

# White Paper on Behavioral Health in the Greater High Point, North Carolina Area



A report from the [UNC Cecil G. Sheps Center for Health Services Research](#)

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## Executive Summary

This White Paper has been commissioned by The Foundation for a Healthy High Point to profile the community behavioral health needs and services available in the Greater High Point, North Carolina area. Behavioral health is defined herein to include both mental health and substance abuse. We review the prevalence of behavioral health conditions both nationally and locally, integrating data from a number of publically available sources, and profile some of the current resources available in the local area. In addition, we have elicited qualitative information from provider and management agency group interviews as well as from key informant interviews conducted with stakeholders in the High Point community. Finally, we also suggest some action steps for the Foundation to consider as it moves forward with its healthy community agenda.

Behavioral health problems are a concern for a substantial proportion of the national population. About 26% of adults in the United States are estimated to have a diagnosable behavioral health disorder in any given year, while one in five children under age 18 have one or more behavioral or developmental disorders. A number of demographic factors are correlated with behavioral health diagnoses. Factors such as age, gender, race, ethnicity, family income, and education have all been shown to affect prevalence rates. Treatment rates are low among people with a qualifying diagnosis. Only one-third of those with any type of mental illness receive services during a given year.

In some respects, North Carolina presents a slightly more optimistic picture than the rest of the nation. It is among the 10 states with the lowest rates of any mental illness, estimated at 16.8%. Further, while the National Survey on Drug Use and Health suggests that a statistically significant increase in illicit substance use had occurred nationally between 2002- and 2012, the trend in use was flat in North Carolina. We compiled information on county-level measures of behavioral health in the two main counties in the Greater High Point area but these measures were not available at a more granular level. In order to supplement local information, we conducted both a focus group of local providers as well as key informant interviews of local experts and advocates. Several general themes emerged from this meeting that echo findings in prior community needs assessment reports. First, severe funding shortfalls continue to limit the variety, availability, and adequacy of local behavioral services in the Greater High Point area. Second, there are critical gaps in the array of services for crisis intervention, case management, substance abuse prevention, housing, transportation, and jail diversion. Third, providers and advocates have actively participated in various volunteer and agency-sponsored efforts in recent years to identify population needs and service gaps. And fourth, the Foundation should focus its grant-making efforts on substantial and sustained investments in needed behavioral health services.

## **A. Introduction**

This White Paper has been commissioned by The Foundation for a Healthy High Point to profile the community behavioral health needs and services available in the Greater High Point, North Carolina area. Behavioral health is defined herein to include both mental health and substance abuse. A secondary goal of this report is to provide the Board and staff of the Foundation with a broad orientation to the behavioral health field and its current challenges. We review the prevalence of behavioral health conditions both nationally and locally, integrating data from a number of publically available sources, and profile some of the current resources available in the local area. In addition, we have elicited qualitative information from provider and management agency group interviews as well as from key informant interviews conducted with stakeholders in the High Point community. Finally, we also suggest some action steps for the Foundation to consider as it moves forward with its healthy community agenda.

## **B. Behavioral Health Nationally**

Behavioral health problems are a concern for a substantial proportion of the national population. About 26% of adults in the United States are estimated to have a diagnosable behavioral health disorder in any given year, while one in five children under age 18 have one or more behavioral or developmental disorders (Glieb et al., 1997; Kessler, 1994; Kessler et al., 2005). Approximately one-quarter of behavioral health conditions are classified as serious, based on diagnosis and burden (Kessler et al., 2011). Neuropsychiatric disorders, a category that includes both mental illness and neurological conditions such as autism and Alzheimer's, has been estimated by the World Health Organization to be the leading category in terms of burden of all types of diseases in the U.S., amounting to 18.7% of the burden of disease; almost three-fourths of which is accounted for by mental and behavioral disorders (NIMH, 2015). This is higher than the second leading disease category, cardiovascular and circulatory diseases, which account for 16.8% of the burden of disease. Behavioral health disorders are the leading cause of disability for persons aged 15-44 in the U.S. and can result in early mortality and morbidity (NIMH, 2015). Behavioral health disorders have been estimated to result in a 33% loss in earnings capacity by those affected. Employers also experience high costs from employees' behavioral health disorders, including high rates of sporadic absenteeism and lower levels of on-the-job performance. Behavioral health disorders have an earlier age of onset than do many chronic physical health conditions (Kessler et al., 2007) and early on-set behavioral health disorders have been shown to significantly predict physical disorders.

Some of the most prevalent categories of behavioral health include anxiety disorders, mood disorders, and substance use disorders. About 19% of the U.S. adult population is estimated to meet criteria for one or more anxiety disorders in a given year (WHO). Mood disorders, which include major depressive disorder and bipolar disorder, affect almost 10% of the U.S. adult population in 12-month period (WHO). 6.7% of the adult population meets diagnostic criteria for major depressive disorder alone each year (Kessler et al., 2005).

Substance use disorders, which include both abuse and dependence, have a 12-month prevalence rate of 11.3%, but an estimated 26.6% of the adult population will be afflicted with a substance abuse or dependence disorder over their lifetime (Kessler et al., 1994). Over 9% of Americans aged 12 and older have been estimated to any illicit drug use in the most recent month (US Department of Health and Human Services, Centers For Disease Control and Prevention, 2014) . The high prevalence of behavioral health conditions suggest that, far from being minor concerns, these are national public health priorities which require attention.

A number of demographic factors are correlated with behavioral health diagnoses. Factors such as age, gender, race, ethnicity, family income, and education have all been shown to affect prevalence rates (Figure 1). Once these characteristics are accounted for, studies such as the National Comorbidity Survey (Kessler et al., 1994), have found similar prevalence rates in urban and rural areas, and by region of the country.

**Figure 1: Correlates of 12 month prevalence rates of behavioral health disorders by demographic and regional factors**

Factor	<u>Anxiety</u>	<u>Affective</u>	<u>Substance Use</u>	<u>Any Disorder</u>
Youth	+	+	+	+
Female	+	+	-	0
African American	0	0	-	-
Latino/a	0	+	0	0
Low Income	+	+	+	+
Not HS grad	+	+	+	+
Urban	0	0	0	0
Region	0	0	0	0

Source: Kessler et al., 1994 (NCS)

There is a large continuum of treatments for behavioral health disorders, from community-based care, which includes outpatient office visits with primary care providers or behavioral health specialists, pharmaceutical care, counseling or psychosocial therapy, and

peer-based supportive options; intensive community based care, such as Assertive Community Treatment, a team-based manualized approach to care for people with severe mental illnesses at risk for inpatient treatment; crisis care, which is available on an emergency basis; day or partial hospitalization, which provides care during working hours but not overnight or residential care; and inpatient or institutional care, including care at specialty or community hospitals, residential care, and nursing facility care.

Treatment rates are low among people with a qualifying diagnosis. In population-based surveys, such as the National Comorbidity Study – Replication (Kessler et al., 2005), only 40.5% of adults meeting criteria for a serious mental illness access any type of service during the year. The rates among those with moderate or mild illness were even lower, at 37% and 23% respectively. Only one-third of those with any type of mental illness received services during the study year. In contrast, 15% of those who did not meet diagnostic criteria during the study year received some type of mental health service (Kessler et al., 2005) but much of this service use has been shown to be accounted for by follow-up care among those with prior behavioral health diagnoses (Druss et al., 2007). Being over the age of 24, female, non-Hispanic White, and not married have all been shown to be positively correlated with treatment receipt among those meeting behavioral health diagnosis (Kessler et al., 2005).

