the RMDM – records manual and documentation manual** to reflect current and pending future requirements as the state moves to EHI – electronic health record to address flexibility and inclusion. Will take a solid year to address these provisions. · **Universal intake and/or screening – person centered plan (PCP) is being considered.** · **Dual eligibility** will be addressed. 2000 BH providers will have the challenges Education for training re: EHI and requirements · **Legislative session –** Pending approval in this session: DHHS needs approval in order to work on a tailored plan for populations including, SMI and SED and SUD and IDD/DD. This plan will have move away from the medical model. Specific address of youth in foster care and CAP-C, Birth to 5-year olds and transitional age youth/emerging young adults are to be determined. · **Next steps in DHHS Strategic Plan** - Move from planning to plan development 108c needs to be addressed. Depending on what happens in May, all planning including the MHBG and SAPTBG plans will be part of that		

	plan development. By June DMH will have a better idea to address role and way to engage with the Council		
7	**Networking Lunch/Information Exchange**		
8	**Behavioral Health Needs Assessment, Quality Management & Data** - Michael Schwartz & **Discussion:** Jennifer Bowman, DMHDDSAS Michael provided a thorough summary and review of the criteria for the needs assessment, the data sources, methodology. Some of the information reflects an update to the data provided in the spring 2017 council meetings and plan discussions. Measures reflect treatment and desired treatment outcomes. Comparison data for each LME/MCO and combined state level inform the plan. Some of the information Jennifer provided in the fall 2017 council meetings regarding QM plans and LME/MCO improvement plans are informed by some of this data. This data informs the DHHS Behavioral Health Strategic Plan. Example prevalence and treated prevalence/incidents of service will inform tailored plans as they are developed.	**MHBG Domain Criteria, Priority Areas & Outcomes (NOMs):** Understand Implications for the MHBG Priority Populations, especially those who are uninsured, underinsured, non-Medicaid eligible, diverse ethnic, cultural & linguistic needs; for impact to the MHBG requirements and criteria on access, comprehensive system, and Council priorities of adult, family and youth peer supports, non-traditional services and supports.	✓ Quality Management staff, Michael, Jennifer and Karen will continue to provide updates and engage the Council in reviews and plans as available. ✓ Future data review: ▪ Look at expenditures to community based and residential services (diagrams are for UCR vs non-UCR) ▪ Look at supported employment – definitions for 14 yrs and up DVR, DPI, DMH ▪ Perception of care survey
9	**Member information exchange** - upcoming opportunities April to June. **NCMHPAC By-Laws** **Resources/Data Sources:**		✓ Members will continue to provide updates to the group

Upcoming Opportunities:
April is **Child Abuse Prevention Month** – set up a pinwheel garden, see and sponsor the film, *Resilience* https://www.preventchildabusenc.org/ , learn more about ACEs – Adverse Childhood Experiences and building resilience for strong families and safe children in healthy communities
https://www.cdc.gov/violenceprevention/acestudy/index.html
https://vetoviolence.cdc.gov/apps/phl/resource_center_infographic.html

May is **Mental Health Awareness Month** – Wear Green
May 10 is National Child Mental Health Awareness Day
May 7-13 is National Child Mental Health Awareness Week

Links to resources and a tool kit for communities:
SAMHSA
https://www.samhsa.gov/children/awareness-day/2018

National Federation of Families for Children's Mental Health
https://www.ffcmh.org/awarenessweek-2018

Tool Kit
https://www.ffcmh.org/awareness-toolkit

NC Parent Resource Center – NC Substance Misuse Prevention Conference on May 8-9 at the McKimmon Center in Raleigh
http://www.ncparentresourcecenter.org/ncprc-conference/ncprc-conference-agenda/

NC Practice Improvement Collaborative (NCPIC) will convene on May 23 at the NCSU McKimmon Center in Raleigh and focus on Community Inclusion
https://www.eventbrite.com/register?orderid=cc4dc65e2f4311e8a7040e1c4bfca588&client_token=159125f9dba24dfd800dbbacf3f4821d&eid=44200210018

