Hearing on "The COVID-19 Pandemic and Beyond: Improving Mental Health and Addiction Services in Our Communities"

Verbal testimony, as prepared, to:

The Senate Finance Committee
Subcommittee on Health

The Honorable Debbie Stabenow, Chairwoman
The Honorable Steve Daines, Ranking Member

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As submitted by:

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Good afternoon, thank you Chair Stabenow, Ranking Member Daines, and the honorable members of the Committee for the opportunity to testify on North Carolina's approach to ensuring equity in community behavioral health services.

My name is Victor Armstrong. I am the Director of NC Division of Mental Health, Developmental Disabilities & Substance Abuse Services. I am a social worker, a husband and a father to three Black boys. I am a mental health advocate, and I am the son of a preacher, born and raised in rural NC--Plymouth to be specific--though I now reside in Charlotte, NC. I share all of this because I am the sum of all these things. This will no doubt create a perception of who I am, based not only on what I have just shared, but also based on both **your** lived experience and mine. Much as you today will interact as tradition and formality dictate, in many ways our mental health and substance use system has worked the same way. Unfortunately, it is a system that has not practiced, nor been funded through, a lens of equity.

The lens of equity is about the intersectionality of race, culture, and ethnicity, ***in addition to*** living with mental health and substance use challenges. It is about being Black and living with a serious mental illness. It is about being Latino and living with intellectual disabilities or traumatic brain injury. It is about being American Indian and living with a substance use disorder. It is about being an Asian, Trans person struggling with an anxiety disorder exacerbated by the discrimination that often accompanies mental illness, the bigotry that is perpetrated toward Trans Americans, and the increasing rates of violence against Asian Americans.

We cannot ignore how a person of color enters the behavioral health system. People of color often do not have access to outpatient services within their communities. This makes it more likely that they are introduced to the behavioral health system when they are in a state of "crisis", and more likely to enter the system via the back of a police car or an acute care Emergency Department, neither of which is conducive to good clinical outcomes and neither of which is likely to foster a positive relationship with the mental health system.

Systemic racism and bias, both explicit and implicit, are multi-layered and seep into every crevice of society. This includes our mental health and substance use care, but we can change that if you are willing to help to reform our system. When we know that inequity exists, it is our moral responsibility to address those inequities by leaning into equity. Every decision that we make as clinicians, policy makers, or simply as agents of change either leans into creating a more equitable system or perpetuates our existing problem of inequity.

We can address the issue of access by supporting the creation of more mental health resources in communities of color and underserved zip codes. We can create more community-based resources that provide access to upstream treatment.

One way that communities are doing this is through the Certified Community Behavioral Health Clinic, or CCBHC model. CCBHCs are required to provide comprehensive, timely, and culturally competent services to everyone in their communities. One CCBHC here in North Carolina—Monarch—has embedded a peer support specialist with the EMS team that responds to opioid overdoses. The peer stays with that person through the trip to the hospital and helps to connect them to community treatment upon release, making sure that the person does not get lost on the road to recovery in the community. We support the CCBHC model and appreciate any funding to increase CCBHCs.

We can support efforts to build a workforce that mirrors the populations served. In NC, we have roughly 4,000 trained Certified Peer Specialists, representing Black, White, Latino, Asian, and American Indians, with only about 1,600 individuals gainfully employed. We need to utilize the peer workforce and pay them a living wage. We need to partner with Historically Black Colleges and Universities (HBCUs) to build a multi-cultural workforce. We need to partner with clinicians of color and provide them access

to government grants and contracts. We need to partner with Faith-Based Organizations, and we need to fund studies that consider the nuances of race, culture, and ethnicity and the impact on mental wellness. Further, we need to better understand the impact of systemic racism and complex trauma experienced by people of color.

In North Carolina, it has taken intentionality to mitigate the effects of the COVID-19 Pandemic, particularly, the disproportionate impact of the virus on Black and Brown communities. As the North Carolina Department of Health & Human Services sought to intervene, we recognized that without incorporating trusted voices who represent the individuals that we seek to assist, we will lack credibility and full engagement will be difficult, if not impossible. Historically marginalized communities--whether marginalized due to race, ethnicity, or diagnosis—are simply looking for a collaborative partner, who will value their expertise and life experience. We have the resources to build a more equitable system. If we do not build equity into our mental health and substance use programs and practices, we will ultimately fail the most powerless and vulnerable. I will leave you with one final thought: mental health and substance use transcends barriers, divides, and differences. People from all walks of life are dying every day from suicide or overdose. Mental health and substance use does not see race, culture, or ethnicity. The same cannot be said of our treatment system. It is time that we fix our system to serve the diverse communities in our nation. Thank you for your time.