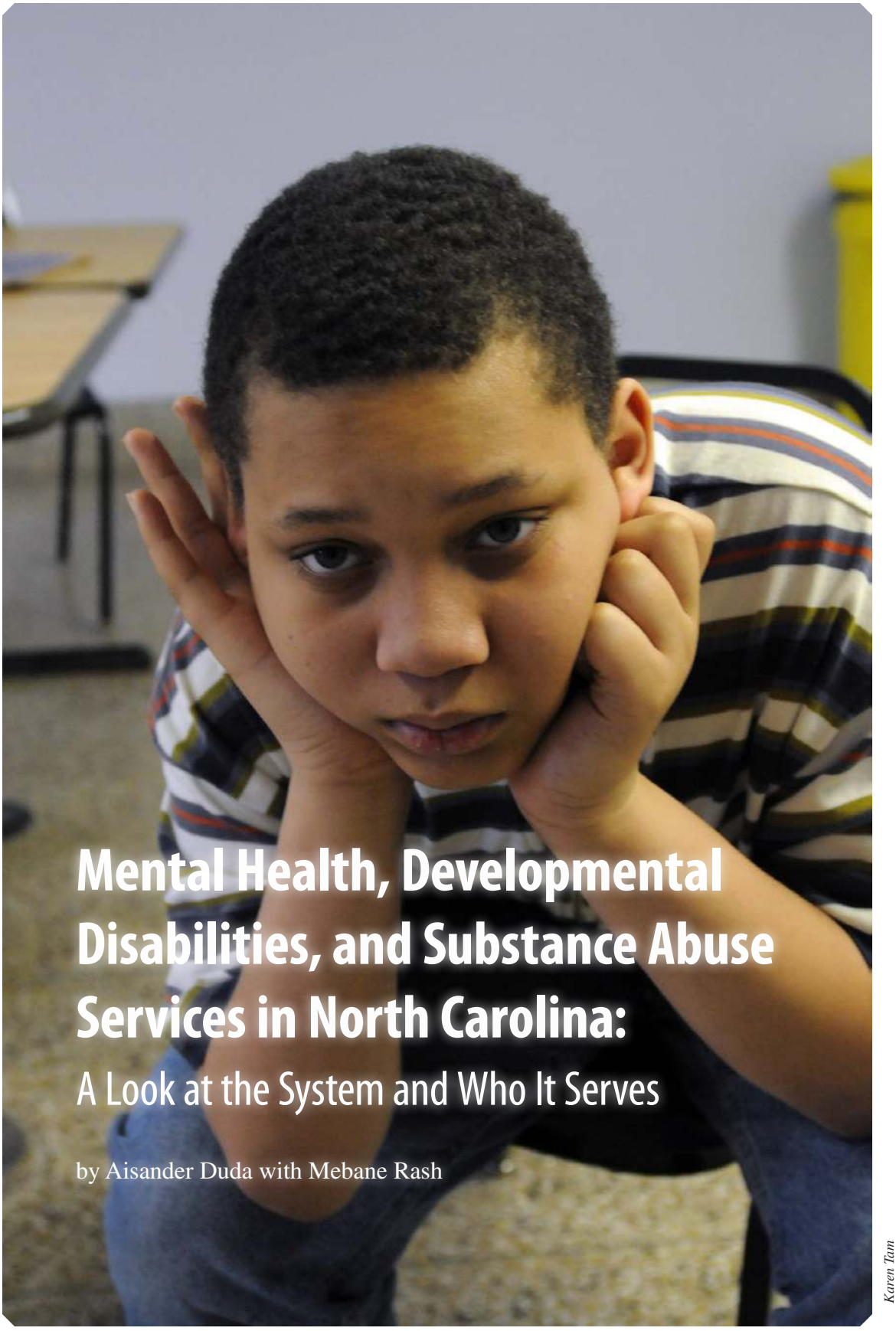


Mental Health, Developmental Disabilities, and Substance Abuse Services in North Carolina:

A Look at the System and Who It Serves

by Aisander Duda with Mebane Rash

Karen Tam

Executive Summary

In North Carolina, there are 1.27 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, 560,970 need mental health services, 106,356 need developmental disability services, and 606,867 need substance abuse services. There are 306,584 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 only 27 percent of those in need of mental health, developmental disability, and substance abuse services. In fiscal year 2009–10, the state's system treated 346,894 people: 332,796 (96 percent) were served in the community, and 14,098 (4 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 15 facilities serving the MH/DD/SAS population in North Carolina. There are four psychiatric hospitals: Broughton Hospital in Morganton, Central Regional Hospital in Butner, Cherry Hospital in Goldsboro, and Dorothea Dix Hospital in Raleigh. Dix Hospital has stopped accepting new patients, and it is scheduled to close.

The four state psychiatric hospitals served 7,188 people in FY 2009–10. Of those served, Cherry Hospital treated 1,780 people; Broughton Hospital treated 1,641 people; and Central Regional Hospital and Dix Hospital combined treated 3,767 people.

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 2009–10, the facilities served 1,375 people, including 1,338 residents and 37 people in respite beds. The Caswell Center served 464 consumers, the Riddle Center served 331, and the Murdoch Center served 580.

The Neuro-Medical Treatment Centers:

Treating People with Disabilities Needing Long-Term Care

There are three state-operated neuro-medical treatment centers, serving 958 disabled adults needing long-term care in FY 2009–10: Black Mountain Neuro-Medical Center serving 389 people, O'Berry Neuro-Medical Center in Goldsboro serving 300, and Longleaf Neuro-Medical Treatment in Wilson serving 269.

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 4,483 people in FY 2009–10 for alcohol or drug addictions: Julian F. Keith ADATC in Black Mountain serving 1,550 people; R.J. Blackley ADATC in Butner serving 1,186; and Walter B. Jones ADATC in Greenville serving 1,747.

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 63 children, and the Whitaker School in Butner serving 31 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.

Currently, there are 23 LMEs statewide. LMEs served 332,796 persons in FY 2009–10. Of those served in the community, 232,397 were mentally ill; 20,127 had developmental disabilities; and 80,272 were treated for substance abuse.

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."

Funding MH/DD/SAS Services in North Carolina

The funding for the public mental health system in North Carolina comes from Medicaid, state appropriations, county funds, and other sources. In FY 2008–09, the total budget was $3.3 billion dollars. Medicaid was the largest payer, contributing $2.3 billion; the state paid $709.6 million; and counties paid $118.8 million. Seventy-seven percent of the $3.3 billion was spent on community-based services, 21 percent was spent on state-operated facilities, and 1 percent was spent on state administration. In FY 2009–10, however, the budget included deep cuts to mental health programs to address a $4.6 billion state budget shortfall. Overall that year, the Division's budget was cut 19 percent. And, in FY 2010-11, $40 million in funding for community services administered through the LMEs was restored, but that was offset by changes in mental health services provided through the Medicaid program to save the state $98.7 million—resulting in lower rates for providers and fewer services for consumers.

Since 2005, the total budget for the Division of MH/DD/SAS has grown by 27.3 percent, with Medicaid registering the most growth of any funding source—a 33.4 percent increase and more than $750 million additional dollars. Funding for both state facilities and community services has increased by more than 20 percent, while funding for administration has declined by 2.8 percent.

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 41 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 effectively monitor such a large provider community. 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.

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, 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."

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 1.27 million people in need of mental health, developmental disability, and/or substance abuse (MH/DD/SA) services (see Table 1)—almost 14 percent of the state population.[1] Of those, 560,970 need mental health services, 106,356 need developmental disability services, and 606,867 need substance abuse services. There are 306,584 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 only 27 percent of those in need of mental health, developmental disability, and substance abuse services.[2] Just 9 percent of adults in need of substance abuse treatment receive state services (see Table 1).[3] In fiscal year 2009–10, the state's system treated 346,894 people: 332,796 (96 percent) were served in the community, and 14,098 (4 percent) were served in state-operated facilities (see Table 2).[4]

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. Whether adult care homes are sufficiently integrated into the community to meet federal law currently is being litigated in the United States Court of Appeals for the Second Circuit in *Disability Advocates, Inc., v. Paterson.*[5]

Aixander Duda

David Swann is the 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.

Mark Long: From State Hospitals to Community-Based Treatment

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.

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 January 2011, there were 281 certified Peer Support Specialists in North Carolina.

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

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. His community-based treatment is his community-based life.

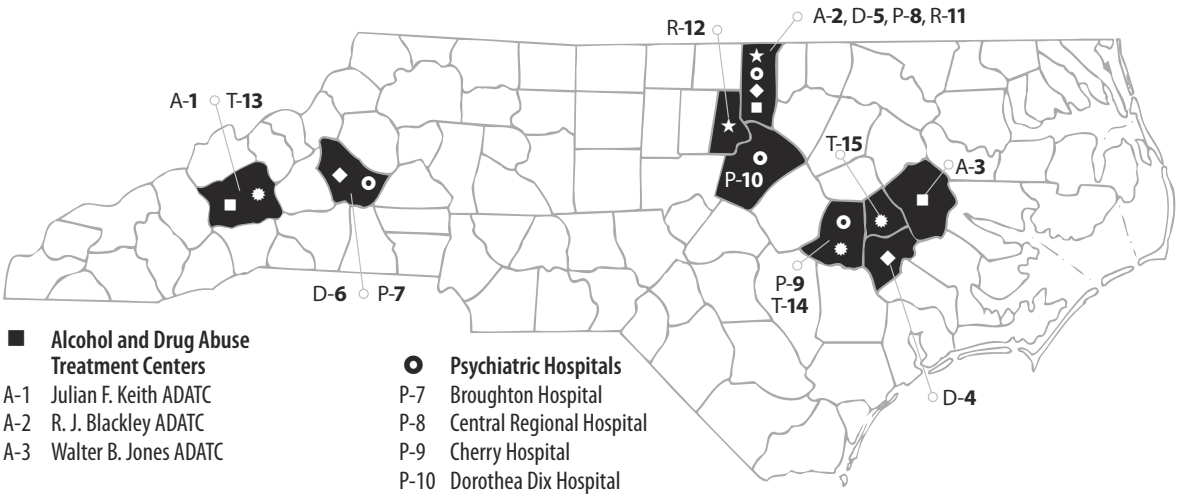
At the Crossroads program, anywhere from 20 to 30 percent of the total services provided are delivered to consumers and paid for without data being submitted because no code exists for the service. Crossroads receives slightly more than $900,000 in county funds, and these dollars are used to provide 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."

Table 1. Number of People in N.C. in Need of Mental Health, Developmental Disability, and Substance Abuse Services, by Age and Disability, 2009

Disability	Numbers of Persons in Need	Percent of People in Need Served by the System
Mental Health	**560,970**	
Adults	356,056	45%
Children	204,914	48%
Developmental Disabilities	**106,356**	
Adults	51,727	39%
Children	54,629	21%
Substance Abuse	**606,867**	
Adults	559,826	9%
Children	47,041	8%
TOTAL	**1,274,193**	

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 Mental Health, Developmental Disabilities, and Substance Abuse Services," Statewide System Performance Report, SFY 2009-10, Spring Report, Raleigh, NC, April 1, 2010, 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, April 24, 2009, 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, 2008 to June 30, 2009.

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

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

Note: Dix Hospital has stopped accepting new patients, and it is scheduled to close.

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

State Psychiatric Hospitals: *Treating People with Mental Illness*

The state operates 15 facilities serving the MH/DD/SAS population in North Carolina (see Figure 1). There are four psychiatric hospitals: Broughton Hospital in Morganton, Central Regional Hospital in Butner, Cherry Hospital in Goldsboro, and Dorothea Dix Hospital in Raleigh.[6] Generally, with state facilities, the goal is to have one in the West, one in the Piedmont, and one in the East.

An October 1, 2009 report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disability, and Substance Abuse Services notes, "In most other states, acute care is provided in private 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."[7] Of the care provided at North Carolina's state psychiatric hospitals, 39 percent is for a stay of seven days or less, 42 percent is for stays between eight and 30 days, 18 percent is for stays between 30 and 365 days, and 1 percent is for a stay longer than one year (see Figure 2).

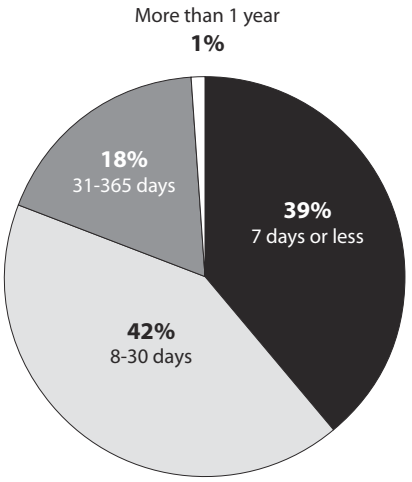


Figure 2.
Length of Stay for Consumers in State Psychiatric Hospitals

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 Mental Health, Developmental Disabilities, and Substance Abuse Services," Statewide System Performance Report, SFY 2009-10, Spring Report, Raleigh, NC, April 1, 2010, Table 3.2.a, p. 16.

