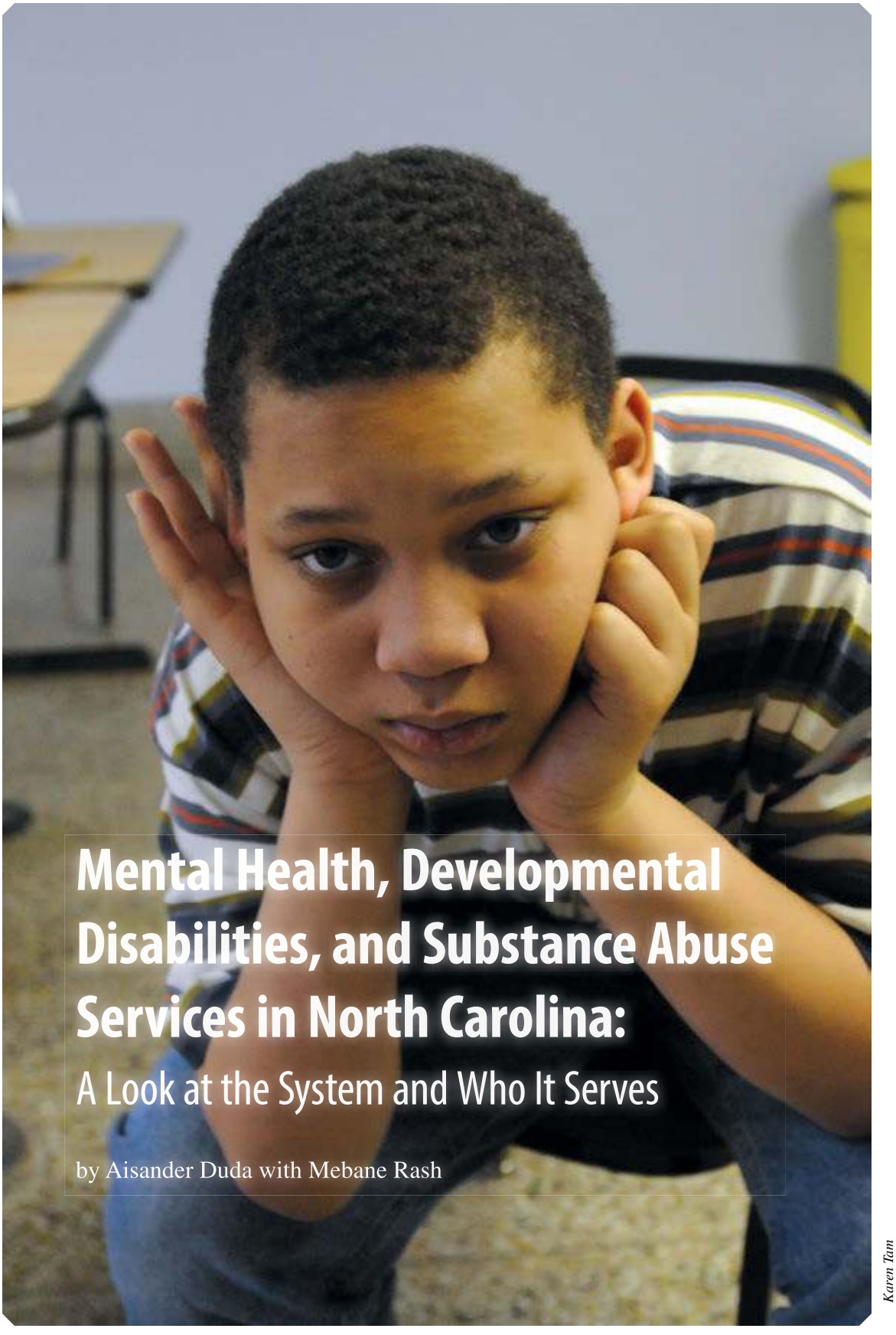

Mental Health, Developmental Disabilities, and Substance Abuse Services in North Carolina:

A Look at the System and Who It Serves

by Aisander Duda with Mebane Rash

Karen Tam

Executive Summary

In North Carolina, there are 1.37 million people in need of mental health, developmental disability, and/or substance abuse (MH/DD/SA) services—almost 14 percent of the state population. Of those, 609,087 need mental health services, 122,813 need developmental disability services, and 639,512 need substance abuse services. There are 313,910 children in need of services. These numbers are calculated by the N.C. Division of MH/DD/SAS using national estimates of prevalence—the occurrence of chronic and serious mental health, developmental disabilities, and substance abuse problems in the population—and then applying them to North Carolina's population.

To evaluate access to mental health treatment, it also is important to look at the number of people that received services through the state's *public* system of care. Overall, the state treated 52 percent of adults needing mental health services, 40 percent of adults needing services for developmental disabilities, and 12 percent of adults needing substance abuse services. In fiscal year 2010–11, the state's system treated 372,995 people: 360,180 (97 percent) were served in the community, and 12,815 (3 percent) were served in state-operated facilities.

State-Operated Facilities for the Treatment of MH/DD/SA

State Psychiatric Hospitals:

Treating People with Mental Illness

The state operates 14 facilities serving the MH/DD/SAS population in North Carolina. There are three psychiatric hospitals: Broughton Hospital in Morganton, Central Regional Hospital in Butner, and Cherry Hospital in Goldsboro.

The three state psychiatric hospitals served 5,754 people in FY 2010–11. Of those served, Broughton Hospital treated 1,352 people; Central Regional Hospital treated 2,119 people; Cherry Hospital treated 1,563 people; and Dorothea Dix Hospital in Raleigh treated 720 people before it closed.

Developmental Centers:

Treating People with Intellectual and Developmental Disabilities

There are three state-operated developmental centers that treat those with profound or severe mental retardation or related developmental disabilities: Caswell Developmental Center in Kinston, J. Iverson Riddle Developmental Center in Morganton, and Murdoch Developmental Center in Butner. In FY 2010–11, the facilities served 1,355 people, including 1,312 residents and 43 people in respite beds. The Caswell Center served 417 people, the Riddle Center served 337, and the Murdoch Center served 601.

The Neuro-Medical Treatment Centers:
Treating People with Disabilities Needing Long-Term Care

There are three state-operated neuro-medical treatment centers, serving 1,000 disabled adults needing long-term care in FY 2010–11: Black Mountain Neuro-Medical Center serving 426 people, O'Berry Neuro-Medical Center in Goldsboro serving 299, and Longleaf Neuro-Medical Treatment in Wilson serving 275.

Alcohol & Drug Abuse Treatment Centers:
Treating People Addicted to Alcohol or Drugs

North Carolina has three state-operated alcohol and drug abuse treatment centers (ADATCs) that treated 4,590 people in FY 2010–11 for alcohol or drug addictions: Julian F. Keith ADATC in Black Mountain serving 1,610 people; R.J. Blackley ADATC in Butner serving 1,296; and Walter B. Jones ADATC in Greenville serving 1,684.

Residential Programs for Children:
The Wright and Whitaker Schools

There are two state-operated facilities that offer residential programs for children with serious emotional and behavioral disorders: the Wright School in Durham serving 62 children, and the Whitaker School in Butner serving 54 children. The Wright School provides residential mental health treatment for children aged 6–12. The Whitaker School is a long-term treatment program for emotionally handicapped adolescents aged 13–17. The Whitaker School has been converted into a psychiatric residential treatment facility (PRTF) so that services provided there will be covered by Medicaid.