### **C. Behavioral Health in North Carolina**

In North Carolina the state mental health authority divides behavioral health broadly into three categories - mental health, substance abuse, and developmental disability. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services within the North Carolina Department of Health and Human Services (NCDHHS) has clear definitions for each of these categories. According to the NCDHHS website on adult mental illness, “[m]ental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (North Carolina Department of Health and Human Services) Substance abuse is defined as “...the overindulgence in and dependence on a stimulant, depressant, chemical substance, herb (plant) or fungus leading to effects that are detrimental to the individual's physical health or mental health, or the welfare of others” (North Carolina Department of Health and Human Services, 2015). Developmental disabilities is defined as “... cognitive, emotional, or physical impairments, especially one related to abnormal sensory or motor development, that appears in infancy or childhood and involves a failure or delay in progressing through the normal developmental stages of childhood” (North Carolina Department of Health and Human Services, 2015).

In some respects, North Carolina presents a slightly more optimistic picture than the rest of the nation. It is among the 10 states with the lowest rates of any mental illness. The rate of any mental illness in North Carolina was 16.8% (SAMHSA, Center for Behavioral Health Statistics and Quality, 2014). Further the rate of severe mental illness was slightly below the national average at 3.92% (SAMHSA, Center for Behavioral Health Statistics and Quality, 2014). The rate of illicit drug use among North Carolinians 12 and older was 7.54%. Further, while the [National Survey on Drug Use and Health](#) (NSDUH) suggests that a statistically significant increase in illicit substance use had occurred nationally between the 2002-2003 administration of the survey and the 2011-2012 wave, the trend in use was downward in North Carolina. That downward trend was not statistically significant (SAMHSA, Center for Behavioral Health Statistics and Quality).

The 2014 edition of America's Health Rankings provides additional recent information on how North Carolina ranks on other behavioral health measures compared to the rest of the U.S. North Carolina is the 8<sup>th</sup> ranked state in adults who binge drank, with 13% of the adult population to had 4-5 (for women-men) or more drinks on a single occasion in the past 30 days, compared to the U.S. average of 16.8%. North Carolina was 24<sup>th</sup> nationally in drug deaths, at 12.6 per 100,000 population compared to the U.S. rate of 13.0 per 100,000 population. Finally, North Carolina ranked 22<sup>nd</sup> on poor mental health days in the previous 30 days, with an average of 3.6 poor mental health days out of 30, compared to the U.S. average of 3.7.

## **D. The High Point Community**

High Point is part of the Piedmont Triad area in the north central portion of North Carolina. The other components of the "The Triad" are Greensboro and Winston-Salem. Although the majority of High Point's population is located in Guilford County, the city overlaps with the counties of Guilford, Randolph, Davidson and Forsythe. It is the only city in NC with boundaries intersected by four counties. This configuration makes it difficult to compile specific information about High Point. Many indicators from publically available data sources, such as the suicide rate, are provided at the county level. For the purposes of this analysis we take as our definition of Greater High Point the cities of High Point, Archdale, Trinity, and Jamestown, which are located in Guilford and Randolph counties. Thus when we conduct county level analyses we will consider both Guilford and Randolph. A complication to this approach is due to the fact that Guilford County also contains the city of Greensboro, which is much larger than High Point and thus may skew the results. Unfortunately, this is unavoidable given that the county level is often the unit for which many statistics are made available for public use.

There are a number of other unique features of the Greater High Point area (Table 1); data are not available from the Census for Jamestown. The total population of the three cities in the Greater High Point area is 125,953, accounting for just over 1% of North Carolina's almost 10 million residents. The high school graduation rate is similar in High Point and Archdale to the State's average of 85%, but somewhat lower in Trinity at 81.7%. The percent of the population that speaks a language at home other than English is similar in the city of Archdale to the state average, but is higher in the city of High Point and substantially lower in Trinity.

The number of Veterans in the area is also approximately 1% of the State's Veterans. The rate of home ownership is substantially higher than the state average in both Archdale and Trinity, but substantially lower than the state average in High Point. The median household income is similar in Trinity to the rest of North Carolina, at approximately \$46,000, with a slightly lower median income in High Point and a substantially higher median income in Archdale, at \$55,000. The statewide poverty rate in North Carolina was estimated at 17.5%, which is above the 15.4% poverty rate nationally. The percent of the population living under the poverty level mimics the patterns of median income, with a similar rate in Trinity to the state rate, a substantially higher rate in High Point (21.4%), and a substantially lower rate in Archdale (11.2%). The poverty rate for Jamestown is also substantially below the state average, at 8.1%.

There are a number of North Carolina state networks and resources that serve the Greater High Point area. Community Care of North Carolina, Inc. the State's medical homes program for Medicaid recipients, is comprised of 14 regional networks. These networks provide a number of services to participating practices in the local area, including care coordination. Both Guilford and Randolph counties are served by the Partnership for Community Care, a three-county network (Rockingham is the third county). Medicaid recipients in the Greater High Point area, including but not limited to those with behavioral health needs and diagnoses, can receive care coordination and medical homes services such as 24 hour access to primary care, through their CCNC network. The most recent enrollment data available (Sept, 2011) indicates that there were over 61,000 Medicaid enrollees in Guilford County, and almost 23,000 enrollees in Randolph County. Both counties are served through the capitated Sandhills Managed Care Organization and Local Management Entity (MCO/LME), which contracts with local behavioral health providers for care of both Medicaid and uninsured residents of the region.

**Table 1: Census data on communities in the Greater High Point Area**

Statistic	North Carolina	High Point	Archdale	Trinity
Population, 2013 estimate	9,848,917	107,741	11,554	6,658
High school graduate or higher, percent of persons age 25+, 2009-2013	84.9%	85.7%	83.1%	81.7%
Language other than English spoken at home, pct age 5+, 2009-2013	10.9%	15.0%	9.9%	3.5%
Veterans, 2009-2013	724,295	6249	874	620
Home ownership rate, 2009-2013	66.4%	56.8%	71.1%	83.4%
Median household income, 2009-2013	\$46,334	\$43,083	\$55,042	\$46,318
Persons below poverty level, percent, 2009-2013	17.5%	21.4%	11.2%	15.1%
Persons per square mile, 2010	196.1	1,939.9	1389.9	392.1

Source: (US Census Bureau).

### D.1 Secondary data sources used for behavioral health measures

We use a number of data sources that provide county-level estimates of various behavioral health indicators. First, we generate county and state estimates from the National Survey of Drug Use and Health (NSDUH). This population-based survey of behavioral health prevalence and service utilization provides a significant amount of information on Guilford County and North Carolina as a whole. Randolph County is only available as part of a seven-county Sandhills area; Because most of the counties in NSDUH’s Sandhills region (which are a slightly different set of counties from the Sandhills LME/MCO, discussed below) are outside of the Greater High Point region, we do not report these estimates. A consistent finding from the NSDUH analysis is that for all factors considered the rates of Guilford county are comparable to

those for NC as a whole; that is, the 95% confidence interval for the estimates for Guilford County include the estimate for NC (Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality).

