MH/DD/SAS Gap Analysis Report Appendices

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Appendices

Appendix A: Local Needs Identified by LMEs

The following descriptions of local needs and priorities are summarized from each LME's annual needs assessment that was submitted to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services in April 2009 as a requirement of the *SFY 2009 DHHS-LME Performance Contract.*

Alamance-Caswell-Rockingham LME

LME Description: The Alamance-Caswell-Rockingham LME catchment area is a mix of urban and rural areas comprised of Alamance, Caswell, and Rockingham counties located between the Triad and Triangle regions of north central North Carolina. Of the 173,000 residents living in this area, 16% are enrolled in Medicaid.

LME Needs Assessment Method: Alamance-Caswel-Rockingham LME conducted a series of satisfaction surveys with consumer and family members, providers and stakeholders to elicit their feedback regarding local MH/DD/SAS services. In addition the LME used internal screening, triage, and referral data, NC TOPPS consumer outcomes data, as well as census information in the development of this report.

NOTE: As of July 1, 2009 Rockingham County moved from Alamance Caswell LME and merged with CenterPoint LME. The data presented in this report is for SFY 2008 and SFY 2009, during which time Rockingham was still a part of Alamance Caswell LME.

LME Identified Areas of Need: The following areas were identified as areas of need in the local service network or areas for improvement:

- Increase compliance with state standard for number of consumers determined in need of routine services who receive an appointment within 14 calendar days
- Implement strategies to assist in improving scheduling efforts, ensuring appointments are available that meet the needs of consumers and families
- Implement strategies to engage consumers in service and decrease the number of no shows
- Increase Community Education and Awareness about the availability and access to services continues to be identified as a significant need for the AC LME
- Increase utilization of natural and community supports is essential, including support groups
- Continue outreach and collaboration with primary care providers
- Identify additional transportation options for consumers in need of routine services will continue to be explored.
- Ensure the availability of services that are easily accessible by all residents and to ensure recruitment efforts target areas with the highest level of need.
- Explore options for transitional services for older adolescents preparing to enter adulthood

- Provide domestic violence and sex offender specific treatment
- Provide services specific to Gay, Lesbian, Bi-Sexual, and Transgender consumers
- Increase the number of providers who accept Medicare
- Foster a Culturally Competent Network by the following:
    - Conducting focus groups with members of the Spanish/Latino community to identify areas for improvement.
    - Providing marketing materials, service record documents, and surveys to be made available in Spanish.
    - Actively recruit service providers that target the Spanish/Latino population.
    - Actively recruit CFAC and Board Members that represent the Spanish/Latino population.
    - Provide Cultural Competency training available to providers and LME staff on a regular basis.
    - Provide tips on improving Cultural Competency for LME staff and provider agencies made available via the LME website, e-mails, and newsletters.
    - Increase collaboration with DJJ and other agencies serving children and adolescents to implement the following: Gang Prevention/Intervention Programming and outreach services to families of gang members and potential gang members
    - Parenting classes and support groups for parents of Hispanic/Latino youth
    - Develop a mentoring program for juvenile offenders
    - Recruit providers to offer Day Treatment/Day Reporting Center for youth offender; Develop a Runaway/Crisis Shelter for Youth; the county does not have a safe haven or 24 hour facility to meet this need

Albemarle LME

LME Description: Albemarle LME provides services in the eastern part of North Carolina to a 10 county catchment area, including the counties of Camden, Chowan, Currituck, Dare, Hyde, Martin, Pasquotank, Perquimans, Tyrell and Washington.. Of the 182,500 residents living in this area, 17% are enrolled in Medicaid.

LME Needs Assessment Method: The LME used a variety of methods to gather information for the needs assessment for FY 2009-2010. Individual interviews were conducted with county officials (county managers and commissioners) sister agencies, CFAC, Division of MH/DD/SAS, providers, and families/consumers. The 2009 Generic Provider Survey was also used to assess the provider needs within Albemarle's region.

NOTE: The excerpt presented below is from the 2009 Needs Assessment conducted by Albemarle LME and submitted to the Division in April 2009. In July 2009 the management of the LME was taken over by East Carolina Behavioral Health (ECBH). ECBH has since contracted with the Behavioral Health Resource Program from the School of Social Work, UNC-Chapel Hill to conduct an independent Community Planning Needs Assessment for the remainder of SFY 2009-10 and SFY 2010-11. The Community Plan will be completed by January 2010.

LME Identified Areas of Need: Through the 2009 needs assessment process the following gaps or needs were identified by the LME. The gaps in table below are not listed in any priority order.

Developmental Disabilities (adult/child):	Mental Health/Behavioral Health (adult/child):	Substance Abuse (adult/child):
1. Respite 2. Transportation 3. Crisis Services 4. Residential Services/Support/Independent Living 5. Developmental Therapy (funding) 6. Supported Employment 7. Training 8. Day Activity/Supports 9. Personal Assistance 10. Peer Supports 11. Culturally Diverse Services (specifically: Spanish speaking and interpreters for the deaf/hard of hearing)	1. Culturally Diverse Service Providers (who specifically treat: Spanish population, the elderly with Medicare, and veterans) 2. Therapy/Counseling (Individual, group, and jail consultation) 3. Mobile Crisis Services 4. Facility Based Crisis Services 5. Partial Hospitalization 6. Assertive Community Treatment Team (ACTT) 7. Community Based Inpatient Treatment 8. Psychosocial Rehabilitation 9. Supported Employment 10. Affordable Housing 12. Residential Services for Adults 13. Peer Supports 14. Medication Management 15. Multisystemic Therapy (MST) 16. Day Treatment 17. Transportation	1. Substance Abuse Intensive Outpatient Services (SAIOP) 2. Residential Treatment – SA specific 3. Detox Services & Inpatient Treatment 4. ADETS & DWI Services 5. Partial Hospitalization 6. Housing 7. Transportation 8. Peer Support 9. Wellness Recovery and Management Groups (adolescent) 10. 12-Step Programs 11. Transitional/Halfway Houses 12. Supported Employment 13. Culturally Diverse Services (who specifically treat: Spanish population and veterans) 14. Outpatient/Counseling Services 15. Crisis Services

Beacon Center

LME Description: The Beacon Center serves the eastern North Carolina counties of Edgecombe, Nash, Greene, and Wilson. Only Wilson County is considered urban. Of the 248,000 residents living in this area, 22% are enrolled in Medicaid. Compared to the state of North Carolina and the United States, residents of these counties are more likely to be female, person of color, uninsured, unemployed, poor, under 18 years of age or 65 years of age and have less formal education. The service area counties are roughly 49% people of color. Latino residents are thought to be under-counted by census takers and migrant farm workers not counted at all.

LME Needs Assessment Method: The LME conducted its needs assessment through a review of a variety of means, including community forums and focus groups. Reports generated by both The Beacon Center and the Division of Mental Health/Developmental Disabilities/Substance Abuse Services were reviewed and LME Board minutes, Management Team meeting minutes,

CFAC minutes, Community Systems Progress Reports, and NC DETECT data were used to identify system gaps and needs.

LME Identified Areas of Need: The organization is committed to the following focus areas in the coming five years.

- Identify and develop strategies to address gaps in the local continuum of care
- Reduce the current reliance on State Institutional services
- Successfully implement a community education program that heightens awareness on how to access services and lessening the stigma associated with seeking mental health/developmental disabilities and substance abuse services
- Maintain financial viability of the agency
- Provide rapid telephonic and face to face response to citizens in crisis
- Stabilization of a fragile provider network

The need for the following services and supports were also identified during the 2009 needs assessment.

- Facility based crisis services
- Outpatient substance abuse services
- SAIOP
- Increased Assertive Community Treatment Team capacity
- Partial hospitalization programs
- Dialectical Behavior Therapy in outpatient settings
- 24 hour drop off center for involuntary commitments
- Education, employment and housing for Consumers
- Education for family members about mental health, developmental disabilities and substance abuse issues
- Spanish speaking providers
- Increased education for consumers and families about medication usage
- Out of home placement for children that focus on levels III and IV and are located outside of the catchment area.
- Insufficient information to assist consumers and their supports to choose between providers

CenterPoint Human Services

LME Description: CenterPoint Human Services (CPHS) was established as a local management entity in 2004, responsible for developing, managing, and coordinating services to support local residents in one predominantly urban county, Forsyth, and two rural counties to the north and south, Stokes and Davie. Rockingham, a rural county, joined CenterPoint on July 1, 2009. Of the 530,000 residents living in this area, 16% are enrolled in Medicaid.

LME Needs Assessment Method: The LME conducted its 2009 needs assessment through surveys and review of multiple reports generated by CenterPoint, by local stakeholders, and by the Division of Mental Health, Developmental Disabilities and Substance Abuse Service.

LME Identified Areas of Need: Needs and gaps identified through the needs assessment are listed below:

- Transportation
- Improved access to services, particularly for routine care, children, and Community Alternative Program (CAP)
- Funding to increase service capacity for all services and new/additional providers for some service types (Partial Hospital, Multisystemic Therapy, crisis services including 24/7 psychiatric assessment)
- Housing

A Needs Assessment of Rockingham County was conducted during the first quarter of SFY 2009-10, resulting in identification of the following major areas of need:

- Community-wide education about service options, availability, and access
- Opportunities for dialogue, problem-solving, and collaboration between community stakeholders and CenterPoint
- Expand service array and capacity, including Assertive Community Treatment Team (ACTT), Psychosocial Rehabilitation Program (PSR), and child/adolescent mental health and/or substance abuse services
- Medication management and pharmaceutical support
- Improved collaboration with hospitals and law enforcement, including local Crisis Intervention Team (CIT) training and reduction in the use of involuntary commitments
- Transportation
- Housing

Crossroads Behavioral Health

LME Description: Crossroads Behavioral Healthcare LME serves the western North Carolina counties of Iredell, Surry and Yadkin. The area extends from the northern county line of Surry County on the Virginia state line to the southern county line in Iredell on the shores of Lake Norman, the largest manmade lake by surface area in the nation. Only Iredell is considered urban. Of the 271,000 residents living in this area, 15% are enrolled in Medicaid.

The citizens in the Crossroads area are predominately white (89%), between the ages of 25 and 64 with about an equal number of males and females. Both Surry and Yadkin counties have significantly more senior citizens (age 65+) than Iredell County and the state as a whole. The population growth in the Crossroads area has seen Iredell County exceeding the state’s rate of growth, while Surry and Yadkin counties have grown slower than the state’s rate of growth. However the rate of growth in the numbers of Hispanics in Surry and Yadkin counties exceeds the state rate of growth and the increase in Iredell County is below the state’s rate of growth.

LME Needs Assessment Method: Crossroads surveyed, sought input and feedback from various consumer, provider and community sources, such as the Consumer and Family Advisory Committee, Communities Caring for Families, Juvenile Crime Prevention Councils, Child Protection Teams, Department of Social Services, Department of Juvenile Justice and Delinquency Prevention, local school systems, and other human service organizations to glean

their input on our citizens' behavioral health needs. The needs assessment compiles these various responses, perspectives and viewpoints to gauge our communities' behavioral health needs. In addition an extensive review was conducted of internal and state data sources such as IPRS [state and federal funding claims] and Medicaid claims, NC-TOPPS reports, Community Systems Progress Reports, census data, State Bureau of Investigation crime statistics, State Center for Health Statistics, and Emergency Department data. In addition surveys and community stakeholder feedback was used to gain an understanding of the issues consumers face.

LME Identified Areas of Need:

Need	Description	Age / Disability	Actions to Address Identified Needs
Expanded Transportation	Single greatest barrier to treatment reported by consumers	AMH ASA ADD CMH CSA CDD	Working with the NC-DOT and Northwest Piedmont Rural Planning Organization to conduct a planning meeting so that application can be made for additional funds for Surry and Yadkin counties.
Reduce State Hospital Involuntary Commitment admissions	No IVC beds currently available in catchment area	AMH ASA ADD	Enhanced State Hospital follow-up; developed Transition Service; implemented 3-way contracts with local LMEs for 17 IVC beds; working with local hospital to develop IVC capacity; expand Crisis Recovery Center capacity and services; enhance Mobile Crisis services; established Urgent Psychiatric Care Walk-in; Centers; NC Start respite beds.
Additional Child Psychiatry	Very limited access in catchment area	CMH CSA CDD	Hired one new recent graduate from WFU; support for one Child Psychiatric Fellow from WFU.
Expanded Services for Children	Very limited services provided (CSPR)	CMH CSA CDD	Co-located clinicians in pediatric practices and one school; expanded System of Care activities, Child and Family Teams, and Family Partners; reduction of child residential placements; Child Services Plan; Cornerstone grant; Reclaiming Futures grant.
Improve Substance Abuse Services	Very limited services provided (CSPR)	ASA CSA	Adult SA Plan, Child Services Plan; development of Transition Service; Surry SIG grant; Iredell SA Academy.
Develop and Enhance Recovery – Oriented Services	Implementing a recovery perspective is a Division Guiding Principle for 2007-2010	AMH	Development of Recovery Education Centers in Iredell, Surry and Yadkin clinics, WRAP Training for consumers and providers; WRM Training for providers. Awarded grant to support WRM training and implementation.

Need	Description	Age / Disability	Actions to Address Identified Needs
Workforce Development	Providers have identified the need for more evidence-based practices	AMH ASA ADD CMH CSA CDD	5 EBP Trainings (with CEUs) to 91 provider staff; development of a proposed graduate course curriculum in addiction studies.
Improved Housing	Improving housing alternatives is a Division Goal for 2007-2010	AMH ASA ADD CMH CSA CDD	Transitioned Supported Housing Program to LME, applied for 8 additional units (not received); added 3 transitional SA housing units; worked with local housing coalitions to expand access; added transitional house for MH/SA adult males.
Improve Internal LME Functioning	To better serve consumers and utilize available resources	AMH ASA ADD CMH CSA CDD	Reduced wait-lists; reduced authorization turn-around time; improved authorization reliability; incorporated CFAC into Quality Improvement activities; improved communication with providers and consumers.
Improve Crisis Services	Strengthen coordination and continuity of crisis services	AMH ASA ADD CMH CSA	Established Urgent Psychiatric Care Walk-in; Centers; contracted with comprehensive provider to operate Mobile Crisis, Crisis Recovery Center, Urgent Care Walk-in Centers and Recovery Education Centers to establish a smooth continuum; contracted with 2 child services providers for rapid response beds.
Coordination with Community Partners	Strengthen community involvement and maximize supports	AMH ASA ADD CMH CSA	Integrated behavioral health professionals at two pediatric practices and at an alternative school; collaborating with CCNC networks; sponsoring Crisis Intervention Team training for area law enforcement; staff System of Care community collaboratives.
Specialized needs and services	Need to develop and or strengthen education / em-ployment; bi-lingual; veteran; and prescription assistance programs and services	AMH ASA ADD CMH CSA CDD	Continued efforts to coordinate with providers, and community resources to address these needs and to maximize existing resources in each community to meet these needs.
Drop-In Center	Consumers	AMH	Budgetary constraints preclude development of

Need	Description	Age / Disability	Actions to Address Identified Needs
	identified the need for drop-in centers in each community	ASA	drop-in centers at this time.

AMH = Adult Mental Health; CMH = Child Mental Health; ASA = Adult Substance Abuse; CSA = Child/Adolescent Substance Abuse; ADD = Adult Developmental Disabilities, CDD = Child Developmental Disabilities; CSPR= Community Systems Progress Report

Cumberland Mental Health Center

LME Description: Cumberland County Local Management Entity (LME) is a single-county in eastern North Carolina. This urban county has 320,000 residents, of whom 17% are enrolled in Medicaid. The County military population is impressive with 46,909 active duty soldiers, 18,239 dependents and 46,457 retirees that represent almost a third of our population. These figures do not include "citizen soldiers" (National Guard and Reserves). These numbers will increase over the next few years due to the Base Realignment and Closure or "BRAC" that will result in reassignment of substantial military assets to Fort Bragg along with approximately 41,000 service personnel and family members. The military has contributed to the diversity in the community, with the county reflecting over 80 different cultures (2004 Metro Visions Study by the Chamber of Commerce). Cumberland County has 3.38% of North Carolina's population with 22.8% of that population being comprised of young adults between the ages of 18 - 34. This is substantially more than would be expected of a county our size. Our population shows that 17.2% of Cumberland County families live in poverty and 23% of children under the age of 18 that reside in Cumberland County, live in poverty.

LME Needs Assessment Method: In collecting data for the needs assessment, the LME participated in various meetings of multiple groups in Cumberland County that work collaboratively in collecting data on the demographics of our citizens as well as gaps, needs, resources, funding, effectiveness and sustainability of initiatives. These include Partnership for Children, Juvenile Crime Prevention Council, Fayetteville/Cumberland County Business Council, United Way, Continuum of Care and Coalition to End Homelessness. The LME also participates with other human services agencies as they look at consumer populations to identify similar gaps and needs in the service delivery system, and ways to work more collaboratively between the agencies to share resources when possible. In addition the LME has also utilized data generated through two public forums hosted by the Cumberland CFAC; focus groups conducted by the Community Collaborative; and online surveys responded to by 55 providers and 35 consumers.