The four state psychiatric hospitals served 16,789 persons in FY 1999–2000, which increased to 18,498 persons in FY 2006–07, before declining to 7,188 in FY 2009–10 (see Figure 3). 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.[8] Of those served in FY 2009–10, Cherry Hospital treated 1,780 people; Broughton Hospital treated 1,641 people; and Central Regional Hospital and Dix Hospital combined treated 3,767 people (see Table 3).

Table 2. Number of People Served by the N.C. Mental Health System, 2010

State-Operated Facilities	Subtotal	14,098
State Psychiatric Hospitals		**7,188** [a]
Developmental Centers		**1,375** [b]
Resident		1,338
Respite Care		37
Neuro-Medical Treatment Centers		**958** [c]
Alcohol & Drug Abuse Treatment Centers (ADATCs)		**4,483** [d]
Residential Programs for Children		**94** [e]
Whitaker School		31
Wright School		63

[a] Jeannette Barham, "Annual Statistical Report, North Carolina Psychiatric Hospitals, Fiscal Year 2010," Division of MH/DD/SAS, Raleigh, NC, Dec. 2010, Table 1, p. 3.

[b] Jeannette Barham, "Annual Statistical Report, North Carolina State Developmental Centers, Fiscal Year 2010," Division of MH/DD/SAS, Raleigh, NC, Dec. 2010, 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 2010," Division of MH/DD/SAS, Raleigh, NC, Dec. 2010, Table 2-A, p. 7.

[d] Jeanette Barham, "Annual Statistical Report, North Carolina Alcohol & Drug Abuse Treatment Centers, Fiscal Year 2010," Division of MH/DD/SAS, Raleigh, NC, Dec. 2010, Table 2, p. 4.

[e] Jeannette Barham, "Annual Statistical Report, Wright and Whitaker Residential Programs for Children, Fiscal Year 2010," Division of MH/SS/SAS, Raleigh, NC, Dec. 2010, Table 2-A, p. 6.

[f] Jeannette Barham, "North Carolina LMEs, Annual Statistics and Admission Report, Fiscal Year 2010," Division of MH/DD/SAS, Raleigh, NC, Dec. 2010, Table 2, p. 6.

[g] In July 2010, the Albemarle LME merged into the East Carolina Behavioral Healthcare LME so that currently there are 23 LMEs statewide.

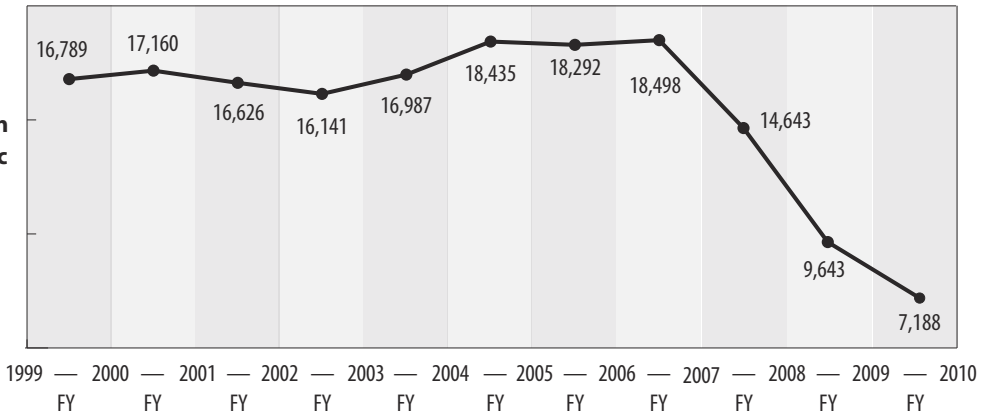
[h] Treatment Accountability for Safer Communities. TASC provides care management services to people with substance abuse or mental illness who are involved in the justice system.

Table 2. Number of People Served by the N.C. Mental Health System, 2010 *continued*

Community-Based Treatment: Local Management Entities	Subtotal	332,796 [f]
1. Alamance-Caswell LME		8,003
2. Albemarle LME [g]		6,007
3. Beacon Center LME		6,260
4. CenterPoint LME		14,309
5. Crossroads LME		8,404
6. Cumberland LME		10,157
7. Durham LME		10,217
8. East Carolina Behavioral Healthcare LME [g]		16,881
9. Eastpointe LME		15,234
10. Five County LME		6,235
11. Guilford LME		16,160
12. Johnston LME		5,267
13. Mecklenburg LME		38,033
14. Mental Health Partners LME		8,323
15. Onslow-Carteret LME		5,247
16. Orange-Person-Chatham LME		7,054
17. Pathways LME		14,867
18. Piedmont Behavioral Healthcare LME		14,742
19. Sandhills LME		17,385
20. Smoky Mountain LME		17,388
21. Southeastern Center LME		15,563
22. Southeastern Regional LME		11,985
23. Wake LME		19,298
24. Western Highlands LME		17,358
TASC [h] Region 1		6,484
TASC Region 2		5,096
TASC Region 3		6,574
TASC Region 4		4,265
Total Served by the N.C. Mental Health System		**346,894**

Note: For counties served by each LME and TASC region, see Table 8, pp. 26–37. A list of counties served in each LME is available on the Internet at *http://www.dhhs.state.nc.us/MHDDSAS/lmebyname.htm*, accessed on July 26, 2010.

Figure 3. Number of People Served in State Psychiatric Hospitals, Fiscal Year (FY) 1999–2000 through 2009–2010



Source: Jeannette Barham, "Annual Statistical Report, North Carolina Psychiatric Hospitals, Fiscal Year 2010," Division of MH/DD/SAS, Raleigh, NC, Dec. 2010, Graph 1, p. 4. The state's fiscal year runs from July 1 to June 30.

More than 57 percent of those served at the state psychiatric hospitals are male. The majority are white (54 percent), while 42 percent are African American. There were 692 children (10 percent) treated that were under the age of 18. Almost 22 percent are between 25 and 34 years old, and 81 percent were involuntarily committed. Thirty-two percent were diagnosed with schizophrenia of some type, and 10 percent were bipolar. Nine percent were diagnosed with drug abuse, and 4 percent were diagnosed with alcohol abuse. If diagnosed earlier, it may be that this group of people would have been better treated at an alcohol and drug abuse treatment center (ADATC).

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 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."

> *"Each night, 3,000 patients sleep in our facilities."*
>
> **J. Luckey Welsh, Jr.**
> **Director, North Carolina Division of State-Operated Health Care Facilities**

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.[9] Over a decade later in FY 2009–10, the facilities served just 1,375 people, including 1,338 residents and 37 people in respite beds. The Caswell Center served 464 consumers, the Riddle Center served 331, and the Murdoch Center served 580 (see Table 4).

Table 3. People Served by the N.C. State Psychiatric Hospitals, by Age, Gender, Race, Ethnicity, Commitment Status, and Diagnosis, 2009-10

	Total Percent	Total Number	Central Regional Hospital	Cherry Hospital	Broughton Hospital	Dix Hospital
Total Persons Served	100.0%	7,188	781*	1,780	1,641	2,986*
Age Groups						
0-14	3.7%	266	64	59	54	89
15-17	5.9	426	71	113	130	112
18-24	13.5	971	113	239	207	412
25-34	21.5	1,543	111	399	341	692
35-44	20.4	1,469	143	328	333	665
45-54	21.0	1,506	150	375	334	647
55-64	9.3	668	62	166	163	277
65+	4.7	339	67	101	79	92
Gender						
Males	57.4%	4,123	430	735	928	2,030
Females	42.6	3,065	351	1,045	713	956
Race						
White	53.5%	3,843	342	873	1,175	1,453
Black	41.5	2,983	390	809	415	1,369
American	0.8	58	1	34	9	14
Asian/Pacific Islander	0.3	22	5	2	6	9
Unknown	0.3	22	9	0	0	13
Other	3.6	260	34	62	36	128
Ethnic Origin						
Hispanic Mexican/American	0.5%	35	4	8	5	18
Hispanic Puerto Rican	0.1	6	0	2	0	4
Hispanic Cuban	0.0	1	0	0	1	0
Hispanic Other	0.1	5	0	1	4	0
Not Hispanic Origin	80.0	5,752	606	1,308	1,631	2,207
Unknown	19.3	1,389	171	461	0	757
Commitment Status						
Voluntary	10.1%	723	68	111	184	360
Involuntary	81.1	5,827	625	1,519	1,457	2,226
Emergency	6.6	472	88	147	0	237
Criminal	2.3	163	0	0	0	163
Other	0.0	3	0	3	0	0
Diagnosis						
Alcohol Abuse	4.1%	298	22	99	14	163
Drug Abuse	9.1	654	66	185	64	339
Mental Retardation	0.2	16	5	0	1	10
Schizophrenia	16.2	1,164	111	362	253	438
Schizophreniform	0.4	30	9	3	6	12
Schizoaffective	15.5	1,116	114	300	299	403
Bipolar	10.1	727	80	204	209	234
Adjustment	2.5	179	16	27	59	77
Personality	3.3	238	33	26	92	87
Dysthymia	0.3	20	1	2	13	4
Major Depressive	8.1	581	34	233	198	116
Other Psychotic	5.9	427	46	41	74	266
Primary Degenerative Dementia	0.0	2	0	0	1	1
Other Organic Mental Disorders	1.7	124	29	25	26	44
Conduct	3.2	227	33	46	67	81
Paranoid	0.3	22	1	0	15	6
All Other	19.0	1,363	181	227	250	705

Source: Jeannette Barham, "Annual Statistical Report, North Carolina Psychiatric Hospitals, Fiscal Year 2010," Division of MH/DD/SAS, Raleigh, NC, Dec. 2010, Table 2-A, p. 8.

* The Central Regional Hospital and Dix Hospital numbers should be combined. Both provider numbers were used during the reporting period. The data was pulled by location rather than by provider.

Table 4. People Served by the N.C. State Developmental Centers, by Age, Gender, Race, Admissions, and Ethnicity, 2009–10

	Total Percent	Total Number	Riddle Center	Murdoch Center	Caswell Center
Total Persons Served	100.0%	1,375	331	580	464
Age Groups					
0-14	2.3%	31	0	31	0
15-17	1.8	25	1	24	0
18-24	4.4	60	13	30	17
25-34	7.7	106	28	47	31
35-44	12.7	175	70	71	34
45-54	29.8	410	121	156	133
55-64	27.3	375	79	150	146
65+	14.0	193	19	71	103
Gender					
Males	60.1%	827	203	350	274
Females	39.9	548	128	230	190
Race					
White	69.2%	951	276	388	287
Black	29.6	407	54	178	175
American Indian	0.1	2	0	1	1
Alaskan Native	0.0	0	0	0	0
Asian/Pacific Islander	0.0	0	0	0	0
Other	1.1	15	1	13	1
Admissions					
Regular	96.2%	1,323	323	555	445
Respite Care	2.7	37	3	24	10
North Carolina Interventions	0.0	0	0	0	0
Mental Retardation Center Residential	1.1	15	5	1	9
Ethnic Origin					
Hispanic Mexican/American	0.1%	1	1	0	0
Hispanic Puerto Rican	0.0	0	0	0	0
Hispanic	0.0	0	0	0	0
Hispanic Other	0.0	0	0	0	0
Not Hispanic Origin	99.9	1,374	330	580	464
Unknown	0.0	0	0	0	0

Source: Jeannette Barham, "Annual Statistical Report, North Carolina State Developmental Centers, Fiscal Year 2010," Division of MH/DD/SAS, Raleigh, NC, Dec. 2010, Table 2-A, p. 8.

Of those served, only 56 are under the age of 18—just 4 percent—and almost 30 percent are aged 45–54. Sixty percent are male. They are 69 percent white and 30 percent black.