Community-Based Services for the Treatment of MH/DD/SA

Local management entities (LMEs) are the agencies responsible for managing, coordinating, facilitating, and monitoring the provision of mental health, developmental disability, and substance abuse services in the area served. LME responsibilities include offering consumers access to services 24 hours a day, seven days a week, 365 days a year, as well as developing and overseeing providers and handling consumer complaints and grievances. They are the basic building block for the state's provision of community-based services, providing referrals to both public and private providers of care.

In 2010–11, there were 23 LMEs statewide serving 360,180 people. Of those served in the community, 257,364 were mentally ill; 20,637 had developmental disabilities; and 82,179 were treated for substance abuse. Many LMEs are in flux

as they merge into the 11 managed care organizations (MCOs) that are expected to exist after the state's implementation of a federal waiver of Medicaid regulations governing mental health services.

Leza Wainwright knows North Carolina's mental health system inside and out. In August 2010, she retired from her position as Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services after working in the Division for almost 27 years. She says, "The system served more than 140,000 more people in 2009 than in 1991 because the number of people with all three disabilities served in the community increased by more than 88 percent. This shift toward community services follows national trends and also creates a more consumer-friendly type of care. People can stay at home in their communities and receive most of the services they need."

Conclusion: Three Important Changes in the System over the Past 30 Years

As Wainwright looks back on her career in mental health in North Carolina, she sees three important changes: the consumer movement, the changes in local service delivery and management, and the evolving role of the state facilities. She believes that the consumer movement changed the provision of mental health services in this state. "Recovery is now the expected outcome for people with mental health and substance abuse issues. For people with developmental disabilities, the goals are self-determination and learning self-advocacy skills. Treatment plans have been replaced by Person Centered Plans, and . . . [c]onsumers' goals and dreams guide the plan."

Wainwright says that 30 years ago, practically all community mental health and substance abuse services in North Carolina were delivered by area mental health programs that were part of local governments. She says, "The state's reform plan, which changed the area programs from service providers to managers of the system at the local level, created a good environment for the growth of private providers. Now there are literally thousands of providers. This has given people needing services a greater choice of provider agencies and has made access to services easier. It also has increased concerns about the quality of the services being delivered since the system is challenged to monitor such a large provider community effectively. And, it has made the system more complicated for some people since there are so many providers and since so many of them deliver only a few services."

The third change Wainwright notes is the role of the state facilities. In 1991, a large number of the people served by the mental health, developmental disability,

and substance abuse services system still were being served in state institutions. "That has changed dramatically over the past 30 years," says Wainwright. "In 2009, the number of people with developmental disabilities served in the state developmental centers had decreased since 1991 by more than 53 percent. The number of people with mental illness and substance use disorders served in state psychiatric hospitals decreased by more than 10 percent over the same period."

But advocates think this paints too rosy a picture. Vicki Smith is the Executive Director of Disability Rights NC, a nonprofit advocacy agency working to protect the right of individuals with mental illness or developmental disabilities. She says, "While I agree with the concept of the system being owned by the people it serves, the current system lacks the infrastructure to support such a concept. Unfortunately, the bag with the pretty bow tied around it that was handed to consumers is empty." Advocates say it is extremely hard to find providers willing to treat the most difficult consumers, and because of the lack of appropriate community-based treatment, many people with acute needs are stuck in limbo—between poor ongoing support and inadequate or non-existent crisis services.

The mental health system in North Carolina is anything but static. The changes in the system can be seen in the numbers of those served and where they are served, but also in the experiences—good and bad—of the consumers.

Editor's Note: A longer version of this article was published online in March 2011. It is available at *http://www.nccppr.org/drupal/content/insightarticle/4072/mental-health-developmental-disabilities-and-substance-abuse-services-in*

Leza Wainwright knows North Carolina's mental health system inside and out. In August 2010, she retired from her position as Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services after working in the Division for almost 27 years.

Wainwright says, "The biggest change I have seen over my career is the increased ownership of the system by the people it serves. It should have always been that way, but it wasn't. Too often, those served were viewed as people who had to be protected. Consumers were not encouraged to be active participants in their own treatment. Treatment plans focused on the individual's symptoms or problems, rather than their strengths and goals. The consumer movement changed all of that. The mission of the system now is to support consumers in living, working, and playing in communities of *their* choice."

But advocates think that paints too rosy a picture. Vicki Smith is the Executive Director of Disability Rights NC, a nonprofit advocacy agency working to protect the right of individuals with mental illness or developmental disabilities. She says, "While I agree with the concept of the system being owned by the people it serves,

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Aisander Duda is a policy analyst and writer living in Durham, N.C. During the day, he works as the Center's development director.

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Debra Dihoff, Executive Director of the National Alliance on Mental Illness–North Carolina, says that though everyone wants the system to be consumer-focused, it is not that way yet. She gives an example of a committee formed in 2010 to look at how long consumers have to wait before obtaining services. The committee included sheriffs, the North Carolina Council on Development Disabilities, providers, local management entities, and hospital association members. Dihoff says, "But where were the consumers and families most affected? No one thought to invite them."

The Number of People in Need of Mental Health Services in North Carolina

In North Carolina, there are 1.37 million people in need of mental health, developmental disability, and/or substance abuse (MH/DD/SA) services (see Table 1, p. 32)—almost 14 percent of the state population.[1] Of those, 609,087 need mental health services, 122,813 need developmental disability services, and 639,512 need substance abuse services. There are 313,910 children in need of services. These numbers are calculated by the Division using national estimates of prevalence—the occurrence of chronic and serious mental health, developmental disabilities, and substance abuse problems in the population—and then applying them to North Carolina's population.

To evaluate access to mental health treatment, it also is important to look at the number of people that received services through the state's *public* system of care. Overall, the state treated 52 percent of adults needing mental health services, 40 percent of adults needing services for developmental disabilties, and 12 percent of adults needing substance abuse services (see Table 1, p. 32). In fiscal year 2010–11, the state's system treated 372,995 people: 360,180 (97 percent) were served in the community, and 12,815 (3 percent) were served in state-operated facilities (see Table 2, pp. 36–37).[2]

There are concerns about how the state counts the numbers of those served in the community compared to those served in state-operated facilities. Vicki Smith of Disability Rights NC says, "The state includes in their community numbers those treated at psychiatric residential treatment facilities (PRTFs), for example. Advocates contend such facilities are more like institutions. PRTFs hardly seem like community placements since many of them are locked facilities." Also in question are adult care homes. The U.S. Department of Justice has been investigating whether adult care homes in North Carolina are sufficiently integrated into the community to meet federal law. In response, state and federal officials have agreed to an 8-year plan to move people out of adult care homes and into the community.

Reprinted with permission

"Yes, yes—angst, indefinable cravings, sleeplessness, weltschmerz, and occasional outbursts of rage. Just something that's going around."

Mark Long: From State Hospitals to Community-Based Treatment

by Aisander Duda

Mark Long also has seen it all in his 30 years as a consumer of mental health services in North Carolina. He has been admitted to every state psychiatric hospital. He has lived in group homes and on the street. Mark has tried nearly every treatment available, often enduring painful side effects.