Governor's Working Group (GWG) http://www.ncveteransworkinggroup.org/
Participate 4th Thursday monthly 2-4 pm. Call in 919/212-5747 and watch Facebook Live
https://www.facebook.com/GovInst/
Newsletter: http://ncgwg.org/newsletter/

Women's MilVets Summit May 2

	http://ncgwg.org/?s=women+milvets+conference SitRep airs on WUNC TV, Saturday mornings, including resource information & Mental Health minute each week for 13 weeks in the Spring and in the Fall. Sandra Robinson, Executive Director, Combat Female Veterans Families (CFVF) United Serving North Carolina Female Combatants *www.cfvfunited.com* **Relevant resources:** NC Institute of Medicine (NCIOM, 2012) http://nciom.org/wp-content/uploads/2017/07/SuicidePrev-report_web.pdf NC Suicide Prevention Plan (DHHS, 2015) https://www.sprc.org/sites/default/files/2015-NC-SuicidePreventionPlan-2015-0505-FINAL.pdf **National Suicide Prevention Lifeline 1-800-273-8255 Press 1 for Vets https://suicidepreventionlifeline.org/**		
8	**Chairperson's Report** Damie provided the chair report: ▪ Meeting format & logistics - Minute formats have additional information related to MHBG Plan relevance for context and reference. ▪ Bylaws – ByLaw revisions were disseminated for review & approval. ▪ Council membership - Five individuals are new members to the Council by email vote. Damie distributed the candidate forms for Billie Deppe and Paula Lachichi. Additional candidates are welcome to apply. Timely travel reimbursement would be helpful; the state office staff will work on this with budget office. ▪ SAMHSA TA – Details were discussed in the best way to plan for on-site TA with the Council in August with potential dates considered in order to map out with Ted	**MHBG Domain Criteria, Priority Areas & Outcomes (NOMs):** Council membership, representatives, role **Resources/Data Sources:** NCMHPAC Bylaws SFY18-19 Plan is posted on the NCMHPAC web page: https://www.ncdhhs.gov/divisions/mhddsas/grants/mental-health-block-grant NCMHPAC candidate nomination form member application form can be found on the NCMHPAC web page:	✓ Members voted unanimously to approve the by-law revisions as outlined; Mary Edwards' motion with second by Jim Swain. ✓ Leadership prior planning will continue between Council chair, vice chair and DMH staff to plan agenda, calendar and additional TA that extends the Learning Community conference calls among other state MHPACs. Agenda items will directly relate to the MHBG.

	Johnson, TA Coach assigned to NC. As a reminder: NC is one of 8 state planning council who were accepted in the MHPAC leadership learning community. NCMHPAC team goals include developing: 1) an orientation process that can be sustained over time; 2) youth advisory capacity to the Council; and 3) effective recruitment of diverse membership and active participation of membership. ▪ MHBG Plan Review Committee – Dave reported that the Committee Dave will coordinate MHBG Plan Review committee meeting in March and map out an implementation plan. ▪	https://www.ncdhhs.gov/divisions/mhddsas/grants/mental-health-block-grant	✓ Council members will contact Damie of interest in the NC TA team that will meet every other month by phone for the next year. ✓ Staff will send member any new candidate nomination forms to Council for consideration; email voting process will be implemented until all positions are filled.
9	**Adjourn:** Damie adjourned the meeting and thanked all participants for attention to the presenters and active discussions.	MHBG/MHPC References Future Items: Look at data related to youth and young adults in transition; and **Resources/Data Sources:**	✓ Meeting was adjourned with Wes Rider's motion to adjourn, Nina Leger's second to the motion; hearing no discussion, no dissensions, no abstentions, motion carried.

2018 Meeting Dates

June 1 – August 3 – October 5 – November 30 11 am call - December 7

https://www.ncdhhs.gov/divisions/mhddsas/grants/mental-health-block-grant

North Carolina
Mental Health Planning Council
By-Laws

We believe an effective responsive system openly engages children, youth, adults, and families as peers and partners. We support an effective coordinated recovery orientated system of care of services and supports that build resilience for children and youth with serious emotional disturbances and adults with serious mental illness delivered efficiently, using limited resources to meet the growing needs in our community.