LME Identified Areas of Need:

	Providers	Community-Stakeholders	Community Forums

	Providers	Community-Stakeholders	Community Forums
General Services Needed	Youth services Psychiatrists Crisis services Language services	Substance abuse for youth Co-occurring Services Access to Interpreters for language barriers Child Psychiatrist Emergency services/ ER wait times too long	Improve overall qualify of provider services Provider training/Customer service Transportation Reduce wait times for services Consumer education
Developmental Disabilities	Day Activities Parental Training Respite CAP Services	School-based Services Transportation	Quality day programs Improve crisis services Expand education on available services & supports More CAP services Peer Support services Employment training
Mental Health	Psychiatric/Medication More Psychiatrists Community-based Inpatient Psychiatric Clubhouse/ Drop-in Center Licensed Therapists Partial hospitalization	Mobile Crisis State funded Substance Abuse services Psychiatric Care	Medication Support to achieve Independence Affordable housing Employment opportunities
Substance Abuse	Medically Monitored Community Residential Treatment More Detox/ Inpatient Residential Treatment for women Comprehensive SAIOP	Detox Residential Treatment Day Treatment	Limited services for very young children at risk of substance abuse More qualified service providers

The Community Collaborative for Cumberland LME summarized the needs as shown below.

- Lack of access to day treatment services for youth- there is only one program and there are limited abilities to access this program
- Need more community based programs.
- Transition from one service or level of care to another is problematic.
- Family members often have limited involvement in treatment team and child and family planning meetings.

- Children are being moved around from placement to placement and as a result are missing too many days from school to receive credit.
- Level IV secure residential placements are not providing the public schools with information on grades or creditable documentation of educational services provided
- There are gaps in services for after- hours crisis response including response on the week-end
- There is a need for the community to develop local inpatient psychiatric beds for children and adolescents.

Durham Center

LME Description: The Durham Center LME is a single-county program in central North Carolina. This urban county is part of the Triangle metropolitan area. Of the 267,000 residents living in the county, 14% are enrolled in Medicaid. The LME served approximately 11,000 adults and children in FY2008-2009 through a provider network of approximately 250 contract agencies. There were approximately 10,629 adult consumers needing mental health services in Durham in 2008. With budget balancing issues, decisions were made for FY2009-2010 to be as equitable as possible in order to preserve the critical services for the community. Service reductions affected all disability areas and age groups, while maintaining crisis and high-risk services. These reductions were in line with recommendations from The Durham Center Gap and Needs Assessment, CFAC and Area Board.

Although more consumers are being served, due to reduced provider capacity there are now waiting lists for consumers to access treatment. Children in need of mental health services represent 11% of Durham's population. During 2008 there were 147 care reviews facilitated through The Durham Center's System of Care, of which 22 were diverted to other placements than high level care or hospitalization. There are over 339 adults and children with developmental disabilities receiving the Medicaid CAP Waiver in Durham County, up from 320 previously. An estimated 19,000 Durham County residents are in need of substance abuse treatment. The number of substance abuse assessments increased substantially over the last calendar year from 395 to 478, but Durham has a waiting list due to a lack of treatment providers. Durham has made significant strides in reducing State psychiatric hospitalizations, from approximately 70 per month to 30 per month (including all service categories) over the past year. The Durham Center continues to be data driven and to use data to make organizational and programmatic decisions for populations in need.

The LME has come online with the NetSmart Avatar system that greatly enhances the LME's ability to manage the provider network, consumer and financial data, including service request management and authorization, scheduling and treatment planning, contract tracking, and claims adjudication and payment calculations.

LME Needs Assessment Method: The Durham Center LME uses many methods to gather and analyze data. Primarily, these consist of surveys of providers, consumers, and other stakeholders, focus groups, and quantitative data collection in each of the disability areas. Endorsed and contracted providers participated in a specific survey asking about challenges and successes in Durham County.

Focus Groups: The Durham Center had staff and members of CFAC facilitate seven focus groups which were conducted at Triangle Empowerment Center, Common Ground, the Provider

Advisory Council, TROSA, the parent group from the ARC of Durham, and at a mental health and developmental disabilities workgroup at a Town Hall meeting. Approximately 131 people participated in the focus groups representing agencies, service providers and community resources.

Surveys: Surveys conducted included a Community Agency Survey, LME Staff and Provider Agency surveys, and a Consumer/Family Member survey in English and Spanish. Surveys were administered electronically via Survey Monkey, as well as manually on hard copies from February 2 to February 23, 2009. On a scale of 0-3, with three indicating the most positive rating, respondents were asked to rate access to services, quality of services and how well consumer needs are met in the following categories:

- Mental Health Treatment
- Substance Abuse Treatment
- Dual Disorder Treatment
- Developmental Disability Treatment
- Housing
- Employment/Vocational
- Crisis Services
- In-home Services
- Peer Support
- Services for families
- Case Management/Community Support

Respondents were also asked to indicate any barriers that had prevented consumers from accessing needed services. Survey responses were compared across disability groups and to the results of the 2008 analysis.

In addition, we administered a Provider Capacity Survey to gather more detailed information from providers about resources and service capacity, along with any new services they are planning to implement in the future. Data was collected through a web-based survey tool during the first three weeks of February. The same questions were used this year as in last year's survey to more accurately measure changes and identify trends. All endorsed and/or contracted providers located in Durham County were encouraged to take the survey. After responses were collected, results were analyzed for current information and changes compared to last year.

LME Identified Areas of Need: The following are areas in which needs or improvements were identified:

- The need for more specialty services across populations (e.g. dual-disorder services)
- Continued development of a full service array in all disability areas
- Improvement in the quality of providers via workforce development, improved/increased communication, collaboration, and coordination
- Addressing the basic needs of consumers (i.e. housing, transportation, income/employment, integration of medical care with services)
- Development of improved public awareness, including public education of resources, information, and access
- Inclusion of family and natural supports in the treatment process
- More prevention and early intervention services

- Improvement in feedback mechanisms for consumers and families
- Increasing partnerships with community-based organizations with the inclusion of peer supported services
- Reduction of stigma associated with addiction and expansion of the System of Care framework to substance abuse treatment
- Continued relationships with local hospitals (Duke and Durham Regional) to facilitate an increase in local inpatient capacity.

The Durham Center will use the information from the Gaps and Needs Analysis as part of our budget process as funding becomes available and as we look at grant opportunities.

Eastern Carolina Behavioral Health (ECBH)

LME Description: East Carolina Behavioral Health (ECBH) is the Local Management Entity (LME) for a nine county area in the northeast section of the state comprised of the following counties: Bertie, Beaufort, Craven, Gates, Hertford, Jones, Northampton, Pamlico, and Pitt. ECBH was formed as a result of a merger of Pitt County Mental Health, Roanoke-Chowan Human Services, and the Neuse Center, which became operationally effective July 1, 2007. The service area runs from the North Carolina/Virginia State line down to the southern border of Jones County, a distance of 114 miles, and at its widest area is 91 miles (as the crow flies). The service is composed of 2 distinct county areas separated by Martin County which lies within the Albemarle LME service area. The LME serves a total population of 404,000 residents, 18% of whom are enrolled in Medicaid.

LME Needs Assessment Method: The needs assessment process had the following steps:

- A series of meetings were held with the Executive Management staff of the LME to determine their service needs and to structure the needs assessment process. Those meetings determined that several different components to the review process were paramount to develop a picture of the current client population needs and services:
- A review of the current services data was to determine the level of client services currently provided
- A review of provider databases, locations, levels of services by location
- A review of most recent literature and public service projection databases would be conducted to insure that the current ECBH delivery system activities and services could be compared to projections of the anticipated service population of the service area
- A qualitative analysis conducted on the data from 15 community stakeholder meetings participants including: persons served, family members of persons served; local human service partners, providers, ECBH staff and the ECBH Consumer and Family Advisory Committee and its Local Empowerment Groups who assisted with the community meetings. The stakeholder meetings were conducted in the winter of 2009 to determine local needs, trends and impressions on services provided by ECBH and its provider network. Input was received from a total of 264 stakeholders.

LME Identified Areas of Need:

In completing the annual gaps and needs analysis for 2009-2010, ECBH LME found that many of the previous recommendations and findings identified in 2008 ECBH Needs Assessment by the Behavioral Health Resource Program (BHRP) were still applicable. Such findings included:

- The ECBH provider network is quite large. While this indicates large provider resources, it is not an indication of quality. Additionally, there are many potential downsides to monitoring a group of providers that is this large.
- The provider network, while large, has many generic service providers as opposed to comprehensive specialty providers. There are more providers delivering a multitude of services to all of disabilities than there are providers who specialize in one disability area. It is difficult to determine whether there is adequate attention paid at the provider level to the specific disability. There are many willing billing organizations but the question of whether there are many willing provider specialists still exists.
- Invest for results. It will be important for the LME to focus its future efforts on clinical practices in its provider network, like Evidenced Based Practices, which can demonstrate that the investment in public funds is effectively implemented and has resulted in effective results for the consumers served.
- ECBH will need to consider how to incentivize it's providers to offer multiple levels of care/services under comprehensive provider organizations. The provider network as it currently exists does not allow a consumer to access multiples services or move through multiple service levels without barriers and unnecessary hardship. The services need to be arranged so that service movement is seamless to the consumer and based upon their needs rather than the needs of the provider.
- Perhaps one of the greatest challenges for the LME in the immediate and long term future is to move from the many individual provider organizations currently in existence to well organized, closely linked continuums of care with an emphasis on clinical specialization located within the LME's geographic service area.
- Providers identified workforce staffing and training as a serious need. The LME should develop some training and incentive mechanisms that could keep the skilled clinicians it currently employs, attract new clinicians at higher levels of education and credentials, and offer training programs which focus on competency development in the implementation of Evidenced Based Practices.

Eastpointe LME

LME Description: Eastpointe LME is comprised of four counties (Duplin, Sampson, Lenoir, and Wayne Counties) located in the eastern region of North Carolina. All but one of the counties (Wayne) are rural counties. Of the 294,000 residents living in this area, 22% are enrolled in Medicaid. This is the third highest ranking in the state, along with the Beacon Center. Located within the region are 3 of the 15 state operated facilities –O'Berry Neuromedical Center, Cherry Psychiatric Hospital, and Caswell Developmental Center. Within the catchment area, Eastpointe has the second most group homes per capita within the state. There are three Federally Qualified Health Clinics within the area. Eastpointe resides within 60 miles of four military bases, with one housed in Wayne County. Eastpointe has experienced a very slight population decline between 2007 and 2008 (-0.31%).

LME Needs Assessment Method: The following sources were utilized to obtain qualitative information for the needs assessment.

- Consumer and Family Forums: One forum was conducted in each of the four Eastpointe counties, hosted and facilitated by Eastpointe staff and CFAC. Eighty-seven consumers and family members participated through the different forums.
- Surveys: Eastpointe sent electronic survey links to providers, stakeholders and community representatives. Four consumers, 73 providers and 91 stakeholders responded to the electronic surveys. *(Please note: Eastpointe's primary vehicle for obtaining consumer and family input was through its community forums held in each county. However, Eastpointe also posted a link to an electronic consumer/family survey on its website as an experiment.)*

LME Identified Areas of Need:

Eastpointe Service Needs Identified in Surveys & Forums	
General Services	Substance abuse services for adolescents Integrated services involving substance abuse Lack of Funding
Housing	Affordable housing Supportive services Safe housing
Employment	Assistance finding community employment Ongoing support with community employment, Transitional support with community employment Help with problems on the job Supportive employment follow-along
Transportation	Public transportation times and locations Vouchers for public transportation Ability to transport self
Developmental Disabilities for Adults	Mobile crisis Developmental Therapy CAP MR/DD slots Vehicle adaptations Traumatic brain injury services Community activities and employment transition Augmentative hearing devices
Developmental Disabilities for Children	Day activity Community activities and employment transition Traumatic brain injury services Vehicle adaptations Community rehabilitation wait times Developmental therapy CAP MR/DD Slots

Eastpointe Service Needs Identified in Surveys & Forums	
Mental Health for Adults	Facility based crisis Centers Supported employment Supported employment follow-along Wellness recovery Action Planning Integrated treatments Clubhouse Diagnostic assessment wait times
Substance Abuse for Adults	Non-medical community residential treatment, Medically monitored residential treatment Wellness recovery and management groups Detoxification availability and wait times Halfway house wait times Inpatient wait times
Mental Health and Substance Abuse for Children & Adolescents	School-based substance abuse treatment School-based mental health treatment Sex offender treatment Substance abuse intensive outpatient program Partial hospitalization Wait times for psychiatric care, therapy and intensive in-home treatment

Five County Mental Health Authority

LME Description: Five County Mental Health Authority serves the central North Carolina counties of Franklin, Granville, Halifax, Vance and Warren counties, all of which are rural. Of the 234,000 residents living in this area, 23% are enrolled in Medicaid. Franklin and Granville Counties, which are located just north of the Raleigh-Durham area, have experienced rapid growth since 2000, while the population of the other three counties has remained relatively stable. Halifax, Vance and Warren Counties have poverty rates ranging from 22% to 25%, while the poverty rates in Franklin and Granville Counties are substantially lower.

LME Needs Assessment Method: The Five County Mental Health Authority conducted the annual Needs and Gaps Assessment during the months of January and February 2009 in collaboration with our Consumer and Family Advisory Committee (CFAC), using a variety of methods including surveys, focus groups, review of statistical information, and establishment of a Needs and Gaps Assessment Committee. Surveys were collected from consumers and families, community partners which are our primary referral sources, provider agency owners and executive directors, provider agency staff, FCMHA Area Board members and FCMHA staff. Focus groups were conducted with CFAC, the Provider Council, and a number of advocacy and community planning groups.

LME Identified Areas of Need: In conducting these surveys, the various groups were asked to identify the three services in each disability category that were most needed or in short supply in each county. Items that were rated in the top 10 by all three groups are as follows:

2009 Five County Mental Health Authority Identified Needs by Disability Group	
Adult Mental Health	Access to psychiatric evaluation and medication Public education about mental illness Supported employment Family counseling
Child Mental Health	Family counseling Crisis foster care Mental health services to juvenile detention Access to child psychiatrists and medication Individual counseling
Adult Developmental Disability	Day activity Targeted case management Supported employment Home and community supports Support groups for families.
Child Developmental Disability	Day activity Home and community supports Targeted case management Support groups for families
Adult Substance Abuse	Inpatient Comprehensive outpatient Halfway house Dual diagnosis services for persons with SA/MI Medical detox Intensive outpatient
Child Substance Abuse	Inpatient Family counseling Intensive outpatient Residential Prevention
All	Transportation Low Cost Housing Public education about behavioral health

Recommendations to Address Identified GAPS: Through the process of reviewing and analyzing information collected through surveys, focus groups and data reviews, various needs and gaps were identified. In comparing these needs and gaps to the current capacity of services and resources, both realistic and perceived needs and gaps were identified and prioritized according to the most frequently identified. Recommendations were established to address these priority needs and gaps within the next fiscal year if financially feasible. The other needs and gaps will be addressed as time and resources allow.

The following is a list of the recommendations considered as a priority:

Multiple Disability Groups

- Increase public education regarding mental illness, developmental disabilities and substance abuse.

- Increase public awareness of the resources available for individual and family counseling, as well as available support groups for families and consumers
- Increase employment opportunities for consumers in all disability groups
- Continue efforts to address transportation needs
- Increase number of consumers served by housing subsidy programs
- Continue to assist with cost and explore alternative funding resources for affordable medications
- Promote Integrated Dual Disorder Treatment for persons with both substance abuse and serious mental illness
- Expand respite services for people with mental health and / or developmental disabilities
- Expand role of Peer Support in the mental health and substance abuse service continuum
- Increase community based crisis interventions / services and insure effective utilization of crisis services continuum
- Continue promoting evidence-based practices for all disability groups
- Expand capacity to accommodate Spanish speaking consumers in the service continuum

Mental Health

- Increase capacity in adult and child psychiatry through recruitment and telepsychiatry
- Promote availability of specialized trauma treatment for children

Developmental Disabilities

- Further assess the service needs of adults and youth with developmental disabilities and reasons for identified delays in engaging consumers in services
- Serve more consumers with developmental disabilities who are in need of services

Substance Abuse

- Continue expanding the substance abuse service continuum for adults and youth
- Continue substance abuse prevention and early intervention programs

Guilford Center for Behavioral Health and Disability Services

LME Description: Guilford Center LME is a single-county program in the Triad metropolitan area of central North Carolina. Of the 477,000 residents living in this urban county, 15% are enrolled in Medicaid.

LME Needs Assessment Method: A Community Assessment Survey was developed and posted on the LME homepage, guilfordcenter.com, in January 2009. A link to the survey, along with an invitation to participate, was distributed to service providers, community members and community collaborative partners. This distribution list included, among others, the Juvenile Crime Prevention Council, School Health Advisory Committee and the Violent Crimes Taskforce. Additionally, paper surveys were distributed to the LME Board, the CFAC and at a Provider Forum. Surveys were received from 316 providers and community members.

LME Identified Areas of Need: The top five service gaps and/or capacity needs identified through this process, by category, are presented below.