Diagnosed with paranoid schizophrenia as a young man, Mark spent most of the 1970s and 1980s in and out of psychiatric hospitals. He says, "I felt like a yo-yo. I would bounce into one situation, and then I would bounce back out. I went from being in a hospital to being back in the community every few months."

After making a third attempt to take his own life, Mark left the family care home where he was living, walked down the street, and found Residential Treatment Services of Alamance in Burlington. He was placed in the Bellshire Apartments in Greensboro, a community of individuals disabled by chronic mental illness. With the help of his apartment coordinator, he began to maintain his own medications and appointments. He even worked with the Division of Motor Vehicles to obtain a driver's license.

> *"I felt like a yo-yo. I would bounce into one situation, and then I would bounce back out."*

After he learned to live independently, Mark decided to attend UNC-Greensboro in 2007, graduating with a degree in social work in May 2009. At the same time, Mark became one of the first Peer Support Specialists in our state. These specialists are people in recovery from mental illness or substance abuse who provide support to others by sharing their experiences. In July 2012, there were 695 certified Peer Support Specialists in North Carolina.

Mark says, "To the people I work with, I can be as important as someone with a master's degree in social work or a psychiatrist. It's my life and experiences that allow me to connect with consumers in a different way and offer the kind of help another professional can't." Mark Long finally has found the right treatment, a place to call home, and a vocation.

David Swann is the chief clinical officer for Partners Behavioral Health Management and former director of Crossroads Behavioral Healthcare, the local management entity serving Iredell, Surry, and Yadkin counties. He says the data used to show the number of people served in the community does not demonstrate the full scope of those treated. Swann explains that reports do not capture the actual number served because some services provided to consumers in the community are not reported. There are codes for each service provided, and if a code does not exist for a service then it cannot be submitted for payment and thus recorded.

At the Crossroads program, anywhere from 20 to 30 percent of the total services provided are delivered to consumers and paid for without data being submitted because no code exists for the service. Crossroads receives slightly more than $900,000 in county funds, and these dollars are used to provide critical services that are not authorized by the state or Medicaid. For example, a six-bed transitional housing program provides shelter and care to keep people in the community, and it lowers the readmission rate to hospitals. Recovery services are offered at three education centers, helping consumers learn to manage their illness while providing access to care. And, provider organizations deliver psychiatric care by using resident physicians from Wake Forest University Baptist Medical Center. Swann says, "These services are essential to the system of care within our community; however no service code exists for these services, and therefore, the services do not get reported or captured by the current state system."

Aisander Duda

State-Operated Facilities for the Treatment of MH/DD/SA

State Psychiatric Hospitals: Treating People with Mental Illness

The state operates 14 facilities serving the MH/DD/SAS population in North Carolina (see Figure 1). There are three psychiatric hospitals: Broughton Hospital in Morganton, Central Regional Hospital in Butner, and Cherry Hospital in Goldsboro.[3] Generally, with state facilities, the goal is to have one in the West, one in the Piedmont, and one in the East.

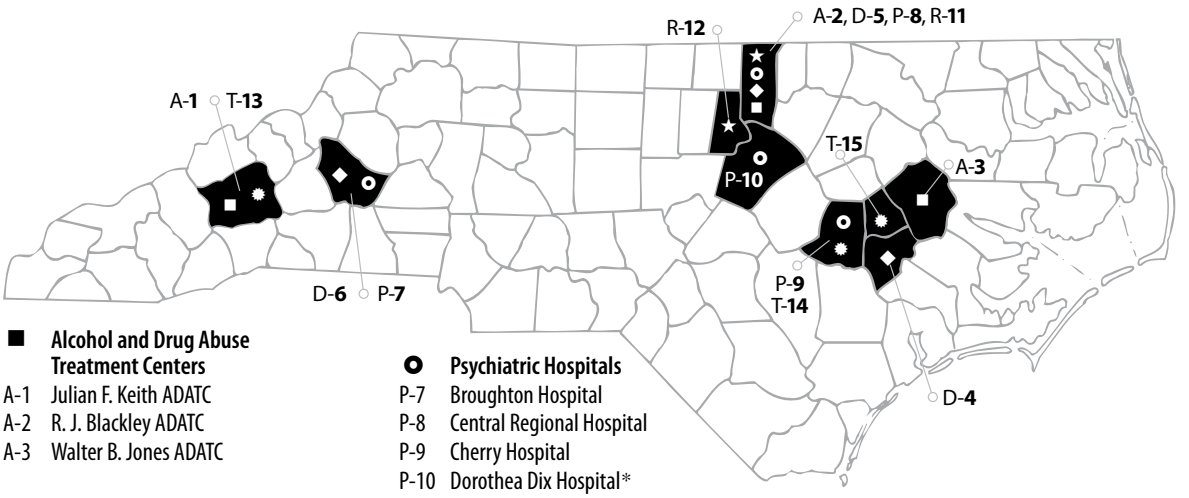
An April 1, 2012 report to the Joint Legislative Oversight Committee on Health and Human Services notes, "In most other states, acute care is provided in community hospitals, reserving the use of state psychiatric hospitals for consumers needing long-term care. North Carolina, however, has historically served more people overall in its state psychiatric hospitals than other states and with shorter average lengths of stay."[4] Of the care provided at North Carolina's state psychiatric hospitals, 21 percent

Table 1. Number of People in N.C. in Need of Mental Health, Developmental Disability, and Substance Abuse Services, by Age and Disability, 2011

Disability	Numbers of Persons in Need	Percent of People in Need Served by the System
Mental Health	**609,087**	
Adults	401,860	52%
Children	207,227	56%
Developmental Disabilities	**122,813**	
Adults	60,398	40%
Children	62,415	21%
Substance Abuse	**639,512**	
Adults	595,244	12%
Children	44,268	10%
TOTAL	**1,371,412**	

Source: N.C. Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "Semi-Annual Report to the Joint Legislative Oversight Committee on Health and Human Services," Statewide System Performance Report, SFY 2011–12, Spring Report, Raleigh, NC, April 1, 2012, Table 1.1.a, p. 6, and Table 1.1.b, p. 7. The numbers of persons in need is calculated based on N.C. Office of State Budget and Management (OSBM) State Demographics Unit, July 2011, population projection data. These numbers are calculated by the Division using national estimates of prevalence – the occurrence of chronic and serious mental health, developmental disabilities, and substance abuse problems in the population – and then applying them to North Carolina's population. The percent of people in need served by the system is calculated using Medicaid and State Service Claims Data from July 1, 2010 to June 30, 2011.

Figure 1. State of North Carolina Facilities for Treatment of MH/DD/SAS



■ **Alcohol and Drug Abuse Treatment Centers**
A-1 Julian F. Keith ADATC
A-2 R. J. Blackley ADATC
A-3 Walter B. Jones ADATC

◆ **Developmental Centers**
D-4 Caswell Developmental Center
D-5 Murdoch Developmental Center
D-6 J. Iverson Riddle Developmental Center

O Psychiatric Hospitals
P-7 Broughton Hospital
P-8 Central Regional Hospital
P-9 Cherry Hospital
P-10 Dorothea Dix Hospital*

★ **Residential Programs for Children**
R-11 Whitaker School
R-12 Wright School

✹ **Neuro-Medical Treatment Centers**
T-13 Black Mountain
T-14 Longleaf
T-15 O'Berry

**Dix Hospital has transferred most of its services to Central Regional Hospital.*

is for a stay of seven days or less, 41 percent is for stays between eight and 30 days, 35 percent is for stays between 30 and 365 days, and 3 percent is for a stay longer than one year (see Figure 2).

