

Governor-Elect Perdue
Transition Advisory Group Sessions
Session Summary 11

**Mental Health,
Developmental
Disabilities,
and Substance
Abuse Services**

November 24, 2008

Session Arranged by the
Governor-Elect Perdue Transition Team

Session Facilitated by the
Small Business and Technology
Development Center (SBTDC)

Report Prepared by the
UNC-Chapel Hill School of Government

Session Summary 11

Mental Health, Developmental Disabilities, and Substance Abuse Services

SECTION 1. Executive Summary

The Department of Health and Human Services (DHHS) and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) identified six priorities for guiding the future direction of public mental health, developmental disabilities, and substance abuse (MH/DD/SA) services in North Carolina.

- Expand community capacity to provide crisis services.
- Improve quality of service in state psychiatric hospitals and other state facilities.
- Support growth and development of a trained and qualified workforce.
- Improve overall system performance.
- Integrate behavioral health care into the primary care setting and improve collaboration with primary health care providers.
- Develop and implement initiatives for specific populations.

These priorities should be pursued within the context of the state's overall mission of helping those with mental illness, developmental disabilities, and addictive disorders live successfully in communities of their choice. This will require building a more unified and cohesive system of services that is understood and appreciated by the public, one that provides a consistent level of care across the state and a continuity of care between state facilities and community services.

The group of policy advisors attending the meeting identified approximately 147 issues (problems or challenges) that need to be addressed. Among these the group identified those that should be considered the highest priority. For many of these priority issues, but not for all, the group made recommendations that can be categorized generally according to the following list. (Specific issues and recommendations are presented in Section 5 of this report.)

- Develop and improve the leadership, staffing, and expertise within DHHS and DMH/DD/SAS, as well as the relationship between the legislative and executive branches of state government.
- Develop and improve the competencies and skills of the provider workforce and ensure that those competencies and skills are relevant to needed services and desired outcomes.
- Establish “safety net clinics” and “clinical homes” (with adequate assessment and stabilization services) in each local management entity and increase psychiatric inpatient capacity in community hospitals.
- Integrate screening and intervention for mental illness and substance abuse into primary care practice.

- Coordinate policy between DMH/DD/SAS and the Division of Medical Assistance and create policies that support and reward implementation of a unified vision for excellent services on the community level.

SECTION 2. **Process Used in Session**

The session began with a morning presentation by Department of Health and Human Services (DHHS) Secretary Dempsey Benton, and Co-Directors of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) Leza Wainwright and Michael Lancaster. They discussed the current administration's efforts, including issues, opportunities, and challenges. Benton, Wainwright, and Lancaster then took questions from the invited policy advisors (advisory group) and other members in the audience (general public) following their presentation. (A complete list of questions, comments, and answers are presented in the electronic supplementary material.)

In the afternoon, the facilitators broke the issues discussed in the morning session into five broad categories: structure, services, resources, culture, and leadership/other. Members of the advisory group and general public were separated into two discrete groups. Each group was first asked to indicate what they viewed as the key issues under each broad category. Both groups were next asked to prioritize the issues under each category. The top issue or set of issues under each category were then assigned to a self-selected, small group that was asked to discuss solutions and make recommendations. Groups were permitted to restate the issues. Facilitators circulated among the small groups during their discussions. The groups then reported on their recommendations.

Index cards were distributed at the end of the morning and afternoon sessions allowing participants to pose additional questions or submit information on any issues that weren't addressed during the course of the day. (This information, broken into morning and afternoon submittals, appears in the electronic supplementary material.)

See facilitator agenda (electronic Appendix 1) for an outline of the process devised and used by facilitators from the Small Business and Technology Development Center (SBTDC).