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

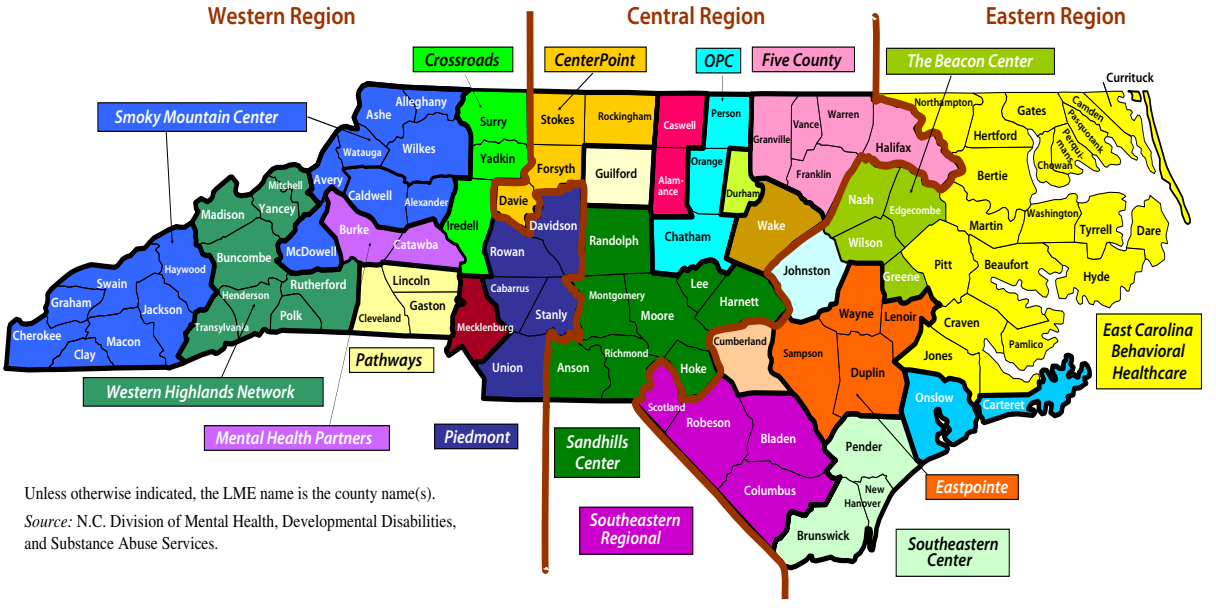
There are three state-operated neuro-medical treatment centers, serving 958 people with disabilities needing long-term care in FY 2009–10: Black Mountain Neuro-Medical Center serving 389 people, O'Berry Neuro-Medical Center in Goldsboro serving 300, and Longleaf Neuro-Medical Treatment in Wilson serving 269 (see Table 5).[10] The Black Mountain Center serves those with lifelong disabilities and those diagnosed with Alzheimer's disease.[11] 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.[12] 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.[13]

Of those treated at the state's neuro-medical treatment centers, 55 percent are 65 and older, and no one under the age of 21 was treated. Fifty-three percent are male. They are 70 percent white and 27 percent black. Thirty-five percent have voluntarily committed themselves to obtain services for mental retardation, 42 percent are there for inpatient nursing care, and 23 percent are respite care patients.

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 4,483 people in FY 2009–10 for alcohol or drug addictions: Julian F. Keith ADATC in Black Mountain serving 1,550 people; R.J. Blackley ADATC in Butner serving 1,186; and Walter B. Jones ADATC in Greenville serving 1,747 (see Table 6).[14]

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.

Joshua Stuart: A Developmentally Disabled Child in Search of Treatment

Joshua Stuart is 13. He is autistic, and he has an IQ of 36. He can only speak a few words, like "Ma" and "hurt." After he violently attacked his mother and little brother at home, 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 now spends six hours each day in 30-minute classes learning everything from new words to daily living skills. There are only four children per class, and 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 has been discharged, and he is now living 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

Table 5. People Served by the N.C. Neuro-Medical Treatment Centers, by Age, Gender, Race, Ethnicity, Commitment Status, and Diagnosis, 2009–10

Total People Served	Total Percent	Total Number	Black Mountain Center	O'Berry Center	Longleaf Center
	100.0%	958	389	300	269
Age Groups					
21-24	0.3%	3	2	1	0
25-34	1.8	17	2	13	2
35-44	5.1	49	11	35	3
45-54	17.1	164	29	110	25
55-64	20.7	198	55	96	47
65+	55.0	527	290	45	192
Gender					
Males	53.0%	508	193	170	145
Females	47.0	450	196	130	124
Race					
White	69.9%	670	341	183	146
Black	27.2	261	33	109	119
American Indian	1.0	10	1	8	1
Asian/Pacific Islander	0.1	1	1	0	0
Unknown	0.0	0	0	0	0
Other	1.7	16	13	0	3
Ethnic Origin					
Hispanic Mexican/American	0.3%	3	3	0	0
Hispanic Puerto Rican	1.0	10	9	0	1
Hispanic Cuban	0.0	0	0	0	0
Hispanic Other	0.1	1	1	0	0
Not Hispanic Origin	98.4	943	376	299	268
Unknown	0.1	1	0	1	0
Commitment Status					
Voluntary Mental Retardation	35.3%	338	36	297	5
Nursing Care Inpatient	42.1	403	139	0	264
Voluntary Mental Health	0.8	8	0	0	0
Respite Care	22.5	216	214	2	0
Other	0.1	1	0	1	0
Diagnosis					
Alcohol Abuse	0.0%	0	0	0	0
Drug Abuse	0.2	2	0	0	2
Mental Retardation	41.0	393	93	299	1
Schizophrenia	0.0	0	0	0	0
Schizophreniform	0.0	0	0	0	0
Schizoaffective	0.1	1	0	0	1
Bipolar	0.0	0	0	0	0
Adjustment	0.0	0	0	0	0
Personality Other	0.0	0	0	0	0
Dysthymia	0.0	0	0	0	0
Major Depressive	0.0	0	0	0	0
Other Psychotic	0.1	1	0	0	1
Primary Degenerative Dementia	13.3	127	122	0	5
Other Organic Mental Disorder	1.8	17	5	1	11
Conduct	0.0	0	0	0	0
Paranoid	0.0	0	0	0	0
All Other	43.5	417	169	0	248

Source: Jeannette Barham, "Annual Statistical Report, Black Mountain Neuro-Medical Center, O'Berry Neuro-Medical Center, Longleaf Medical Center, Fiscal Year 2010," Division of MH/DD/SAS, Raleigh, NC, Dec. 2010, Table 2-A, p. 7.

Of those treated at alcohol and drug rehabilitation centers, about 27 percent were 35–44, and 25 percent were 45–54. Seventy-four percent were white, 24 percent were black, and 63 percent were male.[15] Eighty-two percent were unemployed.

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 63 children, and the Whitaker School in Butner serving 31 children.[16] The Wright School provides residential mental health treatment for children aged 6–12.[17] The Whitaker School is a long-term treatment program for emotionally handicapped adolescents aged 13–17.[18] All of the children served at both schools

—continues on page 38

Collecting Data on Ethnicity, Monitoring Access for Latinos

In 2008, the U.S. Census estimated that 7.4 percent of the population of North Carolina was of Hispanic or Latino origin.[1] Given the 2009 population of the state—9,380,884 persons[2]—that means there are about 694,000 persons of Hispanic or Latino origin living in North Carolina. Yet in FY 2009–10, North Carolina's public mental health system served 12,684 persons of Hispanic origin, less than 4 percent of those served. State psychiatric hospitals served 47 persons of Hispanic or Latino origin (less than 1 percent of those served); the developmental centers served one person (less than 1 percent); the neuro-medical centers served 14 (1 percent); the alcohol and drug abuse treatment centers served 24 (less than 1 percent); the Wright School served one (1 percent); and 12,597 Hispanics were treated in the community (less than 4 percent).[3]

Leza Wainwright

This is confirmed by numbers collected by the federal government. The Center for Mental Health Studies Uniform Reporting System also indicates that just 3.3 percent of those served by the state are Hispanic or Latino. Nationwide, 12.2 percent of those served are Hispanic or Latino.[4] The U.S. Census estimates that 15.4 percent of the population of the United States was of Hispanic or Latino origin in 2008.[5] Leza Wainwright says that about 5–7 percent of those served by the state in North Carolina should be Hispanic.

This possible gap in access to mental health services for the Hispanic/Latino population of the state needs to be monitored. It should be assessed again after the results of the 2010 Census are released to see if there is a gap in access to services for Latinos.

Footnotes

[1] On the Internet at *http://quickfacts.census.gov/qfd/states/37000.html,* accessed Feb. 7, 2010.

[2] U.S. Census Bureau, North Carolina Quick Facts, April 22, 2010. On the Internet at *http://quickfacts.census.gov/qfd/states/37000.html*, accessed on July 26, 2010.

[3] Data on ethnicity was first reported for those served at ADATCs in Dec. 2010.

[4] Center for Mental Health Studies, Uniform Reporting System, Access Domain: Table 1: Demographic Characteristics of Persons Served by the State Mental Health Agency, FY 2008, State: North Carolina, Section on Hispanic Origin, generated on Feb. 7, 2010.

[5] U.S. Census Bureau, North Carolina Quick Facts, April 22, 2010. On the Internet at *http://quickfacts.census.gov/qfd/states/37000.html*, accessed on July 26, 2010.

Table 6. People Served by the N.C. State Alcohol and Drug Abuse Treatment Centers (ADATCs), by Age, Race, Gender, Marital Status, Commitment Status, Diagnosis, Ethnicity, Employment Status, and Education, 2009–10

	Total Percent	Total Number	Julian F. Keith	Walter B. Jones	R.J. Blackley
Total Persons Served	100.0%	4,483	1,550	1,747	1,186
Age Group					
0-14	0.0%	0	0	0	0
15-17	0.0	0	0	0	0
18-20	2.8	126	44	51	31
21-24	9.3	419	158	159	102
25-34	27.9	1,250	460	499	291
35-44	27.3	1,226	435	453	338
45-54	25.2	1,130	366	434	330
55-64	6.8	303	80	138	85
65+	0.6	29	7	13	9
Race					
Asian	0.1%	4	2	2	0
Black	23.6	1,056	203	436	417
Indian	1.0	43	11	18	14
White	74.3	3,331	1,332	1,262	737
Other/Unknown	1.1	49	2	29	18
Gender					
Female	36.9%	1,653	559	683	411
Male	63.1	2,830	991	1,064	775
Marital Status					
Married	17.4%	780	263	280	237
Separated	6.5	292	135	99	58
Divorced	20.4	913	374	356	183
Widowed	2.3	102	39	36	27
Single	53.2	2,386	736	976	674
Unknown	0.2	10	3	0	7
Special Populations					
Injection Drug Users	11.5%	514	299	135	80
All Other Persons Served	88.5	3,969	1,251	1,612	1,106
Pregnant Women	3.7	165	24	141	0
All Other Women	33.2	1,488	535	542	411
Not Reported	63.1	2,830	991	1,064	775
Commitment					
Voluntary	70.7%	3,170	1,058	1,208	904
Involuntary	28.4	1,273	492	539	242
Emergency	0.9	40	0	0	40
Diagnosis					
Alcohol Abuse	47.9%	2,149	838	858	453
Drug Abuse	48.7	2,185	668	880	637
Schizophrenic	0.1	4	1	0	3
Schizoaffective	0.1	4	3	1	0

Table 6. People Served by the N.C. State Alcohol and Drug Abuse Treatment Centers (ADATCs), by Age, Race, Gender, Marital Status, Commitment Status, Diagnosis, Ethnicity, Employment Status, and Education, 2009–10 *continued*

