MAYOR'S MENTAL HEALTH TASK FORCE

REPORT

October, 2009

MAYOR'S MENTAL HEALTH TASK FORCE
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I. Task Force Creation and Activities

On October 15, 2008 Mayor Kevin C. Foy announced the establishment of a Mental Health Task Force to discuss, examine and assess the provision of mental health care in Chapel Hill (see Attachment A). The Mayor noted:

> The future of mental health care is uncertain. Over the past seven years mental health programs in counties across North Carolina (including Orange County) have either discontinued services or become independent nonprofit organizations operating with limited resources.
>
> The location of UNC Hospitals, a state hospital, uniquely affects Chapel Hill and Orange County. Patients from around North Carolina who need mental health services may choose UNC Hospitals as their treatment provider. UNC Hospitals can therefore serve as the initial access point to Chapel Hill for some patients. Patients who seek care at UNC may remain in the area upon discharge. Because of the current situation regarding treatment options, discharged individuals can have trouble getting access to ongoing treatment. Local nonprofits attempt to provide services, but often face the obstacles of limited budgets and limited staff.
>
> The Mayor asked the Task Force to:
>
> - assess the state of the mental health care system in the greater Chapel Hill community, focusing on the services provided, funding, and impact on the community as a whole;
> - create broader awareness of mental health care issues in Chapel Hill and generate discussion; and
> - provide recommendations regarding the future of mental health care services for residents of Chapel Hill and Orange County.

From the outset, it was the intent of the Mayor that the Task Force understand "the community as a whole" to mean both the Town of Chapel Hill and its environs – extending to Orange County as a whole. The composition of the Task Force reflects this intent and to the extent possible this thought guided the Task Force's work.

A BRIEF NOTE: From the outset, we wish to note that throughout its deliberations, and in this report, the Mayor's Mental Health Task Force defined "mental health services/system" to encompasses the mental health (community and institutional), developmental disabilities and substance abuse domains.

The initial "organizing" meeting of the Task Force was held on December 3, 2008 and subsequent meetings were held monthly through June 10, 2009. Agendas, brief summaries and full minutes of these meetings are available at the Mayor's Mental Health Task Force section of the Town of Chapel Hill website (http://www.ci.chapel-hill.nc.us/).

In the course of its deliberations, the Task Force established two work groups which met five times. The first group developed the proposal, "Supervision of Social Work Students and SA Professionals: Creating Capacity", included as Attachment B to this report. The second group created graphic illustrations of the mental health system that, at this writing, are being refined and will be posted on the Town of Chapel Hill Mayor's Mental Health Task Force website. This work group wrote observations/notes about the mental health services for particular age groups; these are included in Attachment C.

The Task Force collected a variety of resources and materials related to mental health reform, local mental services and climate and other pertinent topics. These were posted on an Internet blog site that was active during the period of Task Force deliberations. Many of these materials will continue to be available on the Town of Chapel Hill Mayor's Mental Health Task Force webpage.

One of the objectives of the Task Force was to gather the perspectives of citizens and providers. Thus, we asked Town of Chapel Hill department heads to inform us of their work with and/or exposure to mental health issues; the staff of the Orange County Community Resource Court talked with us; and we conducted two public "listening sessions", where we heard from both family and community members directly affected by mental illness and the providers who seek to serve them. We also received several comments on our blog site.

II. State mental health system reform: background and context for Task Force work

Reform of the North Carolina mental health system of services was mandated by the Legislature in 2001, after a series of federal reviews and actions, fiscal crises, and media exposes suggested that the mental health system was coming apart at the seams (see Attachment D). The intent of the "system transformation" envisioned by the legislature was to move services and programs into communities by 1) transferring individuals from state-operated institutions to community residential settings; 2) spinning off direct service provision from Local Management Entities (LME – in Orange County, OPC – the Orange-Chatham-Person Area Program) to private, service contractors; and 3) redefining the mandate of LME's to be primarily policy, oversight and management of the provider network, as well as certain screening, triage and other access-focused functions. The reform legislation also required input into service planning through consumer and family advisory councils (CFAC).

The consensus view throughout the mental health community is that from the outset, system transformation was under-resourced, poorly planned and monitored and bereft of skilled, coherent leadership. By 2005, with adult admissions to state hospitals actually UP and per capita mental health spending on the decline, criticism (e.g., "runaway train", "lack of accountability", "failure") was extensive in all quarters.

By 2008, when several concerned members of the community began to talk with the Mayor, it was clear that the vision of a consumer-responsive, community-based network of care had not been fully realized in Orange County. As was true elsewhere in North Carolina, the void of transition had been partially filled by providers whose practices increased the instability of the local system of care. Most notable had been the failure of the Caring Family Network as the primary operator of outpatient mental health clinics.

The following perceptions and observations regarding the state of reform in North Carolina capture what the Task Force considers to be the state of mental health system reform in 2009:

- The envisioned transformation of the system has not occurred; the system is fragmented and complex; it is characterized by "silos of care", as well as service and access gaps;
- State leadership has been weak and "reactive";
- Providers are losing money;
- The indigent care system is inadequate;
- Funds get siphoned off in many ways, leaving a landscape with many inequities;
- There are many under-served individuals, including those…
    a. …lost from the system during reform and never found again;
    b. …whose care is funded through Medicare;
    c. …at risk of homelessness or already homeless;
    d. …whose care is not already funded through Medicaid or private insurance;
    e. …in the 18-22 age group.

III. Mental health service delivery in Chapel Hill and environs

As part of its work, the Task Force reviewed and discussed the state of mental health services in the greater Chapel Hill area. Individual Task Force members and guests representing a variety of agencies and interests within the system made presentations and at two public "Listening Sessions", citizens and providers talked with us. Notes from all these presentations are available at the Task Force webpage at http://www.ci.chapel-hill.nc.us/. In addition, as noted above, the work group that focused on visually

describing the mental health/developmental disabilities/substance abuse system wrote notes which offer a broader perspective on issues affecting individuals in particular age groups who require mental health services (Attachment C).

The following represent key strengths of the mental health service delivery system in Chapel Hill and environs:

1. Chapel Hill and environs are served by a committed provider community representing more resources than are available in many other areas of state (Attachment E);

2. The University of North Carolina at Chapel Hill network of inpatient and outpatient clinics and resources has served as a *de facto* "safety net" for many in Orange County (and, of course, the state) who have been unable to gain access to services;

3. Local governments offer a variety of services and supports for families/individuals coping with mental health issues, as well as financial resources for some of the service agencies that work with them (Attachments F and G);

4. Within the difficult constraints of chaotic state reform efforts, the LME serving Orange County (OPC - http://www.opcareaprogram.com/) strives to maximize services;

5. The Orange County Mental Health Association (www.mhaorangeco.org/) and NAMI Orange County (http://www.nami.org/MSTemplate.cfm?MicrositeID=284) provide active, engaged leadership in the effort to better educate the public and overcome the stigma associated with mental illness and to advocate for consumer rights and quality services.

While we understand that these assets are by no means sufficient to address the many needs and concerns faced by families and individuals struggling with mental health/developmental disabilities/substance abuse issues, we do want to recognize that *positive outcomes can be achieved* through the existing system of care. (see Attachment H).

Unfortunately, such results are often overshadowed by the challenges facing those served by the mental health/developmental disabilities/substance abuse system in Chapel Hill and environs (see Attachment I). In the course of its deliberations, the Task Force identified a number of important challenges, including:

1. A wide range of gaps in service, most notable of which appear to be:
    a. Transportation for those needing/wishing to access services;
    b. Adult day programming to provide caregivers with respite and participants with social activities and services;
    c. After hours and weekend services;
    d. Post-hospitalization continuing care;
    e. Services of all types for those aged 18 to 25 and their families;
    f. Social work services for shelter residents;
    g. Services for elderly individuals suffering from depression – with or without the co-existence of dementia.

2. Over-reliance on University of North Carolina – Chapel Hill resources as both first and last resort.

3. The attraction our area holds for people with mental health issues, both because of UNC and the general climate (e.g., free transportation; lower unemployment; richness of resources).

4. The difficulty families and individuals experience with navigating the mental health system. Often, they do not have knowledge/capabilities to make their way through the system and there is no simple road map to help with this.

5. The advantage for access to services held by individuals with Medicaid coverage. HOWEVER, qualifying for Medicaid coverage takes a very long time. Those with private insurance often find themselves having used up allotted hours or unable to afford the co-pay.

6. An inadequate supply of safe, affordable housing – adding to the challenges faced by those served by the mental health system.

IV. The newest challenge: A shrinking resource base

During the period in 2008 when the Mayor was planning for and convening this Task Force, the full extent of the recent, national economic crisis had not yet been revealed. Unfortunately, as we were reviewing the local impacts of an already weak state mental health system, members of the Task Force both witnessed and directly experienced the tightening grip of recession. Within a month or two of her election in November 2008, the new Governor was anticipating a $2 billion budget revenue shortfall and the Department of Health and Human Services was contemplating reduction of the Medicaid budget by some $224 million, as well as sharp cuts in mental health services – including shut-down of the Wright and Whitaker schools for disturbed children.

In August 2009, the Legislature approved the 2010 state budget, which includes major cuts (approximately $75 million) to the mental health/developmental disabilities/substance abuse service system – including elimination of community support services. (See Attachment J.) According to OPC,

> This translates into $2,250,518 in cuts to the state funds available for services in Orange, Person, and Chatham Counties. This represents approximately 21.5% of our non-crisis state service funding. These cuts in service dollars limit the amount of state dollars available to serve adults and children who do not have health insurance, but are in need of mental health, developmental disabilities, and substance abuse services. In addition, reductions in Medicaid services will affect people with these challenges as well.

We have included in Attachment K a detailed Question and Answer document put together by OPC to address the many questions that local citizens and governmental officials may have about the impact of state

budget cuts. This information is posted on the OPC web page (http://www.opcareaprogram.com/) and will be updated as changes occur.

All of us who care about the availability and provision of quality mental health/developmental disabilities/substance abuse services view this turn of events as a major and serious blow to efforts of local citizens, policy-makers, advocates and providers to improve care in our community.

V. Task Force conclusions and recommendations

It is difficult to identify *concrete, meaningful* ways that we at the local level can have an impact on either state system reform or the particular choices made by legislators to address the budget shortfall. Certainly, we can add our voices to those of active advocates for change at the state level (e.g., our local legislators; NAMI; Mental Health Association; other professional organizations). In addition, we believe that efforts to more fully educate and sensitize state legislators and policy leaders would be enhanced if local providers were to come together, develop an advocacy/education agenda and speak collectively. The providers in our community have been working against the tide for many years. Aside from the families and clients themselves, who better understands the devastating impact of over-regulation and under-payment, service gaps and fragmentation, Medicaid cuts, barriers to information-sharing and the litany of other system flaws? While we understand that time spent toward system improvement is not reimbursable and might be viewed as "taking away" from client service, we believe that a strong, collective provider voice could, in fact, significantly "add value".