- Service Gap/Capacity Need Identified by All Respondents

- Short term crisis beds
- Respite services for consumers and families
- Drop-in center for mental health consumers
- Day programming for consumers
- Mental Health wellness education services

- Service Gap/Capacity Need Identified by Community Providers
  - Short term crisis beds
  - Respite services for consumers and families
  - Day programming for consumers
  - Services for transitional youth, ages 16-21
  - Availability of providers accepting Medicare
- Service Gap/Capacity Need Identified by CFAC
  - Drop-in center for mental health consumers
  - Geriatric services for consumers
  - Respite services for consumers and families
  - Services for homeless individuals with disabilities
  - Services that divert consumers from hospital and/or jail
- Service Gap/Capacity Need Identified by Consumers and Families
  - Short term crisis beds
  - Respite services for consumers and families
  - Mental Health wellness education services
  - Day programming for consumers
  - Services that divert consumers from hospital and/or jail
- Service Gap/Capacity Need Identified by LME Board
  - Intensive community based services for youth
  - Independent living with support services for consumers
  - Residential treatment for youth substance abuse consumers
  - Respite services for consumers and families
  - Services for homeless individuals with disabilities

Recommendations for 2009-10 Fiscal Year to Address Identified Gaps

- Complete Adult Developmental Disability Request for Proposal process to select service providers for Respite, Day Activity, Personal Assistance (Individual and Group) and Outpatient Services. Projected service start date of Fall 2009.
- Complete Child Developmental Disability Request for Proposal process to select service providers for Respite, Day Activity, Personal Assistance (Individual and Group), Personal Care and Outpatient Services. Projected service start date of Fall 2009.
- Complete Adult Mental Health Request for Proposal process to select service providers for Facility Based Crisis/Short Term Crisis Beds and Wellness Education Services. Projected service start date of Fall 2009.
- Complete Child Mental Health Request for Proposal process to select service providers for Summer Enrichment programs and Teen Parenting programs that include instruction for both teen mothers and fathers. Projected service start date of July 2009.

- Continue collaborative meetings for Developmental Disability providers, Mental Health providers and Substance Abuse providers, including the Children's Mental Health System of Care Collaborative, to further their implementation of best practice principles and offer training and technical assistance to support their work with consumers.

Johnston County Local Management Entity

LME Description: Johnston County Mental Health Center is a single county catchment area located in east central North Carolina. It has recently been moved from a ranking of 58th in to 31st in growth nationally and is third in the state in terms of growth, with an increase rate of 4.2% from FY08 to FY09. Of the 169,000 residents living in this county, 16% are enrolled in Medicaid.

Overall, Johnston County remains basically rural, even though the county has recently been designated an urban county due to its growth. According to the 2005 Agriculture Stabilization Conservation Service data, the county ranks second in the state for number of farms (4,810). Only 30% of the County's residents live in incorporated towns or municipalities. Current ethnicity estimates show that the County is 72% White, 15.7% African American and 10.5% Hispanic/Latino.

LME Needs Assessment Method: Four different questionnaires were distributed to a variety of stakeholders to determine needs, gaps and capacity in the service system in Johnston County. Each specific survey was constructed by the Needs Assessment Subcommittee of the JCMHC Quality Management Committee, based on questionnaire response from FY08, guidance received from DMH/DD/SAS and additional questions suggested from the Consumer and Family Advisory Committee group. Five groups of stakeholders were sampled in the process: Consumer and Family members, General Citizens, Community Partners, Providers of both Basic and Enhanced Services and Staff of Johnston County Mental Health Center.

LME Identified Areas of Need: The overall feedback from Johnston's needs assessment process is summarized in development in the priorities for planning shown below:

Priority 1: Public awareness of mental health service system and consumer education on issues surrounding mental health, developmental disabilities and substance abuse.

Priority 2: Customer Service including in-house and provider training. This includes customer "etiquette", defusing angry/stressful/difficult situations, staff/provider knowledge of resources, system navigation assistance and using a positive approach in presenting options.

Priority 3: Completion of plans for crisis services. Several initiatives outlined in the Crisis Plan have begun (Child Respite, Protocols for State Hospital follow-up,). Still needed are Adult Crisis Respite, completion/implementation of Crisis Stabilization Unit in JMH, and identification/tracking system for high-risk consumers.

Priority 4: Implementation of several projects with community partners

- Specialized Foster Care Program in coordination with DSS for children who are diagnosed as or at high risk for serious emotional disturbance.
- Prevention services for children who at risk for substance abuse, delinquency prevention, gang prevention, and high school dropout.
- Development of Halfway House for Women with Day by Day Treatment Center

- Peer involvement in training and liaisons for high risk consumers of those who have been hospitalized (Peer to Peer and Family Support Services).
- Cultural competence training for providers/LME
- Family support for geriatric population with Council on Aging.

Priority 5: Enhancing continuum of care both for targeted populations and services:

- Transitional age groups including
  (1) Special needs consumers between ages 3-5
  (2) At risk children of middle school age
  (3) Young people already in targets between 18-21
- Service providers for
  (1) ACTT
  (2) Intensive In-home
  (3) Supervised residential facilities for special needs adults
  (4) Residential facilities for children
  (5) Day treatment for elementary children
  (6) Substance Abuse Medical Non-hospital detox
  (7) Transportation
  (8) Special Support Services for Consumer with Dual Diagnoses

Mecklenburg Area MH/DD/SA Authority

LME Description: Mecklenburg County Area MH/DD/SA Authority is a single-county program that comprises the center of the Charlotte metropolitan area in western North Carolina. Of the 894,000 residents living in this urban county, 14% are enrolled in Medicaid.

The vision of the Mecklenburg County LME is, "To be a community that supports individuals and families who are fully empowered to lead healthy and independent lives."

LME Needs Assessment Method: Throughout the year on an on-going basis, through a variety of advisory and community committees, Mecklenburg County LME identifies needs and service gaps that will promote and achieve the wellness, recovery and independence for Mecklenburg County citizens with mental health, developmental disability and substance abuse challenges and incorporates those needs into the day to day development of an accessible, responsive and quality driven community of providers and into fostering collaborations within and across community systems.

Mecklenburg LME initiated this formal needs assessment process in January 2009. LME staff in partnership with the Mecklenburg Consumer and Family Advisory Committee conducted six forums with consumers and families between January – March 2009; in addition, input was obtained from community best practice committees and the Mecklenburg Provider Council. A total of 189 consumers and family members participated in the process through various forums.

Mecklenburg LME sent electronic survey links to consumers, family members, providers, community partners, and stakeholders beginning February 2009. Electronic survey links were available through March 20, 2009. There were three surveys available; one for consumers, one for staff of provider agencies, and one for stakeholders/advocacy organizations. This was the

first year there was a survey designed specifically for consumers; the 2008 survey combined stakeholder and consumer in the same survey. The consumer survey consisted of eleven open ended questions to allow individuals to share additional feedback and comments regarding their experiences in accessing and receiving treatment services and supports.

Mecklenburg received 447 survey responses, 93 consumers, 103 stakeholders, and 251 providers. This is a 37% increase in the number of survey responses received during the 2008 Community Needs Survey process.

LME Identified Areas of Need:

2009 Mecklenburg Service Needs Identified in Surveys & Forums	
General Services	Substance abuse services for adults and adolescents Integrated dual disorder services across all disability areas Evening and weekend service hours, particularly for children and families, but also for adults, especially those seeking substance abuse services outside working hours. Housing & Employment: (see below) Information dissemination to consumers regarding "the system." Information dissemination to providers and stakeholders re: availability of services throughout the county and among all providers & stakeholders.
Housing	Affordable housing options Available housing for special populations (gender specific, young adult, substance abuse, homeless) Housing in safe neighborhoods
Employment	Employment training: appropriate to individual's abilities Workforce development training of job coaches Diverse jobs for diverse abilities.
Transportation	Public transportation connection points beyond city center Additional bus routes to access service locations Training to use public transportation that supports independence
Developmental Disabilities for Adults	An array of services for individuals with Traumatic brain injury Home modifications Vehicle adaptations Specialized Consultative Services Augmentative Communication Devices Residential services & availability (wait times) Integrated services (DD/MH and DD/SA) Employment services Supported Employment and follow along Transportation Education and training re. community resources Crisis response Psychologists who accept Medicaid Improved coordination across services, disabilities, systems

2009 Mecklenburg Service Needs Identified in Surveys & Forums	
Mental Health for Adults	Transportation Increase community knowledge about available services Additional Psychosocial Clubhouse programs Supported employment, vocational training & follow-along services Additional psychiatric/medication evaluation & management services Add outpatient therapy/counseling sites across community to reduce current wait times Residential & residential support services appropriate for young adults; transitional & permanent housing
Substance Abuse	Inpatient hospital substance abuse treatment (availability & wait times) Non-medical community residential treatment Medically monitored community residential treatment Additional halfway house options Establish wellness recovery & management groups Transitional supports when moving from treatment to aftercare Reduce screening & assessments wait times Transitional and permanent housing Peer run and peer support programs
Child & Adolescent	Additional outpatient therapy/counseling sites across the community An array of Substance Abuse treatment services, with focus of co-occuring disorders (SA/MH) Sex offender treatment Additional psychiatric/medication evaluation and management services Residential treatment all levels & substance abuse

Mental Health Partners [formerly Burke - Catawba]

LME Description: Mental Health Partners, formerly Mental Health Services of Catawba County, manages the delivery of mental health, substance abuse and developmental disability services to two counties in western North Carolina. Burke is a rural county and Catawba is urban. Of the 247,000 residents living in this area, 16% are enrolled in Medicaid. The two counties together have a population of 244,823.

LME Needs Assessment Method: A subgroup from the Quality Management (QM) Committee served as a Steering Committee for this project in setting out the approach and scope of information most practically beneficial in conducting the Needs Assessment. It was determined that MHP would focus on the following tasks (a) build upon information and goals set forth in the previous assessment, assessing feedback from the community on whether they felt the goals had been satisfactorily accomplished or if further work needed to be done; (b) review of all internal and external statistical reports, to then present stakeholders with an update on the current MH system (both at the State and local level) along with anticipated actions to come, and review those factors as an overlay to the catchment area's status; and (c) ask for input on prioritizing areas of attention for the coming year, including suggestions on service/support adjustments that might be made to accommodate the balance of service requests against shrinking financial resources.

To accomplish the tasks noted above, focus groups were held utilizing both existing committees in the QM structure (Burke and Catawba County Provider Quality Council Meetings, Adult and Child Community Collaboratives in both counties, Area Board discussion of issues and feedback in the active Strategic Planning process), and the CFAC's arrangement of consumer focus groups for citizens in both Burke and Catawba Counties. All input was reviewed in the QM Committee, and priorities for the coming year established. The three subject areas identified in the 2008 Community Needs Assessment were still slated as the highest priorities, but the scope and type of attention needed has subsequently changed.

LME Identified Areas of Need: The *top three areas* for LME attention in SFY 2009-10 are the following:

- Continued focus on the crisis service array
- Modification of integrated service delivery models
- Greater network awareness (both providers and consumers) of service availability, service types and access to services (e.g., capacity, service gaps, funding, wait lists, etc.) as changes occur locally in response to state changes in service definitions, transitional requirements, etc.

Though this Community Needs Assessment process has culminated in clear identification of three areas prioritized for LME attention, *other service gaps/systemic issues* also bear attention.

- SA services in Burke County, particularly SAIOP. The SA provider previously in Morganton (and Hickory) has since consolidated service delivery to one site only, in the Hickory area.
- Community Support Capacity
- Continued attention to Child DD Services and supports
- Transportation is an issue in both counties, ameliorated to some degree by funding supports that enhance transportation options, but the need still exists.
- Community interest in a Crisis Center

Onslow Carteret Behavioral Healthcare Services

LME Description: Onslow-Carteret Behavioral Healthcare Services LME serves two counties in eastern North Carolina. Only Carteret is considered rural. Of the 242,000 residents living in this area, 11% are enrolled in Medicaid. Almost 19,000 of the area's residents are veterans. Onslow County is the home of two major military installations, Camp Lejeune and New River Marine Corps Air Station. Camp Lejeune has three major commands II Marine Expeditionary Force, 2nd Marine Division, and 4th Marine Expeditionary Brigade. The mission of Camp Lejeune is to maintain combat ready units, Naval Hospital and support commands.

LME Needs Assessment Method: A solid assessment of service needs, gaps, and capacity include[d] each of the following activities:

- Gathering of existing data and reports.
- Consumer and family forums.
- Consumer Surveys.
- Provider surveys.
- Stakeholder survey to include LME area board and staff.

LME Identified Areas of Need:

Service	Counties With Gap	Reason
Facility Based Crisis Services	Onslow and Carteret	Need a Crisis Unit for evaluation with short-term bed stays if necessary.
Assertive Community Treatment Team	Onslow/Carteret	Minimally 50 consumers with need. Service supports people with severe and persistent mental illness that typically do not do well in traditional services.
Family Living	Onslow/Carteret	Consumers with long term residential needs are better supported in families than in group living situations.
Outpatient Treatment (OPT) individual, family and group (SA and MH)	Carteret/Onslow	Lack of providers who will accept state funded consumers. Family OPT is recognized as effective service for support system to have the ability to assist consumer in daily living. OPT group services are extremely effective in building consumer skills and a support system.
Day/Evening Activity	Onslow/Carteret	Broaden services to include evening and weekend activities for consumers to build a social support system they can use on their own time.
Drop In Center	Onslow/Carteret	Consumer operated and focused program to provide social support system and crisis support.
Half-way House	Onslow/Carteret	Consumers with alcohol and drug issues have to go out-of-county for program.
Hourly Respite; Personal Care or; Personal Assistance (may use combination of services not to exceed total)	Onslow/Carteret	Cost effective relief to care givers to support a healthy support system.
Social Setting Detoxification	Onslow/Carteret	Lower level of detoxification for people with substance abuse issues that will not need higher level of medical care.
Ambulatory Detoxification	Onslow/Carteret	Lowest level of detoxification for people with substance abuse issues that will not need supervised medical

Service	Counties With Gap	Reason
		care during detoxification. Typically consists of a daily group and physician care but the clients go home each night.
Crisis Respite	Carteret	Highly trained families that can provide temporary care for a person experiencing an emergency.
Residential Level III	Carteret	Children placed out of county.

Other Needs Identified

- Transportation
- Provider education /training on service definitions and how to use services to assist consumers to reach outcomes to include friendships, natural supports and community resources.
- Providers need to teach consumers how to develop natural and community resources to meet their needs on an on-going basis. Inconsistency amongst providers in using services to move people towards independence.
- [Activities] to do with other people.
- People stated that they were lonely and did not have anything to do when they were not in a service.
- In many situations, the paid provider is doing things with consumers instead of helping the consumer learn ways to gain relationships with an unpaid person to do something fun.
- Assist people to have long-term, stable, safe and affordable housing. Rent Subsidies, Funding/Budgeting for Deposits, etc.
- Assist people in obtaining and maintaining employment.
- People need access to consistent medical and psychiatric treatment.
- People within the community need more information on available services and how to access care.
- Inconvenient Hours for Services
- Parent/Caregiver Support Groups/Education and Training/Activities.
- Understanding medication and different methods for payment.
- Education on Disability Assistance such as Social Security Disability Income (SSDI) Supplemental Disability Income (SSI), etc.
- Mental Health Services in School System.
- Onslow and Carteret Counties are the home to many people who have a relationship to the military. This includes but is not limited to active duty military, veterans, reservists and their family members. People who have experienced the effect of serving in the military have unique needs that need to be addressed by trained, experienced, qualified

providers with an expertise with this population. Family members, friends and the person's support system need information, education and support to effectively deal with the effects on the family.

Orange-Person-Chatham MH/DD/SA Authority

LME Description:

Orange-Person-Chatham MH/DD/SA Authority (OPC) serves three counties in central North Carolina. Only Orange County is considered urban. Of the 231,000 residents living in this area, 11% are enrolled in Medicaid. OPC's catchment area encompasses significant cultural, socioeconomic and geographic diversity. There is a wide array of difference in the median age, income levels and population density among our three counties. For example, individuals below poverty level in Orange number 14.8% (families below poverty level number 7.7%) compared to 17.1% in Person (families at 13.1%) and 13.8% in Chatham (families at 10.9%), per U.S. Census Bureau 2005-2007 American Community Survey 3-Year Estimates. Per the same survey estimates, Orange has a significantly larger portion of residents who have achieved higher levels of educational attainment (54.1% with a bachelor's degree or higher) than Person (12.8%) and Chatham (32.4%); this is but one measure of the scope of socioeconomic and cultural diversity contained within our geographic range of cities, towns and rural expanse. In addition, it is important to note that OPC currently has the lowest number of Medicaid enrollees of any LME, representing 1.7% of the total enrollees statewide (derived from January 13, 2010 report by North Carolina Department of Health and Human Services).

