

Wake County Human Services
Local Managing Entity
Community Need and Provider Capacity Assessment



March 31, 2009

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Introduction

The Division of Mental Health/Developmental Disabilities/Substance Abuse Services requires each Local Management Entity to conduct an annual needs assessment to determine if there are gaps or an over-supply of various types of services and programs in their catchment area. Additionally, quarterly updates to that needs assessment are required, which provide a method for monitoring growth, capacity and disparities.

This annual needs assessment document represents a compilation of information from numerous sources, including recent surveys completed by consumers, providers and other stakeholders in Wake County. Information gleaned from this document is used by the LME, particularly the Network Development Team, to help determine what types of services are of highest priority to develop, maintain or possibly decrease or even eliminate.

The Network Development Team serves as consultants to providers and other LME staff. They manage the purchase of service budgets, community collaboration projects, system planning and conceptualization, and provider recruitment and endorsement. The Network Development Team consists of a team of professionals with varying areas of expertise. Questions regarding this document may be directed to any members of the Network Development Team listed below:

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Summary of Findings

This document serves as the Wake County Local Management Entity's "2009 Annual Assessment of Adequacy of the Provider Community" as required in section 5.1 of the performance agreement with the NC Division of MH/DD/SA. The intent of this initial report is to compile and summarize available information regarding our community's current capacity and service needs in order to educate the LME and community-at-large concerning the needs and gaps as well as the capacity of the community to provide services to consumers with MH/DD/SA needs. This report will also serve to establish a foundation for future, regular quarterly updates and ongoing capacity development efforts.

Sources of information

The assessment of community need and provider capacity derives its information from multiple sources of information, with varying perspectives, areas of focus, participants, and timeframes. The following sources of information were reviewed for this report:

WCHS 2006 Community Assessment, Behavioral and Social Health chapter (Appendix A, 2/07)

Community Needs Assessment (Appendix B, 11/07)

Wake LME Community Need and Provider Capacity Assessment

Quarterly Updates for Wake LME Board and CFAC on Community Need and Provider Capacity Assessment (Appendix C)

Wake LME Community Needs Survey (Appendix D, 3/09)

Wake LME Endorsed Provider Network Data (Appendix E, 12/31/08)

Consumer Survey responses (Appendix F, 3/09)

World Café consumer forum feedback (Appendix G, 3/09)

LME Consumer Survey (Appendix H, 10/08)

Provider and stakeholder survey responses from Wake Behavioral Health Collaborative and Wake Community Collaborative for Children (Appendix I, 3/09)

WCHS DD Services Wait List (Appendix J, 3/09)

WCCCCF World Café Responses (Appendix K: 1/6/09)

Community Systems Progress Indicators Reports

<http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm>

Progress Report on 2008 Network Development Plan

In response to gaps identified in the 2008 Community Need and Provider Capacity Assessment, the Wake LME Network Development Team has implemented several programs, services, and strategies to enhance the community network. Those that are age/disability specific are described below. However, one initiative covers the full continuum: the Network Development Team has facilitated the implementation of the Wake County Behavioral Health Collaborative (BHC). This initiative is a comprehensive strategy to improve connections between levels of care and service transitions. The BHC will contribute to the development of a comprehensive, seamless and effective system of behavioral health care for residents of Wake County

Subsequent to the closure of a large provider agency in the 1st Quarter of FY09, two other large agencies have closed this year and several others have reduced service scope significantly. In response to concerns about the financial status of providers, the Wake LME convened a Business Forum on 11/4/08 to provide information and assistance to providers regarding “business practices in times of economic crisis.” This event was well attended and generated suggestions for further action that are being pursued by the Behavioral Health Collaborative Business Subcommittee.

Adult Mental Health /Substance Abuse

The following network development initiatives were implemented over the past year for the adult MH/SA continuum of care:

- ❑ A Peer Advocate Program was implemented with Oxford House of NC. Oxford House is a self-run, self-supported recovery house program for individuals with addiction. There are currently 15 houses in Wake County that provide affordable housing and supportive services for more than 125 people. Funding was provided to recruit, hire and train seven recovering individuals to function as liaisons for residents of the 15 Oxford Houses. The responsibilities of these peer advocates include facilitating applicant interviews, assisting with moving in to an Oxford House and helping new residents identify, navigate and access needed supportive services in the community. Due to the success of this model, several other LMEs are considering implementing this program in their catchment areas.
- ❑ In collaboration with stakeholders such as local emergency departments and the Gold Coalition, the Wake LME conducted a Request for Proposals (RFP) for a Geropsychiatric Mobile Crisis Response Team. Although a potential vendor for the service was selected, this initiative has been suspended indefinitely due to reductions in state funding.
- ❑ The LME also began conversations with an established agency about providing a Forensic Assertive Community Treatment Team (Forensic ACT or F-ACT) and identified partners for program development and implementation. This initiative has also been suspended indefinitely due to reductions in state funding.