Ultimately, it was the Task Force's conclusion that our own efforts were best directed to identification of local actions that might be taken by citizens and leaders of our community to improve awareness, coordination, capacity and delivery of mental health, developmental disability and addiction services within the Orange County community. Within an environment of extreme constraint, we believe that the following recommendations, if implemented, could lead to positive local change, in the form of 1) additional service capacity and 2) increased community awareness of and sensitivity to the needs and challenges of the mentally ill AND greater inclusiveness.

Service Capacity Increases

1. *Increase MSW student placements in provider agencies and add clinical supervision for students and provisionally licensed workers.*

One of the key partners in mental health service delivery in our community is the School of Social Work at the University of North Carolina-Chapel Hill. This past year, the school had 68 students in 58 field placements in Orange County. Of these placements, 55 were considered mental health placements. Nationally and in North Carolina, there is a serious workforce shortage of trained mental health social workers, due primarily to retirement, attrition and training-related issues. The school would like to place more students in Orange county mental health agencies with supervision. However, placement locations with good supervision are lacking because students cannot bill for their services; clinical supervision time is time taken away from billable activities; and economic uncertainties make potential field instructors reluctant to take students.

As noted earlier, a Task Force work group met several times to discuss these issues. They developed the proposal included in Attachment B. This proposal is already being circulated as part of the search for funding. Hopefully, a partnership of UNC School of Social Work, Task Force members, town and county leaders, social workers and others concerned about mental health service capacity issues will emerge to carry this plan to fruition.

2. *Create a partnership with the Mental Health Association in Orange County to expand the Pro Bono Counseling Network.*

The Mental Health Association in Orange County (MHAOC) is the local, nonprofit affiliate of the Mental Health Association of North Carolina. In its work, MHAOC emphasizes coalition building/collaboration, peer and social support, volunteerism and public education and advocacy. The Pro Bono Counseling Network is a program operated by MHAOC in partnership with Healthy Carolinians of Orange County, OPC and private practice therapists. The goal of the program is to fill the service gap for people in need of counseling who do not qualify for publicly-funded services and who lack private insurance and cannot afford to pay out of pocket. The Pro Bono Counseling Network recruits private practice therapists to see 1 or 2 clients per year on a pro bono basis. The program coordinator screens and matches referrals and conducts ongoing follow-up.

Recognizing that Orange County is rich in professional resources (both active and retired), the Task Force is recommending expansion of the Pro Bono Counseling Network. We believe that both recruitment of more volunteers and increased volunteer time commitments are possible and we hope that OPC, the MHAOC, provider agencies and town/county leaders will actively promote this volunteer opportunity as a way of increasing the capacity of the mental health service system. The possibility has also been suggested that key professional associations (e.g., National Association of Social Workers) might be asked to consider providing continuing education credits for volunteers or adding participation in such a network as a requirement for licensure.

Enhanced local law enforcement/safety personnel awareness of and sensitivity to mental health issues

1. *Extend Crisis Intervention Training* (CIT) *throughout the ranks of local law enforcement and, ultimately, to other safety personnel.*

The CIT program is a partnership of the mental health/developmental disability/substance abuse service system and consumer, advocacy and law enforcement agencies. Twice yearly, the program provides 40 hours of specialized training by OPC staff to sworn law enforcement officers. Program benefits include:

- Decreased incidents of incarceration of persons with mental illness for misdemeanor charges.
- Connections of persons in mental health crisis to appropriate mental health services rather than the criminal justice system.
- Decreased consumer and officer injury rates.
- Decreased use of force occurrences.
- Creation of an earlier opportunity to engage consumers in mental health services.

A CIT-certified law enforcement instructor must attend each of the 40-hour training sessions and teach certain modules, and personnel from the law enforcement agency must participate on the CIT Implementation Committee on an ongoing basis to assist with development of policies and procedures. The Chapel Hill Police Department has been very involved with OPC in planning crisis intervention training.

The Mental Health Task Force recommends that, over time, CIT be extended throughout the ranks of all law enforcement agencies in Orange County. We urge County and Town leaders (e.g., Mayors, Managers, Commissioners, etc.) to 1) learn more about the benefits of CIT for the community and 2) exercise leadership

in encouraging local law enforcement personnel to participate in training. While the recent shooting of a UNC student by a law enforcement officer did not occur within the boundaries of our county, the incident provides a strong reminder of the need for special care and attention as law enforcement personnel handle individuals with mental health issues.

Strong local government leadership around mental health/developmental disabilities/substance abuse concerns

1. *Use local government offices (Mayors and Managers) and legislative bodies (Council, Commissioners, Aldermen) as platforms ("bully pulpits") and vehicles of support for campaigns/efforts to proactively increase community awareness of mental health/developmental disabilities/substance abuse issues and to reduce associated social stigma.*

The need for stronger political and community leadership ran clear as a theme through the deliberations of the Task Force. We heard this in the pleas of those who spoke to us at our listening sessions and offered a "public face" for the issue. We ourselves had long discussions about the importance of promoting a "message" that would draw members of the community-at-large to a fuller understanding and realization that we have many among us who are facing difficult challenges and who, often, are not living the comfortable and "safe" lives that we assume. As one Task Force member articulated: What does it mean when it is quiet in our towns and county? Is all well? NO. Something is wrong across our dedicated pool of service providers and across our county. A group of community members who were already struggling are now challenged almost beyond imagination. Yet, no alarm is being sounded by our political and community leadership.

We believe that the persistent work of message dissemination and awareness-raising could make a difference for the mentally ill in our county. A clear message from our political leaders that *we care about <u>all</u> our vulnerable citizens* would set a new tone for our community. The Task Force recommends that town and county legislative bodies consider establishment of ongoing capacity for providing *issue leadership* over the longer term. Possibilities include:

- Standing committee(s) of Commissioners/Town Council/Aldermen
- Subcommittee(s) of Human Services Advisory groups
- Joint local government committee/group formed through Assembly of Governments
- Capacity within Mayor/Manager offices

The presence of ongoing capacity and issue leadership within local government would greatly contribute to the ability of OPC, individual Task Force members, MHAOC and others to partner with local government to carry out these particular recommendations:

a. Collaboration of local governments with MHAOC, Healthy Carolinians and other advocacy groups to reduce the social stigma associated with mental illness through a public information campaign: advertising on town buses, public service announcements and other materials for distribution. (Many national resources are available.)

b. Dissemination of information about mental health issues/resources in town/county employee orientations, through pay check notices, OWASA bills, etc.

c. Proactive efforts by town/county officials and school system leaders to 1) increase collaboration between schools and mental health professionals and 2) educate families and children about signs of depression, substance abuse, etc.

d. Increased local government collaboration with UNC Center for Excellence education efforts.

e. Use of the Town of Chapel Hill Mental Health Task Force web page and other local government web pages as vehicles for public education and dissemination of information.

f. Local government support for volunteer groups that are working to increase public awareness of the needs of the mentally ill.

g. Local governments and OPC collaborate to increase public awareness of the OPC Star Unit as the primary entry point into the mental health system. Campaign to publicize telephone numbers - 919-913-4100 or 1-800-233-6834.

In addition, Task Force members themselves have made a commitment to:

a. Continue working with the Town of Chapel Hill to ensure that the Town website includes important information and resources related to issues faced by those with mental health/developmental disabilities/substance abuse issues.

b. Write letters to the editor and seek media opportunities (profiles of provider agencies, Op Eds, etc.) tied in with a campaign to increase public awareness.

c. Increase community awareness of mental health-related issues through appearances before various local government bodies, meetings with governmental staffs, dialogue with the County Human Services Commission and Town Human Services advisory groups, presentations to local service groups and other related activities.

d. Explore ways to partner with the county Third Sector Alliance – perhaps to create an ongoing work group around mental health/developmental disabilities/substance abuse issues.

e. Partner with the Town of Chapel Hill and the UNC Center for Excellence to convene issue-focused symposia.

ATTACHMENT A

AGENDA #5a

MEMORANDUM

TO: Town Council

FROM: Kevin C. Foy, Mayor

SUBJECT: Mayor's Mental Health Task Force

DATE: October 15, 2008

PURPOSE

The purpose of this Task Force is first to identify the impact on the Chapel Hill community of changes in the mental health service system, second to create awareness and generate discussion about the mental health service system, and third to make recommendations for the future.

BACKGROUND

In 2001, the North Carolina General Assembly implemented reforms to the State's mental health service system. The intent of the reform was to transfer patients from hospitals and other state institutions to community programs. However, a combination of the privatization of services and new regulations left many people without services. In addition, hospital admissions continue to rise. Local Management Entities (LMEs) have sometimes been unable to effectively navigate the new regulations and provide adequate care for people in need.

The future of mental health care is uncertain. Over the past seven years mental health programs in counties across North Carolina (including Orange County) have either discontinued services or become independent nonprofit organizations operating with limited resources.

The location of UNC Hospitals, a state hospital, uniquely affects Chapel Hill and Orange County. Patients from around North Carolina who need mental health services may choose UNC Hospitals as their treatment provider. UNC Hospitals can therefore serve as the initial access point to Chapel Hill for some patients. Patients who seek care at UNC may remain in the area upon discharge. Because of the current situation regarding treatment options, discharged individuals can have trouble getting access to ongoing treatment. Local nonprofits attempt to provide services, but often face the obstacles of limited budgets and limited staff.

DISCUSSION

I am creating a special Mayor's Mental Health Task Force to discuss, examine, and assess the situation of the mental health care system in Chapel Hill. The charge of the Task Force is:

1. To assess the state of the mental health care system in the greater Chapel Hill community, focusing on the services provided, funding, and impact on the community as a whole.

2. To create broader awareness of mental health care issues in Chapel Hill and generate discussion.

3. Based on the Task Force's findings, provide recommendations regarding the future of mental health care services for residents of Chapel Hill and Orange County.

ATTACHMENT B

Supervision of Social Work Students and SA Professionals:
Creating Capacity

Background

- There are decreased resources for medically indigent clients (i.e. those without Medicaid or other insurance)
- The current market is a "seller's market", where providers can pick and choose clients
- This results in real difficulty in accessing services for two groups—medically indigent and difficult to serve
- In addition, there is a workforce crisis, for both P-LCSWs/LCAS registrants (workers who are provisionally licensed) and MSW (Master of Social Work) students.
    - State changes in policy result in P-LCSWs being unable to bill for many services – they must have full licensure, or work as Qualified Professional in Community Support Services or other enhanced services, in order to bill and generate revenue
    - P-LCSWs and LCAS registrants also require clinical supervision in order to get their full licenses, but this clinical supervision can be a burden on the agency, since it takes time of a licensed professional away from billable services. So "growing" the next generation of licensed professionals is hard
    - For MSW students, the challenge is finding good field placements that do 3 things: 1) provide good training in evidence-based practices; 2) get students excited about and committed to public sector work; and 3) provide good clinical supervision. The cost of clinical supervision, as mentioned above, is prohibitive in some places.
- Summary: for a number of reasons, we have *reduced service capacity* and are *not growing the next generation of trained workforce* in the public sector.