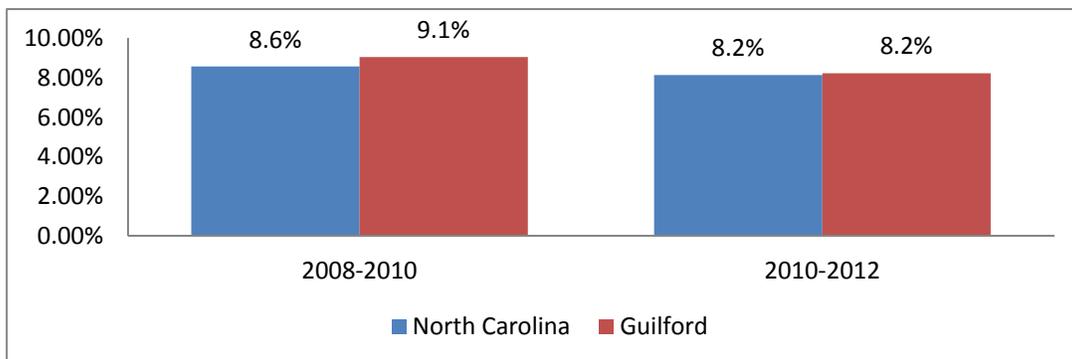
A second source of data is from the US Centers for Disease Control and Prevention (CDCP), which highlights factors related to the health of a community with its Community Health Status Indicators (CHSI), which include data from the Behavioral Risk Factors Surveillance System (BRFSS). The CHSI's were constructed with three goals, namely "1) Assess community health status and identify disparities; 2) Promote a shared understanding of the wide range of factors that are associated with health; and 3) Mobilize multi-sector partnerships to work collaboratively to improve population health" (US Department of Health and Human Services Centers for Disease Control and Prevention). Additional information on suicide was drawn from the National Vital Statistics System – Mortality (NVSS-M) data, as available from HealthIndicators.gov, operated by the National Center for Health Statistics. We also use city and county data from the U.S. Census (<http://quickfacts.census.gov/qfd/states/37000.html>).

## D.2. Measures of prevalence of behavioral health disorders and outcomes

### D.2.1 Substance Use

Compared to North Carolina as a whole, there were slightly higher rates of illicit drug use in Guilford County, both in the 2008-2010 administration of the NSDUH study and the 2010-2012 administration of NSDUH (Figure 2).

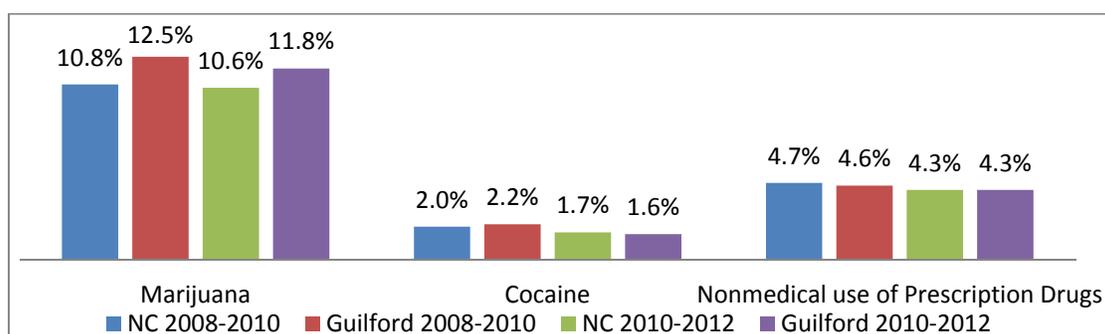
**Figure 2: Percent of Population with Illicit Drug Use in the Past Month: Guilford County and North Carolina**



(Source: Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health: Substate Regions – North Carolina 2010; 2012)

In 2008-2010, Guilford County had a higher estimated annual rate of any use of cocaine and marijuana than North Carolina as a whole, but a lower, estimated rate of nonmedical use of pain relievers (Figure 3). In 2010-2012 the estimated annual rate of any usage of each of these substances declined. The estimate for cocaine use in Guilford County was slightly lower than the statewide estimate, while the estimate for non-medical use of pain relievers was equal to the statewide estimate. Marijuana utilization estimates in Guilford County remained above the statewide estimate.

**Figure 3: Estimated Rates of Specific Substance Use among Persons Aged 12 or Older in Past year: Guilford County and North Carolina**

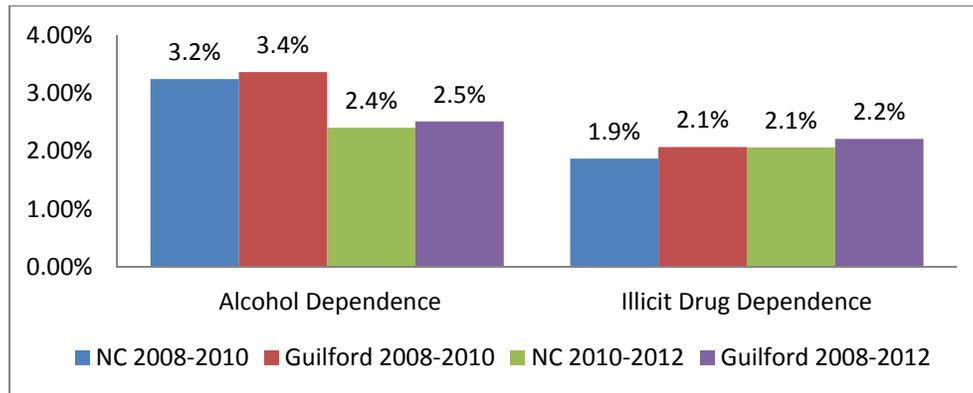


(Source: Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health: Substate Regions – North Carolina 2010; 2012)

### D.2.2 Illicit Drug and Alcohol Dependence, Abuse and Treatment

In addition to collecting useful information on the rates of utilization of particular controlled substances, the NSDUH also provides information on the rates of dependence on alcohol and illicit drugs. The numbers show that in both 2008-2010 and 2010-2012 Guilford County has a higher estimated rate of alcohol dependence and a higher estimated rate of illicit drug dependence than the state of North Carolina as a whole (Figure 4).

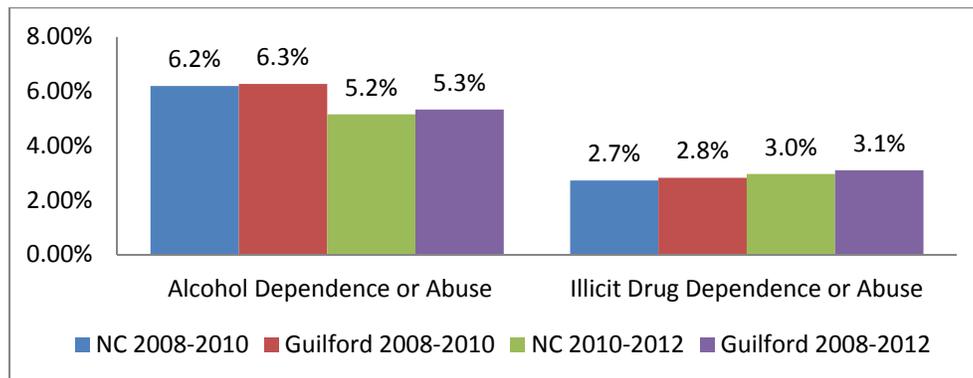
**Figure 4: Estimated Rates of Illicit Drug and Alcohol Dependence in the Past Year  
Guilford County and North Carolina**



(Source: Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health: Substate Regions – North Carolina 2010; 2012)

In 2008-2010 and 2010-2012 Guilford County had a higher estimated rate of alcohol abuse or dependence and a higher estimated rate of illicit drug abuse or dependence than the state of North Carolina as a whole. Further, illicit drug dependence or abuse increased between the two administrations of the survey (Figure 6).