We see outcomes improve when consumers, youth, and families are engaged as full partners. Therefore the intentional inclusion of youth and family partners is critical to ensure that peer run services are innovative and embedded, and sustained in communities.

Article I: Name and Purposes

1. Mission: To advise, consult, and make recommendations to the Department of Health and Human Services concerning matters related to services and programs for adults and children with mental health needs.

2. The name of the council is the North Carolina Mental Health Planning Council, hereafter referred to as the Council.

3. Legislative Authority: The Council is an advisory council to the Division of the Mental Health, Developmental Disabilities, and Substance Abuse Services. The Council is required by Federal legislation (P.L. 99-660, superseded by P.L. 102-321).

4. The Council's purposes include:

    4.1 Serving as advocate for the Mental Health service population.
    4.2 Reviewing the mental health plan of the block grant application. (Any recommendations of the Council must be submitted with the block grant application whether incorporated in the plan or not.)
    4.3 Monitoring, reviewing, and evaluating the yearly block grant allocation and adequacy of mental health services in the state.

Article II: Membership

1. Individuals (except member numbers 2.1 and 2.2) shall be appointed by the Secretary of the Department of Health and Human Services (Identified as Secretary going forward). Members of

the State's Protection and Advocacy Organization and Representative of North Carolina Council of Community Programs will be selected by the group/organization themselves.

2. Membership shall include, but not limited to representation from the following (numbers in () indicate number of representatives):

   2.1 State's Protection and Advocacy Organizations (1)
   2.2 Selected representative of the North Carolina Council of Community Programs (1)
   2.3 Division of Mental Health/Developmental Disabilities/Substance Abuse Services (1)
   2.4 Division of Vocational Rehabilitation (1)
   2.5 Department of Public Instruction (1)
   2.6 Department of Public Safety (1)
   2.7 Housing Finance Agency (1)
   2.8 Division of Social Services (1)
   2.9 Division of Medical Assistance (1)
   2.10 Division of Aging and Adult Services (1)
   2.11 Statewide Family Organization (1)
   2.12 Statewide Consumer Organization (1)
   2.13 Statewide Mental Health Advocacy Organization (1)
   2.14 Statewide Youth Lead Organization (1)
   2.15 Provider of Mental Health Services (2)
   2.16 Education/Training/Research Representative (1)
   2.17 -2.24 Representatives of Adults with Mental Illness, Families of Adults with Mental Illness, and Families of Children with Serious Emotional Disturbances (7)***

   *Other Ad Hoc members as determined appropriate by Council
   **Council membership should reflect diversity in ethnic background and geographic location.
   *** Additional Council seats can be created for individuals with lived experience by a voice vote of existing Council members

3. At least Fifty One Percent (51%) of the Council membership will consist of individuals who are not State employees or providers of mental health services.

4. The ratio of parents of children with serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council.

   Membership of the Council will include a balance of child/youth and adult representation.

5. Members must recuse themselves when faced with a conflict of interest or lack of impartiality.

6. If a member misses a meeting without being excused by the chairperson, that individual will be contacted by either the Chair or Vice Chair after the missed meeting.

7. Missing three consecutive meetings, without being excused by the chairperson, constitutes good cause for being removed from the Council.

8. The Chair has the authority to grant excused leave to any member of council for up to 12 months without that individual losing his or her place on the Council.

9. A member may request a proxy to attend a Council meeting in his or her stead, but that request must be received by the Chair no less than 48 hours before a scheduled meeting. An approved proxy will have voting rights at the meeting.

10. If a vacancy occurs due to death, resignation, or removal; the chairperson shall notify the Secretary of Health and Human Services and make recommendations to fill the vacancy. The position will be filled as soon as possible.

11. Membership terms shall be three years in length, with a two term limit for non-state staff members. Terms are subject to review and termination by the Secretary for appointed council members. Members may request to return to active Council membership after at least a period of three years from the date their prior membership ended.