- The LME received a reduction of funding for Cross Area Services Programs (CASP). This reduction was distributed across all LMEs in order to fulfill a legislative mandate and fund new CASP services. This reduction has primarily affected those individuals from other counties who were receiving opioid treatment and/or methadone maintenance therapy.
- The Wake LME received funding from the Division of MH/DD/SA to establish a Mobile Crisis Team for Wake and Johnston counties. This program is funded as a Cross Area Services Program (CASP) serving both Wake and Johnston counties, with Wake designated as the lead county for the project. In collaboration with the Division of MH/DD/SA, Wake LME has contracted with Therapeutic Alternatives to develop a MCT that will provide 24/7 mobile crisis services. This team serves adults and children with MH/DD/SA problems who are experiencing crisis, in an attempt to divert consumers from inpatient psychiatric treatment.
- The Division of MH/DD/SA has also allocated new funding to establish Walk-In Crisis and immediate psychiatric aftercare services for Wake and Johnston counties. These funds will be used in Wake County to improve psychiatric aftercare for homeless mentally ill consumers, with plans in progress to add psychiatric services at the South Wilmington Street Center and possibly other sites serving homeless adults.
- The capacity for services for the Latino population continues to be a problem. The Wake LME Network Development Team has been working with two provider agencies that specialize in mental health services for this population. One, El Futuro, now has an IPRS contract to serve Spanish-speaking adults and children with mental health needs. A second Pennsylvania-based company has expanded their services to Wake County and has opened a local office, Carolina Community Mental Health Center, with plans to begin serving Latino consumers in the near future.
- The provider network pharmacy has been in operation for five years as of this quarter. Since 2003, this program has enabled uninsured adults with mental illness and substance use disorders to obtain free medication through patient assistance programs and other sources. Latest data indicate that the program has obtained over \$8.5 million in patient assistance medication since 2005 and is currently serving over 1,400 consumers.
- Due to the desire and need to more quickly connect with consumers who are hospitalized, incarcerated, difficult to engage or frequent users of crisis services, the LME developed an alternative service definition called Assertive Engagement. This service, which was approved by the Division, is being utilized by selected providers who have a history of working with consumers with complex needs and who also are endorsed for an enhanced service such as Assertive Community Treatment or Community Support Team.

- ❑ Due to high demand for adult substance abuse services, an additional provider of SAIOP was identified and contracted with during this fiscal year, bringing the number of SAIOP provider agencies in Wake County to four, for a total of seven different programs.
- ❑ For the past two years, Wake LME has contracted with Duke University Medical Center (Partners in Caring) to offer early intervention HIV testing at four sites where substance abuse treatment services are provided. This was recently increased to five treatment provider sites.

Child Mental Health and Substance Abuse

The following network development initiatives were implemented over the past year for the child MH/SA continuum of care:

- ❑ Collaborative discussions are continuing to plan for the location of a PRTF for secure psychiatric residential treatment in Wake County to decrease the number of youth going out of Wake County, or, out of North Carolina for the most restrictive level of residential treatment.
- ❑ Start-up funding was provided to Grandfather Home Community Services for a specialized level III facility located in Wake County for adolescent females with sexually reactive treatment needs during fiscal year 2008.
- ❑ A priority for the Wake County Child MH/SA services has been to utilize intensive family and community based services in order to prevent and reduce the number of youth being placed out of their homes and community for treatment. This year we have seen an increase in the use of the intensive services to prevent out of home placement (i.e. MST and IHH). Wake County has met the service indicator for having less than 6% of its youth served in group residential care for three consecutive quarters.
- ❑ A work group of therapeutic foster care providers has met to discuss the provision of planned respite services for youth, and the development of crisis respite. Collaborative discussions are planned with other LMEs and providers of mobile crisis services to make use of lessons learned as the crisis respite service is designed.
- ❑ Utilization of Level II Therapeutic Foster Care and Level III residential treatment has decreased from FY2007 to FY2008. Utilization of Level II group residential treatment, Level IV residential treatment and non-acute hospital stays has slightly increased from FY2007 to FY2008. Secure psychiatric residential treatment has remained stable.

- Due to an increase in numbers of autistic children with significant behavioral problems, two new initiatives were implemented to serve families with young children with co-occurring MH/DD disorders.
 - Wake LME conducted a Request for Proposals (RFP) for a specialized Intensive In-Home (IIH) team to serve young children (ages 4-13) dually diagnosed with mental health and developmental disorders. Family Preservation Services, Inc., the selected vendor, has implemented an IIH integrating best practice strategies to address both behavioral disorders and developmental disabilities. The objective of this team is to provide a brief intervention in order to prevent out of home or out of school placements. Although it is too early for outcome data, since May of 2008, six children have been admitted to services and feedback from the families has been generally very positive.
 - Wake County Public School System (WCPSS) continues to report an increase of autistic children with significant behavioral problems that are unmanageable in their school settings. This has caused an increase in numbers of autistic children who are being placed on Home Hospital status. Wake LME, in collaboration with WCPSS, has provided Mental Health Trust Funds to a provider chosen by WCPSS to implement a specialized Day Treatment program for children who are dually diagnosed with autism and mental health behavioral disorders. Hope Services, LLC, the chosen vendor, is in the process of training, purchasing specialized equipment for the population, and is scheduled to open early in FY 09-10.
- Beginning in FY 2009 Non-UCR funds have been utilized to provide 1 contracted, FTE with clinical expertise to the Longview Alternative School in an effort to provide on-site crisis management. The goal is to increase the number of students staying in school versus the initiation of suspension or psychiatric hospitalization.
- Wake LME is working with a community provider (Triumph, LLC) to implement an Intensive In-Home team utilizing Functional Family Therapy (an evidence based treatment model for youth with significant behavioral problems) in order to prevent out of home placements for adolescents. The Functional Family Therapy National Trainer group agreed to work with Triumph, LLC to pilot the implementation of this evidence based model within the IIH service definition. Wake LME Network Development is working with representatives from FFT, Triumph, and the Division of MH/DD/SA to monitor the challenges and barriers to integrating this modality into the service definition structure.
- A course entitled Person Centered Planning: A Child and Family Team Approach was developed and implemented in FY 2007 in support of the implementation of child and family team process and system of care philosophy. In FY 2008 a train the trainer course for this curriculum was implemented. The course is offered periodically during the fiscal year for parents, staff of provider agencies and other community stakeholders. Staff that serve adult consumers of mental health and substance abuse services has also attended the course.
- The Wake County Community Collaborative for Children and Families continues to sponsor an annual System of Care conference to encourage collaboration between providers, families and other stakeholders in the community. The FY 2008 conference welcomed 110 participants.