Possible Solution

- For MSW Students:
    - Increase the number of MSW students with internships in Orange County public mental health/developmental disabilities/substance abuse service agencies. Have them focus on providing services to medically indigent to increase service capacity
    - Provide them with strong clinical supervision and with cross-agency training in evidence-based practices, with agencies sharing training resources. By providing a diverse supervision experience in the field, we are literally "taking walls down on silos"

- For P-LCSW and LCAS registrants
    - Provide additional best practice clinical supervision hours to allow them to get their full licenses and to become stronger members of the workforce. Cross-agency group supervision would also provide cross-population training and "cross fertilization"

Strategies

- Provide agencies with a stipend to hire a LCSW or LCAS to provide group clinical supervision to P-LCSW and LCAS registrants, so they can hire more of them and provide supervision without incurring additional prohibitive financial burden.
- Provide agencies with a stipend to offset the cost of providing clinical supervision to MSW students, so that agencies can take on more students. This could be group and individual.
- Share information across agencies about trainings that students could attend (Google calendar?)
- Find resources via grants, leveraged through the Mayor's office

Estimated Costs

- 30 hours per year per student @ $100/hr ($3000/student), 10 additional students==$30,000
- $5000 for supervisor for P-LCSW group
- TOTAL=$35,000

Evaluation

- For MSW Students: Use Field Evaluation form (database) and track to see how many students go into and stay in public system 5 years post-graduation
- For P-LCSW and LCAS registrants, see how many are successful at getting full license, and see how many go into and stay in public system 5 years post-graduation

Phases

Year 1:

- Look for funding
- Design evaluation
- Shared education piece
- Gathering resources for supervision model
- Calendar & training

Year 2:

- Provide stipends to agencies and begin to place and supervise 10 additional MSW concentration year students in Orange county agencies
- Provide funding for a clinical supervisor across agencies and begin to provide clinical supervision to additional P-LCSW and LCAS registrants in Orange county agencies

Proposal developed by:

Trish Hussey
Tom Reid
Anna Scheyett

ATTACHMENT C

Work Group Notes
Mental Health Service Delivery System

0-2 AGE GROUP

- Referrals come from a variety of sources including DPH, DSS, school systems, families, child care, Early Head Start and other community agencies.

- TEACCH is an important resource for individuals who need to be assessed, or have been diagnosed with Pervasive Developmental Disorder or Autism. Families move to Chapel Hill to access TEACCH.

- Although pediatricians are not the PRIMARY point of entry, there is a widespread effort to increase referrals through the "medical home". There is a requirement that children who have Medicaid and are in the Carolina Access system be given a developmental screening at each well-child visit. Adherence to this requirement could help identify children for referral to the CDSA for assessment.

Funding Sources

- Infant Toddler (IT) services are funded through Medicaid, Public Health (Purchase of Medical Care System) and private insurance.

- Children referred for Infant Toddler services primarily qualify under "developmentally delayed".

- If children are referred for mental health concerns and don't qualify for Infant Toddler services they can be funded through Medicaid, or on rare occasion, with state mental health funding. Providers are all private under this system.

- Enhanced services through DMH do not include this group. Basic outpatient services start at birth.

3-17 AGE GROUP

Typical Referral Sources for Public Mental Health Services

- Juvenile justice (typically up to age 16 yrs)
- Department of Social Services
- Chapel Hill Police Crisis Units
- Schools

Funding Sources/Issues

Funding for MH/SA/DD services for individual children
- Medicaid (0-21 yrs)
- IPRS (3-18 yrs)
- Private insurance (age is based on policy and student eligibility)
- HealthChoice (6-19yrs)
- Occasional specialized grant programs

Funding for supports for individual children
- Multiple DSS funds for individual children in DSS custody (ex. room and board, LINKS for teenagers)

- Exceptional Children's services for who have qualified for an IEP (Schools pay for special education services from age 3 to 21 yrs; prior to three years CDSA/public health fund services for children with developmental delays)

Funding for Support of MH/SA/DD Programs
- Smart Start 0-5 year olds
- Some IPRS funds (with approval from the Division)
- Towns of Chapel Hill and Carrboro
- Orange County
- Schools
- Local Foundations
- Grants

Major Challenge
If over 16, a young person is handled in the adult criminal system, but is still considered a child in the service (care) system.

18-21 AGE GROUP

Observations

There are two groups of particular concern:

1) Young people who have been served in the child mental health system
2) Young people who start to experience psychiatric symptoms in their transition years (first break of psychosis, emergence of substance abuse)

Both of these groups may have similar development life issues that lead to ambivalence for continuing or seeking treatment. These young people may be living away from home for the first time and associating with peers involved with drug/alcohol abuse/use which may mask their symptoms for some time before a crisis propels their entry into the system. So when these young people enter or reenter the system, their level of need is quite high. Homelessness is often hidden with this group. If they are homeless, they are often "couch surfing" with friends and not using homeless shelters.

Oasis' (http://www.psychiatry.unc.edu/oasis) experience is that those seen with first psychotic breaks are 70% male and 30% female. They have not been served in the public child system and very few have gone through OPC to access adult services. Many have private insurance. Young people and their families are trying to simultaneously understand this new potentially devastating illness at the same time they are trying to work through what insurance will cover. The insured in this age group are also vulnerable to losing private insurance if they leave school.

Challenges – Young People

- Young people who have been served in the child system may disappear from the service system for some time before reemerging on their own or through mandate by involvement with court system.
- If a young person loses Medicaid after turning 18 yrs, the criteria for eligibility for adult IPRS services is much stricter and some young people will not qualify for services.
- If a young person moves beyond DSS foster care age, (s)he can maintain their Medicaid until age 21. Young people aging out of foster care also have supports for higher education and some limited LINKS funds to support their transition to adulthood.
- Youth previously covered under parents' private insurance may become uninsurable when no longer in school.
- A particular challenge in the system is that if a young person has Medicaid and a service is medically necessary, the mental health provider should be able to request authorization from Value Options to provide

an array of services that meet that young person's set of needs. When XDS has attempted to obtain authorization for ACCT services for young people 18-21 years of age, the amount of time spent on seeking appeals has prohibited XDS' ongoing ability to serve this age range.

- There are few housing and programming options for young people with mental health challenges. The existing mental health programs are often not a good developmental fit for this age group.
- Unless the parents have obtained guardianship, the young person becomes their own guardian at age 18 years.

Challenges – Providers

- For provider to serve this age group, must make a huge expenditure of non-billable time. This is a challenging age group – very few providers.
- Provider agencies never know exactly what their budgets are/can be – cuts can come anytime and can be retroactive.

22-64 AGE GROUP

Challenges

- The system is fragmented - no one knows where to go.

- Lack of preventive care.

- Developmental Disabilities agency can't provide both services and case management; must be separate functions.

- Current case management is ineffective. Agencies set up shop and then find there is no money and leave. Agencies cherry-pick clients who have billable hours. Case management disappeared – there needs to be an access team that knows about local providers and resources and processes

- Sharing of information is a huge challenge – differing interpretations of confidentiality laws. Challenges to continuity of care. Under old system, state hospitals, area programs, and UNC hospitals could share information on shared clients to ensure continuity of care. With privatized, fragmented system, much more difficult.

- Difficult to find providers for particular groups, such as people who set fires and sex offenders; borderline personality disorders; DBT Dialectical treatment areas. These individuals use up resources if not treated properly.

Funding Sources/Issues

- Providers can bill Medicaid but many clients are not eligible for Medicaid AND there are several different types of Medicaid, for which there are various eligibility restrictions. Reapply based on other diagnosis after initial entry. Takes time to follow the client.

- Difficult for mentally ill who do not have Medicaid to access services. Many disabled adults have disability income that is too high for them to qualify for Medicaid. They may have significant service needs that Medicare does not pay for. Co-pays are high. Limited number of providers in the community are certified as Medicare providers. Similar difficulties apply to dual-eligible's – those with Medicare and Medicaid. Medicare is considered the primary insurance, so providers who are not certified Medicare providers cannot receive Medicaid payments either.

- Private insurance does not pay for services needed by the more severely ill (ACTT, Community Support).

65+ AGE GROUP

UNC

- UNC has three psychiatrists who specialize in geriatrics. Clients can get appointments at UNC, but follow-up psychotherapy is limited because the teaching practice focuses on medication management. There are no licensed psychologists or social workers to provide evidence-based interventions as an adjunct to medication.

- No mental health staff in geriatric psychiatry or the geriatric medicine clinic focuses on caregivers to provide behavioral recommendations to mitigate patient's symptoms. Caregiver education and behavior training is not reimbursed by Medicare or private insurance.

Community Providers

- There are very few mental health practitioners outside of the university system who specialize in geriatric mental health. Few therapists have specialized skills or interest in the geriatric population.

- Few mental health practitioners accept Medicare. Those who do often limit the number of Medicare clients they accept in their client mix. At any given time, which therapist will accept a new Medicare client is unknown. This makes referrals difficult and time consuming.

- Home and Community Block Grant funding in local aging agencies can pay for mental health counseling, but this is only *theoretical* since no aging agency in the state uses the funding for this service. Instead HCCBG funds are traditionally used for in-home aides to assist with personal care and other functional tasks with the goal of postponing nursing home placement.

Public Mental Health System

- OPC pays $20,000 to 3 private MH providers to incentivize acceptance of Medicare.

- NC MH/DD/SA has one program for geriatric mental health. They provide "Geriatric Care Specialist Teams" that usually consist of a nurse and a social worker who provide mental health education and consultations to long-term care staff in assisted living facilities and nursing homes in a few counties. The use of designated personnel in facilities has met with mixed reviews at best.

- Individuals who experience late-life mood disorders and/or dementia do not receive public mental health services because they have insurance (Medicare) – even though it is infrequently accepted by mental health providers.

Barriers to Successful Geriatric Mental Health Care

- For people 65+ there is a heightened sense of stigma about mental health issues. Therefore, diagnosis and acceptance of a mental health treatment is rare.

- Geriatric depression estimates in the 65+ community dwelling population range from 16%-32%.

- Mood disorders are often under-diagnosed – partially due to the priority of other acute and chronic illness and partially due to stigma and the lack of skilled geriatric providers.

- Most geriatric patients seek treatment in a primary care setting. Most primary care physicians do not have time to address psychiatric issues, and when they do so, they rely solely on medication, but few 65+ patients take psychotropic medications consistently. In fact, 68% of the 65+ population in primary care practices stop taking anti-depressant medication within 4 weeks of starting it.

Results of Inadequate Mental Health Care in the 65+ Population

- Suicide risk is high. 65+ population accounts for 25% of the suicides but only 13% of the population. The majority of completed suicides in the 65+ population were seen by a primary care doctor in the last month, highlighting a missed opportunity to intervene.

- Geriatric mood disorders lead to increased medical costs, increased hospitalizations, longer hospital stays, physical disability, decreased functional ability, and placement in long-term care facilities.

- Geriatric depression and geriatric behavioral symptoms, especially those caused by dementia, cause significant family stress leading to adjustment and mood disorders among caregivers and early institutionalization of 65+ patients.