The state psychiatric hospitals served 16,789 people in FY 1999–2000, which increased to 18,498 in FY 2006–07, before declining to 5,754 in FY 2010–11 (see Figure 3, p. 38). Wainwright, the former Director of the Division, says the long-term drop in the number of consumers served is due to several factors, including a conscious effort early in the days of mental health reform to close 535 state hospital beds and move patients into the community, as well as the subsequent closure of adult admissions beds at Cherry and Broughton Hospitals due to certification issues with the federal government for Medicaid.[5] Of those served in FY 2010–11, Broughton Hospital treated 1,352; Central Region Hospital treated 2,119; Cherry Hospital treated 1,563 people; and Dorothea Dix Hospital in Raleigh treated 720 before it closed.[6]

Wainwright says, "People do not fit into single categories. Many people with mental illness also have substance abuse challenges, individuals with developmental disabilities sometimes also have behavioral issues, and people with all three types of disabilities have physical health care needs. The system has had to change what it *—continues on page 36*

SFY 2011–12

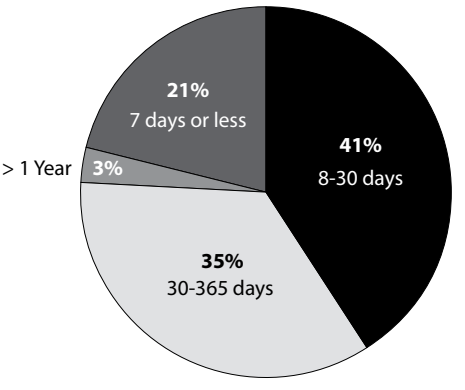


Figure 2.
Length of Stay for Consumers in State Psychiatric Hospitals

Source: N.C. Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "Semi-Annual Report to the Joint Legislative Oversight Committee on Health, and Human Services," Statewide System Performance Report, SFY 2011–12, Spring Report, Raleigh, NC, April 1, 2012, Table 3.2.a, p. 14.

Broughton Hospital in Morganton

Aisander Duda

The new Central Regional Hospital in Butner

—*continued from page 33*

does to be able to serve the whole person. There is a greater emphasis on multiple diagnoses and collaboration between primary health care providers and specialty mental health providers."

But Vicki Smith of Disability Rights NC says that the state hospitals don't do a good job of cross disability care. She says, "Cherry Hospital, for example, could not treat a dual diagnosed patient (mental retardation and mental illness) showing aggression. And, the hospitals don't regularly even screen for substance abuse issues, let alone provide treatment or programming for substance abuse."

Table 2. Number of People Served by the N.C. Mental Health System, State-Operated Facilities and Local Management Entities (LME), 2011

State-Operated Facilities	Subtotal 12,815
State Psychiatric Hospitals	**5,754** [a]
Developmental Centers	**1,355** [b]
Resident	1,312
Respite Care	43
Neuro-Medical Treatment Centers	**1,000** [c]
Alcohol & Drug Abuse Treatment Centers (ADATCs)	**4,590** [d]
Residential Programs for Children	**116** [e]
Whitaker School	54
Wright School	62

Notes:

[a] Jeannette Barham, "Annual Statistical Report, North Carolina Psychiatric Hospitals, Fiscal Year 2011," Division of MH/DD/SAS, Raleigh, NC, Jan. 2012, Table 1, p. 3.

[b] Jeannette Barham, "Annual Statistical Report, North Carolina State Developmental Centers, Fiscal Year 2011," Division of MH/DD/SAS, Raleigh, NC, Jan. 2012, Table 1, p. 3.

[c] Jeannette Barham, "Annual Statistical Report, Black Mountain Neuro-Medical Center, O'Berry Neuro-Medical Center, Longleaf Medical Center, Fiscal Year 2011," Division of MH/DD/SAS, Raleigh, NC, Jan. 2012, Table 2-A, p. 7.

[d] Jeanette Barham, "Annual Statistical Report, North Carolina Alcohol & Drug Abuse Treatment Centers, Fiscal Year 2011," Division of MH/DD/SAS, Raleigh, NC, Jan. 2012, Table 2, p. 4.

[e] Jeannette Barham, "Annual Statistical Report, Wright and Whitaker Residential Programs for Children, Fiscal Year 2011," Division of MH/SS/SAS, Raleigh, NC, Jan. 2012, Table 2-A, p. 6.

[f] Jeannette Barham, "North Carolina LMEs, Annual Statistics and Admission Report, Fiscal Year 2011," Division of MH/DD/SAS, Raleigh, NC, Jan. 2012, Table 2, p. 6.

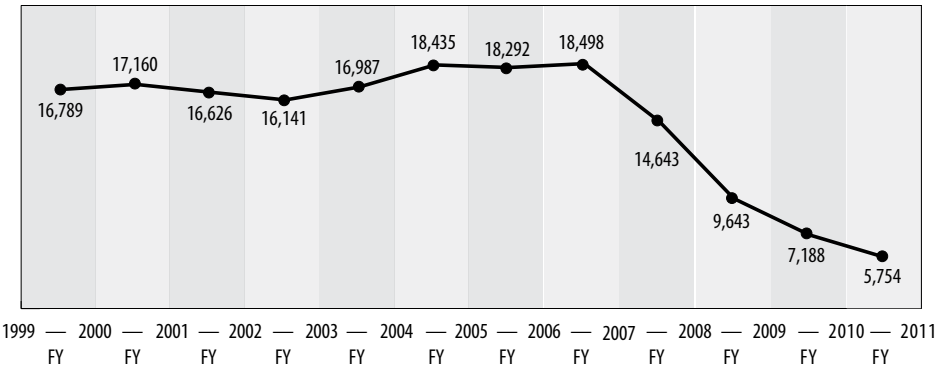
[g] In 2012, Piedmont Behavioral Healthcare (PBH) became Cardinal Innovations Healthcare Solutions.

[h] Treatment Accountability for Safer Communities. TASC provides care management services to people with substance abuse or mental illness who are involved in the justice system.

Table 2. Number of People Served by the N.C. Mental Health System, State-Operated Facilities and Local Management Entities (LME), 2011, *continued*

Community-Based Treatment: Local Management Entities	Subtotal 360,180 [f]
1. Alamance-Caswell LME	7,258
2. Beacon Center LME	5,832
3. CenterPoint LME	14,410
4. Crossroads LME	7,968
5. Cumberland LME	10,182
6. Durham LME	10,460
7. East Carolina Behavioral Healthcare LME	25,646
8. Eastpointe LME	62,780
9. Five County LME	6,455
10. Guilford LME	15,961
11. Johnston LME	5,240
12. Mecklenburg LME	25,144
13. Mental Health Partners LME	7,777
14. Onslow-Carteret LME	3,017
15. Orange-Person-Chatham LME	7,649
16. Pathways LME	15,901
17. Piedmont Behavioral Healthcare LME [g]	12,440
18. Sandhills LME	19,377
19. Smoky Mountain LME	17,211
20. Southeastern Center LME	10,299
21. Southeastern Regional LME	8,277
22. Wake LME	19,443
23. Western Highlands LME	17,837
TASC [h] Region 1	7,247
TASC Region 2	5,741
TASC Region 3	6,140
TASC Region 4	4,488
Total Served by the N.C. Mental Health System	**372,995**

Figure 3. Number of People Served in State Psychiatric Hospitals, Fiscal Year (FY) 1999–2000 through 2010–2011



Source: Jeannette Barham, "Annual Statistical Report, North Carolina Psychiatric Hospitals, Fiscal Year 2011," Division of MH/DD/SAS, Raleigh, NC, Jan. 2012, Graph 1, p. 4. The state's fiscal year runs from July 1 to June 30.