SECTION 3. **Participant List**

SBTDC facilitators: Jeff DeBellis, Kevin McConnaghy, and Dan Parks

UNC-Chapel Hill School of Government reporter: Mark Botts

UNC-Chapel Hill School of Government note taker: Susan Austin

Perdue Transition Team: Mike Arnold and Anne Bryan

Agency Executives:

Dempsey Benton, Secretary of Health and Human Services

Leza Wainwright, Co-Director of the Division of MH/DD/SA Services

Mike Lancaster, Co-Director of the Division of MH/DD/SA Services

Attendees:

Ann Akland	Betsy Allen	Julia Allen
Cynthia Bester	Gail Boswell	Joanna Bowen
Merritt Brinkley	Rita Brown	Nancy Bryan
John Burke	Sally Cameron	John Carbone
Harold Carmel	Norma Carter	Karen Chapple
Megan Cheek	Julia Clodfelter	Tad Clodfelter
C.L. Cochran	Susan King Cope	Yvonne Copeland
Gail Cormier	John Corne	Betty Cranor
Grayce Crockett	Michelle Crom	Anna Cunningham
Hank Debnam	Anne Doolen	Ginger Edwards
Jean Farmer-Butterfield	Debbie Fike	Briana Fishbein
Louise Fisher	Chris Fitzsimon	Denise Ford
Megan Gandy	John Gilmore	Tom Glendinning
Ranota Hall	Jennifer Hancock	Marshall Harvey
Rick Helfer	Michael Heninger	Gina Hubert
Patricia Hudson	Robin Huffman	Johna Hughes
Melvin Humphrey	Verla Insko	Iris Kapil
Jill Hinton Keel	John Koppelmeyer	Ed Kornegay
Marian Kyser	Tara Larson	Rebecca Lawrence
John Leskovec	Darryl Lester	Micki Lilly
Jennifer Mahan	Sara McEwen	Karen McLeod
Andy Miller	Tony Moore	Phil Mooring
Maurean Morrell	Susan Parish	Felicia Parker
Mike Pednean	Patricia Peykar	Drew Pledger
Mary Powell	Sharnese Ransome	Jack Register
William Renn	Dave Richard	Bob Rickelman
Marian Ines Robayo	Holly Riddle	Kathy Rinehart
Tanya Roberts	Dawn Robinson	Gene Rodgers
Jennifer Saphara	Kim Schwart	Jim Slate
Vicki Smith	Karen Stallings	Nezettia Stevens
Wes Stewart	Marvin Swartz	David Taylor
John Tote	David Turpin	Jane Vinson
Leza Wainwright	Michael Watron	Stan Wesner
Roy Wilson		

SECTION 4. **Significant Issues, Opportunities, and Challenges Identified in Morning Sessions about Current Administration Efforts**

The current administration (Secretary Dempsey Benton and Co-Directors Leza Wainwright and Mike Lancaster) identified the following six priorities for guiding the future direction of public mental health, developmental disabilities, and substance abuse services and for achieving the mission of building a unified system of services, intervention, treatment, and supports necessary for consumers to live, work, and socialize successfully in communities of their choice. (See the electronic supplementary material for the administration's PowerPoint presentation.)

1. **Expand community crisis services capacity**—Too many people (300,000) seeking acute care for MH/DD/SA problems go to hospital emergency rooms. Often these community hospitals rely on state psychiatric hospitals for the acute and short-term care needs of these individuals. The agency's goal is to address MH/DD/SA crises in the least restrictive, most culturally appropriate manner possible. State psychiatric facilities should not be used for acute care. When short-term inpatient services are needed, they should be provided in the consumer's community. State facilities should only be used for consumers requiring longer-term, more specialized care. The appropriate continuum of crisis services on the community level must include:

- 24/7/365 access lines operated by LMEs
- "First responder" requirements for providers
- Mobile crisis teams
- Walk-in crisis and after-care clinics
- DD Systemic, Therapeutic, Assessment, Respite, and Treatment (START) teams with access to emergency respite beds
- Inpatient beds in the community

In addition to obtaining sufficient funding for these services, challenges include community hospital resistance to operating inpatient psychiatric beds and ensuring that community partners are aware of crisis alternatives and feel that they can rely on those alternatives to respond appropriately.

2. **Improve quality of service in state psychiatric hospitals and other state facilities**—North Carolina operates state psychiatric hospitals for more challenging patients that need longer-term care and cannot be served in community hospitals, developmental centers for higher-need consumers and those needing specialty services, alcohol and drug abuse treatment centers for patients needing acute care and detoxification services, and neuro-medical facilities specializing in nursing care for previously institutionalized individuals.

These facilities are understaffed by employees that have insufficient training and opportunity for advancement. The state needs to work with colleges and universities to develop relevant training programs and create a reward system that enhances personnel retention. The accountability of leadership at the clinical and management level needs to be increased, and improvements are needed in information technology. The state also needs to prepare for the aging of the population, which will create a greater demand for specialized care for those with brain diseases such as Alzheimer's disease.