Future of Geriatric Mental Health

- There are not enough geriatric psychiatrists in training to manage the next generation of seniors. Current payment structures are a disincentive to practice geriatrics.

- UNC School of Social Work does not have any faculty who specialize in clinical geriatric mental health practice; therefore, students are not being prepared to meet the mental health care needs of the current 65 population or aging boomers.

- Mental health practices will be challenged by the epidemic of dementia-related disorders and the resulting behavioral issues and care needs.

    -- The best practice models of geriatric mental health treatment involve the use of mental health providers in primary care practices to follow through on medication use and to provide therapy based on problem solving and behavioral models. At present, Carolina Access is in conversation with UNC Geriatric Psychiatry to initiate pilot use of a geriatric depression care specialist in primary care practices in Orange and Chatham Counties.

ATTACHMENT D

COMMENTARY ON STATE MENTAL HEALTH REFORM

News & Observer
Published Sun, Apr 30, 2006
Jean P. Fisher - Staff Writer

For mentally ill, reform falls short

Dorothea Dix Hospital was home to Kathi Dunphy's 39-year-old daughter, Jacki, for six years. But a few months ago, Jacki started on a new medication for bipolar disorder that helped her reach her best emotional health in years, so her doctors decided she was well enough to leave.

But instead of going home, Jacki went to a Cary rest home, where most residents are frail and elderly. The place is clean and the staff seems friendly, but Dunphy wonders how long her daughter will stay healthy there. Jacki is prone to depression and thoughts of suicide, and her health deteriorates without structure and daily activities. "Last week, she said she'd give me $20 if I'd take her back" to Dix, Dunphy said.

Trading one institution for another was not what state leaders promised five years ago when they revamped how and where people are treated for mental illness. People like Jacki -- The News & Observer agreed not to reveal her surname -- were supposed to be able to live in small groups or independently in their hometowns. They were supposed to have medical appointments, get job training, learn life skills, socialize -- all within their communities, outside of institutions.

Most everyone involved in the mental health system says those ideals are unmet. This year, however, there are signs that mental health care might finally get the significant funding that was promised. When state legislators return next week, mental health funding will be among the top issues.

Carmen Hooker Odom, state Health and Human Services secretary, acknowledges that transforming the state's mental health system has been difficult. "To create that change, you have to go through the process of destroying the existing system," she said. "You don't have to be a psychiatrist to know that people do not like change."

Many people who are dismayed at how mental health reform has progressed agree in principle with its goal. The idea is to give people with brain disorders every chance to live full, productive lives amid family and friends. "It's a good idea -- I totally embrace it," said Debra King, executive director of CASA, a Raleigh agency that manages affordable housing for people with mental illness. "But it's how you pull it off. I just can't figure out how we could have planned so long for things to have turned out so poorly."

Not a lucrative field

Five years into the reform process, the state still faces a desperate shortage of subsidized housing for the mentally ill. Patients released from state mental hospitals are frequently discharged to homeless shelters or, like Jacki, to adult care homes. And despite predictions that free market forces would ensure an ample supply of mental health programs, many communities have not seen private businesses clamoring to set up new services.

It's not a lucrative field. Many patients live on disability income and are covered by Medicare and Medicaid, which typically pay less than market rates for care. Others are uninsured or covered by private insurance that strictly limits access to treatment and services.

Compounding matters, private businesses aiming to offer new programs didn't know what services the government would pay for, and at what rate. The state Medicaid program was expected to publish that information years ago; it came last month.

"Many providers didn't want to sign contracts, didn't want to step into this until they knew," said Janet Schanzenbach, interim executive director of the N.C. Council of Community Programs. The council represents local mental health agencies, which must line up community-based services and manage patient care. As a result, when some families have sought community care, they have found few options.

Few choices

A lack of enriching day programs in the Triangle was the main reason Chary and Robert Sundstrom of Cary sent their 28-year-old daughter, Juli, who has schizophrenia, to a private residential program in Western North Carolina. When Juli was younger, the Sundstroms enrolled her in college to keep her active and engaged. Chary Sundstrom went with Juli to classes at Meredith College, and if Juli grew disruptive, her mother was there to intercede. With that support, Juli earned a bachelor's degree in mathematics -- with honors. "But I'm not going to live forever, so I can't follow her around forever," Chary Sundstrom said.

At CooperRiis, a working farm community in Mill Spring that residents help run, Juli has a job in housekeeping. She can take exercise classes, explore the 80-acre grounds and join other therapeutic activities. "She's gotten better there," said Chary Sundstrom. "She loves it."

But CooperRiis is not a permanent residence. Its mission is to teach people how to maintain lives in the outside world, and Juli graduates in October. Her parents hope she can be placed in a program affiliated with CooperRiis, though that would keep her hours away. If that isn't possible, the Sundstroms will reconsider the Triangle.

Some new resources have opened in Wake County since the Sundstroms last looked. A clubhouse that helps members practice vocational and social skills, Club Horizon, opened in Knightdale in 2004. But if Club Horizon isn't right for Juli, Robert Sundstrom wonders where the rest of the choices are. "I just don't see a lot of these programs out there," he said.

Cash on the horizon

Bob Hedrick, executive director of the N.C. Providers Council, which represents private service providers, said families and advocates for the mentally ill need to give reform a little more time.

State leaders, anticipating a budget surplus for the first time in years, appear ready to make a significant investment in the mental health system. A legislative oversight committee is seeking $155 million in state money for mental health care. Hooker Odom said Gov. Mike Easley's office thinks a $100 million allocation might be doable. "This will indeed be the year we will have our infusion of money," she said.

Hedrick said he is confident such an infusion will draw more mental health providers into communities that need services. "Some people are judging mental health reform as having failed when in fact it's just getting started," he said.

Meanwhile, parents such as Kathi Dunphy are waiting and wondering whether their family members can hold out until the help they need is available. When Jacki lived at Dix, she got art and music therapy and took workshops on cooking, personal care and social skills five days a week.

Now, living in the rest home, her only planned activities are twice-weekly shopping trips organized by the home's staff. Occasionally, her social worker takes her out for coffee. Her mother brings her home to stay with her at least one night every weekend. "If they don't find her something to do, I don't think it will work," Kathi Dunphy said. "This is just not going to do."

Published Sun, Mar 04, 2007
Lynn Bonner – Staff Writer

Scarcity of mental-health care traps patients in vicious cycle

In the days when mental patients were put away, the symbol of the state mental hospital was a locked door. Now in North Carolina, it's a revolving one. Mental patients are rapidly cycling in and out of the state's four mental institutions. Those checking in for stays of one to seven days increased more than 82 percent from 2001 to 2005. Many are admitted multiple times.

Federal investigators are reviewing the turnover. They found a woman in her 40s being treated at Dorothea Dix last year who was in the Raleigh hospital for the 60th time and overall has been admitted to state mental hospitals more than 100 times. A woman at Broughton Hospital in Morganton last year was being treated there for the 78th time.

Changes at the local level are driving the high admissions rate. Counties are offering fewer mental-health services, and community hospitals are increasingly reluctant to set aside beds for psychiatric patients. When people suffer a mental-health crisis, the state hospitals are often the only choice. The hospitals cannot force stable patients to stay and often lack room to accommodate those who want to remain.

For some, the turnover is too fast. Some kill themselves shortly after being released. Others turn up in jails, homeless shelters, drug treatment programs or emergency rooms.

Mental-health care in North Carolina wasn't supposed to work this way. Under changes made in 2001, more people were supposed to be treated in community hospitals, special crisis centers or at home. In many places, those community services have been slow to appear.

"If you overwhelm a system beyond its point of capacity, it can't do everything it needs to do," said Dr. Jeffrey Geller, a psychiatrist from the University of Massachusetts medical school who is monitoring the hospitals for the federal government.

Geller is working for the state and the U.S. Department of Justice, reviewing hospital practices and procedures. His work is part of a federal investigation of the four state psychiatric hospitals: Dorothea Dix, John Umstead in Butner, Cherry Hospital in Goldsboro and Broughton.

Geller's review of Broughton's records last year found several cases in which patients killed themselves after hospital stays of a few days or weeks. He said hospital records on those patients were not up to standard.

Among the cases was that of a 33-year-old woman from Union County who was admitted in November 2005. On her chart, a psychiatrist wrote that the patient "planned to take too many pills to kill herself. She is clearly a danger to herself." She was released after two days and killed herself three days later with a drug overdose.

A 33-year-old Watauga woman shot herself about six weeks after leaving Broughton.

And Jerry Rodrique Love, a 36-year-old Charlotte man, hanged himself five days after spending two days in the hospital. "I don't think he did get the help he needed," said his mother, Gail Love. Jerry Love, whom friends and family called "Dreky," was diagnosed at the hospital with severe depression. His mother said he drank too much and abused drugs but had tried many times to break the habits. Jerry Love asked hospital staff to keep him, his mother said, and he asked her to send him a coat, thinking he would be at Broughton for a while. But Love was back home before his coat got to him. "His dying like he did -- to send him back [out] -- I'm still struggling," Gail Love said.

In and out - and back in

Of about 17,000 people admitted to the state hospitals in 2005, more than 1,400 were admitted for a second time within a month. About 2,600 returned within six months.

The quick release from hospitals and the lack of community treatment forces those with mental illnesses to seek help elsewhere. It is becoming more common for the Healing Place of Wake County, an addiction recovery program, to have residents who have been in and out of mental hospitals, said executive director Dennis Parnell. He said he is worried that when Dorothea Dix closes next year, the Healing Place shelter and detox program will be overwhelmed by people whose main problem is mental illness. "It could really endanger our whole mission," he said.

The U.S. Justice Department wants the state to have a better grasp of what happens to patients once they leave the hospitals. It has asked Geller for more information about how the hospitals plan for treatment once patients leave. In 2002, a team of mental-health experts working for the Justice Department found that hospitals were discharging patients to unhealthy or dangerous living arrangements. For example, a consultant working for the Justice Department found a 28-year-old man at Broughton who had a sexual relationship with his mother. The hospital's plan was to send him to Florida under his mother's supervision. The consultant described the arrangement as "clinically inappropriate to say the least."

Patients from Cherry left the hospital to live with other former patients. In some cases, those living arrangements offered easy access to illegal drugs.

Michael Moseley, director of the state Division of Mental Health, Developmental Disabilities and Substance Abuse Services, said post-release problems are not the hospitals' fault. Such problems occur, he said, because the state does not have enough housing for patients or emergency mental-health treatment at the county level.

Once hospitals stabilize patients, they often have little choice but to send the patients back to the same circumstances that brought them to the hospital. That fosters a cycle of admission, release and readmission. "If they're returning to what they came out of, the writing's on the wall," Moseley said.

Geller acknowledged the hospitals' dilemma. Hospital staff members cannot force patients to get follow-up care, he said, and they cannot fill gaps in local mental-health services. Still, he recommended Cherry Hospital set up a committee to figure out why it was repeatedly admitting patients for short stays.