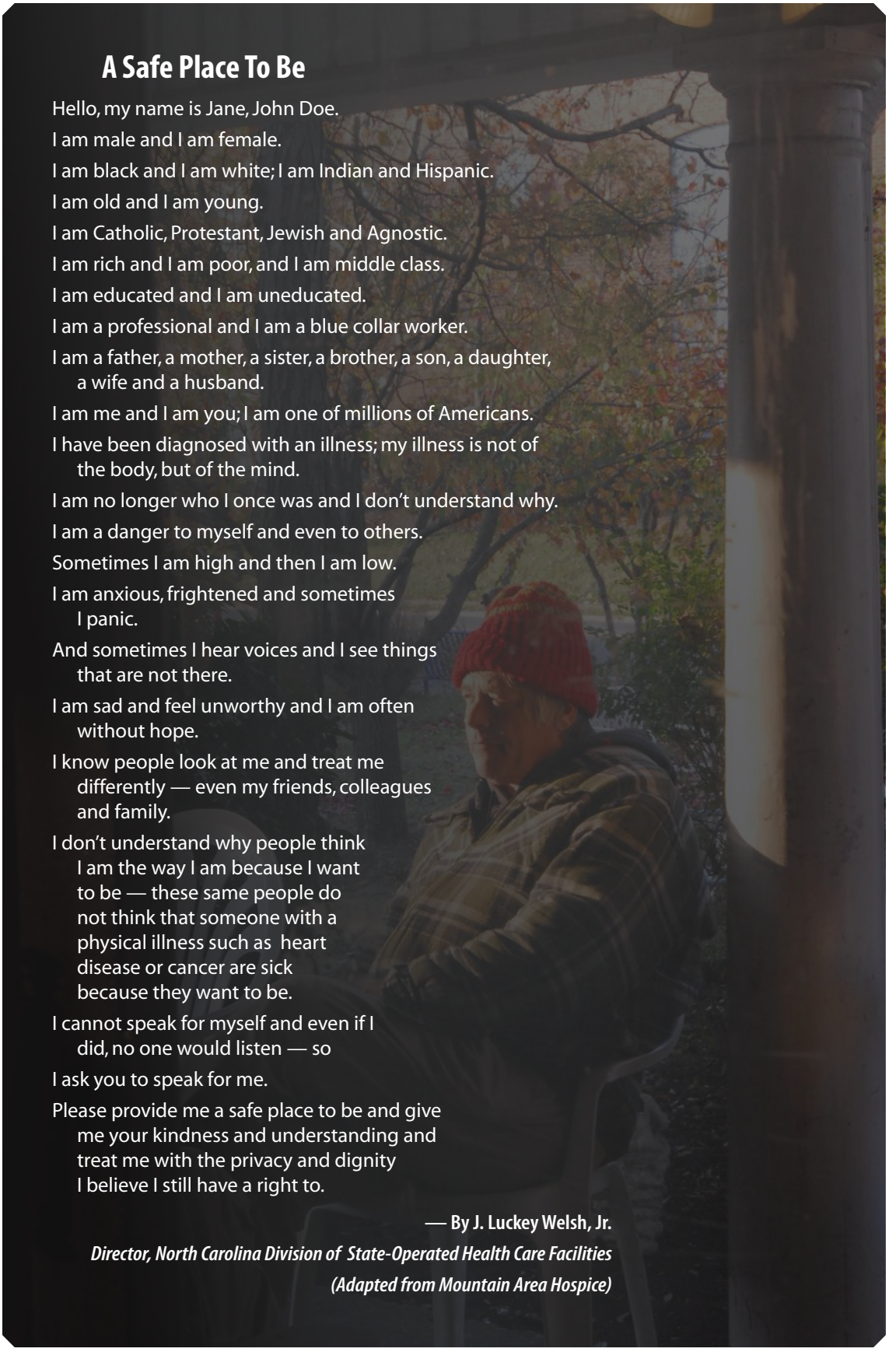
	Total Percent	Total Number	Julian F. Keith	Walter B. Jones	R.J. Blackley
Total Persons Served	100.0%	4,483	1,550	1,747	1,186
Diagnosis, *continued*					
Bipolar	0.4	19	10	1	8
Dysthymia	0.0	0	0	0	0
Adjustment	0.0	0	0	0	0
Personality & Other	0.0	0	0	0	0
Major Depression	0.1	3	2	1	0
Other	0.7	31	25	1	5
Unknown	2.0	88	3	5	80
Ethnic Origin					
Hispanic Mexican/American	0.3	15	8	3	4
Hispanic Puerto/Rican	0.1	6	0	3	3
Hispanic Cuban	0.0	1	1	0	0
Hispanic Other	0.0	2	0	2	0
Not of Hispanic Origin	99.5	4,459	1,541	1,739	1,179
Employment Status					
Full-time	9.9	443	160	150	133
Part-time	3.9	177	44	15	118
Not in Work Force	0.4	17	10	7	0
Armed Forces	0.0	0	0	0	0
Migrant/Seasonal	0.0	0	0	0	0
Other/Unknown	3.8	171	159	3	9
Unemployed	82.0	3,675	1,177	1,572	926
Education					
Kindergarten	0.0%	0	0	0	0
1st–7th Grade	2.0	88	30	35	23
8th Grade	3.9	173	57	67	49
9th–11th Grade	23.8	1,065	373	433	259
12th Grade	41.0	1,837	565	927	345
Some College	0.1	5	0	0	5
Baccalaureate Degree	3.4	153	62	33	58
Post Graduate Degree	0.0	0	0	0	0
Post Bachelor's Degree	0.3	15	11	2	2
General Education Degree	13.9	624	258	199	167
Associate Degree	3.5	157	66	37	54
Technical Trade School	3.4	153	84	4	65
Special Education	0.2	8	4	0	4
Never Attended School	0.0	1	1	0	0
Unknown	4.6	204	39	10	155

Source: Jeanette Barham, "Annual Statistical Report, North Carolina Alcohol Drug Abuse Treatment Centers, Fiscal Year 2010," Division of MH/DD/SAS, Raleigh, NC, Dec. 2010, Table 3a, p. 7; Table 3b, p. 8; Table 3c, p. 10.

Table 7. People Served by the N.C. Wright School and Whitaker School, Residential Programs for Children, by Age, Gender, Race, Ethnicity, Commitment Status, and Diagnosis, 2009–10

	Total Percent	Total Number	Wright School	Whitaker School
Total Persons Served	100.0%	94	63	31
Age Groups				
0-14	67.0%	63	63	0
15-17	33.0	31	0	31
Gender				
Males	73.4%	69	51	18
Females	26.6	25	12	13
Race				
White	59.6%	56	42	14
Black	33.0	31	15	16
American Indian	0.0	0	0	0
Asian/Pacific Islander	1.1	1	1	0
Unknown	0.0	0	0	0
Other	6.4	6	5	1
Ethnic Origin				
Hispanic Mexican/American	1.1%	1	1	0
Hispanic Puerto Rican	0.0	0	0	0
Hispanic Cuban	0.0	0	0	0
Hispanic Other	0.0	0	0	0
Not Hispanic Origin	98.9	93	62	31
Unknown	0.0	0	0	0
Commitment Status				
Voluntary Mental Retardation	0.0%	0	0	0
Nursing Care Inpatient	0.0	0	0	0
Voluntary Mental Health	100.0	94	63	31
Respite Care	0.0	0	0	0
Other	0.0	0	0	0
Diagnosis				
Alcohol Abuse	0.0%	0	0	0
Drug Abuse	0.0	0	0	0
Mental Retardation	0.0	0	0	0
Schizophrenia	0.0	0	0	0
Schizophreniform	0.0	0	0	0
Schizoaffective	0.0	0	0	0
Bipolar	1.1	1	0	1
Adjustment	0.0	0	0	0
Personality	0.0	0	0	0
Dysthymia	0.0	0	0	0
Major Depressive	0.0	0	0	0
Other Psychotic	0.0	0	0	0
Primary Degenerative Dementia	0.0	0	0	0
Other Organic Mental Disorder	0.0	0	0	0
Conduct	21.3	20	0	20
Paranoid	0.0	0	0	0
All Other	77.7	73	63	10

Source: Jeanette Barham, "Annual Statistical Report, North Carolina Alcohol Drug Abuse Treatment Centers, Fiscal Year 2010," Division of MH/DD/SAS, Raleigh, NC, Dec. 2010, Table 2a, p. 6.



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

Table 8. People Served by North Carolina's Local Management (TASC) Regions, by Age

Local Management Entity		Counties Served	Persons Served	Mentally Ill			
				Total	Adult	Children	
1	Alamance-Caswell		8,003	6,317	4,890	1,427	
		Alamance Caswell					
2	Albemarle*		6,007	4,989	3,814	1,175	
		Camden Chowan Currituck Dare Hyde Martin Pasquotank Perquimans Tyrrell Washington					
3	Beacon Center		6,260	4,911	3,035	1,876	
		Edgecombe Greene Nash Wilson					
4	CenterPoint		14,309	9,954	8,026	1,928	
		Davie Forsyth Rockingham Stokes					
5	Crossroads		8,404	6,473	5,357	1,116	
		Iredell Surry Yadkin					
6	Cumberland	Cumberland	10,157	7,829	5,332	2,497	
7	Durham	Durham	10,217	7,735	5,077	2,658	
8	East Carolina Behavioral Healthcare*		16,881	11,230	7,809	3,421	
		Beaufort Bertie Craven Gates Hertford Jones Northampton Pamlico Pitt					

Note: 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.

Entities (LMEs) and Treatment Accountability for Safer Communities and Disability Group, 2009-10

	Developmental Disability			Substance Abuse			Counties Served	LME
	Total	Adult	Children	Total	Adult	Children		
	420	317	103	1,266	1,246	20		1
							Alamance Caswell	
	394	300	94	624	606	18		2
							Camden Chowan Currituck Dare Hyde Martin Pasquotank Perquimans Tyrrell Washington	
	639	423	216	710	686	24		3
							Edgecombe Greene Nash Wilson	
	1,175	858	317	3,180	2,975	205		4
							Davie Forsyth Rockingham Stokes	
	541	382	159	1,390	1,358	32		5
							Iredell Surry Yadkin	
	757	502	255	1,571	1,426	145	Cumberland	6
	726	479	247	1,756	1,718	38	Durham	7
	1,107	649	458	4,544	4,364	180		8
							Beaufort Bertie Craven Gates Hertford Jones Northampton Pamlico Pitt	

Table 8. People Served by North Carolina's Local Management (TASC) Regions, by Age

Local Management Entity		Counties Served	Persons Served	Mentally Ill			
				Total	Adult	Children	
9	Eastpointe		15,234	11,967	9,410	2,557	
		Duplin Lenoir Sampson Wayne					
10	Five County		6,235	4,774	3,618	1,156	
		Franklin Granville Halifax Vance Warren					
11	Guilford	Guilford	16,160	11,856	9,223	2,633	
12	Johnston	Johnston	5,267	4,551	3,734	817	
13	Mecklenburg	Mecklenburg	38,033	26,373	18,698	7,675	
14	Mental Health Partners		8,323	6,331	5,177	1,154	
		Catawba Burke					
15	Onslow-Carteret		5,247	4,076	3,542	534	
		Onslow Carteret					
16	Orange-Person-Chatham		7,054	4,740	3,434	1,306	
		Chatham Orange Person					
17	Pathways		14,867	10,666	8,219	2,447	
		Cleveland Gaston Lincoln					
18	Piedmont		14,742	11,135	9,547	1,588	
		Cabarrus Davidson Rowan Stanly Union					
19	Sandhills		17,385	13,878	9,609	4,269	
		Anson Harnett Hoke Lee Montgomery Moore Randolph Richmond					

Entities (LMEs) and Treatment Accountability for Safer Communities and Disability Group, 2009-10

	Developmental Disability			Substance Abuse			Counties Served	LME
	Total	Adult	Children	Total	Adult	Children		
	916	681	235	2,351	2,328	23		9
							Duplin Lenoir Sampson Wayne	
	540	415	125	921	880	41		10
							Franklin Granville Halifax Vance Warren	
	1,153	828	325	3,151	3,103	48	Guilford	11
	240	133	107	476	473	3	Johnston	12
	1,213	827	386	10,447	10,255	192	Mecklenburg	13
	515	367	148	1,477	1,455	22		14
							Catawba Burke	
	445	320	125	726	712	14		15
							Onslow Carteret	
	621	493	128	1,693	1,683	10		16
							Chatham Orange Person	
	1,394	881	513	2,807	2,749	58		17
							Cleveland Gaston Lincoln	
	769	647	122	2,838	2,787	51		18
							Cabarrus Davidson Rowan Stanly Union	
	998	768	230	2,509	2,317	192		19
							Anson Harnett Hoke Lee Montgomery Moore Randolph Richmond	

Table 8. People Served by North Carolina's Local Management (TASC) Regions, by Age

Local Management Entity		Counties Served	Persons Served	Mentally Ill			
				Total	Adult	Children	
20	Smoky Mountain		17,388	13,457	11,224	2,233	
		Alexander Alleghany Ashe Avery Caldwell Cherokee Clay Graham Haywood Jackson Macon McDowell Swain Watauga Wilkes					
21	Southeastern Center		15,563	9,792	7,441	2,351	
		Brunswick New Hanover Pender					
22	Southeastern Regional		11,985	9,610	6,551	3,059	
		Bladen Columbus Robeson Scotland					
23	Wake	Wake	19,298	14,830	10,000	4,830	
24	Western Highlands		17,358	12,521	9,346	3,175	
		Buncombe Henderson Madison Mitchell Polk Rutherford Transylvania Yancey					

Entities (LMEs) and Treatment Accountability for Safer Communities and Disability Group, 2009-10

	Developmental Disability			Substance Abuse			Counties Served	LME
	Total	Adult	Children	Total	Adult	Children		
	700	508	192	3,231	3,185	46		20
							Alexander Alleghany Ashe Avery Caldwell Cherokee Clay Graham Haywood Jackson Macon McDowell Swain Watauga Wilkes	
	1,114	639	475	4,657	4,584	73		21
							Brunswick New Hanover Pender	
	644	496	148	1,731	1,717	14		22
							Bladen Columbus Robeson Scotland	
	1,556	976	580	2,912	2,772	140	Wake	23
	1,550	1,014	536	3,287	3,232	55		24
							Buncombe Henderson Madison Mitchell Polk Rutherford Transylvania Yancey	

Table 8. People Served by North Carolina's Local Management (TASC) Regions, by Age

TASC Region	Counties Served	Persons Served	Mentally Ill			
			Total	Adult	Children	
TASC Region 1		6,484	550	542	8	
	Avery					
	Buncombe					
	Burke					
	Caldwell					
	Catawba					
	Cherokee					
	Clay					
	Cleveland					
	Gaston					
	Graham					
	Haywood					
	Henderson					
	Jackson					
	Lincoln					
	Macon					
	Madison					
	McDowell					
	Mecklenburg					
	Mitchell					
	Polk					
	Rutherford					
	Swain					
	Transylvania					
	Watauga					
	Yancey					
TASC Region 2		5,096	577	562	15	
	Alexander					
	Alleghany					
	Anson					
	Ashe					
	Cabarrus					
	Davidson					
	Davie					
	Forsyth					
	Guilford					

Note: TASC provides care management services to people with substance abuse or mental illness who are involved in the justice system.