Quality can be improved by making sure that state facilities fill the appropriate role in the services system, but that requires increasing community placements and providing safe housing. For example, state psychiatric facilities should be reserved for the most severely ill individuals in need of long-term care, with acute care needs met in the community. Alcohol and drug abuse treatment centers should focus on expanding short-term treatment, with those needing further substance abuse services directed to long-term treatment provided in their communities.

3. **Support growth and development of a trained and qualified workforce**—Workforce development is a problem in every state, not just North Carolina. The unlicensed workforce needs help developing specific skills. In addition, there is a general shortage of licensed medical and clinical staff. For example, there are not enough psychiatrists and they are in the wrong locations to adequately serve the state’s population. We should expand the use of telepsychiatry to help address the shortage of providers in the rural areas of North Carolina. Doing so will help us reach more consumers without expanding the workforce. There may also be an opportunity to retrain people losing jobs in other fields to work in this area.

A long-range solution to both the shortage of staff and the need to increase the competencies of the unlicensed workforce is increasing collaboration and cooperation with the community college and university systems. Implementing a “centers of excellence” concept will enable academics and providers to share best practices that can be used in these training programs.

4. **Improve overall system performance**—The MH/DD/SA system needs to be more cohesive. Each financial component of the system—federal funding under Medicaid, state funding, and local government funding—has decision points that are interrelated. Understanding the different components is critical to improving system performance. The system does not work as a free market economy; it is taxpayer-driven. Acquiring additional dollars over the next several years will be a challenge due to the current state of the economy. We may need to consider moving to a hybrid, public-private model.

An electronic health record is the single biggest improvement we can make in the system to improve the quality of care for the consumer. Standardization is necessary to increase efficiency and effectiveness. A lack of standardization adds significantly to the regulatory burden and those dollars (approximately \$24 to \$45 million at the local level) could be used for treatment.

Other areas of improvement include

- Paying for and expanding the utilization of practices we know work
- Making sure safeguards and accountability measures are in place
- Raising the bar for providers with an eye to national accreditation
- Having IT systems that can “talk” to each other
- Collecting the right data and using it effectively
- Unifying action with the local level

5. **Improve integration/collaboration with primary health care providers**—There are fourteen community care programs providing health care to Medicaid patients. The state needs to implement strategies to integrate behavioral health care with primary health care. The community care programs could be utilized for this purpose. We want to expand the clinical home category and look at models for co-locating licensed mental health and substance abuse professionals in primary care practices.
6. **Initiatives for specific populations**—Various evidence-based practices must be developed and implemented (or expanded) for specific populations.

Mental health—We must improve the continuity of care for adult mental health services, particularly as consumers of services move between short-term and long-term care and between institutions (prisons and hospitals) and community care. There should be a system-of-care coordinator in every LME to handle child mental health services.

Developmental disabilities—There must be increased opportunities for self-direction, self-advocacy, and community inclusion for individuals with developmental disabilities. This includes additional individual living opportunities to reduce group living settings. We also need to improve the quality of, and access to, vocational training. This should be coupled with assistance in maintaining these jobs long-term.

Substance abuse—A workforce must be developed to provide substance abuse assessments and underpin a peer support model of therapy. State dollars are needed to support the brief intervention model. We must address the stigma of substance abuse. Without identification and treatment it is the most costly illness. An additional problem is that the legislation requiring “parity” between mental health and health care in insurance plans did not include substance abuse.

Traumatic brain injury (TBI)—These injuries are often not immediately recognized, and advances in medical care have resulted in more individuals surviving traumatic brain injuries (180,000 in North Carolina). TBI after age 22 is not covered under the federal definitions but is in the state definition. We need to look at how to grow funding and services for this population.

Veterans and their families—North Carolina is home to a significant portion of the country’s National Guard, reserves, and active military population. Guardsmen and reserves that have been actively deployed are in all 100 counties. They live across the state, not just in Fayetteville, and need care where they live. The state has recently included veterans in the target population definitions for state-funded MH/DD/SA services, but we need to develop providers of care and supportive services in areas outside of Fayetteville.