- ❑ The capacity for services for the Latino population continues to be a problem. A new IPRS contract was implemented with El Futura, an outpatient clinic located in Carboro, NC serving only the Latino population. Wake LME Network Development has been working with a provider agency that specializes in mental health services for this population in Pennsylvania to expand their services to North Carolina, especially Wake County. They have located space and are in the process of recruiting staff.
- ❑ The Wake County Juvenile Crime Prevention Council completed their annual plan data collection for FY 09-10 and shared relevant data regarding juvenile crime, WCPSS suspensions, and delinquency/gang activity with Wake LME for assessing and identifying the MH/SA service needs for the juvenile justice and gang involved population in Wake County.
- ❑ The Wake County LME has a strong partnership with the Wake Juvenile Drug Treatment Court (JDTC). The LME has developed a continuum of care for the JDTC using evidence-based practices known to be effective with the JDTC population (MST, BSFT, and MET/CBT).
- ❑ An increase in the utilization of day treatment has occurred from FY 2007 to FY 2008. With this increase, Quality Management noted an increase in reports of aggression in day treatment settings. Non-UCR funds have been utilized to purchase training materials and provide training for staff of day treatment provider agencies during the 4th quarter of FY 2009.
- ❑ The Wake County Community Collaborative for Children and Families sponsored training related to cultural competency with system of care funds in June of 2008. This workshop was repeated in November of 2008. The collaborative followed up with a January 2009 session with participants of the prior workshops to dialogue about the advancement of cultural competency in Wake County. The collaborative is investigating avenues for further exploration of cultural competence and its relationship to disparate outcomes for Wake County youth. See Appendix M for a summary of issues presented.

Adult and Child Developmental Disabilities

The following network development initiatives were implemented over the past year for the adult and child DD continuum of care:

- ❑ Increased affordable housing options for Wake County residents with DD by supporting the development through a HUD-funded project of The Serving Cup and Lutheran Family Services called the Green Level Apartments. These 6 two bedroom semi-independent living apartments will open in Spring 2009.
- ❑ Assisted the existing facility-based crisis/respite provider in relocating to a facility that will allow services to be provided to people who are non-ambulatory and also to create a safer environment for children in addition to adults.

- ❑ Expanded Crisis Providers. Initiated contracts with new psychologists to increase options for adult and child consumers needing formal behavioral management services.
- ❑ Expanded inclusion opportunities with the City of Raleigh - Parks & Recreation, Special Populations program to support children and adults with DD in accessing all Parks and Recreation programs.
- ❑ Expanded support to childcare centers to serve children with special needs in after-school care. The LME provided additional funding to a community partner to increase their staffing in order to provide training and support to childcare workers to support special needs children in typical childcare after-school programs. Increase support also provides limited 1:1 services to high needs children who may need transition support.
- ❑ Increased financial support to the First in Families program to assist and support seniors with DD in accessing and participating in community-based leisure and retirement activity options.
- ❑ Partnered with LME CMH/SA in developing specialized Intensive In-Home services to children with co-occurring diagnoses of Autism and mental health concerns (see CMH/SA above).
- ❑ Partnered with LME CMH/SA in developing specialized Day Treatment services to children with co-occurring diagnoses of Autism and mental health concerns (see CMH/SA above).
- ❑ Provided regular training to WC TCM and DT providers in Person-centered Planning, Goal Writing, Natural and Community Resource acquisition, and professional skill development.
- ❑ Participated in a statewide collaborative in development of crisis and diversion services for adults with co-occurring Developmental Disabilities and Mental Illness (START).
- ❑ Provided training to WC DD service providers on START model and services.
- ❑ Continued advocacy efforts to increase Medicaid Waiver slot allocation for Wake County consumers.
- ❑ Developed an ongoing committee to reach out to non-contracted but licensed group home facilities serving LME consumers with developmental disabilities in order to build partnerships and offer support for quality improvement.

Current and Projected Community MH/DD/SA Needs

According to the census data for 2005-06, Wake County is the 9th fastest growing county in the United States. Between 2000 and 2007, Wake County's population grew by 33%, and census data released this month 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. The chart below, based on July 2008 population estimates, illustrates the number of individuals from the general population in need of MH/DD/SA services and the numbers served (Community Systems Progress Indicators Report).

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. 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. A revised penetration statistic, using a count of uninsured individuals instead of total population, places the Wake LME close to state average on penetration statistics. However, if held to the current measurement methodology, the Wake LME would require approximately \$10M in additional funding to reach the state average on population penetration.