Entities (LMEs) and Treatment Accountability for Safer Communities and Disability Group, 2009–10

	Developmental Disability			Substance Abuse			Counties Served	TASC
	Total	Adult	Children	Total	Adult	Children		
	0	0	0	5,934	5,864	70		Region 1
							Avery Buncombe Burke Caldwell Catawba Cherokee Clay Cleveland Gaston Graham Haywood Henderson Jackson Lincoln Macon Madison McDowell Mecklenburg Mitchell Polk Rutherford Swain Transylvania Watauga Yancey	
	0	0	0	4,519	4,450	69		Region 2
							Alexander Alleghany Anson Ashe Cabarrus Davidson Davie Forsyth Guilford	

Table 8. People Served by North Carolina's Local Management (TASC) Regions, by Age

TASC Region	Counties Served	Persons Served	Mentally Ill			
			Total	Adult	Children	
	Iredell					
	Montgomery					
	Moore					
	Randolph					
	Richmond					
	Rockingham					
	Rowan					
	Stanly					
	Stokes					
	Surry					
	Union					
	Wilkes					
	Yadkin					
TASC Region 3		6,574	1,131	1,081	50	
	Alamance					
	Bladen					
	Brunswick					
	Caswell					
	Chatham					
	Columbus					
	Cumberland					
	Durham					
	Franklin					
	Granville					
	Harnett					
	Hoke					
	Johnston					
	Lee					
	Orange					
	Person					
	Robeson					
	Scotland					
	Vance					
	Wake					
	Warren					

Entities (LMEs) and Treatment Accountability for Safer Communities and Disability Group, 2009–10

	Developmental Disability			Substance Abuse			Counties Served	TASC
	Total	Adult	Children	Total	Adult	Children		
							Iredell Montgomery Moore Randolph Richmond Rockingham Rowan Stanly Stokes Surry Union Wilkes Yadkin	
	0	0	0	5,443	5,375	68		Region 3
							Alamance Bladen Brunswick Caswell Chatham Columbus Cumberland Durham Franklin Granville Harnett Hoke Johnston Lee Orange Person Robeson Scotland Vance Wake Warren	

Table 8. People Served by North Carolina's Local Management (TASC) Regions, by Age

TASC Region	Counties Served	Persons Served	Mentally Ill			
			Total	Adult	Children	
TASC Region 4		4,265	144	142	2	
	Beaufort					
	Bertie					
	Camden					
	Carteret					
	Chowan					
	Craven					
	Currituck					
	Dare					
	Duplin					
	Edgecombe					
	Gates					
	Greene					
	Halifax					
	Hertford					
	Hyde					
	Jones					
	Lenoir					
	Martin					
	Nash					
	New Hanover					
	Northampton					
	Onslow					
	Pamlico					
	Pasquotank					
	Pender					
	Perquimans					
	Pitt					
	Sampson					
	Tyrrell					
	Washington					
	Wayne					
	Wilson					
State Total		**332,796**	**232,397**	**174,440**	**57,957**	

Source: Jeannette Barham, "North Carolina LMEs, Annual Statistics and Admission Report, Fiscal Year 2010, Division of MH/DD/SAS, Raleigh, NC, Dec. 2010, Table 2, p. 6.

Entities (LMEs) and Treatment Accountability for Safer Communities and Disability Group, 2009–10

	Developmental Disability			Substance Abuse			Counties Served	TASC
	Total	Adult	Children	Total	Adult	Children		
	0	0	0	4,121	4,087	34		Region 4
							Beaufort	
							Bertie	
							Camden	
							Carteret	
							Chowan	
							Craven	
							Currituck	
							Dare	
							Duplin	
							Edgecombe	
							Gates	
							Greene	
							Halifax	
							Hertford	
							Hyde	
							Jones	
							Lenoir	
							Martin	
							Nash	
							New Hanover	
							Northampton	
							Onslow	
							Pamlico	
							Pasquotank	
							Pender	
							Perquimans	
							Pitt	
							Sampson	
							Tyrrell	
							Washington	
							Wayne	
							Wilson	
	20,127	**13,903**	**6,224**	**80,272**	**78,387**	**1,885**		

Note: 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. There are now 23 local management entities. Albemarle merged into East Carolina Behavioral Healthcare as of July 2010. TASC provides care management services to people with substance abuse or mental illness who are involved in the justice system.

were voluntarily committed for mental health treatment. Seventy-three percent are male. They are 60 percent white and 33 percent black (see Table 7).

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.[19] 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. Vicki Smith of Disability Rights NC says that although LMEs are supposed to provide screening, triage,[20] 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 July 2010, the Albemarle LME merged into the East Carolina Behavioral Healthcare LME so that currently there are 23 LMEs statewide (see Figure 4, p. 17). LMEs served 332,796 persons in FY 2009–10, an 11 percent increase since 2000 (see Table 8 and Figure 5).[21] Of these, 22,419 were served by TASCs (Treatment

—*continued from page 21*

Karen Tam

An Advocate's Perspective: Hard-To-Serve Clients, Hard-To-Find Placements

At Disability Rights NC, we have witnessed our clients suffering from a lack of providers willing to serve them. In fact, it is extremely hard to find providers willing to serve the most difficult consumers. For example, many providers feel ill-equipped to treat a child with severe behavioral issues, and the rates paid to providers for services to consumers with higher needs are often insufficient. Providers are unwilling to provide treatment for this hard-to-serve population.

This was illustrated during the closure of the Dorothea Dix Psychiatric Residential Treatment Facility (PRTF) on June 30, 2010. In that situation, Disability Rights NC played an instrumental role in locating transitional placements for nine of the children who had been receiving treatment at Dix. We contacted many of the private psychiatric residential treatment facilities in the state, only to learn that all but one had waiting lists. Also, one of the private facilities denied placement to two of our clients because they did not fit their profile. We learned that many of the services offered by the private providers are not available in the rural communities. It also has been our experience that some private psychiatric residential treatment facilities will dismiss a child for certain behaviors which might on one hand free up bed space, but on the other hand introduces into the system another child without services desperately in need of treatment.

Currently, qualified professionals are only allowed to bill for two hours of case management services per month in order to move a child from a mental institution into community services. At Disability Rights NC, two staff attorneys and one advocate spent an average of 2–3 hours per day trying to locate an appropriate transitional placement for our clients because the qualified professionals were inundated with other tasks or had exhausted their billable time for the month.

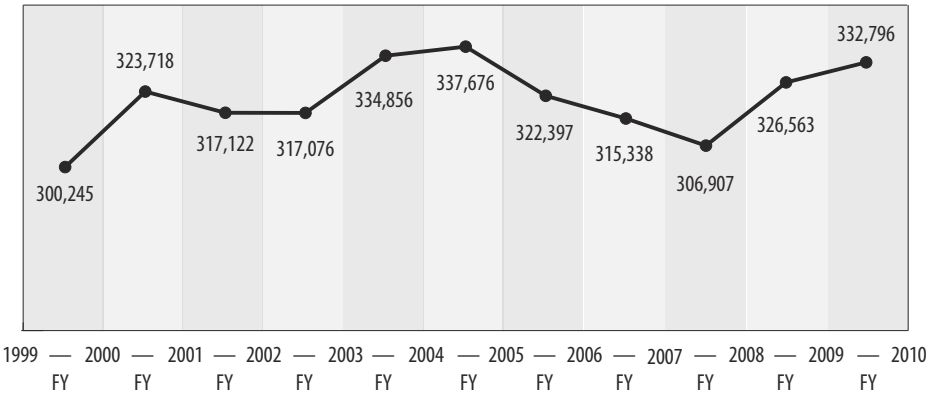
— Vicki Smith, Executive Director of Disability Rights NC

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.[22]

Of those persons served in the community, 232,397 were mentally ill; 20,127 had developmental disabilities; and 80,272 were treated for substance abuse (see Table 8). Of the 332,796 persons served in the community, 66,066 were under the age of 18—almost 20 percent. Fifty-four percent are male. They are 58 percent white and 36 percent black. Seventeen percent were diagnosed with major depression, and 16 percent were diagnosed with substance abuse problems (see Table 9).

Wainwright 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.[23] 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."

Figure 5. Number of People Served in Local Management Entities (LMEs), Fiscal Year (FY) 1999–2000 through 2009–2010



Source: Jeannette Barham, "North Carolina LMEs, Annual Statistics and Admission Report, Fiscal Year 2010," Division of MH/DD/SAS, Raleigh, NC, Dec. 2010, Graph 1, p. 4. The state's fiscal year runs from July 1 to June 30.

Table 9. People Served by the N.C. Local Management Entities (LMEs) and Treatment Accountability for Safe Communities (TASC), by Age, Gender, Race, Diagnosis, Marital Status, and Ethnicity, 2009–10

	Total Percent	Total Number
Total Persons Served	**100.0%**	**332,796**
Age		
0-4	0.4%	1,198
5-9	4.9	16,281
10-14	8.0	26,535
15-17	6.6	22,052
18-20	6.8	22,470
21-24	8.4	28,027
25-34	19.8	66,001
35-44	17.6	58,427
45-54	17.1	56,866
55-64	7.8	25,828
65+	2.7	9,111
Gender		
Males	53.7%	178,746
Females	46.3	154,008
Unknown	0.0	42
Race		
Asian	0.4%	1,311
Black	35.7	118,762
White	58.1	193,369
American Indian/Alaskan Native	1.7	5,624
Other	3.8	12,556
Unknown	0.3	1,093
Pacific Islander	0.0	81
Diagnosis		
Mental Retardation	4.1%	13,484
Attention Deficit	4.8	15,908
Conduct	5.8	19,281
Autism and Pervasive Development Disorder	1.5	5,090

Table 9. People Served by the N.C. Local Management Entities (LMEs) and Treatment Accountability for Safe Communities (TASC), by Age, Gender, Race, Diagnosis, Marital Status, and Ethnicity, 2009–10, *continued*

	Total Percent	Total Number
Total Persons Served	**100.0%**	**332,796**
Diagnosis, *continued*		
Specific Development	0.5%	1,553
Other Childhood Disorders	0.7	2,375
Eating Sleeping Disorders	0.1	182
Medication Induced	0.0	5
Primary Degenerative Dementia	0.0	147
Vascular Dementia	0.0	92
Substance Abuse (Drugs)	16.0	53,270
Alcohol Abuse	7.7	25,690
Alcohol Related Organic	0.4	1,312
Other Mental Disorders	0.5	1,687
Schizophrenic	3.1	10,390
Schizophreniform	0.1	270
Schizoaffective	1.8	6,016
Delusional	0.1	426
Other Psychotic	1.6	5,451
Bipolar	8.1	26,823
Major Depression	17.3	57,690
Dysthymia	0.6	2,135
Anxiety	5.6	18,783
Somatoform/Factitious	0.0	104
Dissociative	0.0	71
Sexual	0.1	205
Personality Other Impulses	0.9	3,018
Adjustment	3.7	12,425
Other Nonpsychotic/Mental	7.0	23,334
Other Problems Not Mental	0.6	2,026
No Mental Disorder	0.5	1,711
Diagnosis Deferred	1.8	6,028
Unknown	4.8	15,814
Marital Status		
Annulled	0.3%	1,089
Married	11.0	36,517
Divorced	13.1	43,695
Domestic Partners	0.6	1,885
Separated	6.9	22,855
Single	65.8	219,114
Unknown	0.4	1,378
Widowed	1.9	6,263
Ethnicity		
Hispanic Cuban	0.1%	255
Hispanic Mexican American	1.8	5,857
Hispanic Other	1.5	5,090
Hispanic Puerto Rican	0.4	1,395
Not Hispanic Origin	95.7	318,356
Unknown	0.6	1,843

Source: Jeannette Barham, "North Carolina LMEs, Annual Statistics and Admission Report, Fiscal Year 2010," Division of MH/DD/SAS, Raleigh, NC, Dec. 2010, Table 2-A, p. 7.

Figure 6.
Source of Funds for Mental Health Services: Actual Expenditures for N.C. Mental Health, Developmental Disabilities, and Substance Abuse Services, FY 2008-09

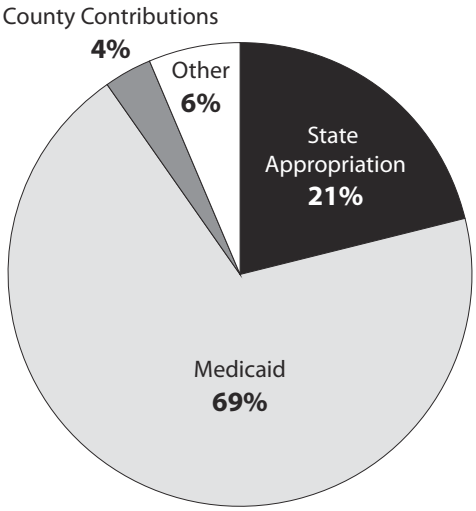


Table 10. Actual Expenditures for the North Carolina Mental Health, by Year, Disability, and

State Fiscal Year		State Appropriation	Medicaid	
2004-05	Mental Health	$ 292,563,006	$ 514,178,592	
	Developmental Disability	119,477,669	825,501,780	
	Substance Abuse	30,352,091	40,361,641	
	Non-Disability Specific	52,076,020	86,177,412	
	Administration	86,010,576	65,571,736	
	Total	**$ 580,479,361**	**$ 1,531,791,161**	
2008-09	Mental Health	$ 279,350,369	$ 1,041,693,919	
	Developmental Disability	49,713,239	1,107,953,774	
	Substance Abuse	30,235,131	48,676,533	
	Non-Disability Specific	328,550,273	39,397,700	
	Administration	21,782,388	60,578,862	
	Total	**$ 709,631,400**	**$ 2,298,300,788**	
Percent growth from 2005 to 2009		**18.2%**	**33.4%**	
Amount of Funding Increase 2005 to 2009		**$ 129,152,038**	**$ 766,509,627**	

Source: Email from Leza Wainwright, former Director of the N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Aug. 10, 2010.