SECTION 5(A). Key Issues and Solutions/ Recommendations (Advisory Group)

An exhaustive list of issues identified by the advisory group appears in a transcription of flip chart notes created at the meeting. (See Mental Health Flip Chart Notes in the electronic supplementary material.) The full advisory group participated in an exercise to prioritize these issues by having each participant choose his or her top six issues. The number next to an issue

in the transcribed flip charts represents the number of individuals who selected the issue as a priority. Issues receiving a high number of “priority votes” were selected for small group discussion. These groups were asked to develop recommendations to address the selected issues.

It is important to note that not all of the issues receiving a high number of “priority votes” were assigned to small groups. Therefore, the issues addressed in the small group discussions and reported here should not be viewed as the only pressing concerns for participants. Rather, with time being limited, the priority-setting process allowed each small group to focus on at least one of the high priority issues identified by the full group. Some groups chose to work on a set of related issues rather than only one issue, and groups were permitted to redefine or refine issue statements by breaking them into subsets of issues. For these reasons, the small group reports—their priority issues and recommendations expressed through worksheets and verbal reports to the large group—do not always align neatly with the issue statements recorded on the flip charts in the large group sessions.

The priority issues identified during the large group session, as well as the issues and recommendations of the small groups, are reported below.

Issue: Leadership

Large group priorities

1. Legislative branch must allow the department to lead rather than micromanage. (18 votes)
2. Need new leadership. (9 votes).
3. Need visionary leadership at DMH/DD/SAS to identify structure of what state system should look like. (8 votes)
4. How can we attract nationally recognized leaders in DMH/DD/SAS when they don’t have the ability and authority to make decisions? There are too many layers of government. (7 votes)
5. Need DMH/DD/SAS leadership—folks who embrace the vision and have the skills to implement it. (7 votes)

Issue focused on by small group

Legislative branch must allow the department to lead rather than micromanage.

Small group recommendations

1. The governor-elect needs to clearly identify goals and priorities for DHHS and effectively relay this information to key legislators.
2. Utilize personnel in key legislative liaison positions with the knowledge and skill sets to work with the General Assembly to clearly articulate the governor’s position.
3. Encourage the governor and her department liaisons to engage in a positive working relationship with legislators to increase the level of trust.
4. Develop leadership capacity within DHHS (with competent support staff to support the leadership work) to effectively move the reform effort to maintain legislative trust.

Issue: Resources (Workforce Development, Systems, Funding)**Large group priorities**

1. Lack of capacity within the divisions of DHHS. Need strong quality staff—not just at the leadership level—to move from reactive short-term “fixes” to a long-term strategic approach to reform. (9 votes)
2. Need to assess current resources and identify best practice modalities that could be used to train existing providers—train the trainer models. (7 votes)
3. Interactive data system cannot be done with existing resources. Need support for electronic medical records, provider data collection, and analysis and use of data to improve services and outcomes. (6 votes)
4. North Carolina’s ongoing reliance on institutions for DD folks is an enormous waste of resources (and contrary to the values of self-direction and national trends). (6 votes)
5. Medicaid money is misallocated for DD services—North Carolina is out-of-step with national trends. A major overhaul is necessary. (5 votes)

Issues focused on by small group

1. Undertrained workforce. Non-targeted training occurring.
2. No incentive to invest in workforce training.
3. Need competent assessor/gatekeeper with broad spectrum knowledge. Assessors now are less experienced, not most competent.
4. We sell the services we have, not what may be needed or what is most effective.

Small group recommendations

1. Develop a core menu of services (with priority to safety net services for acute and intermediate care) driven by measurable need and outcomes.
2. Create a robust endorsement process based on these core services:
 - a. Ensure that the provider workforce has the necessary skill set to deliver core services by requiring a core set of proficiencies to be an endorsed provider.
 - b. Hold the agency endorsing providers accountable for ensuring that providers have the core set of proficiencies.
 - c. Make a provider’s ongoing endorsement and enrollment dependent upon client outcomes.
3. Have the university system include relevant training in academic programs.
4. Adopt minimum best practices standards as determined by the Physicians Advisory Group with multidisciplinary input and disseminate that training.