Wake County MH/DD/SA Prevalence and Penetration

	Number in Need	Number Served / (% Served)	Target
Adult Mental Health	34,738	8,522 (25 %)	38 %
Child Mental Health	21,978	6,483 (29 %)	38 %
Adult Developmental Disabilities	5,309	1,251 (24 %)	36%
Child Developmental Disabilities	5,887	787 (13 %)	19%
Adult Substance Abuse	56,800	3,088 (5 %)	8 %
Child Substance Abuse	5,541	248 (4 %)	7 %

Source: Medicaid and State Service Claims Data for the one-year period: October 1, 2007 to September 30, 2008, as summarized in the FY09 2nd Quarter Community Systems Progress Report

Demand Trends

At the present time, our nation and state are experiencing a significant economic crisis, with uncertain duration, course and impact on numerous factors affecting the MH/DD/SA service system. Consequently, historical trends in growth, service demand, and funding are unreliable predictors of future service needs. While recent data suggests that Wake County's growth continues to be high relative to most other counties in NC and the nation, the demographic characteristics of new residents may not match those of previous years. For example, Wake County's economic downturn, while significant, may be less severe than other areas, attracting unemployed individuals who believe their job prospects may be more promising in an urban area with high rankings for quality of life and business opportunities.

Other sources of uncertainty in projecting future need include the impact of economic crisis on mental illness and substance abuse, loss of insurance due to unemployment and employee benefit reductions, and loss of community resources and natural supports due to financial difficulties, reduced charitable donations and budget reductions. It is important to note that Wake LME has seen an increase in the number of adults presenting with mental health and substance use issues in Wake's Crisis and Assessment unit since February 2009, and a subsequent upward trend in demand for community-based services.

With respect to children and adolescents, there are several local trends that suggest a projected increase in demand for MH/DD/SA services. Wake County Public School System (WCPSS) reports an increase of autistic youth with severe behavior problems. When these dually diagnosed (MH/DD) students, along with other students with special needs, cannot be managed in the school setting they are placed on "home hospital," meaning the students remain at home with no social contact, minimal academic instruction, and no way to intervene and address the behavior problems. There has been an increase in the number of special needs youth placed on home hospital due to unmanageable behavior since last year. There were 67 youth placed on home hospital from 7/1/07-6/30/08, while there have been 98 so far this FY year (7/1/08-3/3/09).

Another alarming trend is an increase in juvenile delinquency, gang involvement, and violent crime among youth in Wake County. WCPSS reports the following reportable offenses on school campus for a three-year trend (2006-2008):

- 33% increase in gang activity per the WCPSS definition of "incident"
- 66% increase in offenses in Middle Schools

(Source: Wake County Public School System Incident Data)

According to juvenile crime statistics from the Department of Juvenile Justice and Delinquency Prevention (DJJDP) the rate of violent crimes compared to total crimes has increased by 3% from 2006-2008 (*Source: Department of Juvenile Justice and Delinquency Prevention (DJJDP) Crime Data*). Wake County youth involved with the Juvenile Justice System are assessed for current risks and needs. The following data for youth involved with Juvenile Court illustrates further demand for MH/SA services:

- 75% have school behavior problems
- 79% have mental health and/or substance abuse needs
- 62% have marginal or inadequate parent/guardian supervision
- 33% have family with a history of or current criminal and/or gang involvement

(Source: DJJDP Risk and Needs Assessment data, 7/1/07 – 6/30/08)

Current Service Array

Adult Mental Health/Substance Abuse

Like many areas, Wake County has undergone much change since the implementation of the enhanced service definitions in March 2006. The number of private provider agencies has increased, both in terms of Medicaid and IPRS services. However, unlike most areas, Wake County Human Services has continued to provide some services, particularly for the adult MH/SA populations. For example, the Alcoholism Treatment Center (ATC) continues to meet a large need by providing medically monitored detox and short-term (3-14 days) inpatient services. Other internal services include behavioral health outpatient, medication evaluation and management, WorkFirst, Step By Step (perinatal services), the Drop In Center, as well as integrated services at regional centers throughout the county.

The chart below illustrates the types and number of services currently provided by our adult MH/SA community providers.

Adult MH/SA Community Providers

Type of Service	Medicaid Endorsed	Non-Medicaid (IPRS)
Behavioral Health Outpatient	300+ indiv. & agencies	11
ACT / IDDT	2 agencies / 3 programs	2 agencies / 3 programs
Community Support Team	22	3
Community Support - Adults	30	9
Medically Monitored Detox	1	1
Mobile Crisis Team	1	1
Opioid Treatment	1	1
Psychosocial Rehabilitation	4 agencies / 5 programs	2 agencies / 3 programs
SA Comprehensive Outpatient Tx	3	1
SA Intensive Outpatient Program	4 agencies / 7 programs	4 agencies/7 programs
Local inpatient – Acute	DDH & HHH	ATC

Child Mental Health/Substance Abuse

Wake County utilizes the System of Care approach in the development and delivery of the Child MH/SA service array. System of Care is based on a set of values and principles for local services and supports in communities. Those principles and values set a high standard for how services and supports are developed and delivered. At the same time, System of Care is not ‘just’ a philosophy; it is a research-based framework that helps communities and states put the philosophy into action by building structures and resources that make System of Care work for children and their families. Wake County’s Child MH/SA System of Care is based on the strengths and needs of the families in our communities.