**Figure 5: Estimated Rates of Illicit Drug and Alcohol Dependence or Abuse in the Past Year: Guilford County and North Carolina**

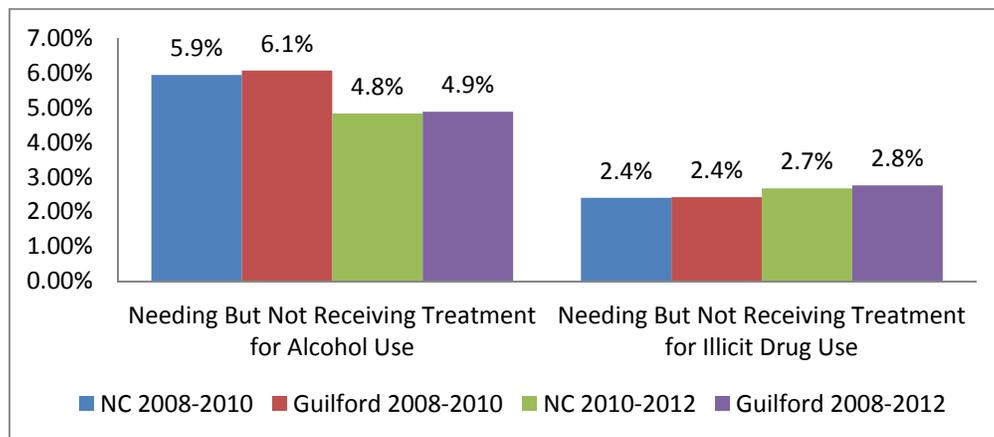


(Source: Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health: Substate Regions – North Carolina 2010; 2012)

A final substance related measure we included is the proportion of individuals needing but not receiving treatment for alcohol use and the proportion of individuals needing but not receiving treatment for drug use. These results indicate that the estimates for Guilford County

slightly exceed those for all of North Carolina in both waves of the study. The results also indicate that the rate of alcohol users receiving necessary treatment increased substantially state-wide and in Guilford County, though there was not a similar trend among illicit drug users (Figure 7).

**Figure 6: Estimated Rates of Illicit Drug and Alcohol Users Needing But Not Receiving Treatment in the Past Year: Guilford County and North Carolina**

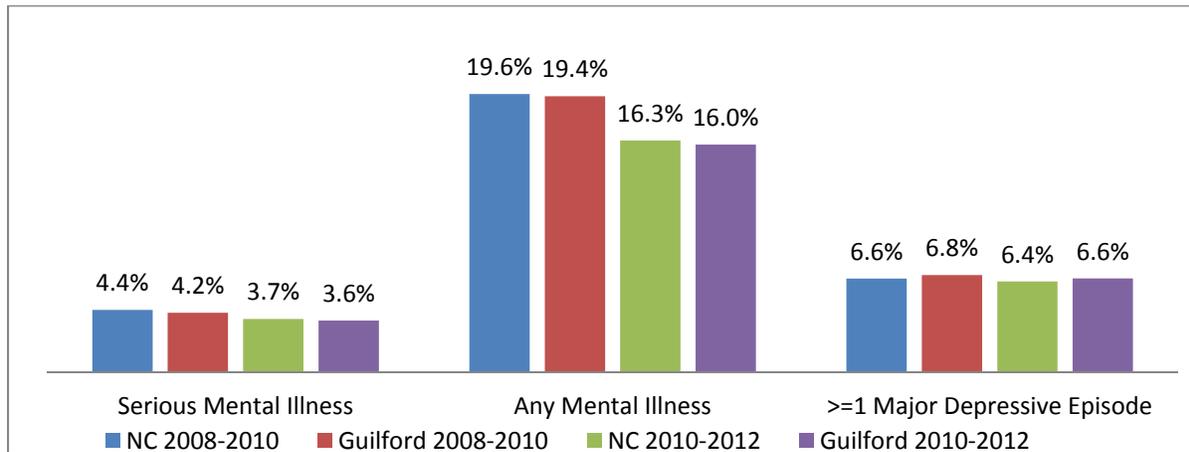


(Source: Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health: Substate Regions – North Carolina 2010; 2012)

### D.2.3 Mental Illness

The NSDUH provides data on several measures of mental health status in Guilford County and North Carolina as a whole. We find that the estimated rates of any mental illness and serious mental illness were lower in Guilford County for both waves of the survey than the statewide estimates. These rates are also lower than the national statistics presented earlier, but there are technical differences in the way the prevalence of mental illness was estimated between the NSDUH and the NCS-R described earlier. The proportion of the population with at least one major depressive episode was very similar to that reported earlier for the overall U.S., with approximately 6.4% of North Carolina’s population experiencing at least one episode of major depression between 2010-2012, slightly lower than the 6.7% estimated for the U.S. as a whole from the NCS-R several years earlier (Figure 8). The estimated prevalence rate for Guilford County is modestly higher than NC’s rate, with 6.6% of the adult population affected. Across all three indicators of mental health status, we find that there was a decline in the estimated rates of each of these outcomes between the 2008-2010 and 2010-2012 survey administrations. The current prevalence of serious mental illness is estimated at 3.7% of the adult population for the state as a whole, and 3.6% for Guilford County.

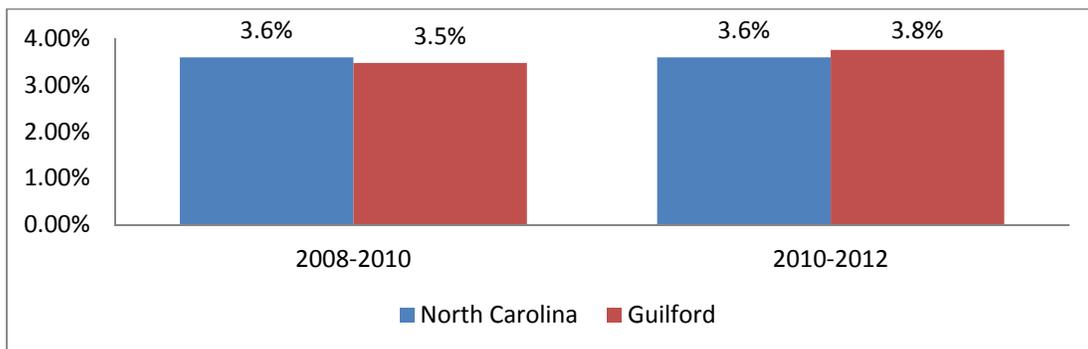
**Figure 7: Estimated Rates of Mental Health Conditions in the Past Year: Guilford County and North Carolina**