Issue: Services**Large group priorities**

1. “Safety net” clinics in all LMEs. “Clinical homes” available to all consumers. Cannot have a safety net under a system of “any willing provider.” (16 votes)

2. Re-evaluate privatization of public mental health system. How can care and safety net services be provided in a privatized model? (10 votes)
3. Need to legislatively amend the Certificate of Need (CON) process to provide incentives for community hospitals to open inpatient psychiatric beds. (5 votes)

Issues focused on by small group

1. “Safety net clinics” for MH/SA clients in all LMEs.
2. “System of care” for DD clients in all LMEs.
3. Whether to retreat from the privatization of services under reform.
4. Obstacles, including the CON process, to community hospitals developing inpatient psychiatric services.
5. Returning to the question: who is the customer?

Small group recommendations

1. Create a safety net for MH/SA clients by having a “safety net clinic” in each LME. (For related clinical home proposal, see the electronic supplementary material, “Clinical Home: Assessment and Stabilization,” 02/28/08, N.C. Psychiatric Association.)
2. Establish a “system of care” in all LMEs for DD clients.
3. Don’t return to the pre-reform system before 2001, but relax the requirements to privatize services by permitting LMEs to provide services in some instances. In these instances, require utilization review/utilization management to be performed by another LME. Let the focus be on the quality of services and what should be done to bring quality to all consumers, rather than on the public or private status of the provider.
4. Eliminate obstacles to, and provide incentives for, the creation of community hospital psychiatric inpatient beds.
5. Need to focus on the mission, which is serving people—consumers and family members of consumers. Focus on the effect on people.
6. Not everything has been a failure under mental health reform. Learn from some of the things we have done well.

Issue: Culture

Large group priorities

1. The need for integrated care (integration of MH and SA services into the primary care setting). Integrated care creates less stigma, makes the system more consumer driven, and frees up specialty MH and SA resources for more serious involvement and intervention. (10 votes)
2. Culture must be mission driven, producing a consumer-oriented system that values people, families, providers, and the public. (6 votes)

Issues focused on by small group

1. The need for greater integration of MH/SA care into primary care, based on the following premises:

- a. Drug and alcohol problems are prevalent and the vast majority of individuals who need treatment do not get treatment.
 - b. If identified early and appropriately treated in the primary care setting, substance use disorders can be successfully managed without further progression.
 - c. Such interventions, which connect the injury or health problem to alcohol or other drug use, can have a powerful effect on future drinking/drug use behavior.
 - d. The limited resources of the specialty SA treatment system can then be used more appropriately and cost-effectively for patients who need specialty services.
 - e. With respect to mental health issues, research shows that many people with mental health issues can be successfully addressed in primary care practice.
2. Primary care professionals do not adequately identify or intervene in MH/SA issues.
 - a. Communication between primary care practice/physicians and MH/SA specialists is insufficient.
 - b. Primary care physician training, internships, and residencies do not adequately recognize the role of mental health and substance abuse in primary health.
 - c. The use of electronic medical records is a critical component of successful integration.
 - d. Rural communities that are underserved by medical/MH/SA care need resources.
 - e. Funding and reimbursement mechanisms create barriers to the integration of care.

Small group recommendations

1. Fund and train primary care practices and physicians to implement early screening, brief intervention, and referral into treatment (SBIRT) for individuals who are at risk for substance abuse problems. (See N.C. Institute of Medicine Task Force on Substance Abuse Services, Interim Report, http://www.nciom.org/projects/substance_abuse/substance_abuse.htm.)
2. Implement strategies similar to 1 for mental health.
3. Support co-location of licensed substance abuse professionals in primary care practices, similar to CCNC models.
4. Work with Medicare/Medicaid to address issues related to funding barriers.
5. Consider legislation to permit the collection of aggregate data for evaluation and analysis.
6. Fund faculty and residency slots to train and expose primary care physicians to SA and MH intervention, treatment, and communication.
7. Study available systems, look at “inter-operability,” and move to a single system in North Carolina.
8. Consider pursuing federal community health center funding, which would provide integrated care. Beef up rural health initiatives to include MH/SA care.
9. Change Medicaid policies to allow more integrated care: payment for telephonic and other consultations, use of telemedicine, and same day visits.