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."

Funding MH/DD/SAS Services in North Carolina

The funding for the public mental health system in North Carolina comes from federal Medicaid dollars, state appropriations, county funds, and other sources. In 2009, the total budget was $3.3 billion dollars. Medicaid was the largest payer, contributing $2.3 billion (69 percent); the state paid $709.6 million (21 percent);

Developmental Disability, and Substance Abuse Service System Funding Source, 2004-09

	County Contributions	Other	Total
	$ 0	$ 60,657,245	$ 867,398,843
	0	17,326,854	962,306,302
	0	36,525,519	107,239,251
	91,850,134	63,367,319	293,470,885
	0	38,450,064	190,032,376
	$ 91,850,134	**$ 216,327,000**	**$ 2,420,447,657**
	$ 0	$ 75,401,362	$ 1,396,445,650
	0	29,854,490	1,187,521,503
	0	47,868,680	126,780,344
	118,771,431	41,427,872	528,147,276
	0	9,797,172	92,158,421
	$ 118,771,431	**$ 204,349,575**	**$ 3,331,053,195**
	22.7%	**-5.9%**	**27.3%**
	$ 26,921,297	**$ -11,977,425**	**$ 910,605,537**

Note: Totals may not add up due to rounding. The state's fiscal year runs from July 1 to June 30.

County contributions to Medicaid have been phased out, but many counties in North Carolina still pay for mental health services through the LMEs.

and counties paid $118.8 million (4 percent) (see Table 10 and Figure 6). Seventy-seven percent of the $3.3 billion was spent on community-based services, 21 percent was spent on state-operated facilities, and only 1 percent was spent on state administration (see Table 11 and Figure 7). In FY 2009–10, however, the budget included deep cuts to mental health programs to address a $4.6 billion state budget shortfall. Overall that year, the Division's budget was cut by 19 percent.[24]

The legislature restored $40 million in funding for community services administered through the LMEs in 2010.[25] But in the budget for the Division of Medical Assistance, which runs the Medicaid program in North Carolina, the legislature has projected savings that will impact consumers of mental health services. To save $41 million, the Department will use rate and utilization management for mental health services, which means rates paid to providers for services will be cut and access to some services for consumers will be limited.[26] To save $7.7 million, independent assessments of consumers will be required for some mental health services in the Medicaid program to make sure the service is really needed.[27] And, to save $50 million, the in-home personal care services program has been changed to provide care to only those individuals at the greatest risk of needing institutional care. To be eligible

Table 11. Actual Expenditures for the North Carolina Mental Health, by Year, Disability, and

State Fiscal Year		State Facilities	Community Services	
2004-05	Mental Health	$ 272,244,524	$ 595,154,319	
	Developmental Disability	237,181,827	725,124,475	
	Substance Abuse	14,583,110	92,656,141	
	Non-Disability Specific	39,895,367	228,570,718	
	Administration	0	153,434,650	
	Total	**$ 563,904,828**	**$ 1,794,940,303**	
2008-09	Mental Health	$ 346,924,186	$ 1,049,521,465	
	Developmental Disability	285,192,594	902,328,909	
	Substance Abuse	26,232,316	100,548,028	
	Non-Disability Specific	54,461,940	449,828,946	
	Administration	0	56,565,014	
	Total	**$ 712,811,036**	**$ 2,558,792,362**	
Percent growth from 2005 to 2009		**20.9%**	**29.9%**	
Amount of Funding Increase 2005 to 2009		**$ 148,906,208**	**$ 763,852,059**	

Source: Email from Leza Wainwright, former Director of the N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Aug. 10, 2010.

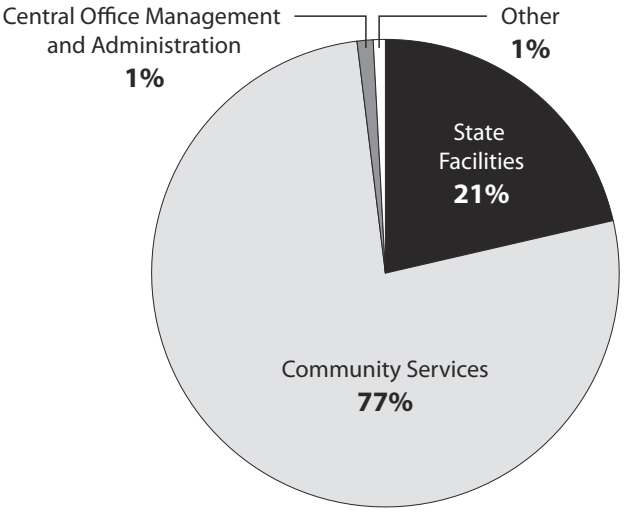


Figure 7.
Percent of Total Expenditures Spent on Patients Served in the Community vs. Patients Served in State Facilities, FY 2008-09

Developmental Disability, and Substance Abuse Service System Setting, 2004-09

	Central Office Management and Administration	Other	Total
	$ 0	$ 0	$ 867,398,843
	0	0	962,306,302
	0	0	107,239,251
	0	25,004,800	293,470,885
	36,597,726	0	190,032,376
	$ 36,597,726	**$ 25,004,800**	**$ 2,420,447,657**
	$ 0	$ 0	1,396,445,650
	0	0	1,187,521,503
	0	0	126,780,344
	0	23,856,390	528,147,276
	35,593,407	0	92,158,421
	$ 35,593,407	**$ 23,856,390**	**$ 3,331,053,195**
	-2.8%	**-4.8%**	**27.3%**
	$ -1,004,319	**$ -1,148,410**	**$ 910,605,537**

Note: Totals may not add up due to rounding. The state's fiscal year runs from July 1 to June 30.

for these services, consumers now will need more assistance with activities of daily living—bathing, going to the toilet, eating, dressing, and getting around.[28]

Still, despite the Great Recession, the total budget for the public mental health system in North Carolina since 2004 has grown by 27.3 percent, with Medicaid registering the most growth of any funding source—a 33.4 percent increase and more than $766 million additional dollars. Funding for state facilities has increased by almost 21 percent, funding for community services has increased by almost 30 percent, while funding for administration has declined by 2.8 percent.

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

Karen Tam

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 41 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 effectively monitor such a large provider community. 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."

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.

Footnotes

[1] N.C. Office of State Budget and Management (OSBM), Annual North Carolina Population Growth, July 2009. The state population was 9,380,884.

[2] This assumes the numerator is 346,894 (total number of person served by the system; see Table 2) and the denominator is 1,274,193 (total number of persons in need of mental health, developmental disability, and substance abuse services; see Table 1).

[3] There is some evidence that the numbers in need of substance abuse services may be underestimated. One report by the N.C. Institute of Medicine suggests the number of persons in need of substance abuse services is 709,000. See North Carolina Institute of Medicine Task Force on Substance Abuse Services. "Interim Report to the North Carolina General Assembly," North Carolina Institute of Medicine, Morrisville, NC, May 2008, p. 36.

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

[5] *Disability Advocates, Inc., v. Paterson,* 653 F. Supp. 2d 184, 188-216 (E.D.N.Y. 2009). In the federal district court opinion, the judge held that adult care homes "are institutions that segregate residents from the community and impede residents' interactions with people who do not have disabilities."

[6] Dix Hospital has stopped accepting new patients, and it is scheduled to close. The 2010 North Carolina General Assembly did not appropriate funds to keep it open. Two units at Dix Hospital will be kept open: the Forensics Minimum Security Unit and Child Outpatient Services. Speech by Luckey Welsh, Director of the Division of State-Operated Health Care Facilities, NAMI-NC Annual Conference, Sept. 11, 2010.

[7] 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 Mental Health, Developmental Disabilities, and Substance Abuse Services," Statewide System Performance Report, SFY 2009–10, Spring Report, Raleigh, NC, Oct. 1, 2009, p. 17.

[8] 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).

[9] Jeannette Barham, "Annual Statistical Report, North Carolina State Developmental Centers, Fiscal Year 2010," Division of MH/DD/SAS, Raleigh, NC, Dec. 2010, Table 1, p. 3.

[10] Jeannette Barham, "Annual Statistical Report, Black Mountain Neuro-Medical Center, O'Berry Neuro-Medical Center, Longleaf Medical Center, Fiscal Year 2010," Division of MH/DD/SAS, Raleigh, NC, Dec. 2010, Table 2B, pp. 9–11.

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

Broughton Hospital, Morganton

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

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

[14] Jeanette Barham, "Annual Statistical Report, North Carolina Alcohol & Drug Abuse Treatment Centers, Fiscal Year 2010," Division of MH/DD/SAS, Raleigh, NC, Dec. 2010, Table 2, p. 4.

[15] Data on ethnicity was first reported for those served at ADATCs in Dec. 2010.

[16] Jeannette Barham, "Annual Statistical Report, Wright and Whitaker Residential Programs for Children, Fiscal Year 2010," Division of MH/SS/SAS, Raleigh, NC, Dec. 2010, Table 2-A, p. 6.

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

[18] 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.

[19] On the Internet at *http://www.ncdhhs.gov/mhddsas/lmedirectory.htm#lmelist*, accessed on Feb. 6, 2010. See also N.C. Gen. Stat. § 122C-115.4.

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

[21] Jeannette Barham, "North Carolina LMEs, Annual Statistics and Admission Report, Fiscal Year 2010," Division of MH/DD/SAS, Raleigh, NC, Dec. 2010, Table 2, p. 6.

[22] 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.

[23] Rep. Verla Insko (D-Orange), Co-Chair of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, says the reason the system served so many more people is because providers were going door to door finding children who qualified for Medicaid and telling parents that their children qualified to have a mentor or a tutor.

[24] Email from Bill Scott, Budget and Finance Office Team Leader of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, on Aug. 13, 2009.

[25] See the Joint Conference Committee Report on the Continuation, Expansion, and Capital Budgets, Senate Bill 897, June 28, 2010, p. G-2.

[26] See the Joint Conference Committee Report on the Continuation, Expansion, and Capital Budgets, Senate Bill 897, June 28, 2010, p. G-10.

[27] *Ibid.*

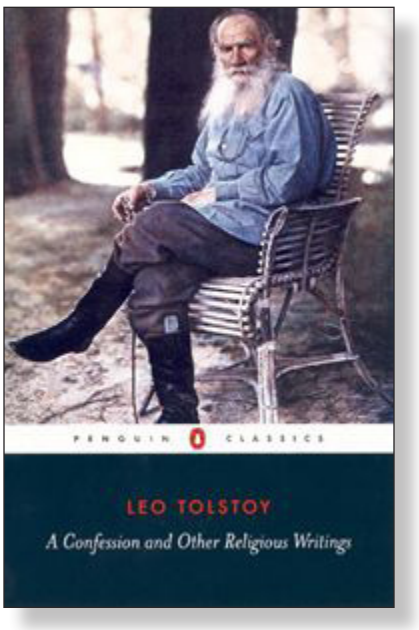
[28] *Ibid.* See also N.C. Session Law 2010–31 § 10.35 (Senate Bill 897).

One Man's Journey Through *A Confession* Out of Depression

by William S. Bost, III

As Leo Tolstoy approached age 50, he was depressed, suicidal, and disappointed with his life, even though he was arguably Russia's most famous and admired citizen. He already has published *War and Peace* (1865-68) and *Anna Karenina* (1874-76), but he rejected literary success, saying the latter novel was "an abomination that no longer exists for me."[1] His work, *A Confession*, is an essay on his definition of the problem within himself and his search for a solution. *A Confession* (1879-82) is important in the discussion of mental health for three reasons. First, for those without a mental health or depression problem or for those who are concerned about a person with such a problem, *A Confession* provides a spot-on description of the feelings experienced by many depressed people. For those with a mental health problem, Tolstoy's book lets us know that we are not alone. In addition, Tolstoy puts in eloquent words the thoughts that are rattling around our heads. And, third, after discussing in-depth his efforts to overcome depression and "soul-sickness," Tolstoy provides his solution to those who are affected.

William S. Bost, III, practices law in Raleigh. Since his journey through A Confession, *he no longer strives for perfection, and he is no longer depressed.*



Editor's Note: Count Leo Nikolayevich Tolstoy was born in Russia in 1928. He married Sonya Andreyevna Behrs when he was 34 and she was 18, and they had 13 children. He ran his vast estate on the Volga Steppes south of Moscow, improved the condition of the Russian peasants, and wrote the books of realist fiction for which he became so famous — *War and Peace, Anna Karenina,* and *The Death of Ivan Ilyich.* Tolstoy was an early believer in the moral force of nonviolent protest and "championed the oppressed by persuasively undermining the entire social, religious and political structure on which the lives of the well-to-do rested; his influence was enormous, both at home and abroad."* Along the way, he encountered a lot of opposition. The government began to censor his writings, and in 1901 after his active support for persecuted religious sects, he was excommunicated from the Russian Orthodox Church. It is said that from then on, there were two powers in Russia – Nicholas II and Leo Tolstoy. He died in 1910 at a small railway station on his way to a monastery. This journey is the subect of the 2010 film, "The Last Station."