LME Needs Assessment Method:

Our goals in conducting the March 2009 Needs Assessment were to define existing capacity across the three county area, identify service gaps as well as underserved areas and populations and to assist with determining priority areas for capacity building efforts and new or restored funding initiatives. The following tools and methods were used:

- Online surveys specific to consumers and family members, providers and stakeholders
- Input from community groups such as child collaboratives, Developmental Disabilities Interagency Council, etc.
- Input from stakeholders such as local hospitals, Departments of Social Services and Public Health, Departments of Juvenile Justice/Delinquency Prevention, etc.
- Active involvement of Consumer and Family Advisory Committee (CFAC), including a CFAC Needs Assessment forum
- Active involvement of OPC Board of Directors
- Provider meetings
- LME participation in Chapel Hill Mayor's Mental Health Task Force, including two community forum listening sessions
- LME participation in a wide variety of community meetings
- Review of relevant local, state and federal data

LME Identified Areas of Need:

Overall Priorities: Foremost service gaps and services in need of increased availability and/or funding are described below per age and disability categories. Please see OPC's 2009 needs

assessment for a full description that includes service and consumer areas as well as system provinces such as geographic, housing and cultural and linguistic issues. OPC continues to target underserved populations utilizing initiatives that maximize resources by emphasizing collaboration with other providers and community stakeholders in order to strengthen the overall MH/DD/SAS system within our three county area. OPC's identified overall priority areas across age and disability categories are:

- Sustained development of a comprehensive community crisis continuum within our three county area
- Services and programming targeted at addressing the needs of individuals who are currently repeat users of state facilities and other crisis services
- Emergency, transitional, and permanent supportive housing as well as supported employment opportunities (with specific attention to emergency housing for households of persons with disabilities who are couples, families who have an adolescent male in family, increased transitional housing for individuals leaving hospitals, jail or prison and inpatient substance abuse treatment programs); expanded affordable housing is a need across our catchment area for individuals with and without MH/DD/SA-related disabilities

The Impact of 2009 Reductions in State Service Dollars: OPC's state service dollars were cut by approximately $1.8 million in fiscal year 2009. Developmental Disabilities (DD) services suffered the largest reduction which necessitated substantial cuts to all DD programs and services. In the arena of Adult Mental Health and Substance Abuse services, significant reductions to basic benefits as well as across the board cuts to virtually all contract providers were made. Although OPC has been able to maintain the highest priorities for Child Mental Health and Substance Abuse services, significant reductions in state service dollars forced the elimination of training and early intervention initiatives as well as a short-term suspension program in Orange County. Funding for family advocacy, screenings, independent living programs and day treatment was also reduced.

OPC makes every attempt to cut spending in areas that minimize potential harmful outcomes for consumers. However, reductions in state service dollars continue to cause major strain to an underfunded service array. As significant reductions in funding to programs and services are implemented, OPC is concerned about potential consequences to the citizens and communities we serve as well as the formal service system. Thus, increased capacity for existing services and restoration of some recently eliminated services are essential to the following lists of priorities for restored or increased funding.

Developmental Disabilities Priorities:

- CAP-MR/DD waiver services (currently the waitlist is 345 people with an average wait of over three years)
- Residential services (group homes), Developmental Day services for children 3-5 years of age, Adult Day Vocational Programs/Supported Employment services and services such as Developmental Therapy and Targeted Case Management
- Respite, including emergency out-of-home respite options for children and adults
- Increased access to Psychiatry/Psychology services from clinicians experienced in working with DD or dually diagnosed individuals

- Comprehensive services for individuals with traumatic brain injury
- Culturally appropriate services for Latino individuals as well as individuals from Burma
- Residential and wrap-around services for individuals with challenging behaviors and/or complex needs, including sex offender and residential treatment centers for dually diagnosed (MR/MI) individuals

Adult Mental Health/Substance Abuse Priorities:

- Increased capacity for existing services with emphasis on quality and evidence-based models
- Expansion of Substance Abuse Intensive Outpatient (SAIOP) Services to all three counties
- Integrated Dual Disorder Treatment (IDDT)
- Service to replace Community Support especially for those people who have been hospitalized and/or are frequent users of crisis services
- Increased crisis services capacity, inclusive of Facility Based Crisis, Detox, after hours walk-in crisis, and Mobile Crisis services in all three counties with attention to the acute need in Person and Chatham
- Increased Psychosocial Rehabilitation capacity (clubhouse models)
- Medication assistance for indigent consumers and those with Medicare
- Increased capacity for outreach services to the homeless population
- Peer Support initiatives
- Support for culturally competent providers able to address demographic diversity present within our catchment area (by provision of culturally appropriate services for Latino youth and families and youth and families from Burma, for example, or increased number of providers trained and willing to serve older adults with Medicare)

Child/Adolescent Mental Health/Substance Abuse Priorities:

- Expansion of school-based mental health services to have at least a part-time therapist in every school for three districts
- Full range of evidence-based adolescent substance abuse options from early intervention to intensive outpatient programs to local residential care and aftercare
- Structured activities for youth with emotional disturbance and substance abuse during non-school times, such as summer, after-school and school suspensions
- Transitional services for youth nearing adulthood, including skill building, housing options and vocational/educational supports
- Trauma treatment by clinicians trained in evidence-based models that cover the range of ages from zero to 18 years and a range of severity of symptoms
- Culturally appropriate services for Latino youth and families and youth and families from Burma
- Continued support of family advocacy organizations in all three counties (these organizations support parents/guardians with one-on-one support and trainings)

- Increased capacity for existing services with emphasis on quality and evidence-based models in all three counties (particularly Multisystemic Therapy, Intensive In-Home, standard and emergency therapeutic foster care, and early childhood mental health services)

Pathways MH/DD/SA Services

LME Description: Pathways MH/DD/SA LME serves the western North Carolina counties of Cleveland, Gaston and Lincoln. Of the 385,000 residents living in these urban counties, 19% are enrolled in Medicaid. Pathways serve as a care manager, a public policy leader, a provider community manager, and a community collaborator around issues involving mental health, development disabilities and substance abuse.

LME Needs Assessment Method: In March 2008, Pathways facilitated five community forums for consumers and family members through whom 161 residents from the counties of Cleveland, Gaston and Lincoln participated. In addition 70 providers and 108 community members and stakeholders responded to electronic surveys.

LME Identified Areas of Need:

The results were summarized as below. More detailed gaps are provided in the two tables.

- Access to services in rural areas (transportation & available services)
- Communication of services
- Co-occurring services, esp. MH/SA
- Cost issues
- Evaluation & treatment for youth w/sexualized issues
- Psychiatry (wait times, turnover, hrs)
- Residential for DD

Pathways Service Needs Identified in Surveys & Forums

	Provider Surveys	Provider Forum	Community-Stakeholder Surveys	Community-Stakeholder Forums
General Services Needed	• Co-occurring treatment needs • Cost of services • Developmental disabilities for adults & youth • Substance abuse services for adults & youth • Transportation	• Access to affordable medications • Bilingual services • Community outreach esp. to diverse languages & cultures • Community support for IPRS • Co-occurring services (MI/SA) • Residential esp. for 18-21) • Transportation • Professional workforce issues	• Better communication of available services • Crisis services (both distance & wait time) • Evaluation / assessment wait times • Substance abuse services for adults & youth	• Communication of services • Consistent quality of providers & case managers in particular • Costs & issues related to reimbursement & insurance • Substance abuse services • Transportation
Developmental Disabilities	• CAP/Funding issues • Residential • Respite	• DD services in general beyond TCM	• Crisis • Residential • Screening /	• Residential support • Supported employment

	Provider Surveys	Provider Forum	Community-Stakeholder Surveys	Community-Stakeholder Forums
	• Counseling/ therapy	• Planned respite for all DD • Residential for all DD	Evaluation	
Mental Health	• Partial hospitalization • ACTT • Inpatient MH	• Inpatient MH • Residential • Community psychiatric hospital beds • Alternatives to involuntary committals in Cleveland Co. • Partial hospitalization	• Crisis • Assessment • Psychiatric • Therapy	• Crisis, mobile crisis (availability, training) • Psychiatrists (turnover, hours, wait times)
Substance Abuse	• Substance abuse general • Detox • Partial hospitalization	• Detox • After-care detox	• Substance abuse general • Detox	• Substance abuse general • Detox • Homeless shelters • Halfway houses • Outpatient
Child & Adolescent	• Substance abuse • Sex offender treatment • PRTF • Respite	• Continuum of kids services • Inpatient for children, 13 and younger, in crisis • Evaluation & treatment options for children w/ sexualized issues • Access to service in rural areas (transportation, avail services…)	• Day treatment • Psychiatric • Substance abuse prevention & treatment • Sex offender treatment	• Adolescent services & transition to adult services, early adult

Piedmont Behavioral Health

LME Description: Piedmont Behavioral Health (PBH) serves five counties in western North Carolina, only one of which is considered rural. Of the 740,000 residents living in this area, 14% are enrolled in Medicaid.

LME Needs Assessment Method: PBH has an established system of advisory councils to ensure ongoing communications and active engagement with our community stakeholders. The councils meet regularly throughout the year to consider issues of importance regarding system performance and community needs. These Advisory Councils were utilized by the Needs Assessment Steering Committee to obtain feedback on how the system was functioning and to identify opportunities for improvement. Advisory Council membership includes stakeholder from:

- DSS
- School System
- Juvenile Justice
- Partnership for Children

- Law Enforcement
- Advocacy Organizations
- Comprehensive Community Providers
- Consumer Family Advisory Committee
- Housing Development
- LME Identified Areas of Need:

LME Identified Areas of Need: The following is a list of priorities identified through the focus groups:

- Crisis Services
    - More resources for crisis services
    - Increase faster response to those needing crisis services
    - Facility based crisis center
    - Improve Mobile Crisis response (additional capacity needed)
- Services and Supports
    - Increase capacity of outpatient services
    - Substance Abuse services
    - More services for children and families (MST, Family Preservation, etc.)
    - Strong SOC including Day Treatment and Structured Day Treatment
    - More State funding for DD waiting list, residential and day program
    - Transportation money for consumers to get to services
    - Develop women's SA services
    - More services for Older Adults in Long term care facilities (under represented for MH Services)
    - Develop women's SA services
    - Additional SA Services for children/teens
    - More Psychiatric Services
    - Getting medication that works better and doesn't harm your body
    - Residential Services and treatment for children
    - Continue to reduce DD waiting list and all other waiting lists
    - Make sure consumers have access to their meds even if they are unable to afford it; psych meds are expensive
    - Hire peer specialists to pick up people who live far away from programs.
    - Halfway houses for detox in Stanly and Rowan counties
    - More outpatient therapists
- Providers
    - Have more appointments closer than every 6 weeks
    - Make doctor's appointments sooner
    - Longer time to spend with doctor
    - Child and Family Teams
    - Less staff turnover
- Housing
    - More affordable housing options

- Encourage providers to offer housing for people who are aging and have special needs
- More independent living options that are affordable
- More different housing other than group homes

- Transportation
  - More accessible transportation
  - Increase transportation connectivity
- Collaboration and Education
  - PBH needs to publicize more about 1-800 number
  - More education and outreach for suicide prevention and MH stigma.
  - Consumer awareness (Education)
  - Need more collaboration for students with behavioral and emotional issues
  - More CIT Training for Law Enforcement Officers
  - Increase communication and collaboration between organizations
- Consumer Affairs
  - Consumers (MH) need transportation to the Mental Health Consumers Organization conference
  - More consumer training programs

Based on review of focus group feedback and reports, the Community Needs Assessment Steering Committee's findings were as follows:

- System of Care for Children continues to be an opportunity area in that there is a need for greater collaboration between stakeholder agencies and a need for providers to be trained in leading Child/Family Teams for consumers with person centered plans. Some progress in this area has been made: Extensive training has occurred over the past year; community stakeholders have been very responsive to our efforts to engage agencies in this important model for children's treatment. A conference for youth with mental health conditions was held in August 2009 that was well attended by children served by PBH providers.
- The Crisis Continuum needs to be expanded to offer more Facility Based Crisis Centers for Adults, DD crisis respite and crisis services for children. Progress in addressing these needs has been made as follows: A DD center based respite center for adults opened on July 1, 2009. Utilization is being monitored to determine adequacy of the facility in addressing the needs of adults with developmental disabilities. PBH has purchased and is renovating a facility in Union County that will be an additional Facility Based Crisis Center with a capacity of 16 beds. This facility will open in January 2010.
- The substance abuse services continuum needs to be expanded to offer more outpatient services detox services, intensive outpatient services and services for dually diagnosed. Intensive In-Home services that specialize in the treatment of children/adolescents with substance use conditions have begun and are actively serving children with these needs. The lack of adequate state funding continues to prevent the expansion of the substance abuse continuum for adults with substance use disorders.

- Continue efforts to reduce DD waiting list and all other waiting lists for services. PBH received 40 additional Innovations Waiver slots and is in the process of adding people to this program.

Sandhills Center for MH/DD/SA Services

LME Description: Sandhills Center LME serves eight counties in central North Carolina – Moore, Montgomery, Hoke, Anson, Richmond, Randolph, Lee and Harnett. The service area is the result of two mergers with Randolph County Area Program in 2003 and Lee/Harnett Area Program in 2005. Sandhills Center serves a large rural area and is responsible for the oversight and management of the delivery of services to a population of 547,000 residents, 18% of whom are enrolled in Medicaid. Sandhills Center is the 4th largest LME in the State and serves the largest geographic area of any LME. The mission of Sandhills Center is to develop, manage and assure that persons in need have access to quality mental health, developmental disabilities and substance abuse services.

LME Needs Assessment Method: Sandhills Center approached the needs assessment as an opportunity to involve all elements of the community in an honest and open review of the service system in the Sandhills area. The Needs Assessment Process was overseen by a Steering Committee composed of Area Board Members, CFAC Members, Community Stakeholders, Service Providers and Sandhills Staff. The Needs Assessment was conducted during the January-March 2009 timeframe and included the following activities:

- Informal information gathering receptions in each of the Center's eight (8) counties—these receptions were hosted by members of the Center's Consumer and Family Advisory Committee (CFAC).
- Key informant interviews with a number of community stakeholders to include members of the Sandhills Area Board, DSS Directors, Health Department Directors, law enforcement and community hospital representatives.
- Community agency meetings held in each of the eight (8) Sandhills counties.
- Computer based survey designed to solicit information from the Center's provider community and a facilitated interactive provider forum that focused on service needs in the Sandhills area.
- The review of significant data concerning service delivery patterns and consumer needs across the Sandhills area.

LME Identified Areas of Need:

The 2009 Needs Assessment identified a number of critical issues associated with the delivery and availability of services in the Sandhills area. Major issues noted in the current assessment include the following:

- Need to improve the availability and quality of outpatient mental health and substance abuse services.
- Continued development of community crisis services to include the expansion of Mobile Crisis Services.
- Improved employment opportunities for consumers.
- Increased availability of clinical services to Hispanic/Latino consumers.

- Expansion of Jail Diversion Services.
- Continued expansion of consumer supports in such areas as housing, transportation and medication.
- Expansion of LME efforts to insure that consumers, families and community agencies know how to navigate the current service environment.
- Continuation of efforts to enhance service quality, availability and access.
- Expansion of services to consumers with developmental disabilities through the CAP MR/DD Program.
- The need to provide community agency and school system staff with basic training on the identification of mental health needs and available avenues for accessing care.
- The need to focus on efforts to improve provider collaboration in the care of mutual consumers.

2009 Identified Needs	Common Themes
I. Quality & capacity of outpatient mental health and substance abuse treatment	Perceived a decline of outpatient service availability for children since last year. Network providers identify current lack of psychiatrist availability within the private sector to meet the needs of their consumers.
II. Local community crisis management resources	Notwithstanding notable progress, a need remains for additional mobile crisis services. Questionable quality of clinical home 1st responder care.
III. Employment opportunities and job-related services	Need for more focus on vocational/employment skills and everyday life skills following graduation.
IV. Hispanic/ Latino mental health outreach & services	Need for clinical staff, rather than use of interpreter service, to provide for acceptable and effective services to Hispanic/ Latino population.
V. Jail Diversion Services	Positive feedback related to effectiveness of mental health services in the jail. Positive feedback related to CIT training with law enforcement officers. Need to keep funding for Drug Court.
VI. Consumer social supports	Acknowledgement of expansion of housing accomplishments yet continued need for apartments for people with disabilities and limited resources. Need for more structured recreational activities for children with disabilities. Continued requests for accessibility to support groups. Transportation continues to be a barrier to access.
VII. Community Awareness of the role of the LME and process to obtain services	Community agencies have better understanding of the role of LME – They continue to have difficulty interfacing with multiple service providers. Community, in general, has difficulty locating "who to call" when needing services (i.e. telephone books, newspapers, TV community

	service ads, primary care, etc).
VIII. Provider Service Availability, Quality, and Access	Identified need for level III facilities for children & Adult MH group homes. Questionable consistent quality of care in residential services Fragmented care. Inconsistent quality of assessments across service providers.
IX. Availability of CAP/MR-DD services	More guidance needed for providers related to CAP/MR-DD referral process.
X. Mental Health "Basic Training" for non-mh/dd/sas service providers	Multiple requests for training for broad array of community agency/human services staff (i.e. DSS, Health Department, Schools, Criminal Justice, in the identification of mh/dd/sa issues and their role as "first responder".
XI. Focus on Network Provider Collaboration	Providers identify lack of knowledge of resources/services by other providers available to their consumer(s).