#### D.2.4 Suicide and Suicidality

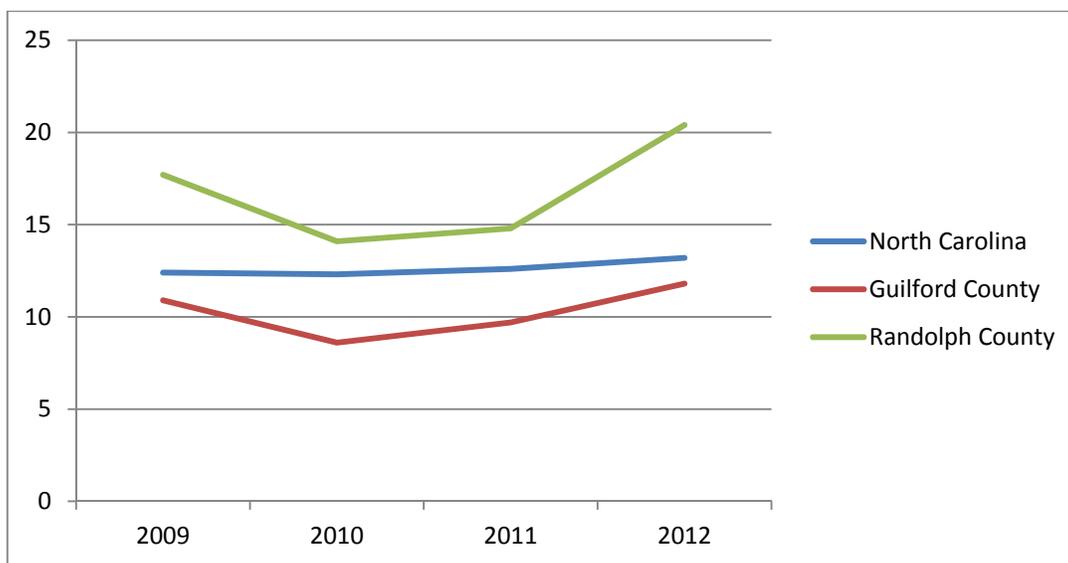
Another important indicator of mental health is suicides and suicidal thoughts, defined as whether an individual had serious thoughts of suicide in the previous year. In 2012, there were more than 40,000 deaths from suicide in the U.S. as a whole, and the rate has been increasing. In 2014, the rate of suicide per 100,000 population for the U.S. as a whole was 12.9 (America’s Health Rankings, 2014), an increase of 7.5% over the 2012 rate. In North Carolina, the rate is higher still, at 13.2 suicides per 100,000 population; North Carolina is the 19<sup>th</sup> lowest state in suicides per population. The estimated rates of suicidal thoughts increased over time in the NSDUH, and even more so in Guilford county than in North Carolina as a whole (Figure 9). The estimated rate of suicidal thoughts was lower in Guilford County than in North Carolina as a whole in the 2008-2010 NSDUH estimates, but the relative estimates reversed based on the 2008-2010 data.

**Figure 8: Estimated Rate of Population That Had Serious Thoughts of Suicide in the Past Year: Guilford County and North Carolina**



Further information on suicide rates are available through 2012 at the county level for North Carolina as a whole, as well as for Randolph and Guilford Counties separately. Figure 10 shows the unadjusted suicide rates for North Carolina as well as Guilford and Randolph Counties from 2009-2012. What is clear is that suicide appears to be a more urgent issue in Randolph County than in the North Carolina as a whole or in Guilford County.

**Figure 9: Trends in Suicide Death Rates per 100,000 Population: Guilford County and North Carolina**



(Source: Center for Disease Control and Prevention. National Center for Health Statistics.)

### D.2.5 Adult Mentally Unhealthy Days per Month

County data from the BRFSS provides estimates of mentally unhealthy days for the data collection period of 2006-2012, solicited through answers to the question "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" In Guilford County the rate of adult mentally unhealthy days per month was 3.1 (US Department of Health and Human Services Centers for Disease Control and Prevention). In Randolph County the number was 3.7 (US Department of Health and Human Services Centers for Disease Control and Prevention). Both these indicators are comparable to the U.S. estimated rate of 3.7 days and considered to be in the lowest quartile compared to peer counties.

## **D.3 Measures of the availability of Mental Health and Substance Abuse Services**

Below we identify the array of mental health and substance abuse services that are available in the Greater High Point area. We are unable to comment on the adequacy of these services relative to mental health needs, the quality of these services, or the extent to which evidence-based practices are followed.

### **D.3.1 Adequacy of Mental Health Work Force**

According to a study by Thomas, Ellis, Konrad and Morrissey (2012), the availability of mental health physicians with prescribing privileges is described as *inadequate* in the Greater High Point area. Although this study only provides data at the county level, it shows that only 63.5% of the need for mental health prescribers was met in Guilford County. In Randolph County the situation is worse, with only 35.1% of need for prescribing physicians met (Thomas et al., 2012). However, many mental health service providers are non-prescribers, such as social workers, counselors, and psychologists. With regard to these types of providers, the supply is more than adequate to meet need in both counties that encompass the Greater High Point area. In Guilford County, about 434.7% of the need for non-prescribers was met, while in Randolph County the number was 279.2% (Thomas et al., 2012). These percentages mean that Guilford County had 4 times the number of non-prescribers needed and Randolph County had nearly 3 times the number of non-prescribers needed.

### **D.3.2 Social Support**

According to the CDCP, 19.2% of adults in Guilford County have inadequate social support. This data was derived from the answers to the Behavioral Risk Factor Surveillance System (BRFSS) question "How often do you get the social and emotional support you need?" with either "all", or "most of the time" in the time period 2006-2012 (US Department of Health and Human Services Centers for Disease Control and Prevention). The rate was slightly higher in Randolph County, at 21.2% (US Department of Health and Human Services Centers for Disease

Control and Prevention). Both of these levels were considered moderate relative to peer counties as defined by the CHSI.

### **D.3.3 Licensed Mental Health Facility Certifications**

There are a significant number of mental health facilities serving Guilford and Randolph counties, offering a varied arrange of services to accommodate a diverse set of needs. According to the North Carolina Department of Health and Human Services - Division of Health Service Regulation there are 296 facilities serving Guilford County, as of April 2015 (NC Division of Health Service Regulation, 2012). The number for Randolph County is over 50. However, when these results are reduced to street addresses in Greater High Point (Archdale, High Point, Jamestown or Trinity), fewer than 50 are available. Each of these sites is authorized and licensed to provide a specific set of services. Below, we summarize the array of services available at the High Point sites.

Facilities are authorized to provide behavioral health services in High Point under the North Carolina Administrative Code. The service descriptions can be found in Section 10A-NCAC-27G.

### **D.3.4 Supervised Living Services in Greater High Point**

The class of services that can be described as “Supervised Living” are defined under 10A-NCAC-27G.4601 as “...residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence.” In Greater High Point there are residences authorized under this code to provide Alternative Family Living, which is where the individuals with disabilities, including behavioral health conditions, reside with a family that provides services. There are residencies in High Point authorized to provide these services to children, adolescents and adults. For the adult population, there are residences authorized to provide supervised living services to individuals with developmental disabilities, mental illnesses and/or substance abuse problems respectively.

There are currently no developmental disability, mental illnesses and/or substance abuse providers of supervised living in Greater High Point for children or adolescents.

### **D.3.5 Substance Abuse Comprehensive Adult Outpatient Treatment (SACOT) Program**

SACOT services are defined under 10A NCAC 27G.4501 as a service “...that provides a multi-faceted approach to treatment in an outpatient setting for adults with a primary substance-related diagnosis who require structure and support to achieve and sustain recovery.” This includes ten services such as counseling and life skills building, and must be targeted to achieve certain beneficial outcomes for the patients. These services are currently available to both adults and adolescents in the Greater High Point area.

### **D.3.6 Substance Abuse Intensive Outpatient Program (SAIOP)**

SAIOP services are defined under 10A NCAC 27G.4401 as a program “...that provides structured individual and group addiction treatment and services that are provided in an outpatient setting designed to assist adults or adolescents with a primary substance-related diagnosis to begin recovery and learn skills for recovery maintenance.” This service type is comprised of nine specialty services, such as individual counseling and drug testing. These services are currently available to children, adolescents and adults in Greater High Point.

### **D.3.7 Social Setting Detoxification for Substance Abuse, Outpatient Detoxification and Non Hospital Medical Detoxification**

Social Setting Detoxification services are defined under 10A NCAC 27G.3201 as “...a 24-hour residential facility which provides social support and other non-medical services to individuals who are experiencing physical withdrawal from alcohol and other drugs.” These services are available both to adults and adolescents in Greater High Point.