Re-evaluation of capacity for endorsed, enhanced service delivery for Wake County youth is in progress. Several provider agencies have ceased enhanced service delivery due to changes in service implementation rules and the current economic downturn. Priorities include increasing the provision of evidence-based practices for youth, increasing access to planned respite services, service development in the areas of crisis respite and secure psychiatric residential treatment.

The service array for Child MH/SA is quite extensive. The chart below illustrates the types and number of services currently provided by our child MH/SA community partners.

Child MH/SA Community Providers

Type of Service	Medicaid Endorsed	Non-Medicaid (IPRS)
Behavioral Health Outpatient	300+ indiv. & agencies	15 agencies/4 Spanish-speaking indep. therapists
Community Support – Child	36	12
Intensive In Home	18	6
Multisystemic Therapy	4	4
Day Treatment	6	3
Crisis Respite	0	0
Planned Respite	1	1
Level II Therapeutic Foster Care*	9	9
Level II .1300 endorsed agencies	2	1
Level III.1700 endorsed agencies	25	10
Level IV .1800 licensed agencies	0	0
PRTF**	DDH	
Local Inpatient – Acute	DDH & HHH	

* Not endorsed services

** State endorsed with facility based rates

Contracts are not reflected above, with out of county providers, for specialized services or when clinical issues require change of environment for health and/or safety reasons. Contracts/MOAs exist for Level II Therapeutic Foster Care (12), Level III Residential Treatment (12), Level IV Residential Treatment (2), PRTF (2), time-limited pending application for Medicaid.

While the number of agencies providing Community Support has decreased this year, it remains the most prevalent of the child MH/SA services. Letters of support for residential treatment have not been issued in Wake County since November of 2007 due to abundant capacity of Level III residential treatment facilities and low utilization of Level II group residential treatment facilities. We have seen an increase in newly endorsed providers of Intensive In-Home and Day Treatment since the new limitations on Community Support went into effect.

Children who have severe needs that require intensive specialized services, including residential treatment, are often at risk for commitment to institutions such as psychiatric hospitals or juvenile justice facilities. The number of Wake County youth served in these facilities is expected to rise should budget cuts eliminate Wright School and Whitaker School.

Available Child MH/SA Evidence-based Practices:

Evidence-based Service	Total Medicaid Endorsed	Total IPRS Contracts
Multisystemic Therapy – An evidence based intensive in-home family treatment model proven effective for adolescents with chronic delinquent behavior problems including aggressive/violent behavior, substance abuse, and gang involvement	4 Agencies	4 Agencies
Functional Family Therapy – An evidence based treatment model for adolescents with oppositional defiant disorders; we have a provider agency that is implementing this within the Intensive In-Home service definition; they are implementing two IIIH teams one of which will serve the Latino population	1 Agency (2 Teams)	1 Agency (2 Teams)
Brief Strategic Family Therapy – Another family treatment model effective with youth with Oppositional Defiant Disorder – one agency has one therapist trained in this model	1 Agency (1 Therapist)	1 Agency (1 Therapist)
MET/CBT – A model proven to be effective for adolescents with moderate substance abuse problems – one agency has one therapist trained in this model	1 Agency (1 Therapist)	1 Agency (1 Therapist)

The use of the intensive services to prevent out of home placement (i.e. MST and IIIH) has increased this year, while we have seen a decrease in residential placements. We have been working with providers to implement evidence-based practices (EBP). There have been challenges. MST has been the longest running EBP, with 4 agencies currently providing this service, and is most stable. The MST providers work primarily with youth involved with Juvenile Court or Juvenile Drug Treatment Court. Outcomes are in the table below.

MST Outcomes for 71/07 – 6/30/08

Total # Consumers Served	Total # that Maintained Home Placement	Total # that Maintained School Placement or Employment	Total # with no New Arrests
104	81%	84%	72%

We have one agency that has just completed training for Functional Family Therapy and have implemented this EBP through both Behavioral Health Outpatient and Intensive In-Home. We are meeting regularly with the provider, representatives from the state, and LME to review challenges and barriers. It is too soon for outcomes. We have had another agency that had several therapists trained in Brief Strategic Family Therapy and in MET/CBT. This agency has had significant staff turnover since the training, which highlights the issue of maintaining a trained workforce.

Child and Adult Developmental Disabilities/Traumatic Brain Injury

A developmental disability, as defined by N. C. statute, is a mental or physical condition that occurs before the age of 22, results in substantial functional limitations and is likely to continue indefinitely. The most common types of developmental disability are Mental Retardation, Autism, Cerebral Palsy and Traumatic Brain Injury. Most people with a developmental disability are able to fully participate in their communities with support and/or publicly funded services. Based upon the most recent U.S. Census figures for Wake County, approximately 14,978 children and adults with developmental disabilities live in the community. This number continues to grow proportionately with the general population.