Smoky Mountain Center

LME Description: Smoky Mountain Center (SMC) serves 15 non-contiguous rural counties in western NC. Initially Smoky Mountain Center (SMC) was comprised of only the seven most western counties of North Carolina (Cherokee, Clay, Graham, Haywood, Jackson, Macon and Swain). In July 2007 the five counties of the former New River Area Authority joined the SMC LME. These five counties (Alleghany, Ashe, Avery, Watauga, and Wilkes) then became known as the SMC "Northern Region". Although this partnership increased the amount of geographic area covered by the SMC substantially, the Northern Region reflects a similar geography and many similar needs compared to the Southern Region (the seven western most counties listed above). In July 2008 SMC added to its catchment area, the three counties that had been managed by the Foothills LME – Caldwell, Alexander and McDowell Counties. These three counties are now known as the SMC "Central Region". This report describes the needs of SMC Northern, Central and Southern Region counties.

Of the 523,000 residents living in this area, 17% are enrolled in Medicaid.

- The most populous counties are Caldwell, Wilkes and Haywood.
- The least populous counties are Graham, Clay and Alleghany.
- The county with the highest population of African-American persons is Caldwell
- The counties with the highest population of Hispanic/Latino persons are Wilkes and Caldwell
- The counties with the highest population of American Indian persons are Swain, Jackson and Graham.

LME Needs Assessment Method: The needs assessment activities conducted by SMC provide valuable, firsthand perspectives from a variety of sources. Anecdotal information is also collected throughout the year from key persons knowledgeable of the network. This data provides SMC with a direct local picture of available and needed services. Surveys were collected from consumers or family members of consumers of services, persons involved in their communities, persons involved in the delivery of services, and informed employees of SMC. The five groups from whom survey data was gathered were: (1) Consumers and Family members (CFAC), (2) Stakeholders (DSS, Law Enforcement, Schools, Local Government officials), (3)

Providers of MH/DD/SA services, (4) Members of the SMC Board of Directors, and (5) Smoky Mountain Center Staff.

LME Identified Areas of Need:

- Need to increase the workforce availability of qualified mental heath service staff and psychiatrists
- Need to reduce the burden of excessive administrative processes on providers – those burdens require staff time; make it difficult to recruit staff and increases difficulty in delivering services.
- Need greater quantity of services and providers (e.g. "need more of X service" or "need more providers/staff"), and
- Need better access to services, need to reduce wait time in accessing services.
- The need for more high-end programs such as:
  - Residential level III through Psychiatric Residential Treatment Facility for kids
  - Residential services for adults
  - Emergency residential placements
  - Intensive In-Home services
  - Psychosocial Rehabilitation programs
  - Community Support Team services
  - Assertive Community Treatment programs
  - Adult Day Vocational Programs
- Need more psychiatry
- Need more programs for kids when not in school (both after and during summer)
- Need transportation to get to programs and services
- Need specialty services for children and adults who have sexually based offenses
- Need more comprehensive treatment options for substance abuse treatment

Responses by Groups

<u>SMC Board of Directors</u> identified the following gaps by region:

Southern Region

- All services in mental health, substance abuse and developmental programs need to be in all areas, and for all age groups. The barrier is funding.
- Residential services are needed in the Southern Region, for child MH, for children/adults with SA issues, and for children/adults who are in the severe range of developmental disabilities

Northern Region

- More beds in hospitals, more money to hire personnel; finding available people to hire is also a major problem
- All accomplishments/concerns of SMC should be presented to the Board

Central Region

- In-house rehab for adult substance abusers, more than one month
- Adult Mental Health – need longer hours, easier access and more staff

- Clients need to be seen more frequently; it is difficult to get MH services for clients who need them on an ongoing basis
- DD CAP services for children are poor due to length of waiting required; lack of stability in DD
- Convenience of service is poor because clients are often required to access services outside the county in order to be seen on a regular, consistent basis
- Need services for indigent clients; need more choice in providers
- More psychiatrists are needed for individual and family counseling
- A lot of individuals who previously received services when providers changed were lost in the transition; need more hospital in-patient beds; need more community-based services

SMC's *Service Management Dept and Provider Relations Dept* identified major ongoing challenges in all categories in the catchment area:

- Lack of availability of qualified workforce,
- Shortage of available transportation to services,
- Increasing capacity and limited state-funds for non-Medicaid services
- Negative impact of Reform; frequent and burdensome changes to the MH/SA/DD system
- Additional evidence-based practices for many of the primary mental health (MH) disorders;
- More psychiatric services, and more accessible psychiatric services,
- Need for more housing of a variety of consumers including crisis or emergency housing.
- Need for Spanish-speaking services, as there is a significant minority population of primarily Spanish-speaking immigrants in the SMC catchment area,
- Need the following to serve specific populations;
    - Children:
        - Child Crisis Stabilization services and Residential services
        - Services of all types for adolescents; while many providers work with younger children, fewer work with adolescents leaving this consumer age-group at higher risk;
        - Appropriate services for aggressive and offending youth;
    - Adult:
        - Recovery Education Centers (REC); currently available in eight of the SMC counties
        - Traditional MH/SA services; while some of these services are available, they are not as prevalent as needed
        - Domestic violence programs
        - Supported employment and long term follow along for DD and MH populations;
        - Supported living apartments for DD/MH/SA consumers

Southeastern Regional MH/DD/SA Services

LME Description: Southeastern Regional Mental Health, Developmental Disabilities and Substance Abuse Services (SER) is the Local Management Entity (LME) which serves residents in Bladen, Columbus, Robeson, and Scotland Counties. The mission of Southeastern Regional LME is to attain positive, consumer-driven social and behavioral outcomes for persons living with mental illness, developmental disabilities and substance abuse through ethical, flexible, integrated, and culturally sensitive services.

Of the 256,000 residents living in these rural counties, 29% are enrolled in Medicaid. The population for the area served by Southeastern. All four counties have child poverty levels above the state average.

LME Needs Assessment Method: The following data was gathered and reviewed during the assessment process:

- Medicaid expenditure data
- IPRS expenditure data
- Community System Progress Indicators published by the NC Division of MH/ DD/SAS
- Census demographic data
- Internal needs-related and quality management data and reports
- Relevant local, state, and federal reports related to service needs and gaps
- Provider staff survey
- Consumer, family, advocate, community, and stakeholder surveys
- Provider CEO Survey
- Consumer and family forums in each of the four counties of the catchment

LME Identified Areas of Need:

The following needs were identified through consumer and family forums

County	Synopsis of Most Pressing Needs
Bladen	Transportation
Columbus	Transportation Medication management Safe neighborhoods for consumers
Robeson	Traumatic brain injury services Transportation Psychiatric services Full range of specialty services (neuro-behavioral, Spanish-language, job training, housing supports) Collaboration across the system
Scotland	Transportation Elimination of cumbersome paperwork requirements to access psychosocial rehabilitation services
CFAC representation from all four counties	Multi-agency collaboration to address employment Employment opportunities and support for those with more competitive skills

Southeastern Regional Service Needs Identified in Surveys & Forums, 2009

Southeastern Regional Service Needs Identified in Surveys & Forums, 2009	
General Services	Additional substance abuse services Integrated services in general Evening hours for children and working consumers Training for support staff (particularly day support) Affordable housing Transportation assistance to services & employment Employment support Increased funding for services Publicity regarding available services Additional psychiatric service providers
Developmental Disabilities for Adults	Vehicle adaptations Home modifications Additional traumatic brain injury funding Augmentative communication devices Supported employment follow-along Specialized equipment & supplies
Developmental Disabilities for Children	Vehicle adaptations Day activity services Additional traumatic brain injury service funding Additional mobile crisis services staff
Mental Health for Adults	Additional clubhouse capacity Peer support services Additional psychiatric service providers
Substance Abuse	Halfway house services Residential treatment services Wellness recovery services Integrated treatment for multiple disorders Decreased wait times for detoxification services
Child & Adolescent	School-based substance abuse treatment Sex offender treatment Additional substance abuse intensive outpatient services Residential treatment services for children with substance abuse issues Additional mobile crisis services staff Day treatment services that utilize evidence-based practices

Southeastern Center for MH/DD/SA Services

LME Description: Southeastern Center (SEC) is the Area Authority functioning as the Local Management Entity (LME) for Brunswick, New Hanover, and Pender Counties, managing mental health, developmental disabilities, and substance abuse services for the region's residents. Only New Hanover is considered urban. Its mission is to ensure an accessible, flexible, and responsive system of care resulting in an improved quality of life for consumers of mental health, developmental disability, and/or substance abuse services.

Of the 355,000 residents living in this area, 14% are enrolled in Medicaid. Unemployment for this region is now at 10.5 % for Brunswick County, 9.1 % for New Hanover County and 10.8 % for Pender County.

LME Needs Assessment Method: Southeastern Center utilized the following sources of data to inform its needs assessment.

- Consumer and stakeholder focus groups and town hall meetings
- Consumer and family surveys
- Provider and stakeholder surveys
- Provider agency survey regarding capacity to for cultural and linguistic diverse services; disaster response; best practice barriers and opportunities
- Update reports regarding services to those homeless
- Comparisons of DHHS quarterly reports 2006-2008
- Analysis of providers by region (zip codes) and county
- Analysis of consumers (total numbers and target populations) served by region (zip codes) and county
- Population demographics
- Provider inventory

LME Identified Areas of Need:

The following strategic objectives were developed in response to the needs assessment.

- Increase crisis service availability and capacity
- Increase community capacity for evidence based and clinical best practices and specialized treatment service
- Increase community capacity and consumer choice for substance abuse outpatient providers;
- Particularly increase Adolescent substance abuse providers for outpatient, residential and SAIOP
- Continued expansion of services in Brunswick and Pender Counties
- Increase service options available to consumers in the public, faith-based, medical, and non-profit sectors
- Evaluate new mobile crisis services and other efforts to expand crisis capacity and continue to assess additional needs and gaps for crisis services
- Continue to work with the community to expand access to services for the Spanish speaking community and the uninsured
- Increase the number of peer support specialists

Southeastern Center Service Needs Identified in Surveys & Forums

Southeastern Center Service Needs Identified in Surveys & Forums	
General Services	Funding for services IPRS funding Residential support (see housing, below) Disability services for adults and children Integrated services for co-occurring disabilities Translation services, particularly for Spanish speakers Communication of available services Services for Pender and Brunswick counties (compared to New Hanover)
Housing	Affordability Support services Residential near communities and schools for children Safe housing
Employment	Assistance finding employment Employment training Support once employment is secured
Transportation	Public transportation times and locations Cost of transportation
Developmental Disabilities for Children	Mobile crisis Traumatic brain injury services Home modifications Residential services Vehicle adaptations Respite Personal assistance Developmental therapy Wait time for screenings, assessment and residential & equipment & adaptive services
Developmental Disabilities for Adults	Supported employment & employment follow-along Specialized consultative service Community rehabilitation Vehicle adaptations Community activities and employment transition Traumatic brain injury services Home modifications Wait time for screenings, assessment and residential & equipment & adaptive services

Southeastern Center Service Needs Identified in Surveys & Forums	
Mental Health for Adults	Residential services Clubhouse Facility based crisis services Integrated treatment for co-occurring disorders Supported employment & follow-along Community-based inpatient psychiatric treatment Wait times for diagnosis, evaluation and psychiatric treatment Developmental therapy (cut off too soon) Physician, staff and parent training
Substance Abuse	Inpatient hospital substance abuse treatment Non-medical community residential treatment Medically monitored community residential treatment Detoxification Halfway house Peer support Wait times for inpatient, intensive outpatient and detoxification programs Facilities for women & women with children
Child & Adolescent	School-based substance abuse & mental health treatment Sex offender treatment Partial hospitalization Substance abuse intensive outpatient Residential: close to homes & schools, level IV & for substance abusers Mobile crisis Psychiatric/medication evaluation and management Emergency services Wait times for screenings, assessment and psychiatric evaluation & management

Consumer and Family Forum Summary **Identified Summary of Service Needs and Barriers (updated Nov 09)**	
General Barriers	Transportation Consumer Education Community awareness Consistently trained providers Housing
Developmental Disabilities	Crisis Services Day Programs/adults Emergency Respite Quality group homes and staff Specialized medical equipment Supported Employment Services for MR/MI Housing

Consumer and Family Forum Summary Identified Summary of Service Needs and Barriers (updated Nov 09)	
Mental Health	Crisis Service Facility Based Crisis Services Outpatient services Day programs/recreation Services for co-occurring mental health and addiction Peer Specialist services Housing
Substance Abuse	Medical and social detox, Crisis Services Recovery housing Outpatient services/IOP Peer Specialist services Prevention Supported Employment
Child& Adolescent	Step-down services from CS and residential

Wake County Human Services

LME Description: Wake County Human Services LME is a single-county program in the Triangle metropolitan area of central North Carolina. Of the 900,000 residents living in this urban county, 9% are enrolled in Medicaid. According to the census data for 2005-06, Wake County is the 9th fastest growing county in the Unites States. Between 2000 and 2007, Wake County's population grew by 33%, and census data released in March 2009 indicates that the Raleigh-Cary metropolitan region leads the nation in population growth. As the population of Wake County continues to grow, so do the needs of its residents. Given the projected increase in uninsured individuals in Wake County due to growth and the current economic crisis, the Wake LME is challenged to expand services and fund evidence-based practices while experiencing reductions in funding. Although Wake is classified as an urban county, it is the 12th largest county in the state, and as such, has less populated outlying areas that lack public transportation, which creates barriers to accessing care much like those experienced in more rural counties. The Wake LME faces additional challenges in improving on state population penetration measures due to higher than average insurance representation and a lower per capita state funding allocation. Wake LME currently ranks 21st out of 24 LMEs in per capita funding, based on the fiscal year 09 allocations published on the DMH/DD/SAS website. If a statewide average per capita were implemented, Wake would see an increase of approximately $2M in additional state funding.

LME Needs Assessment Method:

Gaps in the service continuum for adults with mental illness and/or substance use problems were identified through multiple approaches and sources of information, each of which identified different areas as priorities for community capacity development. Four primary sources of input were surveys of providers and stakeholders through the Behavioral Health Collaborative Forum

and Wake LME Community Needs Survey, and surveys of MH/DD/SA consumers through a consumer survey and World Café Consumer Forum.

LME Identified Areas of Need:

Adult Mental Health/Substance Abuse: The following table highlights the areas of highest identified priority by these sources, but does not present an exhaustive list of areas of need. A more comprehensive description of service gaps and needs is available in the Wake County LME March 2009 Community Need and Provider Capacity Assessment.

BHC Forum Survey (N= 31)	Consumer Survey Results (N=50)	World Café Results (N=40)	Wake LME Community Needs Survey (N=111)
Housing w/supports Supported Employment Family Psychoeducation Peer Supports Support Groups Local Inpatient (MH)	Transportation Employment Housing / supported housing Affordable medication Staff availability, coverage, crisis response	Education and employment supports Improved transition planning and involvement of others in plans (parents, principals, etc.) Housing and supported housing Transportation Social/recreational activities Facility safety, security, hygiene concerns Medication	Housing w/supports Facility-based crisis Mobile Crisis Response Employment services Short-term local inpatient (MH) Support groups Psychiatry Family psychoeducation Transportation

In addition to specific gaps, surveys evaluated perception of populations that are underserved by the current service continuum. Results of the provider and LME staff survey indicated that dually diagnosed MH/SA and MI/DD consumers, Spanish-speaking consumers and substance abusing populations were most frequently reported as being underserved. Further, the Behavioral Health Collaborative survey indicated that homeless adults were perceived as being underserved. Consumer feedback through surveys and the World Café Forum identified concerns about fragmentation of care and a desire for a seamless, well-integrated system of care. A large percentage (58%) of consumers surveyed reported needing more information about service options, and 43% of survey respondents expressed concern that they were not receiving needed services.

Quarterly needs assessment reviews and updates since March 2009, indicate the following additional needs for adults with mental illness and/or substance use problems:

- accessible BHO services, particularly for SA
- housing services and supports
- bilingual/bicultural capacity
- crisis continuum gaps for hospital diversion and step-down
- local Medicaid-funded inpatient beds
- continued/improved interface between MH/DD/SA system and jails

Child Mental Health/Substance Abuse

In reviewing multiple sources of data from the primary public systems serving the youth in Wake County (i.e. mental health/substance abuse services, public school system, and juvenile justice) in conjunction with results from multiple survey sources, there are several themes that highlight

the strengths and gaps in the current Wake County child MH/SA system of care. A significant strength identified is the positive partnership and collaboration of the Wake LME with Wake County Public School System (WCPSS) and the Department of Juvenile Justice and Delinquency Prevention (DJJDP). This is primarily due to the positive work of the Wake County Community Collaborative for Children & Families and the Wake County Juvenile Crime Prevention Council.

The Wake County child MH/SA service array is found to be extensive with minimal service capacity needs. However, the needs assessment identifies significant trends, disparities, and growing needs that produce gaps, challenges, and barriers to maintaining a comprehensive and seamless continuum of care that consists of specific professional specialty expertise in treating children and adolescents with complex emotional, behavioral, and substance abuse problems. Responses from community surveys describe a sense of a fragmented array of services in a very large county with numerous "generic" service providers.

Additionally, diagnostic data reviewed indicates a significantly higher rate of behavior disorders (71%) than emotional disorders (17%) for children and adolescents receiving mental health and/or substance abuse services in Wake County. In contrast to this pattern, the national prevalence data estimate children and adolescents with a disruptive behavior disorder to be at roughly half the rate of those with an anxiety or mood disorder. This inconsistency between local diagnostic trends and national prevalence indicates a need for further review of child and adolescent evaluation services.

