psychiatric services and follow-up care at the local level. In North Carolina, 30 counties do not have a psychiatrist, and an additional 14 counties only have one.[60]

Although work force shortages typically are seen as a problem related to follow-up care, they also bear on the ability of local hospitals to provide short-term care. According to Stephanie Greer of Appalachian Regional Healthcare System in Watauga County, financial concerns are not the sole barrier preventing community hospitals from providing inpatient care. They also need physical and medical resources, but perhaps most importantly, they need direct care workers *trained* to handle varying levels of mental health issues. Without such workers, hospitals will be unable to serve all the patients they could and will refer patients to state psychiatric hospitals even if local beds are funded.

Cristy Williams, the nurse at Catawba Valley Medical Center, says, "It is a totally different way of thinking when dealing with psychiatric patients." She stressed the need for "safety, safety, safety," and how that involves tasks such as knowing where patients are at all times and ensuring that doors are locked.

Because it is impractical and too expensive for most community hospitals to operate their own psychiatric training programs, Stephanie Greer and other community leaders argue that the state psychiatric hospitals should open their existing training programs for their own state hospital employees to the local community hospitals participating in the three-way contract program. Says Greer, "The community hospital can't

Opening Up State Training Programs to Local Mental Health Workers

by Stephanie Greer, Director, Behavioral Health Services, Appalachian Regional Healthcare System in Watauga County

There are two fundamental components to building inpatient behavioral health capacity. The first component is the development of the physical capacity, which is what the state historically has focused on. I believe that the second component of capacity is developing the clinical skills in milieu management, de-escalation, and crisis prevention necessary to be able to treat the level of crisis that is routinely seen in the state psychiatric hospital setting. It is this lack of clinical capacity that results in lengthy waiting lists at the state hospitals while there are still vacant beds in the communities.

I worked as an administrator at Broughton Hospital, a state psychiatric hospital, for 11 years prior to accepting my current position. I have become acutely aware of the fact that in a small community setting it is extremely difficult to duplicate the level of training needed to manage truly acute psychiatric patients. Across our state, small hospitals are forced to "reinvent the wheel" by developing training programs that focus on a psychiatric patient population without the economies of scale and level of expertise available at our state psychiatric hospitals.

I support the proposal that we develop collaborative relationships between our state hospitals and local hospitals who are actively participating in the three-way contracts for training opportunities in milieu management, de-escalation, and crisis prevention. This would involve shared training opportunities in which community employees would participate in training exercises with state hospital employees in the areas mentioned above. This initiative would simply mean opening up the already scheduled and staffed training calendars to the community hospitals to fill any vacant class slots. In doing this, we would be developing more consistency in training and enhancing the provision of clinical services to the patients served under the state