All four hospitals are trying to find out why some patients keep coming back, said Laura White, a state administrator. The rate of mental hospital use in North Carolina is more than twice the national rate. "One of the things the hospitals are really working on is how to work better with the communities around those people who have high numbers of admissions because that's just terrible," said White, who oversees the four hospitals. "We really want to reduce that."

In the past five years, connections have weakened between hospitals and community counselors who help make doctor appointments and living arrangements. Fewer community mental-health workers are available for meetings with hospital staff and patients to prepare patients for life outside.

Some patients say the hospitals are too quick to discharge them. Durham resident Hazel Gulley needed new medications in late 2005 for an illness that combines symptoms of schizophrenia and a mood disorder. She said she spent about a week in John Umstead Hospital to have her medication adjusted, then returned home. A case manager who works with Gulley, 49, noticed she was having delusions, and she was back at Umstead a few days later. "My mind wasn't clear enough to come home," Gulley said. "The medications were all messed up."

Erin Delaney, 30, said she spent a little more than a day at Dorothea Dix in January at the end of a trek through hospitals and clinics in Raleigh. Delaney, who has bipolar disorder and had substance abuse problems, said she was discharged from a private hospital after three days when her insurance coverage ran out. She tried to make an appointment to see a psychiatrist with Wake County but was told the wait would be up to three weeks. She ended up in a WakeMed emergency department bed in Raleigh and was sent to Dix from there. At Dix, Delaney said, a doctor told her during a brief interview that she was not bipolar, though she had been repeatedly diagnosed with the disorder.

"I talked to him for 15 minutes, and he undiagnosed me," she said. Delaney said the doctor took her off one of her two medications and prescribed another. She had a place to sleep for a few hours, then left Dix. She is now in TROSA, a two-year residential program in Durham for substance abusers.

Delaney thought she was sick enough to stay at Dix but was discharged with an appointment to see an outside psychiatrist. Dix hospital director James Osberg said he could not discuss a patient's case, but he said space in Dix's crowded short-term unit is at a premium. Delaney described it another way: "If you're not suicidal and you're not homicidal, they give you meds and send you on your way."

(News researchers Paulette Stiles and Becky Ogburn contributed to this report.)

News & Observer
Published Thu, Aug 21, 2008

Report: Reforms lacked controls

The state Department of Health and Human Services wasn't prepared for changes that came with handing most public mental health treatment over to private businesses, a legislative analyst said Wednesday. When businesses are offered money through government programs and learn that there's little oversight, they will seek to capitalize, John Turcotte, head of a legislative office that evaluates state programs, told a legislative oversight committee. "When you turn off front-end controls, word gets out," he said.

Legislators on an oversight committee reviewed a report by Turcotte's office that was critical of the way the department introduced a variety of new mental health service in March 2006. The report focused on the out-of-control spending on a basic mental health service called community support. Much of the information in the legislative report echoed findings published in The News & Observer in February and in a recent state auditor's report. The N&O reported the state wasted at least $400 million on community support. The state paid companies about $61 an hour for services often provided by workers without college degrees, and companies offered community support to people who did not need it.

The legislative report said the high spending on community support "caught the department by surprise." But the report did not draw any conclusions about the amount of overspending. Rep. Paul Luebke, a Durham Democrat, said the Department of Health and Human Services was slow to tell legislators about the problem and to make corrections. He pointed to a chart that showed community support cost more than $90 million in February 2007 and far outpaced spending on more intensive services. "There were no controls," Luebke said during the meeting. "Nobody knew what it was for. Who is responsible for that?"

Leza Wainwright, a co-director of the state Division of Mental Health, did not answer Luebke. But she said later that there were so many changes happening so quickly, and with so many people working on them, that no single person was responsible for the mistakes.

Rep. Drew Saunders, a Mecklenburg Democrat, called the report "gory." "It appears to me that some of these decisions almost rise to the level of being criminal," he said. "And looking at this report is almost like looking at crime scene photos."

News & Observer
Published Thu, Dec 11, 2008

Wake, Orange risk losing funds

Only half the patients discharged from state mental hospitals received follow-up community care, a new report says.

Five mental health offices around the state could lose millions in state money for failing to make sure former hospital patients receive ongoing treatment. At stake is nearly $1 million that goes to the Wake County mental health office and about $400,000 to the office that covers Orange, Person and Chatham counties. Those offices are in danger of losing their responsibility for ensuring follow-up care, along with the money.

State reports show that those offices are below the state average for getting patients from mental hospitals into community treatment. "They have until the end of the month, or we will be taking action," said Leza Wainwright, a co-director of the state mental health division. Administrators in the Wake and Orange offices say more people receive follow-up care in their areas than the records show.

The state uses Medicaid spending to track patient care, and that misses people whose treatment is paid for with county money, said Crystal Farrow, head of the Wake mental health office. Wake has been talking with the state for months about getting more accurate counts.

"I'm pretty confident that reasonable people will be able to take a look at it and say Wake consumers are seen at least the same rate as consumers across the state," she said. The local administrators said they did not expect their money to be cut at the end of the year because it takes months to collect and evaluate information collected.

Connecting patients to community care after they leave hospitals is a key to getting the struggling mental health system to work as envisioned. The effort is stymied by a lack of psychiatrists, a shortage of beds for psychiatric patients at community hospitals and a lack of intensive mental health programs meant to serve the sickest people.

A report by a legislative office responsible for evaluating state programs exploded a commonly held assumption that community care helps keep people out of hospitals. The report looked at care given to patients in 2007 who were hospitalized at least once in 2006. People who received community services were more likely to be rehospitalized than those who did not receive ongoing care.

Carol Ripple, a program evaluator, said it's likely that the most unstable patients who needed at least one return trip to the hospital were also receiving community treatment. Most of the patients receiving community treatment are in "low-intensity" programs, such as the skill-building program called community support. Only about 54 percent of patients receiving community treatment saw a psychiatrist.

The information used to track patient treatment has limitations, Ripple said. One of her recommendations was to have the state mental health division use electronic health records, which could improve care when patients move between hospitals and private providers.

2009

North Carolina

In 2006, North Carolina's mental health system received a grade of D. Three years later, the grade remains the same, but does not even begin to convey the chaos that now pervades the state's mental health care system.

NAMI warned three years ago that the state's reform initiatives were changing too much, too fast, resulting in an increasingly disorganized environment. This prediction was accurate. Fortunately, a change in governors in 2009 provides broader hope for the future.

Some bright spots exist. North Carolina enacted a mental health insurance parity law in 2007, a major step towards improving access to care. The state has taken jail diversion training seriously and has worked to build evidence-based practices. Assertive Community Treatment (ACT) is an acknowledged interest, although the state recently announced a seven percent cut in the program.

North Carolina has piloted granting resources to Local Management Entities (LMEs) to build local capacity, thereby reducing reliance on overcrowded state hospitals. It also has a promising pilot program that integrates mental and physical health care at four LMEs, including shared data systems and common measures to track results.

The state also gives feedback to doctors about their prescribing patterns, which is a positive development.

North Carolina certifies peer specialists and anticipates growing this area of its mental health workforce, if funding can be sustained.

Another strength is improvement in access to Medicaid for consumers who are incarcerated by suspending, rather than terminating, benefits.

North Carolina faces multiple challenges. One of the most complex changes that the state attempted was privatization of community mental health services, creating LMEs for geographic regions. After two years of billing, an auditor found that over $400 million had been wasted; another level of review subsequently found that number was overstated. Billing issues contributed to both financial and clinical disarray and coincided with the resignation of the HHS secretary.

Currently, ValueOptions manages Medicaid funding, while other state dollars go to the LMEs, resulting in more complexity and fragmentation. Essentially, there is a dual system for outpatient care.

Additionally, in 2005, the U.S. Department of Justice (DOJ) documented numerous safety concerns in North Carolina's state hospitals. Efforts to remedy those issues have not been reassuring. DOJ monitors ongoing problems at Dix and Broughton Hospitals. Cherry and Broughton Hospital in Morganton have lost federal funding due to numerous concerns.

The newly-opened Central Regional Hospital (CRH) in Butner was put on notice in 2008 that it too was at risk of losing federal funds. The loss of federal funds for Cherry Hospital is estimated to cost the state $800,000 per month.

The state's plan to close Dix Hospital and transfer staff and patients to CRH has aroused numerous concerns about safety and staff training. The move has been delayed five times to date.

The new governor, Bev Purdue, inherits a complex, disorganized, and difficult legacy, but at least her charge is clear—to restore confidence and order to the system. Cleaning up the mess and improving care for the state's citizens will require leadership, political determination and involvement of the legislature, and sound investments.

Innovations

- Integrated physical and medical care pilot program
- Prescription pattern feedback
- Post-incarceration Medicaid reinstatement

Urgent Needs

- Restore confidence and order to overall system
- Improve state hospitals to enable transition to newer facility
- Restore ACT funding cuts

Consumer and Family Comments

- *"The state reorganized services several years ago . . . the psychiatrists all left the area."*
- *"The implementation of the peer support program has been the best thing since sliced bread."*
- *"It takes 24-48 hours to get a hospital bed if I need to be admitted."*
- *"Wake County has a crisis intervention program which I am grateful for."*

Additional links to coverage of state mental health reform can be found at the Task Force web page at http://www.ci.chapel-hill.nc.us/.

See also the Carrboro Citizen "Breakdown" series at http://www.carrborocitizen.com/main/breakdown/

ATTACHMENT E

ORANGE-PERSON-CHATHAM AREA PROGRAM
PROVIDER SERVICES

OPC currently has either a Memorandum of Agreement or IPRS service contract with 183 providers. The service array includes the services identified on the following table.

Service	# of Providers	Service	# of Providers
ACTT	2	Level 2 residential (family type)	22
Assertive Outreach (PATH)	1	Level 2 residential (program type)	5
ADVP	3	Level 3 residential	20
Community Rehabilitation	1	Level 4 residential	1
Community Support Child	39	Long Term Vocational Supports	5
Community Support Adult	39	Mobile Crisis	1
Community Support Team	22	MR/MI Day Supports	5
CAP Services	58	Multi-Systemic Therapy	4
Child Day Treatment	4	Non-hospital detox	1
Developmental therapy	14	Psychiatric residential treatment program	2
Developmental day activity	2	Psychosocial rehabilitation	2
Diagnostic assessment	31	Substance abuse comprehensive outpatient	1
Facility based crisis	2	Substance abuse IOP	3
Family living low	5	Supported employment	6
Intensive in-home	19	Target case management	19

(Updated September, 2009)

ATTACHMENT F

To: Mayor's Mental Health Task Force

From: Andrew Pham, Mayoral Intern

Date: January 14, 2009

Subject: Town of Chapel Hill

At the last meeting of the Mayor's Mental Health Taskforce, the membership requested data from the town and its departments. In response several departments submitted data regarding their role in providing services for the mentally ill in Chapel Hill.

The data requested was threefold: the funds allocated for mental health service deliver (or services to other populations who also have mental health issues) to various local agencies/ providers/public departments, provider or agency budget information, and data on their clients.

The following is a brief summary of the responses.