Developmental Centers:

Treating People with Intellectual and Developmental Disabilities

There are three state-operated developmental centers that treat those with profound or severe mental retardation or related developmental disabilities: Caswell Developmental Center in Kinston, J. Iverson Riddle Developmental Center in Morganton, and Murdoch Developmental Center in Butner. In FY 1998–99, the three facilities served 2,409 people, with 2,136 residents and 273 people in respite care beds.[7] Over a decade later in FY 2010–11, the facilities served just 1,355 people, including 1,312 residents and 43 people in respite beds. The Caswell Center served 412 people, the Riddle Center served 337, and the Murdoch Center served 601.

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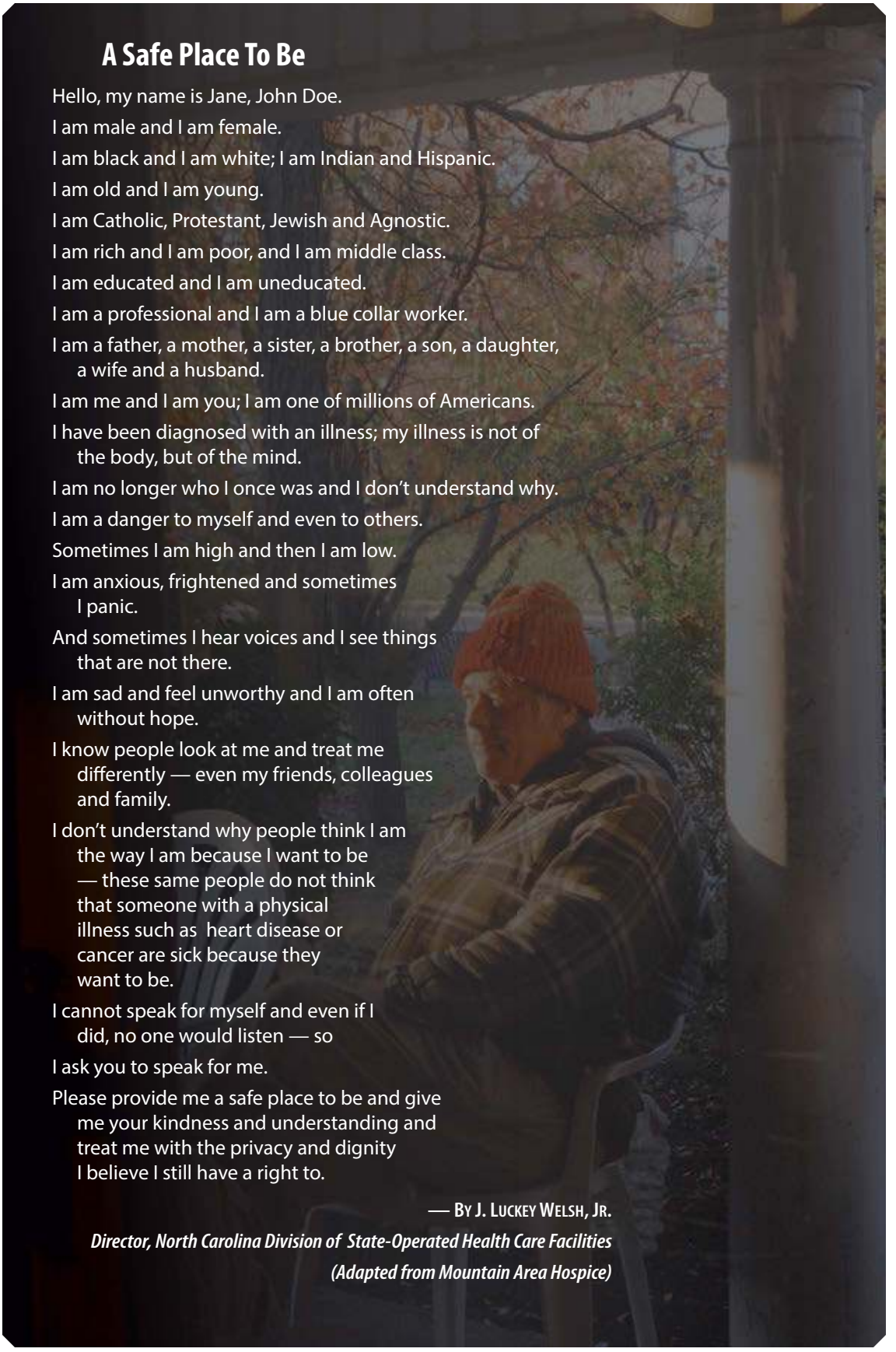
At the Riddle Developmental Center in Morganton

Aisander Duda



A Safe Place To Be

Hello, my name is Jane, John Doe.

I am male and I am female.

I am black and I am white; I am Indian and Hispanic.

I am old and I am young.

I am Catholic, Protestant, Jewish and Agnostic.

I am rich and I am poor, and I am middle class.

I am educated and I am uneducated.

I am a professional and I am a blue collar worker.

I am a father, a mother, a sister, a brother, a son, a daughter, a wife and a husband.

I am me and I am you; I am one of millions of Americans.

I have been diagnosed with an illness; my illness is not of the body, but of the mind.

I am no longer who I once was and I don't understand why.

I am a danger to myself and even to others.

Sometimes I am high and then I am low.

I am anxious, frightened and sometimes I panic.

And sometimes I hear voices and I see things that are not there.

I am sad and feel unworthy and I am often without hope.

I know people look at me and treat me differently — even my friends, colleagues and family.

I don't understand why people think I am the way I am because I want to be — these same people do not think that someone with a physical illness such as heart disease or cancer are sick because they want to be.

I cannot speak for myself and even if I did, no one would listen — so

I ask you to speak for me.

Please provide me a safe place to be and give me your kindness and understanding and treat me with the privacy and dignity I believe I still have a right to.

— By J. Luckey Welsh, Jr.

Director, North Carolina Division of State-Operated Health Care Facilities

(Adapted from Mountain Area Hospice)

Karen Tam

Joshua Stuart: A Developmentally-Disabled Child in Search of Treatment

by Mebane Rash with Karen Tam

Joshua Stuart is autistic. He has an IQ of 36, and he can only speak a few words, like "Ma" and "hurt." After he violently attacked his mother and little brother at home when he was 13 years old, Joshua spent eight days at Wake County Mental Health Services, his local management entity, waiting for a bed to open up. He slept in a chair. He did not have access to a shower.