The following table highlights the areas of highest priority for child MH/SA capacity needs identified in the survey results from the four primary sources of provider and stakeholder input noted above. This is not an exhaustive list of areas of need. A more comprehensive description of service gaps and needs is available in the Wake County LME March 2009 Community Need and Provider Capacity Assessment.

BHC Forum Survey (N= 31)	Consumer Survey Results (N=50)	World Café Results (N=40)	Wake LME Community Needs Survey (N=111)
Partial Hospitalization PRTF Prevention & Support Services Psychiatry Crisis & Hospital Diversion Residential Tx (Level 4) Inpatient Psych. Tx. Day Treatment	Transportation Education and employment supports Housing Affordable medication Staff availability, coverage, crisis response	Education and employment supports Improved transition planning and involvement of others in plans (parents, principals, etc.) Housing and supported housing Transportation Social/recreational activities Facility safety, security, hygiene concerns Medication	Psychiatry PRTF Crisis & hosp. diversion Prevention & Support Services Inpatient psych. Tx Residential Tx Level IV Day Treatment Transportation

Quarterly needs assessment review and updates since March 2009 indicate the following additional needs for children and adolescents with emotional, behavioral, and substance use disorders:

- bilingual/bicultural capacity
- crisis continuum for hospital diversion and crisis bed availability

Child and Adult Developmental Disabilities/Traumatic Brain Injury

Although Wake County DD Services has a broad array of services and service providers, as well as significant amounts of funding, the actual level of funding is not consistent with the presented demand by Wake County residents determined eligible and in need of support. In the current State Medicaid Plan, there are, with the exception of Targeted Case Management, no services specific to the DD population approved. There is, however, a Title XIX Waiver (CAP-MR/DD) that provides significant funding to 707 children and adults with DD. There are approximately 838 people waiting who have been determined potentially eligible and in need of CAPMR/DD funded services. Additionally, due to the economic status of Wake County residents, there are far fewer children eligible for Medicaid than in other parts of the state. Additionally most third party payors do not cover 'habilitative services,' creating a large number of children with DD who do not have access to services to address their needs, including specialized therapies deemed medically necessary, outside the public school system.

The following areas were the most frequently cited services/issues that are not present or are under capacity in Wake's current child and adult DD/TBI service continuum, but does not present an exhaustive list of areas of need. A more comprehensive description of service gaps and needs is available in the Wake County LME March 2009 Community Need and Provider Capacity Assessment.

- More respite options for families
- Lack of funding availability to obtain necessary equipment
- Sufficient (non-work oriented) Day Activity programs to serve lowest functioning individuals (sic)
- Adult Day Care options for aging DD population, designed for seniors with cognitive limitations
- Residential facilities for people with mild/moderate TBI
- Residential homes to serve DD/TBI consumers with a history of physically acting out
- Retirement services; greater options in the types of daily activities; many people are working part-time by choice and need, with limited options during the rest of the week
- High change over in staff, particularly case managers
- All geriatric services
- Residential placements for TBI clients
- Nursing facilities for younger individuals with DD and multiple medical issues are needed because they do not do well in regular nursing facilities if they are too ill for ICF
- Residential services for children
- Semi-independent living opportunities are extremely limited and those providers are often challenged with how to provide ongoing, long-term support when funding only supports short-term assistance

These needs identified in March 2009 remain current. In addition, the waiting list for DD services continues to grow while funding remains stagnant or even decreases. There have been no new CAP/MRDD "slots" allocated in over 18 months.

Western Highlands Network

LME Description: Western Highlands Network is the Local Management Entity serving Buncombe, Henderson, Madison, Mitchell, Polk, Rutherford, Transylvania, and Yancey counties. Of the 507,000 residents living in this area, 16% are enrolled in Medicaid. Each county in the catchment presents a unique challenge to filling service gaps. The most populous counties of Buncombe, Henderson and Rutherfordton are a mix of urban and rural communities. The less populated counties of Madison, Mitchell, Polk, Transylvania and Yancey contain more small towns and rural areas. The population variations, distances to be traveled and the terrain of many counties often make providing and accessing available services very difficult. The Western Highlands Network needs assessment provides a guide to identifying gaps in services and to revising the strategic plan to improve and expand services and supports for consumers within the WHN catchment area. Input was gathered on an ongoing basis from consumers, family members, providers, and community stakeholders.

LME Needs Assessment Method: Western Highlands Network compiled its service gap report from the following sources.

- WHN Contract database
- WHN Provider Profile information
- WHN Endorsement database
- IPRS and Medicaid paid claims data
- WHN Stakeholder Survey
- WHN Provider Survey
- WHN Provider CEO Survey
- WHN Consumer Survey
- System of Care Collaborative meetings
- County Mental Health Coalition meetings
- U.S. Census data
- Mental Health, Substance Abuse, and Developmental Disability Providers

LME Identified Areas of Need:

The following table details the gaps in services by disability: The identification of a particular service as constituting a gap does not indicate that the service is unavailable in all counties. If the service is needed and unavailable in one or more counties in the catchment it is listed once.

Adult MH	Drop-in center IDDT Cognitive Behavioral Group Dialectical Behavior Therapy Illness management Recovery Psychosocial Rehabilitation ACTT Community Support Team
Child MH	Residential Txt Level II Residential Txt Level IV Day Treatment Neuropsychological Testing Residential Level III

	Intensive In-Home Multisystemic Therapy Alcohol and Drug Testing Alcohol and Drug Group Counseling Hourly Respite Therapeutic Foster Care
Adult SA	IDDT Peer to Peer Group Housing support Opioid treatment SA Halfway house Cognitive Behavioral Group Alcohol and Drug Group Counseling SAIOP
Child SA	Family Therapy SAIOP Alcohol and Drug Assessment/Testing Alcohol and Drug Group Counseling
Developmental Disabilities	Dialectical Behavior Therapy (DBT) Psychiatric services Sex Offender Treatment

In addition to the services listed above, a need for Spanish, Ukrainian or Russian speaking providers, translation of materials and interpreters was identified through the Western Highlands needs assessment process.

Appendix B: Input from Stakeholder Groups

Coalition for Persons Disabled by Mental Illness

The Coalition for Persons Disabled by Mental Illness was formed in 1981. It is composed of state-wide, non-profit advocacy, consumer, family and provider organizations who advocate for adequate, quality public services for citizens of North Carolina with mental illness. Member organizations include:

- Disability Rights of North Carolina
- Mental Health Association of North Carolina
- National Association for Mental Illness of North Carolina
- National Association of Social Workers – North Carolina Chapter
- North Carolina Council of Community Programs
- North Carolina Mental Health Consumers Organization
- North Carolina Mental Health Providers Council
- North Carolina Nurses Association
- North Carolina Providers Council
- North Carolina Psychiatric Association

- North Carolina Psychological Association
- North Carolina Recreational Therapists Association

CPDMI provided the following full statement to the Division of MH/DD/SAS:

Housing

Background: Individuals with mental illness often have difficulty securing housing, primarily due to very limited incomes. Studies show that providing affordable housing for people with mental illness helps with long-term recovery and reduces incidents of crisis, including hospitalization. North Carolina has a history of strong partnerships in providing long term housing to individuals with disabilities, including the recent "Housing 400" initiatives that have leveraged state, local and federal funds to add more than 1000 units of housing. The problem is that 1000 units isn't nearly enough to meet the demand: there are 9,000 people with mental illness in adult care homes who could live more independently and while discharges from state hospitals to homeless shelters have decreased by half, even one discharge is too many.

> **Action Steps**: The model of Housing 400 is one, which allows for people to live on their own, in regular neighborhoods, with varying amounts of support. This is the model people with mental illness strongly prefer to congregate care facilities. Continue to fund the disability housing programs which began as the "Housing 400" project through the Housing Finance Agency with an annual appropriation of 10 million dollars with an aim to serve an additional 800 individuals per year.
>
> **Action Steps**: A second area of housing needing attention is that of people with mental illness who have been placed in family care/adult care facilities not intended to serve their particular illness. The Supreme Court in NY recently found that this type of wholesale placement is not only inappropriate; it is a violation of federal law. An expansion of the options provided through the "Housing 400" program would meet the needs of many of these individuals who are inappropriately placed and may in fact present dangers to themselves and the older population living in these facilities.
>
> **Action Steps**: With more than 9,000 people with mental illness in family care and adult care facilities, the state needs to invest in solutions for residential services that support independent living: supported housing (housing with services built in or connected), group homes for people with mental illness, and independent living with service dollars tied to the housing and person so those without Medicare or insurance can qualify for safe stable housing that meets their unique needs. These needs go beyond the 10m for "Housing 400" and require the long-term support of additional service funds of 7 million per year to begin reducing the number of people with mental illness in adult care home/family care homes.

Need for System Integrity--evidence-based, clinically sound services that include trauma-informed care, centers of excellence, peer support

Background: Since the beginning, reform has worked to privatize the mental health system and offer more choices. A consequence, however, has been to decentralize service delivery. In doing so, a critical component of the system integrity has been weakened.

NC needs a sound clinical evidence based framework from which to build the system of care and a funding mechanism that ensures clinical coordination for the consumer—from the hospital to the community setting. Using SAMHSA's six Evidence Based Practices (EBP) as a core menu

of services throughout the state would go a long way to reining in the confusion and chaos. The six EBPs are: Illness Management and Recovery, Supported Employment, Family Psychoeducation, Assertive Community Treatment (ACTT), Integrated Treatment for Co-Occurring Disorders (ITDD), and Medication Management.

Action Steps: Ensure Appropriate Clinical Diagnosis and Treatment Planning. There needs to be an appropriate clinical diagnostic workup so that assessment drives the treatment plan. The treatment plan must be based on evidence-based services that work and are needed by the client, not just what is readily available. We have lost integrity and coordination in reform. A treatment team that brings together everyone who is doing treatment, services and supports is desperately needed.

Action Steps: Create Centers of Excellence. With a foundation in place of core services, adding the centers of excellence to provide the consistency of training to providers will also fill a large gap. NC is fortunate to have numerous outstanding universities and community colleges throughout the state that could provide a base to connect research with practice. These centers would work to motivate providers to use treatments that work, train them to use EBPs, provide technical assistance to assure fidelity to the models, and monitor providers in this work.

Action Steps: Improve Consumer Focus, Peer Supports.The most critical piece of a system with integrity is one that has a consumer focus. Building a cadre of peer support moves the system closer to one of a recovery model. Peer supports provide the boots on the ground day-to-day assistance some consumers need and is an important part. This focus on recover must become woven into a foundation of services across the state. While much work and focus has gone into a comprehensive person centered plan, the system lacks in ensuring these plans are communicated and utilized.

Action Steps: Focus on Trauma-Informed Care. NC is poised to be on a new frontier with regard to trauma and care for our veterans. Due to the large number of military bases in our state we have an opportunity to become a leader in trauma-informed care. As we begin to more clinically recognize and embrace the role of trauma in our service people, we should expand our view of the role of trauma in the day-to-day treatment of everyone in our public mental health system. Identifying trauma should be a "universal precaution," and there should be recognition that a consumer may need a layered approach to their plan. With foundational services like ACTT, crisis services, and in-patient beds in local communities, as well as access to clinical care at all levels.

Conclusion: System integrity is predicated on the idea that first the system is consistent in all parts of the state. In order for this to happen there must be a foundation. It is our view that this foundation be comprised of the six EBPs. Also, we recommend the development of at least three Centers of Excellence in the next three years in order to increase the clinical and supervisory capacity. We recommend one of these centers have a trauma care focus in order to meet the needs of NC veterans and their families.

Supported Employment

Background: North Carolina has been a national leader in the use of supported employment as a model to assist those with severe disabilities to be placed in an integrative, competitive employment setting, averaging approximately 1000 persons annually.

The NC Division of Vocational Rehabilitation assumes responsibility for contracting with private providers to complete the first stage of supported employment, the job assessment, job development, and on the job site training

The second part of supported employment comes after the client has been closed by Vocational Rehabilitation and is called Long Term Vocational Support. LTVS services assure that the initial investment to secure employment pays off as the individual becomes both a long-term employee and a taxpayer. Funding for LTVS has traditionally been through DMHDDSAS.

Across the state, utilization and authorization of long-term support is based on arbitrary limits imposed on the limited long-term vocational support dollars in the system and not on best practice empirical evidence. Inadequate data tracking renders the authorization system less effective for tracking the need for LTVS across the state.

> **Action Steps:** In order for North Carolina to continue to be a leader in the successful use of Supported Employment as a model for placing citizens with significant disabilities in competitive employment, there must be a specific and protected funding stream that is designated wholly for long term support.
>
> **Action Steps:** Also, North Carolina needs to continue to look for best practice ways to administer long-term support dollars.

Services for Individuals with a Mental Illness and are also Deaf

Background: The last budget increase for mental health services for the deaf, hard of hearing and deaf-blind was in 2001, despite the settlement agreement that was to provide more services and supports. System reform has had a significant impact on the ability to meet the needs of this target population. The services for persons who are mentally ill and deaf need to be equitable to the services available to non-deaf consumers with mental illness. They ARE NOT.

> **Service Needs/Action Needed:** Funding is needed to support a group home in the eastern part of North Carolina. There is currently only one group home and it is in the western part of the state. Mentally ill deaf consumers are more isolated from their families due to consolidation of services in one geographic area.
>
> There is a continuing need for interpreters and funds to pay for interpreter services.
>
> Funding is needed for continuous training – sign language instruction, prevention materials, staff training and broadband connections for video relay.
>
> The program at ECU to teach social workers to work with the deaf closed due to lack of enrollees. A program is needed in the central portion of North Carolina to attract and train appropriate clinical staff.
>
> There is only one inpatient unit – at Broughton. This has made it very difficult for families of persons who are mentally ill and deaf who do not live in the western part of North Carolina to be part of the recovery process. Residential services are needed in the other regions of the state.

Medication Access

Background: Medication must be part of any clinically sound system of care. With the access to the most appropriate medication decision being made by client/consumer choice and physician input first. Costs, as all advocates believe, must be taken into account. With that, a belief that if someone is new to the diagnosis, and just trying medications, that is a good time to try a generic. But we are opposed to further barriers being established, such as prior authorization

requirements, between the person needing medications, and getting their needs met. Too much research has shown that any barrier can be a reason to simply not take medications. Medication compliance is already an issue- and for many good reasons; the side effects can be devastating. But we know medications in combination with supports and therapies really work.

> **Action Steps**: A second area of concern is the money to buy needed medications. Compared to the cost of a day in an institution, even the most expensive of medication becomes small in comparison. Yet our public support for funded medications for indigent groups has declined with the economy. Rebuild our psychiatric medication assistance fund, and help people stay out of the more expensive hospital setting. Also, an increase in the access or reinstatement of patient assistance programs through manufactures would assist families, caregivers, and the client/consumer in getting the needed medications.

In addition to priorities submitted by CPDMI, several of its member organizations submitted individual statements. These are included below.

Mental Health Association in North Carolina (MHANC)

There are numerous needs and gaps in our service system, so these priorities MHANC has listed should not be taken as the only gaps that exist, simply that these items are our highest priorities at this given time.

1. ***Services and outreach for people who are deaf and hearing impaired who have a mental illness***. Advocates through The Coalition have been asking for additional funds for services and outreach for this population for many years. The requests have been small and yet have been ignored. We propose at least 7 million additional dollars over the next two-three years for outreach to this population, funds for direct services (including funds for interpreters and or technology to bridge the language gap). Additional funds may also be needed for specialty housing for people with mental illness who are deaf
2. ***Residential:*** This is divided into two areas 1) funds to develop additional low income housing for people with mental illness both independent living and group homes, with a prioritization on moving people out of adult care homes and family care homes. 2) supportive services for those residents, including additional support for room and board, residential managers, and transportation of people residing in these low income units. We support 10 million per year for "Housing 400" type projects, but we must also look at allocating an additional 2-4 million per year for services that help keep them in housing and/or to move them from adult care homes.
3. ***Basic levels of service that come to the individual rather than being office based***: Many people can live successfully in communities with a basic level of support that is a step up from outpatient treatment and a step down from ACTT or CST. We need to assure that we have a well thought out service that is monitored, incorporates evidence based practices, and achieves good outcomes. MHANC believes that is unrealistic to think that outpatient providers will suddenly deliver home based services, or that individuals with mental illness will suddenly find the resources to go to outpatient clinics when past experience shows a high no show rate. Or that peer support and case management alone will be sufficient for them (once enough peer support workers are trained). Its not clear what the dollar figure

would be for this, but at a minimum there are 10-15,000 people who are being removed from Community Support who still need a similar type of service.