1. Chapel Hill Police Department has three units that deal with mental health: Crisis, Human Services, and Project Turn Around. Expenditures: Primary $56,100; Secondary $50,500. In-kind contributions: $210,000 Staffing Costs: CU: $315,000 PTA $160,000
    - Human Services distributes $250,000 to 39 different organizations, nine of which primarily provide for those with mental illnesses and four more organizations serve mentally ill populations.
    - The Crisis unit serves as a liaison with the community mental health resources and those impacted by victimization. The Crisis unit serves around 3,000 people with an estimate that 30% have mental health issues.
    - Project Turn Around provides case management for substance abuse criminal charges, some participants have mental health issues. PTA serves 175 total participants.

2. Chapel Hill Parks and Recreation Department serves populations with mental health issues with the Special Olympic program and Therapeutic Recreation Program. The Special Olympics provides athletic activities for those with intellectual disabilities. The program served 271 people in the last year, taught 120 children sports and had 250 volunteers. The budget from the Town is $60,308 for 08-09 with $15-20,000 in additional fundraising. The Therapeutic Program's main mission is to provide inclusion for those with disabilities into typical recreation programs. The program supports 1,000 people with mental health concerns many of which are school age children. The budget for 08-09 is $102,153

3. Chapel Hill Public Works does not provide direct service to those who have mental health issues. It provides services which *may* benefit those who have mental health concerns. These services include: curbside collection exemptions, ADA ramp curb cuts, commercial inspections and in kind financial support to the IFC Community House. The Town's contribution to the IFC Community house is $192,000 per year in rent and $59,000 a year in utilities.

4. Chapel Hill Planning Department contributes to mental health issues on the issue of homelessness; a percentage of the homeless have a mental illness. This department spent $24,600 to employ a Coordinator for the Orange County Ten Year Plan to End Chronic Homelessness. Additionally the Planning Department granted $15,000 to the Real Change from Spare change program to fund a street outreach worker.

5. Chapel Hill Transit does not have funding to provide direct mental health services. However, Transit provides daily trips from Northside Mental Health, Caring Family Network Center and Club Nova on the EZ Rider Program. The estimated yearly cost is $13,000 for transportation. *Transit notes that transportation issues may prevent many mentally ill residents from receiving mental health services*.

6. Chapel Hill Public Libraries provide mental health services such as maintaining collections with information regarding mental health, free access to the internet, safe location for reading, and information and referral sources – all in an environment that promotes respect for all patrons. Additionally, the town library often hires workers from Club NOVA to help shelve library materials.

ATTACHMENT G

LOCAL GOVERNMENT FUNDING FOR AGENCIES
PROVIDING MENTAL HEALTH AND ASSOCIATED SERVICES

A HELPING HAND
Goals: to enable senior citizens to live independently, maintain high levels of wellness and avoid institutionalized care. Services include accessibility to health care, mobility assistance, medication reminders, adequate nutrition, a safe home environment, respite for caregivers and advocacy.

Chapel Hill	*2008-09 Allocation:*	*$4,000*	*2009-2010 Allocation: $3,500*
Carrboro		*$2,500*	
Orange County		*$5,000*	

BIG BROTHERS BIG SISTERS OF THE TRIANGLE
Mission: Help children reach their potential through professionally supported, one-to-one relationships with measurable impact. The program provides adult mentors to children who live in single parent homes or other children in need of a secondary role model.

Chapel Hill	*2008-09 Allocation:*	*$5,000*	*2009-2010 Allocation: $6,000*
Carrboro		*$ 500*	
Orange County		*$5,000*	

CHAPEL HILL-CARRBORO MEALS ON WHEELS
Mission: Provide nutritious food and personal visit to individuals who are unable to prepare meals for themselves due to illness, disability or convalescence.

Chapel Hill	*2008-09 Allocation:*	*N/A*	*2009-2010 Allocation: $3,000*
Carrboro		*$2,000*	

CHARLES HOUSE
Mission: Care for older adults with disabilities, providing enriching social and recreational activities during daytime hours; providing respite, service referrals and educational services for family caregivers; advocating for and supporting development of a system of community eldercare alternatives.

Chapel Hill	*2008-09 Allocation:*	*$7,500*	*2009-2010 Allocation: $7,500*
Carrboro		*$2,500*	
Orange County		*$11,000*	

CLUB NOVA
Promotes and provides opportunities for individuals with mental illness to lead meaningful and productive lives of their choice in the community.

Chapel Hill	*2008-09 Allocation:*	*$5,000*	*2009-2010 Allocation: $5,000*
Carrboro		*$4,000*	
Orange County		*$75,000*	

DISABILITY AWARENESS COUNCIL

Orange County	*2008-09 Allocation:*	*$ 3,500*

DISPUTE SETTLEMENT CENTER
Conflict resolution and mediation services.

Carrboro	*2008-09 Allocation:*	*$ 7,000*
Orange County		*$34,000*

DUKE HOMECARE AND HOSPICE
Mission: Provide palliative care for terminally ill patients regardless of ability to pay. Provides medical, psychosocial, spiritual and bereavement care for terminally ill patients and their families.

Chapel Hill	*2008-09 Allocation:*	*$3,500*	*2009-2010 Allocation: $3,500*
Carrboro		*$3,500*	
Orange County		*$4,000*	

EL FUTURO
Mission: Provide and advance model behavioral health resources for underserved Latinos in North Carolina. Offers outreach/education, capacity-building and clinical services.

Chapel Hill	*2008-09 Allocation:*	*$4,000*	*2009-2010 Allocation: $4,000*
Carrboro		*$2,000*	

FAMILY VIOLENCE PREVENTION CENTER
Mission: Prevent and end family violence through client services and community education.

Chapel Hill	*2008-09 Allocation:*	*$15,000*	*2009-2010 Allocation: $15,000*
Carrboro		*$ 4,000*	
Orange County		*$19,400*	

FREEDOM HOUSE
Provides extended care, transitional living and outpatient services to promote recovery from the disease of substance abuse addiction and mental illness. Provides halfway house/treatment services, non-hospital detox, acute SA stabilization and transitional living services.

Chapel Hill	*2008-09 Allocation:*	*$17,000*	*2009-2010 Allocation: $17,000*
Carrboro		*$7,000*	
Orange County		*$24,000*	

FRIENDS OF THE ROBERT AND PEARL SEYMOUR CENTER
Association of persons interested in providing and improving facilities to promote the well-being of all older adults in Orange County.

Chapel Hill	*2008-09 Allocation:*	*$30,000*	*2009-2010 Allocation: $5,000*

HOUSING FOR NEW HOPE
Encourage and assist homeless people and other persons in crisis to move toward lives marked by increased levels of stability, dignity, hope and independence.

Chapel Hill	*2008-09 Allocation:*	*N/A*	*2009-2010 Allocation: $6,500*
Carrboro		*$2,500*	

INTER-FAITH COUNCIL
To meet basic needs and help individuals and families achieve their goals. Provide emergency shelter, food, direct services, advocacy and information to people in need.

Chapel Hill	*2008-09 Allocation:*	*$9,600*	*2009-2010 Allocation: $10,000*
Carrboro		*$8,550*	
Orange County		*$36,480*	

JUDICIAL DISTRICT 15B DRUG TREATMENT COURT
Offer the substance abuse participant a comprehensive individualized treatment program that includes court sanctions and incentives to address his or her substance abuse issues and minimizes costs to community without compromising community safety.

Chapel Hill	*2008-09 Allocation:*	*N/A*	*2009-2010 Allocation: $2,500*

KIDSCOPE (CHAPEL HILL TRAINING AND OUTREACH)
Early intervention program seeking to provide comprehensive services to young children, their families and providers who are experiencing social, behavioral and/or developmental issues.

Chapel Hill	*2008-09 Allocation:*	*$4,500*	*2009-2010 Allocation: $4,500*
Carrboro		*$1,000*	
Orange County		*$89,000*	

MENTAL HEALTH ASSOCIATION
Dedicated to improving the life of Orange County residents impacted by mental illness, through direct service, advocacy, education and information dissemination.

Chapel Hill	*2008-09 Allocation:*	*N/A*	*2009-2010 Allocation: $5,000*
Carrboro		*$1,500*	

OE ENTERPRISES
Vocational services for developmentally disabled people.

Carrboro	*2008-09 Allocation:*	*$ 3,000*
Orange County		*$63,175*

ORANGE COUNTY DEPARTMENT ON AGING
Provides comprehensive and integrated approach to the delivery of services to Orange County's senior citizens in the fields of health, mental health, social services, recreation, employment and other programs under federal, state and local authority.

Chapel Hill	*2008-09 Allocation:*	*N/A*	*2009-2010 Allocation: $18,900*
Carrboro		*$5,552*	

ORANGE COUNTY DISABILITY AWARENESS COUNCIL
ADA-related workshops, etc.

Carrboro	*2008-09 Allocation:*	*$1,000*

ORANGE COUNTY RAPE CRISIS CENTER
Stop sexual violence and its impact through support, education and advocacy. Provides direct services through a 24-hour crisis line, support groups and community education.

Chapel Hill	*2008-09 Allocation:*	*$14,000*	*2009-2010 Allocation: $14,000*
Carrboro		*$ 3,000*	
Orange County		*$28,000*	

PIEDMONT HEALTH SERVICES
Increase access to high-quality affordable primary health care services for underserved communities in north-central North Carolina. Delivery of bilingual medical and dental care to underserved Chapel Hill residents.

Chapel Hill	*2008-09 Allocation:*	*$ 3,000*	*2009-2010 Allocation: $3,000*
Orange County		*$10,750*	

PROJECT TURN AROUND
Court diversionary program for first-time, non-violent drug offenders with a goal of enabling drug offenders to overcome drug-dependent lifestyles and contribute to the community in a positive manner.

Chapel Hill	*2008-09 Allocation:*	*$70,824 (CHPD)*	*2009-2010 Allocation: $25,000*
Carrboro		*$ 2,000*	
Orange County		*$64,424*	

SENIOR CARE OF ORANGE COUNTY
Adult day care.

Orange County	*2008-09 Allocation:*	*$ 50,000*

STREET SCENE TEEN CENTER
Provide a safe, drug and alcohol free environment for Chapel Hill teens in the downtown area where community youth traditionally go to meet their friends and spend their leisure time.

Chapel Hill	*2008-09 Allocation:*	*$3,500*	*2009-2010 Allocation: $3,500*

THE ARC OF ORANGE COUNTY
Provide advocacy and services to Chapel Hill residents with developmental disabilities that promote community involvement, active lifestyles and social value.

Chapel Hill	*2008-09 Allocation:*	*$8,500*	*2009-2010 Allocation: $8,500*
Carrboro		*$3,000*	
Orange County		*$4,000*	

TRIANGLE RESIDENTIAL OPTIONS FOR SUBSTANCE ABUSERS
Enable substance abusers to be productive, recovering individuals by providing comprehensive treatment, work-based vocational training, education and continuing care.