* Commentary of Jane Kentish, Translator of *A Confession,* pp. 8-9.

Tolstoy's Description of Depression

Tolstoy wrote *A Confession* at the age of 51. He was among the wealthiest, the most famous, and most beloved men in Russia. And he was miserable. He describes his condition as follows:

> My life came to a standstill. I could breathe, eat, drink and sleep and I could not help breathing, eating, drinking and sleeping; but there was no life in me because I had no desires whose gratification I would have deemed it reasonable to fulfil. If I wanted something I knew in advance that whether or not I satisfied my desire nothing would come of it.
>
> If a magician had come and offered to grant my wishes I would not have known what to say. If in my intoxicated moments I still had the habit of desire, rather than real desire, in my sober moments I knew that it was a delusion and that I wanted nothing. I did not even wish to know the truth because I had guessed what it was. The truth was that life is meaningless.
>
> It was as if I had carried on living and walking until I reached a precipice from which I could see clearly that there was nothing ahead of me other than destruction. But it was impossible to stop, and impossible to turn back or close my eyes in order not to see that there was nothing ahead other than deception of life and of happiness, and the reality of suffering and death: of complete annihilation.
>
> Life had grown hateful to me, and some insuperable force was leading me to seek deliverance from it by whatever means. I could not say that I wanted to kill myself. The force beckoning me away from life was a more powerful, complete and overall desire. It was a force similar to my striving after life, only it was going in the other direction. I fought as hard as I could against life. The thought of suicide now came to me as naturally as thoughts of improving my life had previously come to me. This idea was so attractive to me that I had to use cunning against myself in order to avoid carrying it out too hastily. I did not want to rush, simply because I wanted to make every effort to unravel the matter. I told myself that if I could not unravel the matter now, I still had time to do so. And it was at this time that I, a fortunate man, removed a rope from my room where I undressed every night alone, lest I hang myself from the beam between the cupboards; and I gave up taking a rifle with me on hunting trips so as not to be tempted to end my life in such an all too easy fashion. I myself did not know what I wanted. I was afraid of life and strove against it, yet I still hoped for something from it.
>
> All this was happening to me at a time when I was surrounded on all sides by what is considered complete happiness: I was not yet fifty, I had a kind, loving and beloved wife, lovely children, and a large estate that was growing and expanding with no effort on my part. I was respected by relatives and friends far more than ever before. I was praised by strangers and could consider myself a celebrity without deceiving myself. Moreover I was not unhealthy in mind or body, but on the contrary enjoyed a strength of mind and body such as I had rarely witnessed in my contemporaries. Physically I could keep up with the peasants tilling the fields; mentally I could work for eight or ten hours at a stretch without suffering any ill effects from the effort. And in these circumstances I found myself at the point where I could no longer go on living and, since I feared death, I had to deceive myself in order to refrain from suicide.[2]

What Was the Source of Tolstoy's Depression?

Tolstoy was perplexed by his unhappiness and emptiness. He reflected on his path through his life. In that reflection, he found that he had focused on those things that his peers focused upon. He had been guided by a quest for perfection and a sense of competition. As Tolstoy says,

> Now, looking back at that time, I can clearly see that the only real faith I had, apart from the animal instincts motivating my life, was a belief in perfection. But what this perfection consisted of, and what its aim was, were unclear to me. I tried to perfect myself intellectually and studied everything I came upon in life. I tried to perfect my will, setting myself rules I tried to follow. I perfected myself physically, practising all kinds of exercises in order to develop my strength and dexterity, and I cultivated endurance and patience by undergoing all kinds of hardship. All this I regarded as perfection. The beginning of it all was, of course, moral perfection, but this was soon replaced by a belief in general perfection, that is a desire to be better not in my own eyes or before God but in the eyes of other people. And very soon this determination to be better than others became a wish to be more powerful than others: more famous, more important, wealthier.[3]

This path through life brought him to a point at which he could not find a way forward. As he said,

> My question, the one that brought me to the point of suicide when I was fifty years old, was a most simple one that lies in the soul of every person, from a silly child to a wise old man. It is the question without which life is impossible, as I had learnt from experience. It is this: what will come of what I do today or tomorrow? What will come of my entire life?
>
> Expressed another way the question can be put like this: why do I live? Why do I wish for anything, or do anything? Or expressed another way: is there any meaning in my life that will not be annihilated by the inevitability of death which awaits me?[4]

How Does This Apply Now to Us?

Many people reach a point in their life in which they no longer feel passion for living. Like Tolstoy, even if they are at the top of the social and educational ladder, they feel empty, exhausted, and with a complete lack of desire and purpose. The emptiness and pain manifests itself in poor work habits and even poorer relationships with family and others. Ineffective coping mechanisms lead to aberrant behavior, substance abuse, clinical depression, and, more often than we like to admit, suicide. And how could we describe more perfectly than Tolstoy the competitive drive for personal perfection that propels many of us to success and accomplishment.

What Did Tolstoy Do About It?

"But perhaps I have overlooked something, or failed to understand something?," Tolstoy asks. "It cannot be that this state of despair [referring to Tolstoy's condition] is common to all men!"[5]

And so he set out to find the answer. He observed those around him closely to determine whether and how they dealt with the problem. He also did some research, asking experts in the physical sciences, philosophy, and religion about their opinions.

What Did Tolstoy Observe Regarding How Others Deal with the Problem?

Tolstoy identified four different approaches among his peers to the problem, that is, in a few words, the inability to find meaning in life. The first approach was ignorance which "consists of failing to recognize, or understand, that life is evil and absurd,"[6] that life is meaningless. Tolstoy believed that people of this sort simply have not thought and do not think about their purpose or the meaning of life. Tolstoy concluded there was little to learn from these people; as Tolstoy says, "we can never cease knowing what we know."[7]

The second approach is epicureanism. It consists, while being aware of meaninglessness, in making use of the advantages one has to enjoy the immediate and material pleasures of life. As in Tolstoy's time,

> This second method of escape sustains the majority of people of our circle. The conditions in which they find themselves dictate that they have a greater share of the good things in life than the bad; their moral torpor allows them to forget that all the privileges of their position are accidental and that not everyone can have a thousand wives and palaces as Solomon did; that for every man with a thousand wives there are a thousand men without wives, and that for every palace there are a thousand men who built it by the sweat of their brow, and that the same chance that has made you Solomon today might make you Solomon's slave tomorrow. The inertia of these people's imagination enables them to forget why it was Buddha was granted no peace: the inevitability of illness, old age and death, which can, if not today then tomorrow, destroy all these pleasures.[8]

These people did not inspire Tolstoy as he could not artificially dull his imagination to eliminate the concept of meaninglessness.

The third approach that Tolstoy observed was one of "strength and energy:" suicide. Tolstoy believed that those who truly understood the meaninglessness "act accordingly and instantly bring an end to this stupid joke, using any available means: a noose round the neck, water, a stab in the heart, a train on a railway line."[9] Tolstoy thought that this was the worthiest means of escaping his misery, but he could not do it.

The fourth way to address the meaninglessness Tolstoy felt is that of weakness consisting "of clinging to a life that is evil and futile, knowing in advance that nothing can come of it."[10] Tolstoy found himself in that category.

Tolstoy's four categories apply equally today to wealthy and well-educated Americans. There are those who do not think of, or have not yet thought of, the issue; those who engage in the pleasurable activities of life in spite of their knowledge of the problem; those who end their lives; and those, like me, who wait. For something.

What Did the Physical Sciences Have To Offer?

Tolstoy, like many educated people, began his search with the premise that the answer must lie in science. He divided science into two categories: physical science and philosophy. Neither offered a satisfactory answer to his question.

With respect to physical sciences, he found that they did a superb job of describing the process by which we live and by which events occur in the known universe. In other words, physical sciences were occupied with the answers to the questions of "How?," "What?," or "When?" Tolstoy's problem, however, was a question of "Why?" Physical science simply did not bother with this issue.

As Tolstoy puts it –

> If we turn to those branches of knowledge that attempt to provide solutions to the questions of life, to physiology, psychology, biology and sociology, we encounter a startling poverty of thought, extreme lack of clarity and a completely unjustified pretension to resolve questions beyond their scope, together with continual contradiction between one thinker and another (or even with their own selves). If we turn to the branches of knowledge that are not concerned with resolving life's questions, but which answer their own specialized, scientific questions, we may be enraptured by the power of the human intellect, but we know in advance that they will provide no answers to the questions of life. These branches ignore the question. They say, 'As for what you are and why you live, we have no answers and do not involve ourselves with it. On the other hand, if you need to know about the laws governing light, or about chemical combinations, or about the laws governing the development of organisms; or if you need to know about the laws governing physical bodies and their forms, and the relationship between their size and quantity; or if you need to know about the laws governing your own mind, then we have clear, precise and irrefutable answers to all this.'[11]

How About the Abstract, Philosophical Sciences?

Philosophy, art, and other abstract sciences also offered no answers to Tolstoy. These sciences acknowledged the problem and acknowledged the existence of an essence of life. But, philosophy, in all of its forms, could not answer the question of our purpose generally or our purpose individually.

As Tolstoy says,

> [Philosophy] clearly poses the question: who am I? And: what is the universe? Why do I exist and why does the universe exist? And since it has existed this science has always given the same answer. Whether the philosopher calls the essence of life that is within me and within everything an idea, or a substance, a spirit or a will, he is saying the same thing: that I exist and that *I* am this essence. But how and why he does not know, and if he is a precise thinker he does not answer. I ask, 'Why does this essence exist? What comes of the fact that it is and will be?' And philosophy not only fails to answer but can only ask the same thing itself. And if it is a true philosophy, its whole task lies precisely in posing this question clearly. And if it holds firmly to its purpose then it can have no other answer to the question of what I am and what the universe is than: 'All and nothing.' And to the question of why the universe exists and why I exist, then: 'I do not know.'[12]

Tolstoy infers in *A Confession* that his despair deepened when he finally accepted that science and philosophy offered him no answers to the most important question of his existence. He, like many of us, proceeded through life with the idea that the answers to the questions that puzzle or affect us will be made available to us. We learn science and math and English in school, we learn to make a living, and we learn to raise a family. Many of us have access to the knowledge that we need and want when we need and want it. Often science advances at exactly the pace we need to satisfy our growing individual and collective curiosity.

This sense of confidence that knowledge will be made available remains when we first begin to ask "Why?" As the question becomes more important, and the answer becomes more elusive and maybe even unknowable, despair and anxiety set in.

What About Religion?

Tolstoy was most disappointed by the answers that organized religion provided to his predicament and a significant portion of *A Confession* discusses its shortcomings. But faith is a different story…[13]

What Was Tolstoy's Solution?

Two of Tolstoy's findings affected me greatly. The first was that Tolstoy was struck by the fact that "the poor, simple, uneducated folk," "the labouring people," "knew the meaning of life and death, endured suffering and hardship," and yet found "tremendous happiness in life."[14] For them, uncertainty, discomfort, and boring toil are parts of life that those who find contentment accept without question.

> In contrast to what I saw happening in my own circle, where the whole of life is spent in idleness, amusement and dissatisfaction with life, I saw that these people who laboured hard throughout their entire lives were less dissatisfied with life than the rich. In contrast to the people of our class who resist and curse the privations and sufferings of their lot, these people accept sickness and grief without question or protest, and with a calm and firm conviction that this is how it must be, that it cannot be otherwise and that it is all for the good. Contrary to us, who the more intelligent we are the less we understand the meaning of life and see some kind of malicious joke in the fact that we suffer and die, these people live, suffer and approach death peacefully and, more often than not, joyfully. In contrast to the fact that a peaceful death, a death without horror and despair, is a most rare exception in our circle, a tormented, rebellious and unhappy death is a most rare exception amongst these people. And there are millions and millions of these people who are deprived of all those things, which for the Solomons and I are the only blessings in life, and who nevertheless find tremendous happiness in life. I looked more widely around me. I looked at the lives of the multitudes who have lived in the past and who live today. And of those who understood the meaning of life I saw not two, or three, or ten, but hundreds, thousands and millions. And all of them, endlessly varied in their customs, minds, educations and positions, and in complete contrast to my ignorance, knew the meaning of life and death, endured suffering and hardship, lived and died and saw this not as vanity but good.
>
> And I came to love these people. The further I penetrated into the lives of those living and dead about whom I had read and heard, the more I loved them and the easier it became for me to live. I lived like this for about two years and a great change took place within me, for which I had been preparing for a long time and the roots of which had always been in me. What happened was that the life of our class, the rich and learned, became not only distasteful to me, but lost all meaning. All our activities, our discussions, our science and our art struck me as sheer indulgence. I realized that there was no meaning to be found here. It was the activities of the labouring people, those who produce life, that presented itself to me as the only true way. I realized that the meaning provided by this life was truth and I accepted it.[15]

A significant part of our dissatisfaction with life is that "we don't like what we do," "work is hard," "my boss doesn't appreciate me," "work is not emotionally fulfilling," "coworkers are difficult to deal with," "I don't make enough money," "the deadlines are unreasonable," or any number of a list of common complaints, some true and

some trivial. In order to find contentment, we must accept that these unpleasant things, whatever they may be, and struggle through them as a part of life – our life, the one that we are living now. When we accept our hardships as integral to our being, instead of complaining of them like a temporary ache that will go away, then we can live with more peace.