12. Members are allowed to bring support persons to any meeting without any type of approval.

13. Per Diem for eligible Council members shall be paid as specified in General Statute.

Article III: Officers

1. Family members or individuals with lived experience shall be the only consideration for Chair and the Vice Chair.

2. The Chair shall be elected by the Council members and serve a two (2) year term.

3. The Vice Chair shall be elected by the Council members and serve a two (2) year term. The Vice Chair shall become Chair at the end the end of the term as Vice Chair, or if the Chair would voluntarily leave that role.

4. Officers take office in December.

5. Duties of Officers:

5.1 The Chairperson shall preside at all Council meetings and nominate committee chairs subject to the approval of the Council. The Chairperson shall be an ex-officio member of all committees. The Chairperson shall plan the Council meeting agenda in conjunction with the staff assigned by the Department of Health and Human Services, Division of MH/DD/SAS to assist the Council in performing its duties.

5.2 The Vice Chair shall aid the Chairperson in the conducting of Council business. The Vice Chair shall perform all duties of the Chairperson in the latter's absence as well as other responsibilities as assigned by the Chairperson.

6. The Council may elect such additional officers as are deemed necessary.

Article IV: Meetings

1. Regular Meetings:

1.1 Full Council meetings will be held six times a year.

1.2 The agenda for the next meeting, minutes from the last meeting, and any supporting materials necessary to conduct business shall be distributed two weeks in advance of the meetings by Division staff in consultation with the Council Chair.

1.3 Any Council member may propose an agenda item by sending it in writing to the Chair at least 21 days prior to a scheduled meeting.

1.4 Meetings may engage the Roberts Rules of Order when needed as determined by the Chair.

2. Special Meetings:

2.1 The Secretary, DMH/DD/SAS Division Director, or Chairperson may call such special meetings as deemed necessary to carry out the duties of the Council.

2.2 Notice of special meetings shall be given to all Council members in writing or by telephone at least five (5) days in advance.

3. Committee Meetings:

3.1 Committee meetings shall be scheduled as needed.

3.2 The committees' chair may schedule and notify all committee members and the Council Chairperson of special meetings by telephone or in writing at least five (5) days in advance.

4. A quorum shall consist of at least nine of the Council members being present. A quorum shall be required to conduct Council business.

5. The Chair has the authority to call for an email or telephone vote on Council business.

Article V: Committees

1. Committee Functions

1.1 Committee shall be identified as either standing or special.

1.2 Members of standing committees shall be appointed by the Chairperson. Unless specifically stated otherwise, the chair of each committee shall be appointed by the Council Chairperson. The Chairperson and Vice Chair may sit on standing committees as ex-officio members.

1.3 Each committee shall report on its deliberations/recommendations/findings first to the Chairperson and then to the Council-at-large. A record of attendance shall be kept by the recorder of each committee and shall appear in written minutes.

1.4 All committee decisions shall be made by simple majority vote of members present. After being received by the Chairperson, recommendations shall be forwarded to the Council for a final disposition.

1.5 All Council members are automatically eligible to serve as voting members of committees. Non-Council members may also serve as committee members with the approval of the Council Chairperson, but may not serve as chair.

1.6 Special or "ad-hoc" committees will be called for a specific purpose by the Council Chairperson and will be dissolved once objectives have been accomplished.

2. Special Committees

2.1 Special ad-hoc committees may be appointed from time to time for the purpose of undertaking specified inquiries or recommendations. They shall confine their work to the purpose for which they were appointed.

2.2 The need for continuance of these special committees shall be reviewed by the Council Chairperson and recommendations to the Council-at-large will be made for appropriate action.

Article VI- By-Laws Revision

1.1 Revisions to the By-Laws may be made by the Council through the following process:

1.1 Proposed revisions shall be placed on the agenda for scheduled meeting.

1.2 Revisions shall be discussed by the Council and adopted by a majority of those members present.

Notification of change shall be provided to the Director of the Division of Mental Health/Developmental Disabilities/Substance Abuse Services and to the Secretary of the Department.

North Carolina Planning Council By-Laws were approved on 04/06/2018.