Nonhospital Medical Detoxification services are defined under 10A NCAC 27G .3101 and are very similar to those offered in a social setting but with the exception that they are offered under the supervision of a physician. These services are only available to adults in High Point.

Outpatient Detoxification is similar to Nonhospital Medical Detoxification, with the exception that it is periodic and non-residential. It is defined under 10A NCAC 27G .3301 as “[a]n outpatient detoxification facility is a periodic service which provides services involving the

provision of supportive services, particularly active support systems under the supervision of a physician for clients who are experiencing physical withdrawal from alcohol and other drugs, including but not limited to appropriate medical, nursing and specialized substance abuse services.” This service is available to adolescent adults in Greater High Point.

### **D.3.8 Residential Treatment Services**

Residential treatment services available in High Point fit into three categories. The first two categories are for treatment of children and adolescents with severe mental illnesses. These are called Residential Treatment Level II and Residential Treatment Level III and are respectively defined under 10A NCAC 27G.1301 and 10A NCAC 27G.1701. Though both provide residential care for similar populations, the difference between the two is that Residential Treatment Level III states that “...staff are required to be awake during client sleep hours and supervision shall be continuous...” Although Residential Treatment III is provided in a “staff secure facility” it is not the same as an inpatient psychiatric facility. According to the policy cited above, children and adolescents that meet the requirements for inpatient psychiatric care are not eligible for this service.

The third category of residential treatment service available at licensed mental health facilities in Greater High Point is Residential Treatment/Rehabilitation for Individuals with Substance Abuse Disorders. This service is available to adolescents and adults, subsequent to detoxification and is defined under 10A NCAC 27G .3401. It provides “...24-hour residential service which provides active treatment and a structured living environment for individuals with substance abuse disorders in a group setting.”

### **D.3.9 Sheltered Workshops**

Sheltered Workshops, are defined by 10A NCAC 27G.5501 as “day/night facility which provides work-oriented services including various combinations of evaluation, developmental skills training, vocational adjustment, job placement, and sheltered employment to individuals of all disability groups 16 years of age or over who have potential for gainful employment.” These programs are designed for and available to adults in Greater High Point.

### **D.3.10 Day Activity or Day Treatment Services Available in Greater High Point**

Day treatment services are non-residential care services provided that offer activities or treatments for children, adults and adolescents. They can be provided during day or night, but in a community based outpatient settings. In Greater High Point Day Treatment for Children and Adolescents with Emotional or Behavioral Disturbances, defined under 10A NCAC 27G .1401 is available to Adolescents. It seeks to "...increase the ability of a child or adolescent to relate to others and function appropriately within the community while serving as an intervention to prevent hospitalization or placement outside the home or community."

A second form of day treatment is intended for adolescents or adults with substance abuse disorders. This service is defined under 10A NCAC 27G .3701 as facilities that "...provide services in a group setting for individuals who need more structured treatment for substance abuse than that provided by outpatient treatment, and may serve as an alternative to a 24hour treatment program." These services are available for both adults and adolescents in Greater High Point.

Day activity is also available in Greater High Point. Facilities licensed for day activity can be authorized to provide it for children, adults and adolescents. All these age groups have access to services in Greater High Point. The service is defined under 10A NCAC 27G .5401 as "a day/night facility that provides supervision and an organized program during a substantial part of the day in a group setting to individuals who are mentally ill, developmentally disabled or have substance abuse disorders.

There are no sites of facilities certified by the North Carolina Department of Health and Human Services authorized to provide day treatment for adults with mental illnesses in Greater High Point.

### **D.3.11 Psychosocial Rehabilitation Services for Individuals with Severe and Persistent Mental Illness**

Psychosocial rehabilitation services are non-residential care facilities that are defined as "...a day/night facility which provides skill development activities, educational services, and pre-vocational training and transitional and supported employment services to individuals with severe and persistent mental illness." They are available to children, adults and adolescents in Greater High Point and are defined under 10A NCAC 27G .1201.

### **D.3.12 Adult Vocational Development Programs (ADVP)**

ADVP is available in Greater High Point. This service is defined under 10A NCAC 27G .2300 as offering “organized developmental activities for adults with developmental disabilities to prepare the individual to live and work as independently as possible.” This service is only available for adults, and is only intended for adults.

### **D.3.13 Other Services Not Available In Greater High Point**

Despite the variety of adult vocational development facilities that are currently authorized to serve Greater High Point, the following services are currently not available at locations in High Point, Trinity, Archdale or Jamestown but are available in other parts of North Carolina. These are:

- 1) Facility Based Crisis Services for Individuals of all Disability Groups – Defined under 10A NCAC 27G .5001 as “a 24-hour residential facility which provides disability specific care and treatment in a nonhospital setting for individuals in crisis who need short term intensive evaluation, or treatment intervention or behavioral management to stabilize acute or crisis situations.”
- 2.) Therapeutic Homes for Individuals With Substance Abuse Disorders And Their Children – Defined under 10A NCAC 27G .4101 as “a professionally supervised residential facility which provides trained staff who work intensively with individuals with substance abuse disorders who provide or have the potential to provide primary care for their children.”
- 3.) Partial Hospitalization for Individuals who are Acutely Mentally Ill – Defined under 10A NCAC 27G .1101 as “day/night facility which provides a broad range of intensive and therapeutic approaches which may include group, individual, occupational, activity and recreational therapies, training in community living and specific coping skills, and medical services as needed primarily for acutely mentally ill individuals.”
- 4.) Outpatient Opioid Therapy – Defined under 10A NCAC 27G.3601 as “outpatient opioid treatment facility provides periodic services designed to offer the individual an opportunity to effect constructive changes in his lifestyle by using methadone or other medications approved for use in opioid treatment in conjunction with the provision of rehabilitation and medical services.”

- 5.) Community Respite Services for Individuals of All Disability Groups – Defined under 10A NCAC 27G.5101 as “...a service which provides periodic relief for a family or family substitute on a temporary basis. While overnight care is available, community respite services may be provided for periods of less than 24 hours on a day or evening basis.”
- 6.) Specialized Community Residential Centers for Individuals With Developmental Disabilities – Defined under 10A NCAC 27G.2101 as a facility that “provides care, treatment and developmental training over an extended period of time, through integration of medical services and close supervision, for individuals who are developmentally disabled or have multiple disabilities.”
- 7.) Psychiatric Residential Treatment Facility (PRTF) for Children and Adolescents – Defined under 10A NCAC 27G.1901 as a facility that “provides care for children or adolescents who have mental illness or substance abuse/dependency in a non-acute inpatient setting.”
- 8.) Before/After School and Summer Developmental Day Services for Children With or At Risk for Developmental Delays, Developmental Disabilities, or Atypical Development – Defined under 10A NCAC 27G.2201 as “facilities that provide individual habilitative programming and recreational activities.”
- 9.) Supervised Therapeutic Community – Defined under 10A NCAC 27G.4301 as “...a highly structured, supervised, 24-hour residential facility designed to treat the behavioral and emotional issues of individuals to promote self-sufficiency and a crime and drug-free lifestyle
- 10.) Developmental Day Services for Children With or At Risk for Developmental Delays, Developmental Disabilities, or Atypical Development – Defined under 10A NCAC 27G.2401 as “...a day/night service which provides individual habilitative programming for children with, or at risk for developmental delay, developmental disabilities or atypical development in specialized licensed child care centers.”
- 12.) Intensive Residential Treatment for Children or Adolescents – Defined under as “...a 24-hour residential facility that provides a structured living environment within a system of care approach for children or adolescents whose needs require more intensive treatment and supervision than would be available in a residential treatment staff secure facility.”