Publicly funded services available to support children over the age of three and adults with developmental disabilities in Wake County include: Case Management, Skill Development, Respite Care, Vocational/Day Activity and a broad array of Residential Supports. The intensity of support varies depending on individual needs and preferences. The intent of providing publicly funded supports is to assist people with disabilities to live as independently and inclusively in their communities as possible. Services are funded by state allocation, Medicaid and the NC Medicaid Waiver - Community Alternative Program for people with Mental Retardation and Developmental Disabilities (CAP-MR/DD). State allocated funds, including CAP-MR/DD, have not kept pace with population growth. Most children in Wake County with disabilities live in families that do not meet Medicaid income eligibility, and for those who do, Medicaid pays for case management only. Waiting lists for all services continue to grow as the population of Wake County increases. Even as people are enrolled in services from waiting lists, nearly 30 new eligible individuals request services and are enrolled or added to waiting lists each month.

Yearly Trends

	2004	2005	2006	2007	2008
Client Services*	2631	2337	2675	2606	2325
Waiting for Services	970	1,046	1,074	1172	853

The discontinuation of both Community Based Services (CBS) and Developmental Therapies from the state's Medicaid plan resulted in the Division of Medical Assistance terminating these service options. The Legislative Oversight Committee subsequently implemented state funding for a replacement service called Developmental Therapy (skill development) in 2006.

Wake County DD Services operates under the fundamental philosophies of Person Centered Planning, Least Restrictive Alternatives, and community-based services in the provision of services and supports to children and adults with developmental disabilities. Wake County DD Services has had the benefit of stable and long-standing relationships with a network of non-profit and for-profit provider agencies, some who have been providing services to Wake County residents with developmental disabilities for over 30 years. Services to people with DD are often times life-long although the focus of need will predictably change as people mature. Because the need for supervised living and other significant supports are ongoing, turnover in many services is very low. In other words, once someone is established in a residential setting that meets their needs and preferences, they are likely to remain indefinitely as this becomes their home. As the population of Wake County grows, so too does the number of residents who have developmental disabilities. Additionally advances in diagnostic tools have contributed to early detection, especially in Autism, and demand for services.

In spite of a viable network of established provider agencies in Wake Co., the job market of qualified staff is limited and public funds to support service provision have not kept pace with demand leading and so people often are waiting a long time for the support they and their families need.

Child and Adult DD Community Providers

Type of Service	Medicaid	Non-Medicaid (IPRS)
Targeted Case Management	13 accepting referrals	5 accepting referrals
Developmental Therapy	N/A*	16
Respite Care	1 provider, CAP funded only no wait	1 provider, no wait
Long Term Vocational Support	6 providers, no wait (for CAP funding only)	6 providers, no wait
Adult Developmental Vocational Programs (ADVP)	N/A*	2 providers
Semi-independent Living	N/A*	3 homes, 1 provider
Group Living	N/A*	51 beds, 5 providers, waiting list
Non-IPRS funded group homes	N/A*	Approx. 62 homes with almost 90 empty beds**
Community based ICF group homes	144 beds, 4 providers, long waiting time	
State MR Centers	Murdoch Center (considered institutional)	

*Medicaid does not fund these services

** SSI/SA funds only

The following table provides information about the number of child and adult consumers with DD served during fiscal year 07-08 using state IPRS funds by the type of program/service received. Please note that the number of consumers may be duplicated. For example, the same consumer may be counted in both 'Residential' and 'Long-Term Vocational supports.'

IPRS-funded services

	Number of Consumers	IPRS Funding
Targeted Case Management	112	\$127,440
In-Home Support (includes DT, PC and PA)	551	\$3,012,276
Long-Term Vocational Supports	256	\$303,809
Adult Developmental Vocational Program	163	\$680,728
Residential	60	\$1,094,475
Residential DD/MI	74	\$2,552,633
Other*	Not readily available	\$1,016,446
Total	1216	\$8,787,807

*Includes services such as Raleigh Parks and Recreation, Respite, First in Families, Residential Subsidy, After School Supports, etc.

As part of the Local Business Plan to meet reform expectations, the Wake LME has successfully divested internal DD Case Management and shifted these services to private providers. Whereas Targeted Case Management is not an approved service in the current state Medicaid Plan, the service continues to be paid through a previous technical amendment. This allows Wake County DD Services to be able to better leverage Federal, state, and local dollars and other supports to such an extent as to utilize Care Coordinators to aid in reducing the numbers of people with DD waiting for services in Wake County by enrolling them in services by a provider agency, connecting them with natural supports, or removing them from the waiting list due to relocation or no longer meeting eligibility, etc.

Consumer Demographics

Analysis of consumer demographics was accomplished through review of NC TOPPS initial interview data for FY07-08 as well as analysis of diagnostic data for Wake LME consumers. Each source of data is subject to limitations that should be taken into consideration when drawing inferences and conclusions. For example, NC TOPPS data are obtained for recipients of IPRS-funded services and enhanced benefit services paid by Medicaid, but not for clients served by Medicaid-funded outpatient treatment programs or for developmentally disabled populations. Nonetheless, review of the populations sampled by the NC TOPPS does provide a snapshot of consumers served by a relatively wide range of program areas.