At the time, there were open beds at Central Regional Hospital. There were only 13 children there, and they have the capacity for 34. But there were not enough workers to care for Joshua. After his eight-day wait, he was transferred to Broughton Hospital in Morganton, 200 miles west of Raleigh. It was the first time he had ever been away from his mother for more than two days. Then he was moved to the Murdoch Developmental Center in Butner in the PATH program—Partners for Autism Treatment and Habilitation.

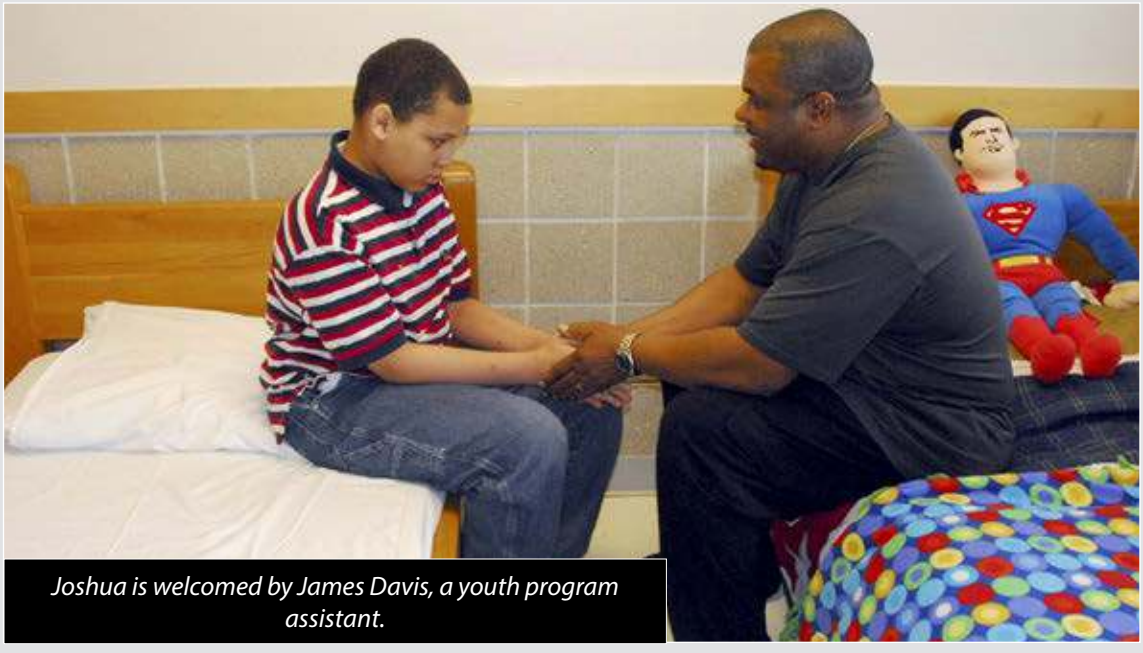
This program is designed to serve children from ages six to 16 with autism spectrum disorder and serious behavioral challenges. The goal is to reduce behavior problems and to promote positive social skills. Joshua's treatment includes person-centered teaching in the areas of self-help, education, communication, and recreation, as directed by the interdisciplinary team of professionals working with him.

Joshua spent six hours each day in 30-minute classes learning everything from new words to daily living skills. With only four children per class, each child has an individualized education and therapy plan. The staff at the Murdoch Center closely follow the progress of each child, monitoring everything from sleep schedules to diet and nutrition to changes in a child's daily completion of basic tasks (e.g., brushing teeth and getting dressed). Some of the children in the PATH program go to classes at the Butner-Stem Middle School, giving them an opportunity to learn tasks and activities in a regular school setting. Other children receive educational services at the Murdoch Center. It depends on the needs of the child. Joshua was discharged, and he now lives back in the community.

The family is greeted by the staff, including Aleck Myers, the Director of the Murdoch Developmental Center.

Joshua with his parents, arriving at Murdoch Developmental Center in Butner.

Joshua laughing with his dad, Antonio Stewart.



Joshua is welcomed by James Davis, a youth program assistant.

Joshua's parents, Salima Mabry and Antonio Stewart, are surrounded by 16 staff members in a meeting room. They ask questions about Joshua's needs, wants, likes, and dislikes.

Karen Tam

—continued from page 38

The Neuro-Medical Treatment Centers:
Treating People with Disabilities Needing Long-Term Care

There are three state-operated neuro-medical treatment centers, serving 1,000 people with disabilities needing long-term care in FY 2010–11: Black Mountain Neuro-Medical Center serving 426 people, O'Berry Neuro-Medical Center in Goldsboro serving 299, and Longleaf Neuro-Medical Treatment in Wilson serving 275.[8] The Black Mountain Center serves those with lifelong disabilities and those diagnosed with Alzheimer's disease.[9] The O'Berry Center was the first institution in N.C. for African Americans with mental retardation, and now it serves those with developmental disabilities in need of long-term care.[10] Longleaf Neuro-Medical Treatment Center serves adults with severe and persistent mental illness with long-term medical conditions requiring residential, medical, and nursing care. The Center also serves adults with a diagnosis of Alzheimer's or dementia who are unable to be treated in a traditional nursing home setting because of assaultive and combative behavior.[11]

Alcohol & Drug Abuse Treatment Centers:
Treating People Addicted to Alcohol or Drugs

North Carolina has three state-operated alcohol and drug abuse treatment centers (ADATCs) that treated 4,590 people in FY 2010–11 for alcohol or drug addictions: Julian F. Keith ADATC in Black Mountain serving 1,610 people; R.J. Blackley ADATC in Butner serving 1,296; and Walter B. Jones ADATC in Greenville serving 1,684.[12]

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Figure 4. Local Management Entities (LMEs) and Their Member Counties, as of July 1, 2010

Unless otherwise indicated, the LME name is the county name(s).

Source: N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

Residential Programs for Children:
The Wright and Whitaker Schools

There are two state-operated facilities that offer residential programs for children with serious emotional and behavioral disorders: the Wright School in Durham serving 62 children (see p. 45), and the Whitaker School in Butner serving 54 children.[13] The Wright School provides residential mental health treatment for children aged 6–12.[14] The Whitaker School is a long-term treatment program for emotionally handicapped adolescents aged 13–17.[15]

Community-Based Services for the Treatment of MH/DD/SA: Local Management Entities

Local management entities (LMEs) are the agencies responsible for managing, coordinating, facilitating, and monitoring the provision of mental health, developmental disability, and substance abuse services in the area served. LME responsibilities include offering consumers access to services 24 hours a day, seven days a week, 365 days a year, as well as developing and overseeing providers, and handling consumer complaints and grievances.[16] They are the basic building blocks for the state's provision of community-based services, providing referrals to both public and private providers of care. Vicki Smith of Disability Rights NC says that although LMEs are supposed to provide screening, triage,[17] and referral 24 hours a day, seven days a week, there is nothing that actually requires the provision of treatment services around the clock.