## **E. High Point Provider and MCO/LME Agency Interviews**

We conducted a group interview on April 27, 2015 with representatives from local provider agencies and the Sandhills MCO/LME to obtain their perspectives on behavioral health needs in the Greater High Point community (see Appendix 1). Several general themes emerged from this meeting that echo findings in prior community needs assessment reports. First, severe funding shortfalls continue to limit the variety, availability, and adequacy of local behavioral services in the Greater High Point area. Second, there are critical gaps in the array of services for crisis intervention, case management, substance abuse prevention, housing, transportation, and jail diversion. Third, providers and advocates have actively participated in various volunteer and agency-sponsored efforts in recent years to identify population needs and service gaps. And fourth, the Foundation should focus its grant-making efforts on substantial and sustained investments in needed behavioral health services. Below are summary highlights from this wide-ranging discussion.

### **E.1 Mental Health**

One of the unique challenges faced by agencies providing behavioral health services in Greater High Point is that the community is located at the nexus of four counties. High Point is the only city in North Carolina with this county configuration. As a result, people can live in one county and work in another. This may mean crossing LME/MCO boundaries that affect what services are available and who pays for them.

Gaps were noted in the current array of services provided including transitional living arrangements for persons with severe mental illness while they are served in one or another program, transportation services from home to care sites, and supported housing. Housing for people with mental illness was described as a huge problem currently. One participant noted that after mental health patients receive crisis services at the hospital, they often do not get the housing and support services they need in the community, so they come right back to the hospital. Homeless shelters do not want to deal with people with severe mental illness and dumping of patients from one setting to another is common. So HGH has often no place to send patients without stable residences.

Establishing a transition care team to assist patients from hospital to community was one idea for improvement. Another suggestion was for a facility-based crisis residence. Longer hours of operation at RHA was also mentioned as a way of addressing some of these issues.

Rising rates of inpatient psychiatric admissions in Guilford County were noted, especially for state psychiatric hospitals. The NC Division of Mental Health and the Sandhills MCO/LME encourage the use of 3-way beds [contracted beds for indigent patients] which are part of a state-wide network of 22 general hospitals with psychiatric inpatient units including three hospitals in the High Point/Greensboro area. (Sandhills MCO also contracts for additional indigent beds with local hospitals.) It was mentioned that there is no problem in getting a bed in this network except for adolescents for whom specialized inpatient services are extremely rare. It was noted, however, that the High Point Regional Hospital has found it difficult to use 3-way beds in its own inpatient unit.

Funding shortages for mental health services was described as another chronic and continuing problem. Providers find it difficult to secure enough revenue to operate in the High Point area and some providers in recent year had to close-down and move to Greensboro. It was suggested that Medicaid expansion through the federal Affordable Care Act would solve a big part of this funding problem as the many people who are currently uninsured would have insurance coverage to pay for needed services.

Another area where more services are needed is the local criminal justice system in High Point. Currently, estimates are as high as 75% of the inmates in the Guilford County jail have behavioral health problems. The county jail in Greensboro has an active jail diversion program but the facility in High Point does not. Also, it has been difficult to get High Point police officers to participate in Crisis Intervention Training (CIT). It was mentioned that the police department's response has typically been that they would not have enough officers to protect public safety if they allowed released time for CIT training.

## **E.2 Substance Abuse**

Opioid addiction was identified as a major problem in Greater High Point. One statistic that was mentioned is that in 2014 High Point had 119 overdoses, as reported by the police department, including 15 deaths. Already this year there have been 15 deaths due to opioid overdosing. It was mentioned that this problem has a long history in High Point. In the 1960's, because of its location close to two major north-south and east-west interstate highways, High Point became the center of a heroin distribution system which survives to the current day. Social media regularly refer to High Point as a place to get good heroin and 59% of those overdosing in the city limits do not live in High Point. Although there also is an increase in illegal use of prescription medications, heroin can be purchased on the street in High Point for about 25% of the cost of prescription drugs.

Another cause of the uptick in heroin use was described as a rebound effect from newer prescription opioid antagonist drugs that one cannot abuse by crushing and snorting. Narcan (Naloxone Hydrochloride Injections) is now being prescribed for addicts in the High Point area. Some users see this as a license to go elsewhere for a high, often back to heroin, because they believe that Narcan can bring them back from severe overdosing. However, this drug is only issued in two vial packets and, in extreme situations, up to six vials are needed. So deaths occur even after this medication is applied.

There is a severe shortage of residential treatment for opioid users. Only one of the three state-operated Alcohol and Drug Abuse Treatment Centers (ADATCs) serves opioid addicts and the General Assembly has proposed closing these facilities and transferring their funding to the MCO/LMEs.

Drug treatment courts were described as an active and positive intervention in High Point. They are widely perceived as being very effective and pre-post studies have shown that over 90% of graduates have not incurred additional charges. However, there is no targeted funding for drug courts and there is an inadequate provider mix in Greater High Point to support them.

Veterans with behavioral health problems were identified as a growing challenge in Greater High Point, attracted to the Triad because of the Veterans Medical Center in nearby Salisbury, NC. Veterans with PTSD and trauma histories were described as a unique population not trusting people who themselves are not veterans. Self-medication often starts a spiral that leads to more severe addictions. Because veterans' needs were often being neglected, a Triad Veterans Coalition was formed with broad community participation to serve in an advocacy role for their needs. The Coalition functions without funding.

Substance abuse prevention services for adolescents were identified as another critical situation. Funding is dwindling with a cutback in Federal block grant funding to the states. As a result, block grant funding to the Sandhills MCO/LME will be reduced by 29% this year alone. The result is that prevention services for the K-12 school population in Greater High Point will be sharply curtailed. The urgency is that many youngsters are using illegal substances but they do not yet meet criteria for treatment. So there is a huge need for timely interventions to prevent further abuse.

### **E.3 Foundation's Role**

Much enthusiasm was expressed about the Foundation for a Healthy High Point and its potential role in meeting the problems and service gaps discussed both in our meeting and in earlier reports, including the 2013 Community Health Needs Assessment and Implementation Strategies conducted by High Point Regional Hospital and the Sandhills MCO/LME FY 2014-2015: Community Needs Assessment/Gaps Analysis.

One participant stressed that “there are no small behavioral health problems in Greater High Point . . . no problems that can be affected by a little money here and there. The Foundation’s response must be substantial and sustained.” Currently, almost all of the service funding comes from sources outside the local area that residents of High Point have little influence over. “It would be excellent to have a local source that believes in sustaining long-term investments.”

Among the specific suggestion for Foundation funding was support for case management services. It was noted that current Assertive Community Treatment (ACT) Teams are falling far short of their service definition requirement regarding the intensity of services for people with severe mental illness, partly due to burnout and chronic staff turnover. This was identified as a state-wide problem and a major one in High Point. Case management is a special problem for Medicaid beneficiaries without a medical home and for uninsured consumers.

Dual mental health and substance use disorders were seen as another area needing attention. Rates of dual diagnosis are very high often approaching two-thirds of those seen in the public system. But current reimbursements are based on categorical diagnosing. New funding formulas need to be explored so that dual disordered individuals can be properly served.

### **F. Key informant interviews**

We also conducted a limited number of key informant interviews of advocates and local experts who were not part of the group discussion. Key informants describe unmet demand for mental health services and discontinuities in care that fall most heavily on minority populations and individuals with comorbid conditions and problem behaviors. For example, since the dissolution of the Guilford LME, while many patients were able to follow their providers to new organizations, all of the people with IDD and SMI at Monarch receive their treatment via Skype. They explained that Monarch did not receive accurate numbers for clientele, so that their staffing is inadequate. A major problem is that, since privatization, no one has leverage over

difficult-to-treat expensive patients, and every incentive to let them go, so they end up without services.