4. ***Transportation:*** We need to find better ways to ensure that people with mental illness have access to transportation so they can get to appointments, pick up medication, go to work, to school and participate in their communities. Low income individuals with mental illness need to be part of the larger discussion about a 21st century transportation system for North Carolina communities. There are many options that have been used in communities to serve the elderly and other low income persons. We need small grants to establish and maintain transportations programs. 10 million to 1) explore options 2) start new pilot programs 3) pay existing programs that offer transportation to expand their reach. 10 million per year to start.
5. ***Medication Access:*** Not everyone has Medicaid or insurance; in fact about 60% of those we are serving with mental illness do not. Despite the good work that North Carolina does to help people get free medications through pharmaceutical companies, many people stop using medications, use less than therapeutically recommended, or use them intermittently because they cannot afford to buy them. We need to ensure that people with mental illness have access to a variety of medications while they wait for free programs, to qualify for Medicaid, or when they simply have no health coverage. The program should be carefully managed and include something similar to CheckMeds NC. 2.5 million per year to start.

National Alliance on Mental Illness (NAMI) North Carolina

Thank you for the opportunity to provide feedback to the Division and the General Assembly on such an important topic. NAMI NC represents those living with mental illnesses, and others affected by mental illness including family members. Our look at the gaps and needs is thus particularly important, salient, and credible. Specifically feedback was framed by input from our Consumer Council and our board Public Policy Committee.

Our gaps/needs are not necessarily in priority order.

1. ***Need for a functional crisis response system that is embedded within a system defined by continuity of care for those most in need.***

   Certainly NC has made a tremendous effort to intensify the services necessary in times of crisis to fill the gaps created through system upheaval in reform. We believe a return to inpatient services available locally (these used to be required in rule) is a great step in the right direction, as is the addition of additional models such as CIT, mobile crisis, facility based crisis options, etc. However, individuals continue to cycle in and out of state institutions, sometimes as many as 4-5 cycles per year, with no clear plan upon discharge about what will change. It is time to get timely discharge plans into the hands of the providers who will pick up the care for the person, time to examine more closely the person centered plans and why the crisis plans embedded therein are not working. We must address more clearly accountability and responsibility- are LMEs allowed to require crisis plans from their providers? Can they insist that a copy be sent to the local inpatient facility and as well to the LME so they can get it to the right people at the right time? Minimally the LME should have the document on file electronically, and it should be shared with the treating providers, and with the applicable hospital. And the quality of the crisis plans needs to improve through robust review and monitoring and a system of consequences for those who are not complying with good care. As we move towards the inclusion of paid peer support, the crisis plans should include a linkage with a paid peer support upon discharge from any

state or local inpatient bed. With that support, from someone with lived experience, we may see this turn around.

Discharges to homeless shelters has improved in NC, but largely for those who have been hospitalized 30 days or longer, which is a very small number of the total admissions. We need to look at the length of time people are receiving necessary hospitalization to ensure that they are stable before discharge. And perhaps we need a temporary housing situation, perhaps a small specialty waiver, so that absolutely no one gets discharged from our state hospitals to a homeless shelter. In FY 2009 there were 459 discharges to shelters, while in FY 08 there were 1192; a great improvement, but still 459 too many.

2. ***Housing***

NAMI NC has a fear that with so much funding going towards crisis service development that there simply won't be enough left for housing. After all, people are only in crisis for a fraction of their life in any given year, the rest of the time they need safe, affordable, decent housing.

Individuals with mental illness often have difficulty securing housing, primarily due to very limited incomes. Studies show that providing affordable housing for people with mental illness helps with long term recovery and reduces incidents of crisis, including hospitalization. North Carolina has a history of strong partnerships in providing long term housing to individuals with disabilities, including the recent "Housing 400" initiatives that have leveraged state, local and federal funds to add more than 1000 units of housing .The problem is that 1000 units isn't nearly enough to meet the demand: there are 5,000 people with mental illness in adult care homes who could live more independently and while discharges from state hospitals to homeless shelters have decreased by half, even one discharge is too many. We need to have l000 more funded next year

A second area of housing needing attention is that of people with mental illness who have been placed in family care/adult care facilities not intended to serve their particular illness. The Supreme Court in NY recently found that this type of wholesale placement is not only inappropriate, it is a violation of federal law. An expansion of the options provided through the "Housing 400" program would meet the needs of many of these individuals who are inappropriately placed and may in fact present dangers to themselves and the older population living in these facilities.

With more than 5,000 people with mental illness in family care and adult care facilities, the state needs to invest in solutions for residential services that support independent living: supported housing (housing with services built in or connected), group homes for people with mental illness, and independent living with service dollars tied to the housing and person so those without Medicare or insurance can qualify for safe stable housing that meets their unique needs. These needs go beyond the 10m for "Housing 400" and require the long term support of additional service funds of 7 million per year to begin reducing the number of people with mental illness in adult care home/family care homes.

3. ***The right treatments available at the right time, throughout NC***

North Carolina has certainly struggled with getting the right treatment mix, with marked lack of success in the Community Support debacle. Years ago, there were requirements that all public programs ensure the availability of a continuum of services in their catchment areas. That requirement went away with reform, and it is time to bring it back. No matter where

you live in NC, you should have access to ACTT for example, one of six SAMSHA recognized evidenced based practices (EBP). Also, people should have available within a reasonable drive access to a good psychiatric inpatient bed. We need to make sure that we provide what works, not just what providers, or others advocate for. An example is Integrated Dual Diagnosis Treatment (IDDT) – another one of the six EBP approved by SAMSHA. While you can conceivably figure out a way to bill for this, it is very hard, and therefore it simply doesn't happen.

Another example - NAMI NC provides natural supports in the form of family psycho education – another SAMSHA EBP that is not included on our menu of billable services. We believe it would not be a good fit for fee-for-service, but we also believe it is one of the most effective, and inexpensive (think volunteer) services out there- but we need more funding for getting it everywhere in NC . We advocate the old principle of "if you build it, they will come" – the way to get these treatments readily available is to make them a clear service definition, get it a rate, and make it available for billing. Then you need to reward those who get good results from providing the right treatments, by giving rate differentials for achieving certain outcomes – like keeping people out of jail, helping with employment, decreasing hospitalizations, aiding in recovery.

A lesson learned to accompany making sure the right treatments are accessible is that we must do better to train providers consistently, in an ongoing manner, to provide those services in the right way. Our training model does not work. Let's create what is called in other states Centers of Excellence, where linkages between universities and the Division of MHDDSAS connects research with practice through regional centers. These are small, inexpensive, but work to motivate providers to use treatments that work, trains them to do the work with a fidelity to the model, and monitors them in their work.

Employment is an EBP for which we have a service definition, but it is not working as well for those with mental illness as it could and should. Perhaps with a focus through the Centers of Excellence, NC can begin to experience much greater success with supported employment for those living with mental illness.

The introduction of paid peer supports is an excellent advance in North Carolina, but it must be accompanied by a system of care that really values recovery, and aids in people's recovery by having access to training, support, and services that are targeted towards illness management and wellness/recovery. People with mental illnesses truly have modest needs- let's make recovery a centerpiece of our system, not an afterthought. It should be woven into all rules, laws, practices, etc.

4. ***Decriminalization***

We are so proud of the excellent work done around the state in training police officers to recognize mental illness and take people to treatment rather than jail (CIT- pre jail diversion). But the problem remains: all police departments must buy in and be trained. Those who were incarcerated before that program existed all too often still remain incarceration. We must advance our reform of the prison rules that process has taken far too long. Rule making needs to be re-examined and streamlined so necessary reforms can take place when problems are recognized. Transition planning from prison and jails must be improved according to newer findings on what works. People must have access to the medications that work while they are imprisoned; and they should not be forced to change medications without a consult with their primary psychiatrist. We must figure out a way for providers to become involved

in the transition planning and get paid for that work – through forensic case management or forensic peer support.

5. ***Access to Medications***

Medications truly do work differently on everybody. While we must spend the public dollar wisely, to stretch it to serve so many needs, following what may be decades of trial and error to find the right medication, no one needs to be forced to change to a cheaper form of the medication. NAMI NC believes that we should look at cost, the doctor and the patient alike, in making a truly informed decision on medication. We also believe that if someone is new to the diagnosis, and just trying medications, that is a good time to try a generic. But we are opposed to further barriers being established, such as prior authorization requirements, between the person needing medications, and getting their needs met. Too much research has shown that any barrier can be a reason to simply not take medications. Medication compliance is already an issue- and for many good reasons; the side effects can be devastating. But we know medications in combination with supports and therapies really work- let's let them work by maintaining open access.

A second area of concern is just having the money to buy needed medications. Compared to the cost of a day in an institution, even the most expensive of meds becomes small in comparison. Yet our public support for funded medications for indigent groups has declined with the economy. This is a perfect example of pound foolish, penny wise. Let's rebuild our psychiatric medication assistance fund, and help people stay out of the more expensive hospital setting.

North Carolina Psychiatric Association

Thank you for the opportunity for the North Carolina Psychiatric Association to provide Feedback to the Division as it prepares its report for the NC General Assembly. NCPA has more than 900 psychiatrists across the state, many who are actively engaged in the treatment of patients in the public mental health system. Here are some of the Association's thoughts on gaps in our service system.

1. ***Lack of a Comprehensive Clinical System that Coordinates Care for Patients—A Clinical Home***

Despite many service providers in many parts of the state, our system has become fragmented. There is little coordination of care for or communication about patients in the system (especially post hospital discharge). There is no consistency in the service array across the state. There needs to be a Clinical Home for each high risk person in our system to assure that appropriate services are being delivered—right treatment at the right time. Currently, some treatment is being ordered simply because the service is available. (Please see the document attached for details of implementing a psychiatric clinical Home.)

Action: Continue funding for Crisis Walk-In Clinics, expand their scope to be clinical homes for those with SMI.

2. ***Severe Shortages for Child Services***

There are severe shortages in child psychiatrists and child psychiatric in-patient beds in the state.

Action: Adjust Medicaid rates for these services as an incentive to build them. Consider psychiatric modifier codes (and rate adjustments) for services child psychiatrists deliver.

3. ***IPRS Services Are Woefully Underfunded***

   State funding for those with mental illness or addiction who do not have Medicaid or other insurance falls woefully short. There is a lack of access to psychotropic medications and laboratory services. The results in neglecting this population are expensive ER visits, preventable hospitalizations, homelessness, prisons, jails, disability, etc.

   Action: Provide funding for core MH/SA services, medications, and laboratory services for citizen who are poor but do not have Medicaid coverage.

4. ***Inadequate Psychotherapy Available in the Community***

   There is inadequate access to evidence-based psychotherapies in the community, particularly for those with IPRS funding. Psychiatrists are being used only for medication interventions.

   Action: Co-locate other mental health professionals with psychiatry in the community for public sector patients. Restore Medicaid rates to an adequate level for this service to be viable.

5. ***Rebuilding Clinical Teams***

   The licensed, professional workforce has devolved in recent years, leading sometimes to unqualified people conducting diagnostic and treatment evaluations. Building clinical treatment teams to work with patients will, ultimately, make the system more efficient and provide better care. There needs to be funding so that the recovery piece and peer services work together with the clinical team, wedding the medical treatment of brain diseases with realistically funded programs for recovery. Clinical integrity should be the key factor in endorsing service providers.

   Action: Begin demanding adequate psychiatric and clinical coverage and services in system providers. Fund peer support services within the clinical team.

6. ***Establish Center of Excellence Related to Integrated Care***

   With workforce issues and the need for improved medical care in the SPMI population, a more intentional approach to bringing together primary care physicians and psychiatrists and other mental health professionals must be developed.

   Action: Establish a Center of Excellence for Integrated Care to develop the necessary protocols, training, and communication vehicles for improving the collaboration between primary care and psychiatrists.

NC Mental Health Block Grant Planning Council

The Mental Health Planning Council is appointed by the Secretary of NC DHHS to:

- Review the annual Mental Health Block Grant Plan and to submit to the state any recommendations of the Council for modifications to the plans;
- Serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems; and
- Monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state.

The Council includes individuals appointed to three-year terms who represent:

- families of children with serious emotional disturbances

- adults with mental illness and their families
- public and private entities concerned with need, planning, operation, funding and use of mental health services
- state agencies

Details on the Council can be found at http://www.ncdhhs.gov/mhddsas/mhplanning/index.htm. The Council submitted the following priorities to SAMHSA for the SFY 2009-2010 MH Block Grant.

- **Housing and Transitions to Independent Living –** This includes transition-age youth and young adults.
- **Employment, Education and Transitions to Adult Living –** This includes transition-age youth and young adults.
- **Evidenced Based Practices –** This includes ensuring consumer/family involvement and training, necessary supervision and supports to sustain practices once begun; consumer education about expectations and practices; ways to promote through consumer grass roots initiatives. Practices the Council recommends be in place statewide include the following: Peer Support/Certified Peer Specialists, Family Partners (Children, Youth and Families in System of Care), School Based MH services, Wellness Management and Recovery (SAMHSA tool kit), ACTT, Mobile Crisis and other crisis services, MST, Intensive In home, Parent Child Interaction Therapy, Cognitive Behavioral Therapy, Trauma Focused Cognitive Behavioral Therapy, and Dialectical Behavioral Therapy, among others as well as promising practices.

Because the service system is now so fragile due to the serious and deep budget cuts in these economic times, the Council encourages the North Carolina Division of MH/DD/SAS and its interagency partners remain focused on the pressing needs of North Carolina's most vulnerable citizens with serious mental health treatment needs. We must sustain the progress we have made in achieving improved outcomes as outlined in this Plan.

In Summary, the Council recognizes and affirms that North Carolina has taken some of the following steps to transform our system of care:

- Development of ***crisis response services and improved coordination with first responders*** around the State to ensure every county has access to a crisis portal of entry for individuals, children, youth and families in crisis.
- Identification of the need for ***diversion from jails and juvenile justice*** and facilitating community based treatment as part of the diversion plan and for those re-entering the community who are in need of treatment.
- Improvement of the ***management and coordination of the service delivery system*** in streamlining functions, reducing administrative costs, clarifying provider roles and services, and actively partnering with consumers and families.
- Supporting the need to ensure ***healthy youth transitions*** - building youth voices and youth leadership with Family Partners and Adult Consumer Advocates. This investment is imperative to prevention, early intervention, treatment and recovery.
- Development of ***information <u>by</u> consumers and families <u>for</u> consumers and families*** to better inform decisions and navigate the service delivery system.
- Engaging in outreach, cross-agency training, increasing ***access and care coordination for***

North Carolina's veterans, National Guard and military members and their families who have mental health and/or substance abuse treatment needs in their communities.

As a Council, we see improvements in the NC system of care in meeting the national outcomes measures. We know that system challenges still exist. We do believe by building on strengths and encouraging next steps, we will see critical elements in a system of care framework to meet all consumer, family and youth strengths and needs.

North Carolina is working and moving toward a system of care in which consumers, families, policy makers, advocates, and qualified providers share common outcomes that emphasize education/training, treatment, self-determination, supports and recovery.

As a Council, we see that the NC Division of MH/DD/SAS listens to and considers the input of consumers, youth and families in a number of ways. The NC Mental Health Planning & Advisory Council has also been an active participant in the development of [the Mental Health Block Grant] Plan. The Council believes that we will continue to have more opportunities for meaningful participation in moving the system forward. We stand ready to work together and see these changes reflected in positive block grant outcomes across all levels in our state.

As part of its Mental Health Block Grant planning process the Planning Council identified the following service needs that need to be addressed.

Adults' Needs:

- Increase in local capacity to provide ***assertive community treatment team services and other intensive services*** in order to support and treat people effectively in their local communities.
- Increase in the availability of ***safe, affordable supportive housing*** for adults with mental illness
- Increase in ***service and housing needs of individuals who are homeless***.

Provision of timely post-incarceration services to individuals with mental illness

Specific population groups that need increased access to appropriate services include:

- Persons who are deaf, hard of hearing, and deaf-blind
- Older adults with serious mental illness
- Adults who do not have safe, affordable housing
- Adults who are unemployed, but who want to work

Children's Needs

- Continued ***coordination with other child-serving agencies and the 'first responder' service provider*** during Child and Family Team meetings to prevent crisis, mediate in crisis, and ensure diversion from hospitals when appropriate.
- Continued provider education and compliance with ***crisis prevention planning and transition planning*** for children, youth and their families is critical for continuity of care and recovery.
- ***Cross-agency Child and Family Team training from the family's perspective*** is a key component to promoting compliance as well as increased clinical supervision of service providers.

- Increase in local capacity to provide ***multi-systemic therapy (MST), intensive in home services, and evidenced based and trauma-informed treatment services*** in order to support and treat children and youth effectively in their local communities.
- Increase in the availability of ***services and supports to promote healthy youth transitions*** to independent living and completion of education (school based mental health and behavioral health services)/vocation skills.
- ***Coordination of services with juvenile justice, administrative office of the courts, substance abuse and mental health treatment services*** to prevent initial and/or repeat juvenile offense involvement.

Specific population groups that need increased access to appropriate services include:

- Services for children and youth who are deaf, hard of hearing, and deaf-blind
- Healthy youth transitions
- Improved outcomes for youth with mental health and/or substance abuse treatment needs who are involved in the juvenile justice system
- Youth who are in out of home placements (such as foster care or in mental health treatment settings)

Developmental Disabilities Consortium

The Developmental Disabilities Consortium includes representatives of individuals with intellectual and developmental disabilities (I/DD), family members, I/DD service agencies and advocacy organizations. Members come together to advocate for the needs of persons with I/DD. In addition to the final recommendations of the Consortium, which are included in the main body of this report, members of the Consortium reviewed the recommendations of the NCIOM Task Force on Transitions for Persons with Developmental Disabilities during their Summit on Developmental Disabilities and made the following supporting recommendations:

Summit Recommendations that Support NCIOM Recommendations

Transitions from Congregate Settings to Homes in the Community

- Ensure availability and access, statewide, to specialized services, including: crisis; respite; behavioral; primary health; dental services; assistive technology; special vision and hearing supports; and health/wellness supports.
- Create financial incentives that assist LMEs and providers to transition people from ICF/MR-DD congregate facilities to homes in communities of their choice.
- Expand the availability of affordable, accessible, safe housing and home ownership.