Chapel Hill	*2008-09 Allocation:*	*$4,000*	*2009-2010 Allocation: $4,000*

ATTACHMENT H

WEDNESDAY, SEPTEMBER 2, 2009 THE CHAPEL HILL NEWS 5A

'Why you have to treat me differently?'

Many people who experience homelessness have a mental illness. Ms. Williams was diagnosed with schizophrenia when she was 28 and has been hospitalized three times since. In her late 30s now, she spent nine months of the past year living in a local homeless shelter. As part of the Community Read on homelessness, I interviewed Ms. Williams about her experience.

GUEST COLUMN

SELDEN HOLT

Well, I've got paranoid schizophrenia. It doesn't let me think clearly without my meds. And basically I don't think as clearly with my meds as I did before I was diagnosed. Before I thought a whole lot more rational. Now I question my thinking and hope it is rational.

When I was sick, I was very paranoid, thinking people are seriously out to get me, to hurt me or harm me in some sort of way. It wasn't true, but it was a hurtful feeling, those thoughts. I stopped taking my medicine [and] made some very bad choices — not thinking realistically. ... I was evicted, and went to a shelter. It was a hard place to be. I wanted to stay on my medications so I could get out of there, for myself and for my kids. My kids are my main motivation to keep myself together.

COMMUNITY READ

Orange County's Partnership to End Homelessness will hold a "Community Read" of "The Soloist," the story of the friendship between reporter Steve Lopez and musician Nathaniel Ayers, a mentally ill homeless man. Discussion groups will be held in September with mental health and homelessness professionals:

Sept. 14, 6:30 to 8 p.m., Carrboro Cybrary, 100 N. Greensboro St., Carrboro

Sept. 15, 6:30 to 8 p.m., Orange County Main Library, 300 W. Tryon St., Hillsborough

Sept. 15, 7 to 8:30 p.m., UNC Campus Y, 180A Cameron Ave.

Sept. 17, 7 to 8:30 p.m., Chapel Hill Public Library, 100 Library Drive, Chapel Hill.

For more information contact Jamie Rohe, Orange County Homelessness Program coordinator, jrohe@co.orange.nc.us or go to http://www.co.orange.nc.us/housing/endinghomelessness.asp.

Going to the clinic has been helpful. I learned some things about my illness I didn't know. It brought a different light to what was going on.

I'm thankful for having my own place now. What I'd say [to others experiencing homelessness] is that it may take time, but if you are serious about doing what you are supposed to do, it will happen. I had to apply for Section 8, I had to look for my own place. I had to do some legwork on my own.

If I had diabetes, I would feel sad, but I'd feel normal, like everybody else. With schizophrenia, you feel different. It's something you can't help, but people just don't view it the same. People don't want to deal with people who have schizophrenia. I know that people, if I'm on my meds, might not be able to tell that I have a mental illness. But once they find out I have to take meds to maintain my sanity, they view me differently. I don't understand why you have to treat me differently. It's just a disease.

I'm a devoted mother, determined to maintain a normal life, not trying to hurt nobody, a humanitarian at heart, suffering from something I don't necessarily want to be suffering with, but trying to deal with it. I am proud of my kids because they are good kids. I'm really thankful for them. I'm proud that we finally did get out of the shelter and we're maintaining OK.

Selden Holt, a licensed clinical social worker, works at the STEP Community Mental Health Clinic, part of UNC's Schizophrenia Treatment and Evaluation Program (STEP).

ATTACHMENT I

Frustration and Grief

Not long after reform was implemented, one of my long-term therapy clients who had a very severe psychotic disorder developed multiple sclerosis (MS). She blamed the MS on her antipsychotic medication and was angry at her psychiatrist so she decided to change providers (She had been with [our program] for more than 10 years). She had also moved from Chapel Hill to Durham. When she got to her new provider, she refused to sign a release for them to get her prior history. After establishing care with the new provider, she called me upset about the psychiatry services she was receiving. I talked with her about ACT services, as she clearly met the criteria and had Medicaid. She thought it sounded great, so I told her to ask her new community support worker to refer her for these services. She called me again to say that her new worker didn't know what ACT was. I called her provider and told them she was interested in a referral to ACT. They said they couldn't refer her because they didn't have the history to support the need. I called the Durham Center to see if I could refer her for ACT. They said I couldn't because I was no longer her provider. Well, the final outcome of this was that the woman died of an accidental overdose of pain medication. She was floridly psychotic at the time of her death, and refusing all mental health services. So my frustration with what has happened to the system is also tinged by grief. I know there are other stories like this.

News & Observer - Editorial
Published Wed, Aug 26, 2009

A verdict on violence

Prosecutors and defense attorneys agreed on one thing regarding Alvaro Castillo, the 22-year-old man who will serve a life term for the murder of his father and other crimes: he is mentally ill, and seriously so. Castillo's story played out in dramatic fashion in a Hillsborough courtroom last week, but in the end, the jury seemed to reach the inevitable verdict in finding him guilty.

Judge Allen Baddour said he would recommend that Castillo get mental health treatment in prison. That's good, for this was a tragic tale indeed, in which earlier treatment might have helped.

As related in the course of Castillo's trial (his attorneys were seeking a verdict of not guilty by reason of insanity) his father, Rafael Huez Castillo, ruled the household with an iron hand. His son was clearly disturbed. At one point he talked his mother into taking him to see the site of the infamous Columbine school shooting of 1999 in a suburb of Denver.

In addition to his father's murder, Castillo was convicted of firing on students at his former high school, Orange High. Clearly he was obsessed with committing school violence. In light of horrific school massacres around the county in recent years, his action against the school, which he planned in advance, was inexcusable. Apparently, only alert action by a teacher and school security guard prevented bloodshed there.

While Castillo clearly and by his own admission is disturbed, the jury faced a serious challenge. Not to imprison someone who did what he did would be to engage in a risky optimism. Even though

there are treatments for people who are suffering from illnesses that can make them violent and dangerous, young Castillo had turned that potential into reality, and it's profoundly fortunate that he did not do harm to others before and after killing his father.

And as prosecutor Jim Woodall said, no matter what may have been said about the father, Rafael Huez Castillo, during the proceedings, ..."the bottom line is, he was brutally murdered."

It's impossible to know for sure what might have been done to prevent this tragedy. There were tears all around in the Hillsborough courtroom. But in holding Alvaro Castillo responsible for what he did, jurors took a necessary step toward discouraging similar violence in the future.

ATTACHMENT J

STATE FUNDING CUTS

News & Observer
Published Thu, Aug 06, 2009
Lynn Bonner – Staff Writer

Mental health spending slashed

The mentally ill in North Carolina will have less access to care as the state makes dramatic changes to save money in the recession. The budget approved by the legislature Wednesday cuts about $40 million, or 12 percent, in mental health treatment for people without other insurance. The cuts come despite the state's goal of providing more treatment to people where they live.

The cuts and changes rip holes in an already-weak mental health system, advocates say. They predict it will be harder for poor people without insurance to get community mental health care, and more could end up in emergency departments and jails.

Other changes are under way:

• The legislature is phasing out a mental health service called community support, low level services to help people with mental illnesses or addictions to gain skills, such as how to manage bus schedules or a household budget, or to help a child stay out of trouble in school. Lawmakers are cutting money for the service and eventually will replace it with one that has not yet been developed.

•The state will reduce spaces in group homes for children and adolescents, with plans to start a new program of high-intensity therapeutic foster care. Local mental health offices would work harder to return children to their homes, enrolling them in high-level services. Some children would be eligible for admission to community psychiatric treatment centers.

These new services have not been tested or approved by the federal government, which must OK all services paid by Medicaid.

The $40 million reduction to aid for uninsured patients surprised patient advocates.

Michael Murray, director of the Disability Action Network, an advocacy group, said such a cut could lead to more admissions to state mental hospitals, patient pileups in emergency rooms and more mentally ill inmates in jail. "I think there's the potential for overcrowding in places they don't need to be," Murray said. "They can't stay in the least-restrictive environment because of the lack of support."

Doomed to repeat it?

The state does not seem to have learned from its failed efforts to improve mental health care, said Frank Edwards, a co-president of the National Alliance on Mental Illness' Wake County chapter. Programs and policies should be tested before they are launched, he said.

In 2001, a state mental health reform resulted in increased short-term stays in hospitals and expensive, poorly monitored care in local communities. "They didn't plan it well then, they're not planning it well now," Edwards said. "That really does honestly scare me."

Legislature 'being forced'

The legislature has no choice but to make changes, said Rep. Verla Insko, a Chapel Hill Democrat who helps run an oversight committee on mental health.

"The problem is right now, we're being forced into this," she said. "We don't have the option of taking a lot of time doing in-depth planning. What we can do as an alternative is watch very closely and be ready to make adjustments."

The cut in community support, the basic mental health service, will be particularly hard on rural patients, said Barry Graham, chief operating officer at Advantage Behavioral Healthcare, which provides the service.

Rural counties don't have the therapists with advanced degrees that the more intensive community care programs require, Graham said. That leaves community support, Graham said, which legislators have targeted for cuts because of past financial abuses by providers.

A News & Observer investigation last year found that the state had wasted more than $400 million on community support in less than two years. A recent legislative report said the state wasted even more.

Cuts will hurt patients, Graham said, while companies committing fraud will find a way to survive. "They are the ones who will suffer from reform," he said of patients. "A crook will find a way to beat the system."

Hospital pay increased

One of the few significant increases in the mental health budget is $12 million to allow the state to pay local hospitals that agree to short-term treatment for mentally ill patients.

Last year now-Gov. Beverly Perdue campaigned on how she would handle the mental health system, promising accountability and a focus on rural and underserved areas. She promised to develop mental health courts, programs that seek to keep mentally ill people out of trouble. She also said she would improve care by creating "centers of excellence" at colleges and universities. There's no additional money for courts in the budget and no mention of "centers of excellence."

Perdue's spokeswoman, Chrissy Pearson, pointed to the money that will open more local hospital beds as evidence of Perdue's attention to improving care.

With money from past budgets, the state was able to reserve 75 local hospital beds, according to DHHS, though 19 fell into disuse at the end of June because the budget had not passed.

The new $12 million will increase the number of beds to 175, said Lanier Cansler, secretary of the state Department of Health and Human Services.

"The concept of trying to have enough beds to keep people in the community is a solid concept," he said. "The goal is "having the beds at the community hospital where people don't have to travel across three or four counties to get care."

Club Nova faces immediate challenge

Sep 10, 2009 News Jump to Comments

By Taylor Sisk
Staff Writer – Carrboro Citizen

North Carolina Speaker of the House Joe Hackney's Wednesday morning visit to Club Nova in Carrboro was a social call, a stop-in by invitation of club members to hear how things are going. Not that he wasn't already aware, but what Hackney heard was that Club Nova faces some tenuous times in the immediate future, and that it soon may have to turn out some clients with no alternative services in sight.

Club Nova operates under a clubhouse model designed to promote rehabilitation and reintegration into the community for individuals living with mental illness. In the best of times, it struggles financially to get by. But with the cuts made to mental health services in the new state budget, times are growing harder still.