The following two tables provide data for gender and race/ethnicity for adult and child MH/SA consumers:

Gender

	Male	Female
AMH (N=1172)	38%	62%
ASA (N=806)	47%	53%
CMH (N=652)	58%	43%
Adol MH (N=909)	58%	42%
CSA (N<100)	90%	10%

Source: NC TOPPS Initial Interview Data, 7/1/07 – 6/30/08

Ethnicity

	Caucasian	African American	Hispanic
AMH (N=1172)	47%	43%	6%
ASA (N=806)	59%	39%	2%
CMH (N=652)	16%	74%	8%
Adol MH (N=909)	20%	72%	7%
CSA (N<100)	26%	68%	5%

Source: NC TOPPS Initial Interview Data, 7/1/07 – 6/30/08

As the table above indicates, there are significant differences between the racial/ethnic representation in services and the racial/ethnic characteristics of Wake County. Further, racial/ethnic representation varies considerably between age/disability groups, particularly for African American consumers. This area clearly warrants further examination as the Wake LME addresses goals of improving service access and reducing disparities.

Additional information about current adult MH/SA consumers includes the following:

- ❑ 38% of AMH consumers and 48% of ASA consumers reported having children under age 18
- ❑ 50% of AMH consumers and 52% of ASA consumers reported having changed residences one or more times in the past year
- ❑ 62% of AMH consumers and 77% of ASA consumers were reported as being in the labor force, meaning that they are either currently working or unemployed and looking for work. Of those in the labor force, 56% of AMH consumers and 51% of ASA consumers reported being unemployed and looking for work.
- ❑ 49% of AMH consumers and 78% of ASA consumers reported smoking cigarettes in the month prior to their assessment:

Source: NC TOPPS Initial Interview Data, 7/1/07 – 6/30/08

Additional information about current child MH/SA consumers includes the following:

- ❑ 31% of Child/Adolescent MH consumers have had suicidal thoughts
- ❑ 88% of Child/Adolescent MH consumers have hit or physically hit another person
- ❑ 22% of Child/Adolescent MH consumers are involved with Juvenile Justice
- ❑ 54% of Child/Adolescent MH consumers have been suspended or expelled from school
- ❑ 10% of Child/Adolescent MH consumers report having carried a handgun or other weapon
- ❑ 80% of Adolescent MH consumers have Medicaid

Source: NC TOPPS Initial Interview Data, 7/1/07 – 6/30/08

- ❑ 43% of youth assessed by the Juvenile Court Evaluation and Referral Team are dually diagnosed with mental health and substance abuse problems

Source: Juvenile Court Evaluation and Referral Team data, 7/1/07 – 6/30/08

Diagnoses for Consumers of MH/SA Services:

To the extent that diagnostic information represents a consumer's presenting symptoms, review of diagnoses can provide a general picture of estimated treatment needs. Although a diagnosis does not provide information on severity of specific service needs, aggregate diagnostic data may indicate a need for specialized service availability or further capacity development. This information, like the information above, should be interpreted with caution due to sampling size and scope limits, as well as a lack of control for multiple diagnoses. Nonetheless, this information may serve as a rough indicator of the range of treatment needs within the community, and a basis for further exploration of the service needs of the community.

Diagnostic information for adult and child MH/SA consumers is provided in the tables below:

Adult Mental Health

NCTOPPS DATA¹ (N=1172)	Wake LME Diagnostic Data²
32% Major Depression 27% Schizophrenia 21% Bipolar Disorder 11% Anxiety Disorder 11% PTSD	25% Major Depression 17% Schizophrenia 13% Bipolar Disorder 12% Anxiety Disorder

¹Source: NC TOPPS Initial Interview Data, 7/1/07 – 6/30/08

²Source: Wake LME Diagnosis Index Report, which includes diagnoses of all MH/DD/SA consumers who are open to Wake LME

Adult Substance Abuse

NCTOPPS Data¹ (N=806)	Wake LME Diagnostic Data²
Primary Substance Problem 25 % Alcohol 25% Cocaine 33% Heroin and Other Opiates 14% Marijuana 3% Other Drugs	Most Frequent Diagnoses 48% Alcohol Dependency/Abuse 22% Cocaine Dependency/Abuse 9% Heroin and Other Opiates Dependency/Abuse 7% Marijuana Dependency/Abuse 6% Other Drugs

¹Source: NC TOPPS Initial Interview Data, 7/1/07 – 6/30/08

²Source: Wake LME Diagnosis Index Report, which includes diagnoses of all MH/DD/SA consumers who are open to Wake LME

Child & Adolescent Mental Health

NCTOPPS DATA¹ (Child MH: N=652) (Adolescent MH: N=909)	Wake LME Diagnostic Data²
<p>Child MH:</p> <p>36% ADHD 27% Oppositional Defiant Disorder 24% Adjustment Disorder 21% Disruptive Behavior</p> <p>Adolescent MH:</p> <p>33% Oppositional Defiant Disorder 25% ADHD 16% Disruptive Behavior 14% Major Depression 13% Conduct Disorder 6% PTSD</p>	<p>Child & Adolescent MH:</p> <p>31% Conduct Disorder 21% Adjustment Disorder 19% Attention Deficit Disorder 9% Major Depressive Disorder 8% Anxiety Disorder</p>

¹Source: NC TOPPS Initial Interview Data, 7/1/07 – 6/30/08

²Source: Wake LME Diagnosis Index Report, which includes diagnoses of all MH/DD/SA consumers who are open to Wake LME