In 2010–11, there were 23 LMEs statewide serving 360,180 people, a 46 percent increase since 2001 (see Figure 4 above and Figure 5, p. 47). Of these, 23,616 were served by TASCs (Treatment Accountability for Safer Communities), which provides care management services to people with substance abuse or mental illness who are charged with or convicted of a crime.[18] Of those persons served in the community, 257,364 were mentally ill; 20,637 had developmental disabilities; and 80,179 were treated for substance abuse.[19] Many LMEs are in flux as they merge

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The Wright School: A Place for All Kinds of Faces

by Mebane Rash

Since 1964, the Wright School has been a place in North Carolina for more than 2,000 kids with all kinds of faces. Kids who are mad and scared. Kids who are exhausted and sad. Kids aged 6–12 with severe emotional and behavioral diagnoses. The state-operated residential treatment services provided at the Wright School in Durham enable these same kids to feel silly and happy, surprised and mischievous. They come for treatment, which is called re-education. The goal is not to cure them. Instead, the school provides each child and their caregivers with enough skills so the kids can move back home and go to school in their own communities.

A typical child at the Wright School has three psychiatric diagnoses, takes three psychotropic medications, and has had two hospitalizations in the previous year. The capacity of the school is 24 children. They serve three groups of eight children: the Olympians, the Royals, and the Eagles. In 2010–11, there were 37 admissions, and 62 children were served. The staff ratio is two staff for eight children.

> *CL is 10 and from Alamance County. He had seven hospitalizations between 2005 and 2009 prior to his admission to the Wright School. He is diagnosed with post-traumatic stress disorder, oppositional defiant disorder, and expressive language disorder. He takes Thorazine, Clonidine, Depakote, and Strattera. Prior to admission, he was being educated in a state psychiatric hospital school setting.*

> *JB is 10 and from Cumberland County. She had three hospitalizations between April 2009 and January 2010. She is diagnosed with bipolar disorder, mania with psychotic features, attention deficit hyperactivity disorder (ADHD), and oppositional defiant disorder. She is treated with Thorazine, Depakote, and Strattera. Prior to admission, she was educated in an alternative public school setting.*

“A typical child at the Wright School has three psychiatric diagnoses, takes three psychotropic medications, and has had two hospitalizations in the previous year.”

SC is 10 and from Durham County. He had five hospitalizations between September 2009 and March 2010. He is diagnosed with cyclothymia, ADHD, and oppositional defiant disorder. He takes Lithium, Depakote, Benztropine, Chlorpromazine, and Propranolol. He had three changes in his public school setting in the 2009–10 academic year.

The budget for the Wright School is $2.6 million annually. It is entirely funded with state dollars because it does not qualify for Medicaid. The cost per bed is $443.49—cheaper by the day and by the course of treatment than other residential options. The state leases the property for $1 each year from a private foundation.

The school's director, Deborah Simmers, has been there since 1984. On her watch, turnover among the psychiatrists has not been a problem, with only four in 28 years. In fact, most of the staff has worked at the Wright School a long, long time. Of the more than 40 employees, 70 percent have worked there five or more years. Two have been there for more than 30 years.

From 2006 to 2010, surveys' of parents' satisfaction with services averaged 90 percent or higher annually. There were no investigations into the care the Wright School provided in 2010.

"The treatment at the Wright School is so much more normalizing and less traumatic than other kinds of out-of-home care, like a hospital or a psychiatric residential treatment facility," says Simmers.

A study of the treatment provided by the school published in *Behavioral Disorders* in 2006 found that "children with very serious problems and from families facing multiple challenges… made substantial improvement and maintained much of this improvement for at least 6 months postdischarge."[1]

Glossary

These definitions are from the U.S. National Library of Medicine's A.D.A.M Medical Encyclopedia, available online at *http://www.ncbi.nlm.nih.gov/pubmedhealth/.*

- *Oppositional defiant disorder* is a pattern of disobedient, hostile, and defiant behavior toward authority figures.
- *Post-traumatic stress disorder* (PTSD) is a type of anxiety disorder. It can occur after you've seen or experienced a traumatic event that involved the threat of injury or death.
- Children with an *expressive language disorder* have problems using language to express what they are thinking or need.
- *Bipolar disorder* is a condition in which people go back and forth between periods of a very good or irritable mood and depression. The "mood swings" between mania and depression can be very quick.
- *Mania with psychotic features* is an abnormally elated mental state combined with a loss of touch with reality.
- *Attention deficit hyperactivity disorder* (ADHD) is one of the most common childhood disorders and can continue through adolescence and adulthood. Symptoms include difficulty staying focused and paying attention, difficulty controlling behavior, and hyperactivity (over-activity).
- *Cyclothymic disorder* is a mild form of bipolar disorder in which a person has mood swings over a period of years that go from mild depression to euphoria and excitement.

Endnote

[1] Elaine Fields, *et al.*, "Treatment and Posttreatment Effects of Residential Treatment Using a Re-education Model," *Behavioral Disorders*, Vol. 31, No. 3, Council for Children with Behavioral Disorders, May 2006, pp. 312–22.

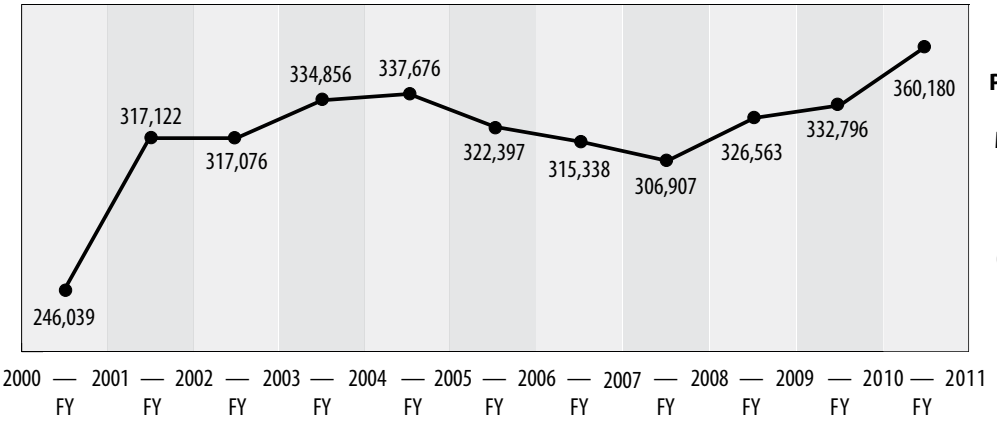

Figure 5. Number of People Served in Local Management Entities (LMEs), Fiscal Year (FY) 2000–01 through 2010–11

Source: Jeannette Barham, "North Carolina LMEs, Annual Statistics and Admission Report, Fiscal Year 2011," Division of MH/DD/SAS, Raleigh, NC, Jan. 2012, Graph 1, p. 4. The state's fiscal year runs from July 1 to June 30.

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into the 11 managed care organizations (MCOs) that are expected to exist after the state's implementation of a federal waiver of Medicaid regulations governing mental health services.

The system served more than 114,000 more people in the community in 2011 than in 2001 (see Figure 5). Wainwright says, "This shift toward community services follows national trends and also creates a more consumer-friendly type of care. People can stay at home in their communities and receive most of the services they need. The state facilities now play a very different role than they have in the past. They are no longer the first place people get treatment. Instead, they now are used for those people with special challenges and for difficult-to-serve populations."

But advocates do not agree. Says Vicki Smith of Disability Rights NC, "State facilities can be used for people with special challenges and for difficult-to-serve populations, but the lack of an appropriate continuum of care in the community results in many institutionalizations for individuals more appropriately served in the community—if appropriate services were available. In fact, due to the lack of appropriate community-based treatment, many people with acute needs are stuck in limbo—between poor ongoing support and inadequate or in some areas non-existent crisis services. The result is long waits in hospital emergency departments. Crisis services are not available in adequate numbers throughout the state to maximize the potential to keep people out of the state facilities. There is no safety net for community services, particularly for adults with mental illness."