Issue: System Structure

Large group priorities

1. Supported employment funds would be better handled by the Division of Vocational Rehabilitation, not DMH/DD/SAS. And, supported employment should not be handled by LMEs. They do not know employment. Money gets lost in “single stream funding.” (11 votes)
2. Stop debating the governance issue and focus on developing a quality service delivery system. Work within the current construct to achieve measurable goals important to consumers and families. (5 votes)
3. Link regulation to accreditation. (5 votes)

Issues focused on by small group

The priority issues assigned to and further defined by this group were several, broad, and not limited to structural issues. The discussion moved between issues of structure and leadership, with the understanding that leadership plays a role in defining the system’s vision and creating structures to implement that vision.

1. There is a lack of clear vision about what the system should look like, what it should provide, and who it should serve.
2. The financial rewards and incentives at the LME and provider level do not induce the desired outcomes.
3. The relationship between providers, LMEs, and the Division of MH/DD/SAS needs to be clarified. There is a need to clarify the relationship between the public and private sectors.
4. There needs to be clear accountability, a clear definition of who does what, and clearly defined outcomes.
5. The structural relationship of the Division of Medical Assistance (DMA) to the DMH/DD/SAS leads to problems in coordinating policy between DMA and DMH/DD/SAS.

Small group recommendations

1. Hire a nationally recognized leader (through a national search) to work with and modify the current system in accordance with clearly identified outcomes.
2. Give leaders clear authority to move the system forward and set clear expectations for accountability.
3. Integrate DMA and DMH/DD/SAS authority, accountability, and information systems. Align policies. Create co-located DMA–DMH/DD/SAS positions or develop clear MOA on how these divisions can function together (See the electronic supplementary material, Letter from Marvin Swartz, M.D., to Anne Bryan and Mark Botts, November 24, 2008.)
4. Improve staffing and expertise at the DMA and DMH/DD/SAS level.
5. Create policies that support and reward implementation of a unified vision on the LME and provider level.
6. Nail down who manages what, to what end, and at what cost.

SECTION 5(B). **Key Issues and Solutions/ Recommendations (General Public)**

During the afternoon, members of the general public who attended the session participated in a process that mirrored the advisory group process. Approximately 117 issues (problems or challenges) were identified. Issues designated by the group as priorities on the flip charts are listed below. Recommendations that appear related to the priority issues are also listed. Not all recommendations and issues are listed. (For a complete list of priorities and recommendations, see the Mental Health Flip Chart Notes—General Public Session in the electronic supplementary material.)

Issue: Resources (Workforce Development, Systems, Funding)

Issue

1. Additional resources are needed for TASC (Treatment Accountability for Safer Communities)—cannot meet the needs of criminal justice system. (16 votes)

Recommendations

1. Increase funding (TASC) opportunities to impact treatment issues for criminal justice/juvenile justice population and reduce recidivism. Add additional TASC staff to address growing need for CJS substance abuse.
2. Governor's forum to educate legislature on prevailing juvenile and criminal justice/TASC issues/best practice models. (See North Carolina TASC Network, in the electronic supplementary material, and/or <http://northcarolinatasc.org/TASCfactsheet07.pdf>.)

Issue: Structure: (State and Local Infrastructure, Relationships, Allocation of Responsibility among Parts)

Issues

1. Ensure that Institute of Medicine (IOM) recommendations related to substance abuse services are implemented. (13 votes)
2. Who is responsible for managing mental health care (MH/DD/SA) in North Carolina? Values-based and competency-based training for direct support workers, career path, pay commensurate with work. (10 votes)

Recommendations

1. Fund the IOM recommendations. Who: legislators via the Legislative Oversight Committee on MH/DD/SA Services.
2. TASC: \$2 million a year for next 5 years, total of \$10 million recurring.
3. LMEs manage system with Division oversight.
4. State leadership in policies, standards/practices and measurements.

Issue: Services: (Access, Quality, Consistency, Integration, Accountability)**Issues**

1. Substance abuse services need to be present with all levels of care in all communities. (CASPs are great!) (16 votes)
2. Development of services should be directly consistent with the needs of our citizens and driven by them. Service providers should be licensed and governed by their fields of study. (8 votes)

Recommendations

1. Additional funding for CASP Programs to assist rural areas and incentives for providers to move into areas.
2. Substance abuse (SA) resources guide for N.C. broken down into subgroups/counties.
3. Use/training of providers in cognitive reality based theory, DDT model for co-occurring disorders, and funding for organizations willing to provide dual services.
4. Cultural competency committees under each LME addressing gender, race, and ethnic disparities. Access to services/resources for SA. Targeting women with/without children, dually diagnosed.
5. Add peer support services (PSS) for community support, and drug treatment court, and other substance abuse services into the existing service definitions. Add PSS certification programs and SA-specific programs to the curriculum.