And the second of Tolstoy's concepts is that once we accept hardship as a part of life, our purpose here is to help others with their toils. By "toils" Tolstoy did not mean intellectual questions about theoretical matters of interest or issues related to the allocation of wealth or where we are going to build the next monument to ourselves or others. "Toils" to him meant matters that directly affect the comfort and well-being of all people:

> Indeed, a bird is made in such a way that it can fly, gather food and build a nest, and when I see a bird doing these things I rejoice. Goats, hares and wolves are made in order to eat, multiply and feed their families, and when they do this I feel quite sure that they are happy and that their lives are meaningful. What should a man do? He too must work for his existence, just as the animals do, *but with the difference that he will perish if he does it alone, for he must work for an existence, not just for himself, but for everyone.* And when he does this I feel quite sure that he is happy and that his life has meaning. And what had I been doing for all those thirty years of conscious life? Far from working for an existence for everyone, I had not even done so for myself. I had lived as a parasite and when I asked myself why I lived, I received the answer: for nothing. If the meaning of human existence lies in working to procure it I had spent thirty years attempting, not to procure it, but to destroy it for myself and for others. How then could I get any answer other than that my life is evil and meaningless? Indeed it was evil and meaningless.
>
> The life of the world runs according to someone's will; our lives and the lives of everything in existence are in someone else's hands. In order to have any chance of comprehending this will we must first fulfil it by doing what is asked of us. If I do not do what is asked of me I will never understand what it is that is asked of me, and still less what is asked of us all, of the whole world.[16]

As a lawyer, as my career advanced, my office become more opulent, my clients became more wealthy, and my cases became bigger and more document-intensive. Along the way, I lost contact with humanity, the great number of people who live out their days in some form of contentment without the ability or the desire to do "important" things. When I lost my contact with them, I lost my opportunity to know what was wanted of me, and I lost my sense of self. My way back to peace, and out of depression and despair, was to reconnect with humanity and to do my part "toiling" together with others. Tolstoy also lived the rest of his life helping others.

Footnotes

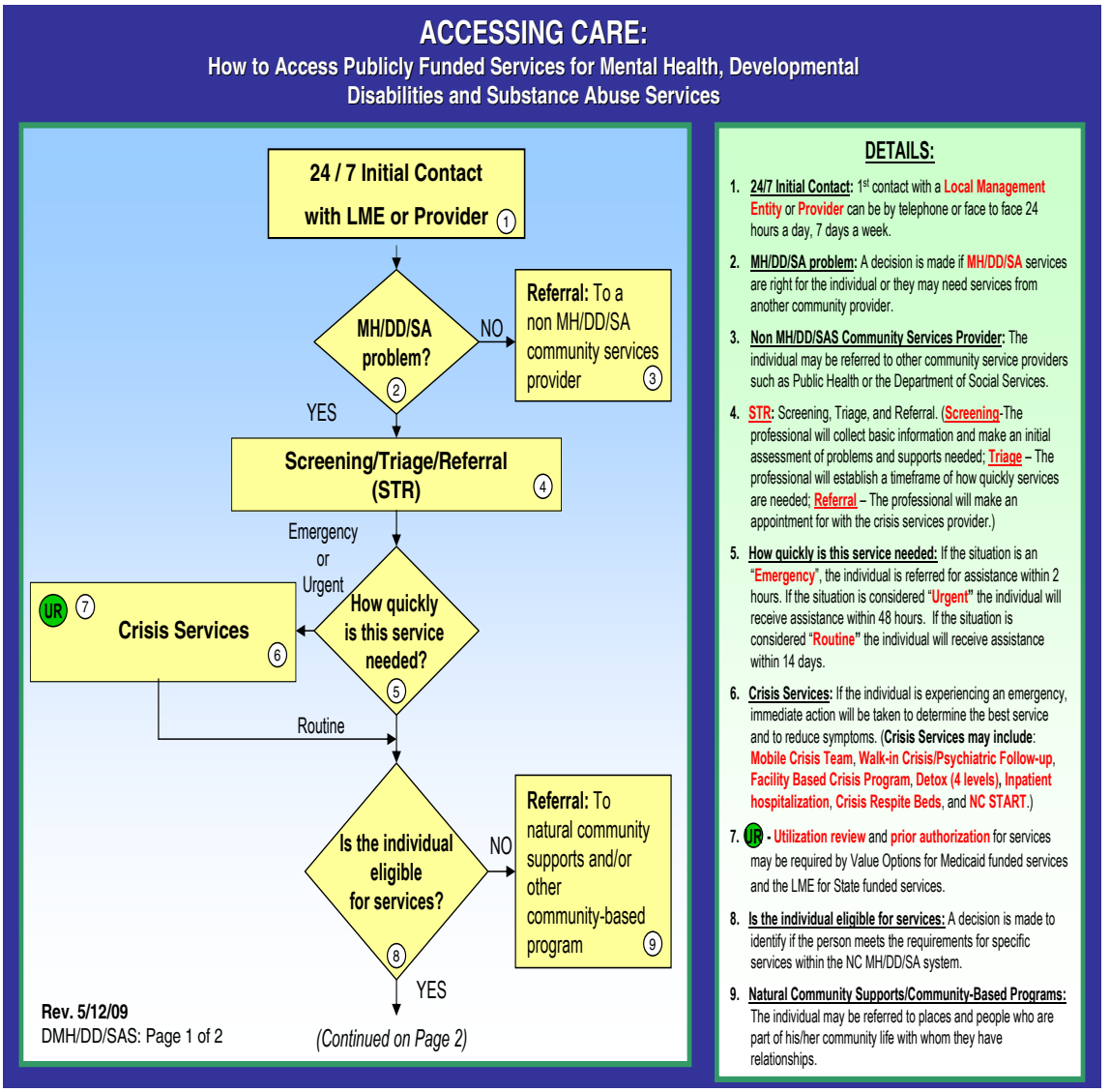
[1] Leo Tolstoy, *A Confession and Other Religious Writings,* Translated with an Introduction by Jane Kentish, Penguin Books, London, England, 1987, p. 7.
[2] Chapter 4, pp. 30-31.
[3] Chapter 1, p. 21.
[4] Chapter 5, pp. 34-35.
[5] Chapter 5, p. 34.
[6] Chapter 7, p. 45.
[7] Ibid.
[8] Chapter 7, pp. 45-46.
[9] Chapter 7, p. 46.
[10] Ibid.
[11] Chapter 5, p. 36.
[12] Chapter 5, p. 38
[13] See Chapters 1, 9, the first part of 10, and 12-15.
[14] Chapter 10, pp. 58-59.
[15] Chapter 10, p. 59.
[16] Chapter 11, p. 61 (emphasis added).

Memorable Memo

LMEs, CABHAs, and Other Acronyms To Challenge Your Mental Health

LME stands for Local Management Entity. CABHAs are Critical Access Behavior Health Agencies. Unless you are an insider in the world of mental health services, these acronyms are hard to understand. Once you get past the acronym, the only clue that they relate to mental health services is the use of behavioral health. Plenty of North Carolinians don't know what behavioral health is either.

Take a look at the chart provided by the state to consumers of mental health, developmental disabilities, and substance abuse services. There are 16 different steps and 16 different acronyms. LME, MH/DD/SAS, STR, NC START, IIH, MST, ACTT, CST, SAIOP, SACOT, TCM, CS, CAP-MR/DD, NC-TOPPS, UR, 24/7. All of these acronyms need to be reviewed—perhaps by the Joint Select Legislative Study Committee on the Use of Acronyms in Mental Health Services Provided by the State, or JSLSCUAMHSPS for short.

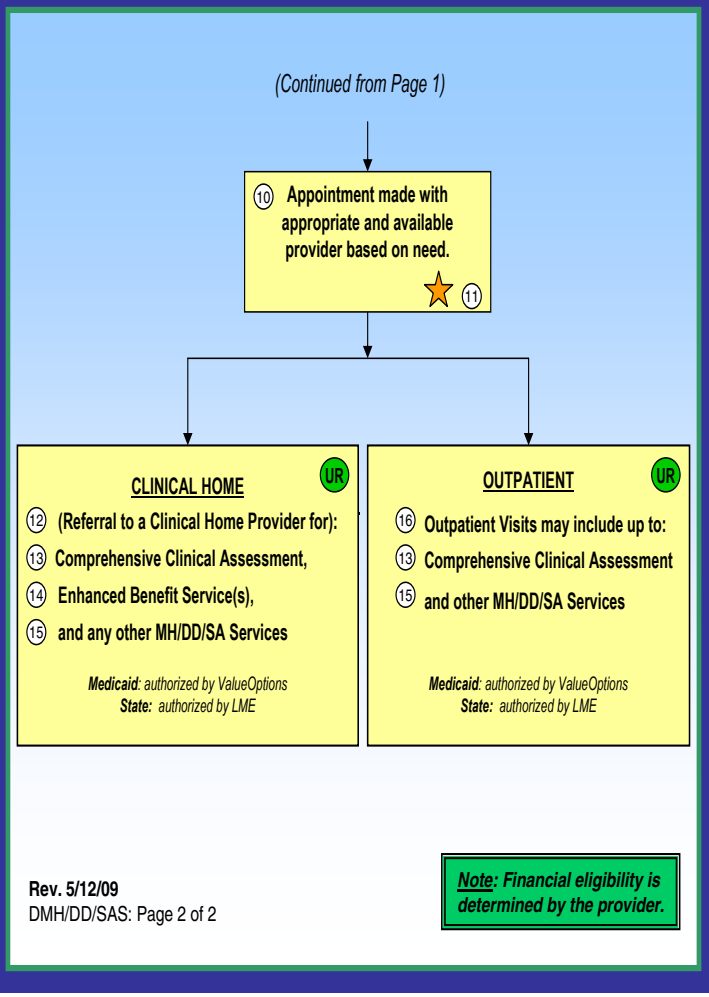


The people who use this system of care are often in crisis. Many are mentally ill. Others have developmental disabilities. The state has a duty, at a minimum, to use plain English, and provide a guide to the mental health system that can be understood and accessed easily by the consumers it is intended to serve.

In 1978, newly elected Governor Jim Hunt penned what became known as the Rock Ridge Memo, which *Insight* reprinted in 1982. This memorandum was directed to those in his administration who believed "the best way to impress the Governor is to fill pages and pages with obscure, multi-syllabic words." Instead, the Governor requested simple, direct language. Coming from the small rural community of Rock Ridge in Wilson County, Hunt's test for a good memo was "Would the average person at Rock Ridge understand it?"

Our test is "Would the average person needing mental health, developmental disability, or substance abuse services understand it?" The answer in this case is no.

ACCESSING CARE: A Flow Chart for New Medicaid and New State Funded Consumers, *continued*



DETAILS:

10. **Appointment made with the appropriate provider based on need:** The professional makes an appointment with a provider for specific services based on the individual's needs.
11. ★ - The individual may choose an appropriate and available provider.
12. **Clinical Home Provider:** If the individual is in need of multiple or complex services, a provider is responsible for coordination of all of his/her services. A **Qualified Professional** schedules a Comprehensive Clinical Assessment and assists the person in developing their **Person Centered Plan** & **Crisis Plan**, in completing various authorization forms and the **NC –TOPPS**. They also act as a **First Responder** in the event of a crisis.
13. **Comprehensive Clinical Assessment:** - A licensed professional conducts an assessment which is used to gather the clinical and diagnostic information necessary to develop the person centered plan. Assessment tools include, but are not limited to: Diagnostic Assessment, Evaluation/Intake, and State Substance Abuse Assessment.
14. **Enhanced Benefit Services:** Any of the following services may be included on the individual's Person Centered Plan:
    - **Intensive In-Home (IIH)**
    - **Multisystemic Therapy (MST)**
    - **Assertive Community Treatment Team (ACTT)**
    - **Community Support Team (CST)**
    - **SA Intensive Outpatient Program (SAIOP)**
    - **SA Comprehensive Outpatient Treatment (SACOT)**
    - **Targeted Case Management (TCM)**
    - **Community Support-Children/Adolescents (CS)**
    - **Community Support-Adults (CS)**
15. **Other MH/DD/SA Services:** There are other Mental Health, Developmental Disabilities and Substance Abuse Services that may be offered, including **CAP-MR/DD Waiver services**.
16. **Outpatient Visits:** If your needs can be met by outpatient services, you can receive services without prior authorization by **ValueOptions** or the LME. Authorization for services is required after 8 visits for adults, and 26 visits for children.