Conclusion: Three Important Changes in the System over the Past 30 Years

As Leza Wainwright looks back on her career in mental health in North Carolina, she sees three important changes: the consumer movement, the changes in local service delivery and management, and the evolving role of the state facilities. She says "Nothing about us, without us" is the rallying cry for consumers, and she believes that the consumer movement changed the provision of mental health services in this state. "Recovery is now the expected outcome for people with mental health and substance abuse issues. For people with developmental disabilities, the goals are self-determination and learning self-advocacy skills. Treatment plans have been replaced by Person Centered Plans, and when done correctly, the focus is on the services and supports that are important *for* the

"In Lincoln County, near a public road… is a log cabin strongly built and about 10 feet square, and about seven or eight feet high; no windows to admit light… no chimney indicates that a fire can be kindled within, and the small low door is securely locked and barred… You need not ask to what uses it is appropriated. The shrill cries of an incarcerated maniac will arrest you on the way… Examine the interior of this prison [and] you will see a ferocious , filthy, unshorn half-clad creature, wallowing in foul, noisome straw. The horrors of this place can hardly be imagined; the state of the maniac is revolting in the extreme…."

—Dorothea Dix

person *and* those that are important *to* the person. Consumers' goals and dreams guide the plan."

Wainwright says that 30 years ago, practically all community mental health and substance abuse services in North Carolina were delivered by area mental health programs. Consumer access and choice were limited by the number of clinicians working for the area program. She says, "The state's reform plan, which changed the area programs from service providers to managers of the system at the local level, created a good environment for the growth of private providers. Now there are literally thousands of providers. This has given people needing services a greater choice of provider agencies and has made access to services easier. It also has increased concerns about the quality of the services being delivered since the system is challenged to monitor such a large provider community effectively. And, it has made the system more complicated for some people since there are so many providers and since so many of them deliver only a few services."

The third change Wainwright notes is the role of the state facilities. In 1991, a large number of the people served by the mental health, developmental disability, and substance abuse services system still were being served in state institutions. "That has

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changed dramatically over the past 30 years," says Wainwright. "In 2009, the number of people with developmental disabilities served in the state developmental centers had decreased since 1991 by more than 53 percent. The number of people with mental illness and substance use disorders served in state psychiatric hospitals decreased by more than 10 percent over the same period."

The mental health system in North Carolina is anything but static. The changes in the system can be seen in the numbers of those served and where they are served, but also in the experiences—good and bad—of the consumers.

Endnotes

[1] N.C. Office of State Budget and Management (OSBM), Annual North Carolina Population Growth, July 2011. The state population was 9,735,890.

[2] Others pay for treatment themselves and are served through private providers.

[3] Dorothea Dix Hospital in Raleigh has stopped accepting new patients. Three units at Dix Hospital will be kept open: the Forensics Minimum Security Unit, Child Outpatient Services, and Clinical Research Outpatient Services. Most of the services have been transferred to Central Regional Hospital in Butner.

[4] N.C. Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "Semi-Annual Report to the Joint Legislative Oversight Committee on Health and Human Services," Statewide System Performance Report, SFY 2011–12, Spring Report, Raleigh, NC, April 1, 2012, Table 3.2.a, p. 14.

[5] In 1999, the U.S. Supreme Court handed down the *Olmstead* decision, which required states to place people with mental disabilities in the least restrictive setting possible and in community settings rather than in institutions. This decision led to mental health reform in all 50 states and in North Carolina to legislation called the Mental Health System Reform Act in the 2001 session of the General Assembly. See *Olmstead v. L.C.,* 527 U.S. 581, 119 S. Ct. 2176, 144 L.E.2d 540 (1999). See also N.C. Session Law 2001–437 (House Bill 381).

[6] Jeannette Barham, "Annual Statistical Report, North Carolina Psychiatric Hospitals, Fiscal Year 2011," Division of MH/DD/SAS, Raleigh, NC, Jan. 2012, Table 1, p. 3, and Table 2-A, p. 11.

[7] Jeannette Barham, "Annual Statistical Report, North Carolina State Developmental Centers, Fiscal Year 2011," Division of MH/DD/SAS, Raleigh, NC, Jan. 2012, Table 1, p. 3, and Table 2-A, p. 8.

[8] Jeannette Barham, "Annual Statistical Report, Black Mountain Neuro-Medical Center, O'Berry Neuro-Medical Center, Longleaf Medical Center, Fiscal Year 2011," Division of MH/DD/SAS, Raleigh, NC, Jan. 2012, Table 2A, p. 7.

[9] On the Internet at *http://www.bmcnc.org/body_bmc_home.htm,* accessed on Feb. 6, 2010.

[10] On the Internet at *http://www.ncdhhs.gov/mhddsas/oberry.htm,* accessed on Feb. 6, 2010.

[11] On the Internet at *http://www.longleafneuromedical.ncdhhs.gov/,* accessed on Feb. 6, 2010.

[12] Jeanette Barham, "Annual Statistical Report, North Carolina Alcohol & Drug Abuse Treatment Centers, Fiscal Year 2011," Division of MH/DD/SAS, Raleigh, NC, Jan. 2012, Table 3A, p. 7.

[13] Jeannette Barham, "Annual Statistical Report, Wright and Whitaker Residential Programs for Children, Fiscal Year 2011," Division of MH/SS/SAS, Raleigh, NC, Jan. 2012, Table 2-A, p. 6.

[14] On the Internet at *http://www.wrightschool.org/,* accessed on Feb. 6, 2010.

[15] On the Internet at *http://www.ncdhhs.gov/mhddsas/whitaker.htm,* accessed on Feb. 6, 2010. The Whitaker School has been converted by the state into a psychiatric residential treatment facility (PRTF) so that services provided there qualify for Medicaid. See the Joint Conference Committee Report on the Continuation, Expansion, and Capital Budgets, Senate Bill 897, June 28, 2010, p. G-2. Vicki Smith, Executive Director of Disability Rights NC, says the Whitaker School "doesn't have the staff to serve at that capacity (30 children)." She also notes that there is typically a waiting list of 30 to 60 kids at any given time. "There is no capacity to serve the neediest children," she says.

[16] N.C. Gen. Stat. § 122C-115.4.

[17] Triage is the process of determining which patients need to be treated first, based on their condition.

[18] According to the Treatment Accountability for Safer Communities website, "In North Carolina, TASC operates as a component of a community mental health/substance abuse service provider maintaining close relationships with their local criminal justice system, which refers eligible clients to TASC. Eligible clients are those who demonstrate a need for addiction treatment and/or mental health services and have been charged with or convicted of crimes eligible for intermediate or community punishments. Referrals come from the criminal courts, as well as community corrections." On the Internet at *http://www.dhhs.state.nc.us/mhddsas/tasc/files/TASCfactsheet07.pdf*, accessed Aug. 10, 2010.

[19] Jeannette Barham, "North Carolina LMEs, Annual Statistics and Admission Report, Fiscal Year 2011," Division of MH/DD/SAS, Raleigh, NC, Jan. 2012, Table 2, p. 6.

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