Issue: Culture (Consumer-Driven)**Issue**

1. Educate on substance abuse and diseases/addiction to enhance services for criminal justice population. This is a disease—with need for services. Building additional correctional facilities will not break the addiction cycle. (10 votes)

No recommendations discussed**Issue: Leadership****Issues**

1. Lack of accountability from top down. (2 votes)
2. Not taking care of or disciplining wrongdoers at DHHS sends the wrong message. (5 votes)
3. Attention needs to be given to developing and sustaining a high quality of performance to direct service employees at state hospitals and institutions with rewards for patient-focused care. These front-line employees have been regarded as the “lowest” people, resulting in poor patient care, and so forth. (3 votes)

Recommendations

1. Need clarification/coordination of roles and responsibilities across entire system and monitoring protocol.

2. State must become “buck stops here” for issues, needs, services (see state’s “Medicaid contract” with CMS).
3. Outcomes based, transparent (“user friendly”) annual release of consumer satisfaction data and other performance-based data on systems performance, workforce, health and safety; provider data, LME data, state level data—see national care indicators for DD as example (hsri.org).
4. Tie no. 3 above to “carrot/stick” to give data “teeth” and advance evidence-based best practice. “Whistleblower” protection. Give CFACs a role in report out/analysis of data.
5. Develop and implement a provider report card.
6. Core concepts of contemporary disability policy should be written into statutory law—regulations must support the same.

Electronic Supplementary Material

- Appendix 1: Facilitator agenda provided by the Small Business and Technology Development Center (SBTDC)
- Agency transition reports and other documents provided for session:
 - Letter from John P. Burke, C.P.A to Anne Bryan, November 25, 2008
 - “Clinical Home: Assessment and Stabilization,” Community and Public Psychiatry Committee Proposal, February 28, 2008, NC Psychiatric Association
 - Mental Health Flip Chart Notes
 - Mental Health Flip Chart Notes—General Public Session
 - Letter from Marvin Swartz, M.D., to Anne Bryan and Mark Botts, November 24, 2008
 - Transition November 24, 2008, PowerPoint, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
 - “Integrated Care: Substance Abuse Screening and Brief Intervention (SBIRT) in Primary Care,” submitted by Sara McEwen, M.D., M.P.H., Governor’s Institute on Alcohol and Substance Abuse, Inc.
 - North Carolina TASC Network, fact sheet
 - “Indicators of the Impact of North Carolina’s ‘Mental Health Reform’ on People with Severe Mental Illness, NAMI Wake County, Gerry and Ann Akland. Available at www.nami-wake.org
 - “Best Practices for Implementing the Recommendations of ‘Looking Forward: A Summit on the Developmental Disabilities System in North Carolina,’” Technical Report, October 16, 2008, N.C. Council on Developmental Disabilities
 - “Reforming Mental Health Reform in North Carolina—A Think Tank Roundtable to Move Toward Solutions,” October 26, 2007, NAMI North Carolina. Available at http://www.naminc.org/thinktank_roundtable/index.htm

- NC Council of Community Programs, compilation of position papers: “The LME as a Public Safety Net: A Critical Local Clinical Presence Within a Management Entity,” October 17, 2008; “Efficiencies in LME Systems Management,” December 12, 2007; “State Psychiatric Hospital Downsizing,” March 16, 2007; “Partnerships & Collaboration: Mental Health and Jails,” July 20, 2007; “Developmental Disabilities,” December 12, 2007; all available at http://www.nc-council.org/members/AM/Template.cfm?Section=Council_Position_Papers&Template=/CM/HTMLDisplay.cfm&ContentID=2443
- Mental Health Questions/Responses Following Morning Presentation
- Mental Health Questions/Comments Submitted at End of a.m. Session
- Mental Health Questions/Comments Submitted at End of p.m. Session
- “Wilson County Mental Health Roundtable,” October 2008, Mental Health Association in Wilson County
- “Critical Core Values and Policies for the New Leadership of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; Division of Medical Assistance; and Department of Health and Human Services,” Mental Health Association in Wilson County