MHPC Priorities SFY18-19,19-20				
Priority Populations	**need**	**strategy**	**Outcome/ measures**	**opportunities**
Children& Youth with SED B-18 (3-18-DMH)				
	Keep children with MH/SUD needs in school Involved in school/stay in school LME/MCO role with children & youth Trained school personnel in Youth MHFA & suicide prevention	DPI – SMHI NC Collaborative – coordinated info DPS – diversion contracts Court counselors ? SRO role - ? not dependent on who employs SRO; work with target training & MHFA & CIT & strengthen skill set in working with BH Schools establishing MH services DPI working with DMA to provide MH services to students in schools # of schools have MOAs or contracts with providers	DMH NCTOPPS – Yr 1 - Yr 2 - # of referrals to schools vs. JJ (JJ seen as best chance for services) # of suspensions/expulsions –DPI # students placed on homebound SMHI annual report Outcomes include race & ethnicity to address disparities (include this for all populations and measures	School MH Services - State plan - DPI working with DMA DPS - SRO organization – work with and annual conference –coordinated joint training Seek funding opportunities - DJJ grant out for workforce development now

	Access to MST in all regions in NC Access to FFT (modify Intensive In-Home Service definition) Comprehensive assessments	DPS explore changing criteria & protocol	DMH NCTOPPS – involved in justice DPS – JJ community programs data – case/program level data from contractors (Sept)	School Justice Partnerships – court counselors in schools October mg (Cindy Porterfield/Jean S) DPS doesn't refer to MST because of DMH/DMA Comprehensive Clinical Assessment required
				ECMH – young children with mental health needs
				Trauma informed systems
	Family and Peer to peer			SOC High Fidelity Wraparound Teams
	Youth leadership & peer to peer	Building capacity across the state Sustainability VR funding for peer to peer		NC Youth MOVE Youth Leadership Forums across state through the State Independent Living Council
Priority population	**need**	**strategies**	**Outcomes/measures**	**opportunities**
Adults with SMI (including young adults 18-25, working age adults, older adults)	Peer to peer IPS peers & family advocates	VR funding for peer to peer Ongoing inventory of resources across the	Yr 1 - Yr 2 – Complete inventory (respondents?)Disseminate inventory (audience?)	DVR –program funding Ongoing inventory of resources across the state beyond known entities.

		state beyond known entities.		
	Older adults – SUD, suicide prevention Co-occurring /SUD Co-occurring / IDD/DD & Autism Spectrum Increase primary care for older adults with MH/SUD – Medicare/Medicaid	Consider: embedding requirement for community outreach, training, marketing, promotion in order to grow service components NCIOM TF recommendations Community re-entry, assessments & treatment delay transitions -provider education -self-advocacy with older -NC Medical Society - A role for consumer/family advocates in this training - Tool kit	Trainings provided # trained, behaviors changed	Consider: embedding requirement for community outreach, training, marketing, promotion in order to grow service components NCIOM TF recommendations
	# adults entering guardianship – in adequate	DSS provide overview of issue and #s referred,		Rethinking Guardianship for IDD/DD

	funding or services for assessment (Medicaid doesn't see as a deemed medically necessary service to be covered)	evaluated, outcomes of those evaluations; funding levels – ??over utilization vs CM navigating MH system (referral for guardianship occurs by default in order to access CM to navigate the system; guardianship is seen as a criteria for discharge when not needed)		
Priority Population	**need**	**strategies**	**Outcome/measures**	**opportunities**
Children/youth 16-25 yr. old with ESMI/FEP	Large need Sustain TTA – hospitials, primary care/ community pscyh, high schools, community colleges, higher ed		Yr 1 – develop training Yr 2 – provide training # transition coordinators trained (high school to college, work) – how one builds their team	Target the TTA efforts planned – hospitals, primary care/ community mental health practitioners, psychologists/psychiatrists, high schools, community colleges, higher ed Tap into higher education opportunities (system level – community college, UNC system) – ways to ID and ways to support & engage