## **G. Evidence-based practices in Behavioral Health Treatment and Prevention**

Evidence-based practices are interventions for which there is strong and consistent evidence showing that they improve outcomes compared to an alternative (which might be an inactive control group, such as “usual care”, or a different active treatment, such as a different psychotherapy). Standards for evidence can vary, but generally strong evidence is obtained from a number of randomized controlled trials that compare the intervention to an alternative strong practice. Systematic reviews can provide a summary of what the highest quality evidence concludes about particular practices. These reviews involve a rigorous and methodical approach to clarifying the important questions, identifying the key variables to consider (which can include the population, the intervention or assessment tool in question, a comparison group, the important outcomes, the proper time frame, and the setting), comprehensively searching the available literature databases, abstracting the important information, and synthesizing the results in a qualitative and, if possible, quantitative summary. Quantitative synthesis can involve meta-analysis, which is used to combine the evidence across trials, yielding specific information about the strength and variation in the evidence and the populations to whom it applies. The body of evidence-based practices is constantly evolving; new evidence is added on to the prior evidence base, providing a summary assessment that considers the full weight of all relevant and available information. A current emphasis is to develop practices that support outcomes that are valued by the individuals who use them and their families (Fleurence et al., 2013; AHRQ, 2015; SAMHSA, 2015; Drake et al., 2001).

Systematic reviews of the literature have identified a core set of evidence-based practices that improve symptoms, functional status, and quality of life for adults with mental illness. These evidence-based practices include medication prescribed within specific parameters, training in chronic disease self-management, assertive community treatment, family psychoeducation, supported employment and integrated treatment for co-occurring substance use disorders (AHRQ, 2015; SAMHSA, 2015; Drake et al., 2001; DHHS, 2000). For children with mental health needs, there is evidence on practices to reduce barriers to service engagement, the importance of family-based treatment, psychotherapy, medication management, intensive case-management, home-based intervention such as multi-systemic

therapy, school-based intervention such as targeted classroom-based contingency management and cognitive group interventions (AHRQ 2015; SAMHSA, 2015; Hoagwood et al., 2001).

Central to the discussion of evidence-based practices is their implementation and the policy, organizational, and provider factors that support effective provision of these practices. There is evidence that community coalitions in behavioral health, which include important leaders and stakeholders, needs assessment, and identification, implementation and ongoing monitoring of targeted evidence-based practices, can produce significant reductions in problem behaviors that prevent future mental health problems (Steverman & Shern, 2014; Hawkins et al., 2008; Spoth & Greenberg, 2005). Research indicates that fidelity to the standards of the practice is critical to achieve positive outcomes (Drake et al., 2001). The literature provides measures of program fidelity to support monitoring and accountability (McHugo et al., 2007). There is evidence that provision of services within integrated settings achieves more positive outcomes than nonintegrated settings (Butler et al., 2011). Furthermore, choice of treatment among the full set of appropriate options is essential to maximize adherence and treatment response (Gillard et al., 2012; Corrigan et al., 2012; Adams & Drake, 2006). The policy challenge is to balance resources to support access to care, treatment choice among evidence-based practices, and fidelity monitoring (Lehman et al., 2004). For children, evidence-based practices must also take into account developmental status and the dynamic interactions among the child, family and their environment (Hoagwood et al., 2001). One strategy for improving the speed and quality of implementation of evidence-based practice that has been implemented successfully, is to distinguish between the roles of developer and purveyor of the practice. A purveyor is typically a business that provides implementation and fidelity monitoring services (Steverman & Shern, 2014; Fixen et al., 2005).

## **H. Future Behavioral Health Initiatives in the Greater High Point area**

There are clearly important investment opportunities for the Foundation in the Greater High Point area. Directly funding more staff for behavioral health services to existing agencies in the area would provide greater capacity to treat and prevent behavioral health conditions. Enhancing services such as care coordination would not directly expand capacity, but would make the existing resources for behavioral health treatment more productive and in this way create greater opportunities to expand the package of services received by those with behavioral health conditions. Opportunities exist to work with local schools and youth-centered resources to prevent future cases of behavioral illnesses. Below we highlight some additional possibilities for investment.

However, given the several week period in which we were asked to prepare this White Paper, we were unable to conduct an independent assessment of local behavioral health needs and current services. As a result, we are unable to make specific recommendations to the Foundation for what types of services should be funded, for whom, and where they should be situated. Nonetheless, we believe there are several infrastructure initiatives that the Foundation should consider supporting as a way of enhancing the community's capacities to meet the current and future behavioral health needs of local residents.

## **H.1 Devote resources to intensive examination of behavioral health needs of the population**

As highlighted in this White paper, it is difficult if not impossible to gather information on the prevalence, impact, and unmet needs related to behavioral health at the city or regional level; at best only county-level information is available. An approach seldom attempted for behavioral health, but that could significantly enrich the information for the Greater High Point area would be a detailed population-level analysis of the disease prevalence, risk factors, and population needs in this area. Potentially modeled after the Framingham Heart Study, which put the small community of Framingham, Massachusetts on the map for its detailed and sustained assessment of cardiovascular disease in population of a small New England community, a High Point Behavioral Health Study could provide detailed information on the diagnostic prevalence of behavioral health conditions, treatment seeking behavior, risk factors such as poverty, medical comorbidity, and genetic factors in the Greater High Point area.

## **H.2 Devote resources to a mapping and assessment of behavioral health service system resources in Greater High Point**

This system mapping initiative would be the organizational counterpart to the individual needs assessment suggested above. As noted earlier, in the preparation of the White Paper, we were unable to assess the adequacy, quality, and effectiveness (via use of evidence-based practices) of the services currently provided in the Greater High Point area. A systematic inventory of resources that focused on the performance characteristics of the local service system would provide a platform for considering how to respond to current and emerging needs as identified through the individual needs assessment mentioned above. Service gaps could be identified as well as areas where newer evidence-based practices could be introduced.

While these activities overlap with the mandate of the Sandhills MCO/LME the key difference is that this resource inventory would focus exclusively on High Point rather than the nine county Sandhills area and be more responsive to local circumstances.

### **H.3 Devote resources to the creation and staffing of a Greater High Point Behavioral Health Council**

The local community has benefited from the efforts of provider agencies and other stakeholders to assess needs and suggest program interventions both in mental health and substance abuse areas. However, going forward, there is a great need to formalize these efforts so that there is a single entity that can plan for the future of behavioral health in Greater High Point, develop a common voice that can suggest new initiatives to the Foundation, and work with Sandhills MCO/LME (and whatever successor agency might be identified as North Carolina reviews its Medicaid program and reconsiders participation in the Affordable Care Act) to enhance the behavioral health of residents in the Greater High Point Area.

## Appendix 1: Focus Group and Key Informant Participants

We are grateful to the following individuals for their generous participation in the collection of local information:

Sarah Bobo, Director, RHA Health Services

Jackie Butler, Alcohol & Drug Services of Guilford Inc.

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Bambi Cottle, Program Manager, High Point Behavioral Health

Matthew Hallsey, Therapist, High Point Behavioral Health

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Mitch McGee, Vice President of NAMI Guilford, Social Worker, Guilford County DSS

Angela Maxwell, Alcohol & Drug Services of Guilford Inc.

Roger Rau, President & CEO, Alcohol & Drug Services of Guilford Inc.

Terry Wicker, Hospital Liaison, Sandhills LME

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