Incentives to Reduce Use of Congregate Services

- Create incentives for the LMEs and the state to reduce the admissions to public and private congregate facilities.
- Prevent nursing home and “rest home” admissions of people with I/DD by supporting people to age-in-place; secure hospice care when needed; and connect with a “medical home” in their local community.

- Identify all individuals with I/DD living in adult care and nursing facilities and make this information transparent. Ensure that these individuals receive person-centered supports in the most integrated setting appropriate to their needs.
- Revise statutes, eligibility and licensing rules to eliminate the connection between the place where a person lives and eligibility for and level of financial support (e.g., Special Assistance).

Employment and Economic Opportunities

- Increase coordination and collaboration among public employment and education programs--e.g., the Division of Vocational Rehabilitation Services, LMEs, high schools, community colleges and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS)--to facilitate employment, post-secondary education and other valued outcomes for people with I/DD.
- Assess the state's reliance on congregate work and day settings and provide inclusive alternatives in the community, expanding Medicaid coverage as necessary.
- Afford people with I/DD control over the direction of employment supports.
- Disseminate information to people with I/DD with regard to employment and economic opportunities, e.g., information on rights and asset building strategies.
- Remove barriers to and provide incentives for public and private sector employment of people with I/DD.

Case Management

- Enhance accountability by ensuring strong communication and coordination between case management entities and LMEs.

Viable Direct Support Workforce

- Establish statewide, competency- and values-based, portable training and certification requirements for direct support workers, front-line supervisors, and case managers. Develop a state level certification and career path for direct support workers, front-line supervisors, and case managers, based on the demonstration of these competencies.
- Fund, statewide, the "College of Direct Support" online training program to promote the mastery of core competencies by direct support workers and case managers.
- Provide financial support to providers to cover the costs of staff training; the payment of a living wage; and incentives for staff who develop specialized skills. Ensure that funds allocated for wages pass through to direct support workers.
- Work with community colleges and the university system to incorporate I/DD training into diverse, post-secondary curricula.
- Implement the recommendations in the Commission on MH/DD/SAS Workforce Development Report concerning direct support workers.

Fostering Leadership and Innovation

- Develop, within each LME's senior management structure, a dedicated position for an I/DD specialist who is knowledgeable about core I/DD concepts and values; program access and eligibility; funding; and the provider network.

Quality Management and Quality Improvement

- Enhance planning by reinstating a comprehensive, statewide waiting list that is transparent and based on published criteria.
- Ensure that quality standards support the development of individual choice, person-centered practice, and self-determination.

Funding Model

- Develop a funding allocation formula that takes into account population, inflationary increases and the long-term nature of I/DD services and supports.
- Establish an individual funding allocation model that accounts for all funds; corresponds to the intensity and complexity of an individual's needs; and allows for multiple funding tiers.
- Give individuals and families the support and tools necessary to control, within CMS guidelines, the use of an individual resource allocation or individual budget.

Summit Recommendations Not Reflected in NCIOM Report

Transitions from Congregate Settings to Homes in the Community

- Develop ***incentives for providers of congregate residential and day services to transition their agencies*** to the delivery of individualized housing and employment supports.
- Ensure that the state ***rebalances the I/DD system*** in favor of a contemporary, community system of services and supports, utilizing such tools as the Centers for Medicare and Medicaid Services (CMS) "Money Follows the Person" demonstration grant. With rebalancing, provide direct support workers in institutions with opportunities and contemporary training for jobs in the community.

Case Management

- Establish ***case load standards*** for I/DD case managers that correspond to the recommendations of the National Case Management Association.
- Eliminate potential conflicts of interest where waiver and state-funded case managers are employed by direct service providers.
- Explore new ways of organizing case management to ***standardize practice, increase accountability and eliminate conflicts of interest***.

Person-Centered Services and Supports

- Ensure that service definitions for state-funded and Medicaid waiver services are designed to support individual outcomes and cost-effective service delivery.
- Review intake, access, and authorization procedures to determine whether these are user-friendly and result in the provision of services and supports that match individual needs; ***ensure that service authorizations and related decisions are made as close to the individual and family as possible***.
- Ensure that resources are available to individuals to secure and maintain affordable, accessible homes in the community, along with the services and supports necessary to remain there.

- Promote inter-agency collaboration between the Department of Transportation and the Department of Health and Human Services to ***improve access to transportation*** across the state for people with I/DD.
- Ensure the ***inclusion of people with I/DD and families in all inter-agency, collaborative efforts impacting I/DD service delivery***.

Empowering Individuals and Families

- Support ***revisions to the statutory base*** and regulations that reflect core concepts of intellectual and developmental disability policy and advance community inclusion and full citizenship for people with I/DD.
- Strengthen ***self- and family-advocacy*** through user-friendly training and information on access to services and supports, including entitlements and benefits. Ensure the full and meaningful participation of individuals with I/DD and their families in the state and local Consumer and Family Advisory Councils (CFACs).
- Review ***guardianship laws*** to ensure that the rights of individuals with I/DD are not unnecessarily abridged and that alternatives to guardianship are pursued whenever possible. When guardianship is warranted, the principles of least restrictiveness should apply and guardians should be fully trained in laws applicable to guardianship, rights, and the principles of self-determination.
- Expand the opportunity for all people receiving services, regardless of their level of disability, to ***direct their own services***.
- ***Employ people with I/DD as mentors*** to others with disabilities around such issues as self-determination; rights; employment; community inclusion; health and wellness; and training/mentoring for professionals.

Quality Management and Quality Improvement

- Review licensure, endorsement, and ***provider quality standards*** to determine whether they adequately identify sub-standard provider performance and recognize excellent performance; delineate steps to improve performance; and, when necessary, eliminate sub-standard providers.
- Create capacity at all levels of the system (DHHS and other state agencies that deliver services to people with I/DD, LME, provider, Consumer and Family Advisory Committee, individual) to ***use performance information to improve the delivery of services and supports***; to track progress toward desired outcomes; and to support individuals and families in making informed choices about services and supports.
- Ensure that provider monitoring makes the most efficient use of resources and is ***not redundant or duplicative*** of other state or national accreditation or monitoring requirements.
- Ensure ***paperwork requirements maximize efficiency*** and that there is added value in these for people with I/DD and their families.

Fostering Leadership and Innovation

- Actively recruit and hire ***state-level I/DD leadership*** with a proven track record in a state I/DD system of effectively implementing those practices and policies that result in

outcomes valued by families and people with I/DD and that achieve accountability to funders.

- Review, update and upgrade, as necessary, the personnel classifications for I/DD managers at both the state and local level.
- Provide substantial funding to expand and demonstrate competency in emerging and best practices within the field of I/DD and to develop new, or support existing,, "home grown" innovations that have an evidence base.

Substance Abuse Federation

The NC Substance Abuse Federation is a consortium of substance abuse organizations and groups that promote policies to assure quality systems of education, prevention, and the expansion of a continuum of treatment services to effectively meet the needs of the substance abuse population.

Membership is open to designated representatives of groups and organizations that identify with the mission of the Substance Abuse Federation. Organizations are defined as entities incorporated to benefit its dues paying members. Groups are defined as incorporated or unincorporated entities organized to advocate and/or advise.

The Federation's recommendations are included in full in the main body of the report.

State Collaborative for Children and Families

The North Carolina State Collaborative for Children and Families, through a System of Care framework, provides a forum for collaboration, advocacy and action among families, public and private child and family serving agencies and community partners to improve outcomes for all children, youth and families.

Feedback Received During Public Comment Period

The Division posted a draft of this report for public comment during the month of February 2010. This was done to gain input from NC residents who had not previously had an opportunity to voice their concerns. It also provided organizations that had previously provided input a chance to update their recommendations. All comments received from individuals were also submitted in the CFAC feedback below.

State Consumer and Family Advisory Committee

SCFAC members submitted feedback which included both original language from the draft report and their members' responses as one document.

Priorities

- Better quality and strategic use of existing resources must be the paramount concerns...
- The gap report states their priorities are; improve the quality and stability of the service system, maximize use of existing resources, and protect critical core services, including crisis services. To do these things for consumers and families:
  - Will need more funding,
  - Have a trial period before making to many changes to quick.
  - We know from the past, that changes were made almost every month or two.

  - Many are now only receiving minimal services because of funding cuts to stabilize the services funds must be increased. I know that money drives what services can be offered, but if the state does the things needed in the report, it will need to set aside more funding and keep changes to a minimum to stabilize.

Services in Rural areas

- In looking over the categories of need and evaluating the current steps being taken to meet those needs, it is obvious that our state is falling behind. Chances of catching up are poor in light of our present money situation.
  - One of the biggest problems is the lack of available services in our rural areas (mountains and coast).
  - I see that good efforts are being made in Long Term Supports and Quality and Accountability but problems still exist: Transportation, Post-secondary opportunities, and community recreation opportunities are just some of the gaps.
  - I would like to suggest that the problems listed in this report could be lessened if NC would take advantage of all of the facilities and expertise available in this state. Political pressure has separated and restricted the State Operated facilities from helping meet the needs of our citizens by downsizing and negative publicity. Actually, some of the best care available in this state for DD consumers is found in the state operated facilities. With proper funding to fill in the gaps in services, especially in rural area, these facilities could serve as a source of training, recreational services, Job training and even transportation. Think about it!

Access to Services

- Lack of awareness among the public regarding awareness of services and how to access them.

System, Providers

- Leadership and System Management, including State and local disability-specific specialists, interagency collaboration and cooperation, and use of effective funding policies (e.g. consumer-directed budgets)
- Need for System Integrity.
- Need to develop and expand to a comprehensive and integrated service network.
- Improve collaboration between Division and LMEs.
- Implemented standardized processes and tools for endorsing and monitoring providers and ensuring providers' use of a person-centered approach to planning services.
- Continuing the work of the Practice Improvement Collaborative to identify best practices
- Develop a recovery-oriented system of care. Recommendations include supporting several pilot programs.
- Incentives to providers to improve the service growth and delivery.
- Ongoing, affordable training for providers.
- Improve Service Quality through workforce development projects.
- Is this the direction we're headed (i.e. Medicaid waiver, CABHA, Medically necessary service, etc)?

Quality Case Management

- Enough, and highly skilled. This can be the key to coordinating and implementing a good PCP, best utilizing both clinical and community resources!!!

Housing, Recreation and Leisure opportunities

- For people with disabilities which is imperative to good mental health. Overall well-being is undervalued and under funded in our communities.
- Increased local efforts to develop affordable housing opportunities. Community resources need to be developed, utilized, and coordinated to supplement our more limited funding sources. Areas able to be affected could cover Recreational Opportunities, Transportation, Housing, along with various other needs...

Psychiatric Services

- Lack of access to and delay in receiving* Psychiatric Services *(psychiatric evaluation and assessment).
- Need more psychiatrists in the state.

Mental Health

- Appropriate treatment can alleviate, if not cure, the symptoms and associated disability of mental illness. With proper treatment, the majority of people with mental illness can return to productive and engaging lives.
- North Carolina has designed its public mental health system to serve those persons with the greatest functional impairment and thus the highest need for ongoing specialty care. Priority cannot be only focused on this; I see the Urgent getting resources, while Emergent waiting, and then often becoming Urgent ("efficient" to focus resources here also in order to prevent deterioration and various sundry consequences).

Substance Abuse – The "Step Child"

- Very Unequal Funding!!
- The North Carolina service system is designed to provide a full continuum of treatment services to all people with addictive disorders, due to their limited access to private resources for treatment. Treating addictive disorders effectively requires being ready to initiate treatment and engage individuals in that treatment when they are motivated to seek help.
- Expansion of substance abuse services and provider network.
- Building recovery-oriented systems of care for substance abuse.
- SA Housing and SA Halfway Housing for women with children!
- Expanding availability of cross-area service programs for regional delivery of substance abuse services.
- Improve the workforce. Recommendations include hiring additional substance abuse staff in the Division, training MH/DD/SA professionals about the medical and behavioral health needs of returning veterans and their families, and supporting new residency training rotations for psychiatrists, family physicians, emergency medicine, and other physicians likely to enter the addiction field.
- Comprehensive System of Specialized Substance Abuse Services Delivered as Cross Area Service Programs (CASPs). Citizens needing treatment services should have access to a complete array of services organized around a recovery-oriented system of care.

These must include but are not limited to outreach, evidence-based treatment models, access to medications and health care, housing, vocational/education and aftercare services in their home communities. The plan should utilize the American Society of Addiction Medicine levels of care.

Need to develop dual diagnosis services

- Co-occurring conditions raise the complexity of individual challenges and societal costs well beyond those associated with each disability in isolation. Co-occurring conditions are associated with a variety of negative outcomes, including high rates of relapse, hospitalization, violence, incarceration, and homelessness. In addition, co-occurring disorders are often chronic and/or episodic.
- In particular, there is a need for more refined diagnostic assessment and development of comprehensive treatment and rehabilitation goals that address both physical and behavioral health issues simultaneously (including Dual Diagnosis). There is also need for better understanding of how combinations of pharmacological, psychosocial, behavioral and environmental approaches can be used to achieve service goals. However, historically practitioners have specialized in serving one population alone. The shift to providing integrated care takes time and continued education!!!! - For Dual Diagnosis.
- Trained law enforcement officers to become community intervention teams and increased jail diversion programs.
- Implementing a Medicaid waiver for services to persons with traumatic brain injuries.

Communication

- I have been a mental health, substance abuse consumer for about 20 years. I have been on several boards and committees and am currently on the State Consumer and Family Advisory Committee as well as NAMI-Wake and NC-CANSO. I work part-time helping persons who are homeless who are severely and persistently mentally ill. What I have personally experienced and see so much of is persons "falling between the cracks." For this reason or that reason some persons, more than we want to admit, do not qualify for certain services or any services at all.
  - Several years ago I knew a senior citizen about 90 years old who lived in subsidized housing. She did not qualify for services because she made a dollar too much! Such issues much change. We cannot let the most weak among us to be left to handle things by themselves and flounder in a quagmire called "the system."
  - My personal experience is a mixed bag. I recently started receiving food stamps again in the amount of $16.00 per month. I work part-time and receive disability. More than half my income pays rent and bills. The other half has to purchase everything else. This does not allow me to put any dollars into savings.
  - Don't get me wrong. I am grateful for the services and aide I have received and do receive. My main point is that communication is not available across the spectrum of LME's, CFACS, programs, agencies, etc. Communication must be paramount in dealing with this GAPS Analysis. Or should I say, "GASP!" A state funded communication system must be put into place especially in rural areas. I see communication as the key that will keep persons from "falling between the cracks," and loosing out on what is each person's rights.

Eastern Regional Consumer and Family Advisory Committees

On Tuesday, 2/23/2010, at Cumberland County LME, consumers and family members representing eight (8) LMEs in the Eastern Region met and reviewed several sections in Communication Bulletin #108 - Analysis of MH/DD/SAS Service Gaps Draft Report, which included the appendices to this report for their county. The LME CFACS that participated are Cumberland, Johnson, Onslow/Carteret, Southeastern Center, Southeastern Regional, Beacon Center, and Eastern Carolina Behavioral Health. … As a Region we identified additional information for your report. The red check(s) indicates that [more than one] group identified this same issue during their presentation.

1. Transition from child services to adult services
2. √Peer Support Specialist Training
3. Recovery orientation training for providers to pass on to staff
4. √√Consumer based monitoring
    a. Better monitoring at the State level.
5. Ongoing Case Management training
6. Second Mile Program
    a. training staff to be compassionate
7. Collaboration between consumers and family advocacy groups with Local Management Entities
    a. Different programs should filter down so everyone can benefit
8. Worker back-up from providers
9. Peer Support groups for families for all disabilities
10. √Crisis Drop Off Centers throughout the State
11. Cross training of providers
    a. Dual diagnosis
12. Lack of daytime services and programs
    a. Saturdays and Sundays
13. Campaign to reduce underage drinking/substance abuse
14. Goal of 25% CIT officers, magistrates, dispatchers, EMTs, school resource officers
15. Service definition for Case Management
    a. To client
    b. Waivers
    c. MH/SAS/DD
16. Release discharge preparation
    a. Jails
    b. Hospitals
    c. Transition preparation and support for re-entry into community
17. Help and support for military personnel, veterans and their families
    a. Support groups
    b. Housing

   c. Treatment
   d. Continuum of care
18. Quality of Life Survey for clients by CFAC
19. Early intervention
   a. Between birth to 5 years
   b. RIP – Regional Intervention Programs for child and parent (parent pays back time)
20. Partnership between State – Providers – Employers – Consumers' Families to provider employment

NOTE: Vision for the future plan: What do we want the system to look like in the future? Not what is has to be, but what we want best practices to look like.