				DVR – requirements to provide training # self-advocacy targeted for these individuals – increase options and innovations e.g. PETS
Across populations	need	strategies	Outcome/measures	opportunities
	Structures for meaningful consumer & family voice/input (advisory, leadership) going forward in a different proposed local, health/BH care administration and state levels Strengthen communities to lessen contacts with law enforcement Add WRAP – 7 advanced level trainers, to adequately help individuals to do WRAP plans	May be: Local CFAC Existing local structures? Build consensus and implement strategies and measure those outcomes of this (feedback loops) e.g. NCPIC – community inclusion (broad-based) plan effective what would it look like to be inclusive and responsive to youth, families, adult consumers As a routine part of doing business? NCIOM patient consumer involvement in health care – lessons	e.g. degree to which consumer family voice is engaged across all levels in decision-making bodies/advisory committees (process vs outcome – presence of vs making a difference – quality?) DMH and/or DMA contracts # of counties who engage/partner with consumers/families? Method to track meaningful beyond the presence of...e.g. listened w/o immediate influence decision-makers Measure part 1, part 2 - Honor expertise - Quality of voice - impact	DHHS Medicaid Managed Care Plan just released – (broaden from local CFAC) Study other models seek TTA & NCPIC Work with county commissioners?? NCIOM patient consumer involvement in health care – lessons learned & recommendations Qualitative data – observations MHPC letter to groups to increase awareness of how engaging consumer/family

NC Mental Health Planning and Advisory Council (NCMHPAC)

Drafted by Council Consensus on August 4, 2017

SFY18-20 Plan Priority Populations

During the course of the next two year plan, with much consideration of the service and population data, trends, gaps and needs data, and public comments the Council identified the following priority needs objectives, opportunities and strengths to build on, and potential resources within each of the three required populations for whom the community mental health services block grant services are intended. The Council meeting agenda will be informed by these priorities in the next two years and subsequent recommendations provided to the NC Division of MHDDSAS.

The following lists the needs objectives, opportunities, and resources and partnerships for each of the three priority populations which are: Children& Youth with SED B-17 (3-17-DMH); Adults with Serious Mental Illness (SMI) (including young adults 18-25, working age adults, older adults); and Children/youth 16-25 yr. old with Early Serious Mental Illness (ESMI)/First Episode Psychosis (FEP). In addition, the Council identified cross-cutting priority needs across all populations.

Required Population: Children& Youth with SED B-17 (3-17-DMH)

The needs objectives identified include:

- Children with MH and/or SUD and other co-occurring needs stay in school, are involved and graduate, including preschool age children.
  - reduce rate of suspension and expulsion that is often undocumented
  - reduce rate of in home school services by default that inadequately equip student or life course success
  - Support and expand LME/MCO System of Care Coordinators and their role with children & youth with SED, age 3 thru 17.
  - School personnel who interface with students are trained in Youth Mental Health First Aid (MHFA) & suicide prevention.
  - School personnel who interface with students are trained in community resilience, trauma and adverse childhood experiences (ACEs).
  - School Resource Officers are trained in Youth MHFA, suicide prevention and ACEs, trauma, and building individual and community resilience.
    - **Opportunities:** Implement School Mental Health Initiative Policy adopted by State Board of Education and Department of Public Instruction (state/local education agency for IDEA); https://stateboard.ncpublicschools.gov/policy-manual/student-health-issues/school-based-mental-health-initiative , promote suicide prevention school personnel training (existing, Question, Persuade, Refer - QPR, Columbia Suicide Severity Risk Scale – CSSRS); Implement State-funded Tiered Case Management High Fidelity Wraparound pilot.
    - **Resources & Partnerships:** Young adult consumers, children, youth and families with lived experience. State Board of Education and Department of Public Instruction (state/local education agency for IDEA), Division of MHDDSAS and LME/MCOs, NC State Suicide Prevention Plan Partners, Juvenile Justice/Department of Public Safety (DPS), National Center for Homeless Education and the NC Center for Homeless Education (SERVE) at UNC-Greensboro http://center.serve.org/hepnc/ , LME/MCOs and provider networks, primary care providers, NC Pediatric Society, Community Care in NC (CCNC).