In 2006, clubhouse services were reclassified as enhanced services, which means that for Club Nova to continue to receive state and federal funding its members are required to receive community support services. But the new state budget called for the phasing out of community support services by June of next year. These services include assistance with such everyday activities as paying bills, shopping for groceries and picking up medications.

This leaves Club Nova in a predicament. Club director Karen Dunn said that two steering commitees comprised of state officials and other stakeholders are trying to develop a plan that may help keep people in clubhouses such as Club Nova. But nothing is known for certain. And if a solution isn't found, Dunn will have to begin discharging clients in December.

Hackney expressed his support for Club Nova. "It's a great program," he said. "The staff is very committed and is dedicated to getting through this difficult period….
"I'm hopeful they can survive this and come out the other side so we can get them properly funded, because they certainly aren't now."

Club Nova has been allocated $99,000 in the state budget, but Dunn isn't counting that money until it's in hand. She received $75,000 for the coming year from Orange County's human services grant and $100,000 through the county's mental health local management entity, the latter having been cut 50 percent from last year. The club has been bringing in between $90,000 and $140,000 in private funds, but, as Dunn points out, those dollars are more difficult to come by these days.

"We're still here," Dunn said, "and that's pretty amazing. It's just been an ongoing onslaught of bad news."

The decision to eliminate community support services baffles her.

“I understand that North Carolina is short on revenues, but what I don’t understand is why they would dismantle something when there’s nothing in its place for people with mental illness,” she said.

She points out that when mental health care reform legislation was passed in 2001, community-based services were seen as the linchpin by which those with mental illness could be moved out of state institutions and reintegrated into their communities.

“Now they’re the worst thing in the world?…
“How could we be that wrong?

ATTACHMENT K

OPC Area Program Q & A
Regarding Impact of State Budget Cuts
(September, 2009)

How will the state budget cuts affect mental health, developmental disability, and substance abuse services in Orange, Person, and Chatham Counties?

Approximately $75 million dollars were cut from the statewide mental health/ developmental disabilities/substance abuse services, in addition to reductions in Medicaid rates and services. This translates into $2,250,518 in cuts to the state funds available for services in Orange, Person, and Chatham Counties. This represents approximately 21.5% of our non-crisis state service funding. These cuts in service dollars limit the amount of state dollars available to serve adults and children who do not have health insurance, but are in need of mental health, developmental disabilities, and substance abuse services. In addition, reductions in Medicaid services will affect people with these challenges as well.

- How will these cuts affect adult recipients of mental health (MH) and substance abuse (SA) services? Will there be services that are no longer available? What services will be available?
  Reduction in state funds for mental health and substance abuse services will have a huge impact on OPC's array of services. We have received a cut of approximately 21.5% to our state funds, causing major strains on already under-funded services. It will definitely affect how we provide care to consumers in the OPC catchment area. We have to reduce the number of slots available for the enhanced services and also reduce the number of units for individual therapy. After the limited units of services have been utilized, consumers may be moved to group therapy or referred to self-help groups and /or natural support systems in the community.

- How will these cuts affect people with developmental disabilities? Will there be services that are no longer available? What services will be available?

  OPC's developmental disability (DD) state funds will be cut in two ways. First, a portion of the overall reduction in state funding ($55M statewide) will be taken from OPC's DD service dollars. Secondly, the legislature reduced DD funds by $16M, with the idea being that limited state dollars should not be spent on individuals who are CAP-MR/DD waiver recipients. OPC's share of this cut is $928,923. Combined the cuts will mean a reduction of just over 23% in DD state service dollars. In terms of Medicaid services, cuts to service rates for CAP-MR/DD services and the freeze on CAP-MR/DD slots will have the biggest impact on individuals with DD.

  Cuts of this magnitude will require significant reductions in funding to many of our DD programs and services including residential services (group homes), Adult Day Vocational Programs (ADVP/ employment services), Developmental Day services for children 3-5 years of age, as well as other services such as Developmental Therapy. As a result of these reductions it is expected that providers will have to downsize programs. Fewer people will be able to receive services and those that do get service will likely be getting less.

  Will there be services that are no longer available? What services will be available to individuals with developmental disabilities?
  There has been no determination to fully eliminate any DD service entirely at this time. Rather, significant reductions will be required to the types of services listed above. Services that will remain available to individuals with developmental disabilities (in limited quantities based on available funding) include: Targeted Case Management, Developmental Therapy, Personal Assistance, ADVP, Supported Employment, Long Term Vocational Support, Respite, Developmental Day, residential services, services for individuals who are dually diagnosed, and Mobile Crisis services.

- How will these cuts affect children and adolescents who are receiving services and their families? Will there be services that are no longer available? What services will be available?

  The cuts in funds and changes in legislation will impact child/adolescent mental health and substance abuse services in primarily three areas. These include the reduction in the use of certain types of group care, elimination of community support which provides the bulk of case management and skill building services, and a reduction in service funds for youth who are uninsured.

  Reduction in Use of Level III and IV Groups Homes:
  The use of Level III group homes (typically small homes of 4-6 youth in a neighborhood) and Level IV group home (locked facilities) will be reduced as it will become harder to enter these facilities and the lengths of stay will be shorter (maximum of 120 days). OPC Area Program has been working for years to reduce its use of level III and IV group homes as we have felt it was not best practice to congregate youth with behavioral challenges together. There are certainly young people who use this level and have benefited, but many youth can be served in therapeutic foster care. North Carolina has requested a strengthened definition of therapeutic foster care from the federal Medicaid authorities.

  Group homes that have over 16 beds will either need to close or reduce their beds to below 16. Therapeutic wilderness camps like Three Springs and Timberidge will be closed. Three Springs, which is located outside of Pittsboro, will close its level III facility, but is planning to open a Psychiatric Residential Treatment Facility (PRTF), day treatment, and offer intensive in-home services.

  In July, OPC had 46 children in Level III or IV group homes. Presently there are 21 youth in level III and IV group homes. Transition plans for all youth in levels III and IV are being reviewed through county based care review teams.

  Challenges:

  - Sufficient capacity of therapeutic foster parents especially within our three counties.
  - Small number of youth for who therapeutic foster care is not a good option and who do not qualify for PRTF.

  Elimination of Community Support: This service which encompasses case management services and skill building services will be phased out in the next few months. No new youth will be able to have this service after 10/12/09. Presently there is not a substitute service for this the case management function. In the beginning of September there were approximately 400 youth receiving community support in Orange, Person, or Chatham counties.

  Reduction in Service Funds for Uninsured Youth: OPC will receive fewer funds to serve the uninsured. This will translate into less available services for young people who do not have insurance. This means that there will be tighter criteria for receiving state funded services.

  What services will be available for children, adolescents, and families in Orange, Person, and Chatham Counties? Outpatient therapy, medication management, intensive in-home, Multisystemic Therapy, Day Treatment, Therapeutic Foster Care, Psychiatric Residential Treatment Facilities, and Hospitals. Residential services are only available to clients with Medicaid.

- How will these cuts affect providers of services in our community?
  Providers will be significantly impacted by the budget reductions and service changes in many ways. Not only will the amount of overall funds available to provide services be decreased, but in some

cases the reimbursement rates for services will be reduced as well. In addition, providers of Community Support services will have to decide which, if any, services they will provide instead, as this service will be reduced significantly over the coming months and will no longer be available as of June 30, 2010. These changes will require providers to make changes in both staff and the amount of service they are able to provide. It is anticipated that providers will have to implement a variety of cost saving measures over the coming months.

- How will the OPC benefit plan be amended?
  In anticipation of budget cuts, changes were made to the OPC IPRS benefit plans reducing outpatient services effective 7/1/2009:

  - Adult MH basic benefits were reduced from 26 to 8 individual sessions (69% cut) and from 52 to 12 group sessions (77% cut) for each consumer for the fiscal year.
  - Adult SA benefits were reduced from 26 individual sessions to six (76% cut) and from 52 to 24 group sessions (54% cut) per fiscal year.
  - All adults must meet much more restrictive criteria to qualify for CSS and the units have been reduced. Many individuals who might have qualified for this service in the past no longer do so. This has resulted in a drop from 344 consumers having been authorized for this service last fiscal year to 105 at present, a 69% decrease.
  - An exception to cuts in the Adult SA benefit plan is for consumers referred by TASC (Treatment Accountability for Safer Communities). Services for this population have not been reduced.
  - Child MH benefit benefits were reduced from weekly individual and group therapy to no more than 26 sessions per year of each of those services, a 50% cut.
  - CS Support for children is somewhat more restrictive; now only those children who are at risk of imminent out of home placement qualify for the larger amount of units.
  - No significant changes were made to the Child SA Benefit Plan.
  - All other services such as Psychosocial Rehabilitation (PSR), residential, etc, have suffered de facto reductions as a result of fewer funds being allocated to the providers of these services.
  - All providers are encouraged to link consumers with natural and community resources early in treatment, to develop solid crisis plans with each consumer and to inform consumers of the process for accessing crisis services.

- What is OPC Area Program doing to manage these changes and cuts?

  OPC staff is meeting on a regular basis to plan and prepare for the budget reductions. Workgroups are developing strategies to address both short-term and long-term issues. Benefit plans have been revised (see above.) OPC staff is meeting with key providers on a regular basis to address issues of concern, service system changes, etc. OPC will also be updating our community partners, stakeholders, CFAC, OPC Area Board and providers at meetings attended, via email communication, and on our website as developments occur over the coming weeks.

- What crisis services will be available?

  Crisis services will remain available in all three counties in a variety of means. Daytime weekday crisis services are available to residents of each county at the following sites:

Orange County:	Person County:	Chatham County:
Chapel Hill Outpatient Clinic 104 New Stateside Drive Chapel Hill, NC 27514 919-942-2803 or UNC Hospitals/ Dept of Psychiatry Walk-In Clinic Neurosciences Hospital 1st Floor 101 Manning Drive Chapel Hill, NC 27514 919-966-2166	Person Counseling Center 355 S. Madison Blvd. Suite C1 Roxboro, NC 27573 336-599-8366	Chatham Counseling Center 287 East St, Suite 421 Pittsboro, NC 27312 919-542-4422 or 1105 E. Cardinal St. Siler City, NC 27344 919-742-5612

Crisis Services are available 24/7 by calling the OPC STAR line at 919-913-4100 or 1-800-233-6834

Mobile Crisis Services are available 24/7 by calling 919-967-8844 or 1-800-233-6834

- Who do I call if I have concerns and questions?

  Providers: Call your provider relations representative at OPC Area Program.

  Consumers: Talk to your provider about the changes and call OPC Customer Services if you continue to have questions and concerns at 919-913-4120 or 1-888-277-2303.

  Community partners:
  For questions about services to adults and children with developmental disabilities contact, Cim Brailer at cbrailer@opc-mhc.org or 919-913-4150.

  For questions about services for children and adolescents with mental health and substance abuse challenges, contact Lisa Lackmann at llackmann@opc-mhc.org or 919-913-4011.

  For questions about adults with mental health or substance abuse challenges, contact Tom Velivil at tvelivil@opc-mhc.org or 919-913-4014.