- Children with MH and/or SUD and other co-occurring needs children, youth and families involved with or at risk of involvement with the justice system can access comprehensive clinical assessments, Multi-systemic Therapy (MST) and Functional Family Therapy (FFT) in all regions of North Carolina.
    - **Opportunities:** Review the clinical policy service definitions and recommend modifications and include in Medicaid reform and state BH plan.
    - **Resources & Partnerships:** Young adult consumers, youth and families with lived experience. Juvenile Justice/Department of Public Safety (DPS) and Division of Medical Assistance (Medicaid), Division of MHDDSAS, LME/MCOs and provider networks, primary care providers, NC Pediatric Society, Community Care in NC (CCNC). NC Families United, NC Youth MOVE, SAYSO and other family and youth run organizations, NC Collaborative for Children, Youth and Families, Community Collaboratives.

- Family and youth leadership & peer to peer services and supports will be expanded across the state.
    - **Opportunities:** Implement State-funded Tiered Case Management High Fidelity Wraparound pilot; study innovations through Division of Vocational Rehabilitation (DVR), non-profit peer-run and family-run organizational leadership development.
    - **Resources & Partnerships:** Adult consumers, youth and families with lived experience. NC Families United, NC Youth MOVE, SAYSO and other family and youth run leadership organizations. Divisions of MHDDSAS & Medical Assistance, and Vocational Rehabilitation (DVR), Division of Older Adults and Aging, NCIOM report recommendations, other state models – TX, KY, TN, OH, PA, NH, Center for Child and Family Health, National Child Traumatic Stress Network, Alliance on Disability Advocates, State Independent Living Council, NC Public School Forum's NC Resilience & Learning Project, LME/MCOs and provider networks. NC Collaborative for Children, Youth and Families, Community Collaboratives.

Required Population: Adults with Serious Mental Illness (SMI) (including young adults 18-25, working age adults, older adults)

The needs objectives identified include:

- Explore and expand access to evidence informed and innovative peer to peer supports and services
- Increase access to IPS and benefit counselors across the state through effective innovative partnerships with peers & family advocates
- Address older adults with serious mental illness, co-occurring SUD and other disabilities and integrate targeted suicide prevention practices in partnership with peers and primary care – service array and targeted training to increase practitioner skills while resources are being developed through the Medicaid reform and DHHS strategic behavioral health plan
- Implement statewide training on community resilience, inclusion, wellness and the impact of ACEs and trauma on adult health and behavioral health outcomes.
- Address all adults especially those transition age young adults with serious mental illness, co-occurring SUD and other disabilities including IDD/DD and Autism spectrum and/or with co-occurring SUD
- Increase integrated health and primary care for older adults with MH/SUD, especially those who are dually eligible for Medicare/Medicaid

- Study and make recommendations to reduce the number of adults entering guardianship – in adequate funding or services for assessment (Medicaid doesn't see as a deemed medically necessary service to be covered)
    - **Opportunities:** Coordinated interagency partnerships in addressing population needs; blending and/or leveraging funding among community partnerships with non-traditional partners such as community businesses and other stakeholders to promote inclusion and community resilience and wellness, implementation of recovery oriented systems of care.
    - **Resources & Partnerships:** Adult consumers and families with lived experience. The Cures Act plan, NC TLC strategies, crisis services array, NC Suicide Prevention Plan and NCIOM report recommendations, and proposed state reforms. DPS, DPI (16-22 year olds), DVR, Division of Older Adults and Aging, Division of Social Services, DD and TBI Councils. NC Housing Finance Agency, Alliance on Disability Advocates, State Independent Living Council, NC Public School Forum's NC Resilience & Learning Project. NC Families United, NC Youth MOVE, SAYSO and other family and youth run organizations, NC Collaborative for Children, Youth and Families, Community Collaboratives.

Required Population: Children/youth 16-25 yr. old with Early Serious Mental Illness (ESMI)/First Episode Psychosis (FEP)

The needs objectives identified include:

- Address the under-identified unserved population of young people who experience first episode psychosis (FEP).
    - Provide training and technical assistance to increase awareness and provide algorithm for screening, assessment, referral, treatment and recovery through developmental stages and gender specific needs – target audiences: families, hospitals, primary care, community psychological services, mental health practitioners, high schools, community colleges, higher ed and other child serving agencies such as social services and justice services, guardian ad litem
- Establish clinical policies and funding mechanisms to integrate and sustain implementation
- Identify additional funds to increase CSC implementation sites across the state and expand CSC practice model in the existing three sites to nearby communities.
- Integrate suicide prevention, WRAP, counseling on access to means, and safety planning as a part of the routine practice milieu.
    - **Opportunities:** Cross-training with primary care and SUD providers as an integrated part of the Cures Act Opioid prevention and treatment services
    - **Resources & Partnerships:** Adult and young adult consumers, youth and families with lived experience. Divisions of MHDDSAS and Medical Assistance (Medicaid), OASIS FEP CSC training and technical assistance (TTA), current pilot sites, stakeholders and families previously noted. Alliance on Disability Advocates, State Independent Living Council, NC Public School Forum's NC Resilience & Learning Project, Center for Child and Family Health, National Child Traumatic Stress Network, NC Housing Finance Agency. NC Families United, NC Youth MOVE, SAYSO and other family and youth run organizations, NC Collaborative for Children, Youth and Families, Community Collaboratives. NC Pediatric Society, Community Care in NC (CCNC).

All populations:

- Expand and sustain certified peer specialists, family partners, and youth partners and innovative ways in which peers, and peer-run services can be funded, embedded and sustained in communities to meet gaps and build on strengths. We can improve outcomes when we engage consumers, youth and families as partners as part of the solution – creating new opportunities (health coaching, case management skills, life skills management, health navigators, basic disease management (e.g. Healthy Ideas for suicide prevention) and other examples such as those outlined in A Partnership for Culture Change A Report of the NCIOM Task Force on Patient and Family Engagement (NCIOM, 2015) http://www.nciom.org/wp-content/uploads/2015/07/PFE-Report-FINAL.pdf and in the Suicide Prevention and Intervention Plan: A Report of the NCIOM Task Force on Suicide Prevention and Intervention (NCIOM, 2012) http://www.nciom.org/wp-content/uploads/2012/08/SuicidePrev-report_web.pdf .
- Spend mental health block grant funds on needs to meet public safety net and monitor and document expenditures and outcomes to demonstrate this – sustainability.
- Create and sustain structures for meaningful consumer & family voice/input (advisory, leadership) going forward in a different proposed local, health and behavioral health care administration and state levels.
- Create and sustain a process for the capacity to fund innovation and incorporate sustainability which can take a lot of forms such as phasing in next steps, expanding in other parts of the region and state, replicating, sharing expertise and providing technical assistance to replicate site.
- Embrace as the NCMHPAC embraces community inclusion i.e. as outlined in Well Together – A Blueprint for Community Inclusion: Fundamental Concepts, Theoretical Frameworks and Evidence (Salzer & Baron, 2016) and growing a healthy well able North Carolina from the youngest infant, toddler and preschooler to the oldest individual, students, those parenting, vets and active military and their families and caregivers, those most serious and those most at risk in their life course. https://media.wellways.org/inline-files/Well%20Together_2%20May%202016_Final_Web_0.pdf
- Embrace, create and sustain Community Resilience Model such that statewide mental health promotion and mental health recovery is the norm and possible.
- Implement effective strategies to strengthen resilient responsive proactive communities and specifically lessen contacts with law enforcement, the legal and justice system.
- Equip and strengthen community capacity for using tools for recovery, addressing health disparities and promoting natural supports, especially in light of the current highly politically charged climate. Some examples include scaling up across the state the use of tools such as Wellness Recovery Action Plan (WRAP) skills and other exceptional and accessible models to promote statewide mental health recovery action agenda.
- Transportation, cost of medication, community inclusion, and the culture of mental health providers and cultural responsiveness to consumers, youth and families were barriers identified for all populations across the state.