Adolescent Substance Abuse

NCTOPPS DATA¹ (N<100)	Wake LME Diagnostic Data²
<p>100% Co-occurring MH/SA 70% Any Drug Abuse 25% Alcohol Abuse 40% Disruptive Behavior 35% Conduct Disorder 25% Oppositional Defiant Disorder</p>	<p>51% Cannabis Dependency/Abuse 41% Alcohol Abuse 3% Cocaine Dependence/Abuse 2% Polysubstance Abuse 1% Amphetamine Dependence/Abuse 1% Hallucinogen Dependence/Abuse 1% Inhalant Abuse</p>

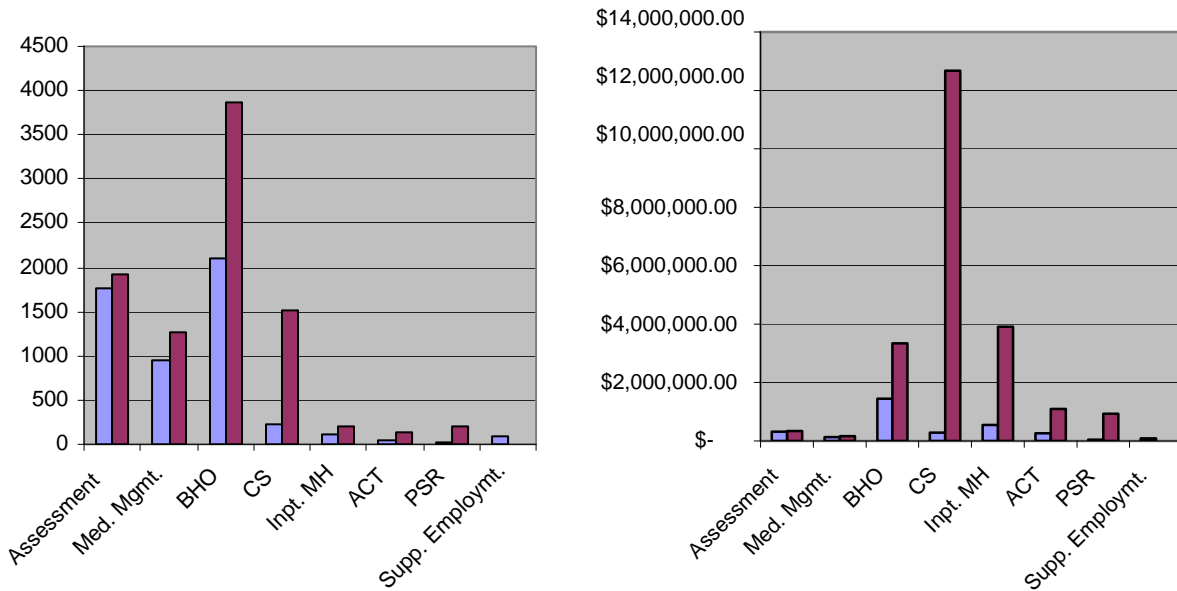
¹Source: NC TOPPS Initial Interview Data, 7/1/07 – 6/30/08

²Source: Wake LME Diagnosis Index Report, which includes diagnoses of all MH/DD/SA consumers who are open to Wake LME

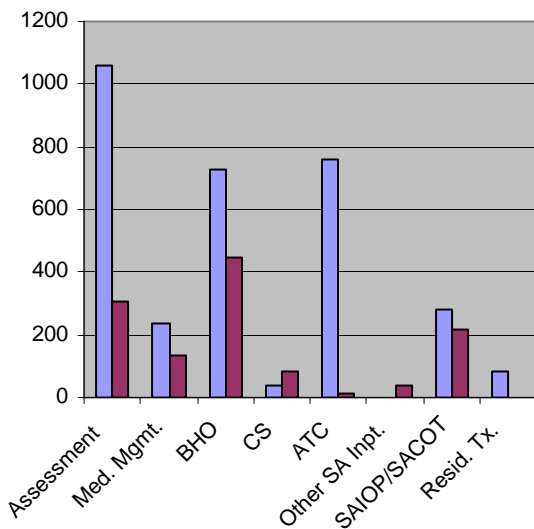
Current Utilization of Services/Supports

The following charts provide separate illustrations of the number of adult MH and adult SA consumers served during fiscal year 07-08, as well as a breakdown of expenditures by service and fund type.

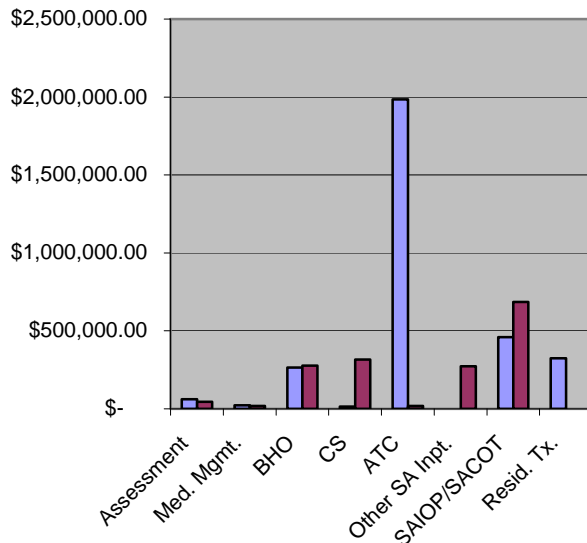
**AMH and ASA consumers served and funds expended in FY08
by service type (blue: IPRS; red: Medicaid)**



AMH Consumers Served



AMH Expenditures



ASA Consumers Served

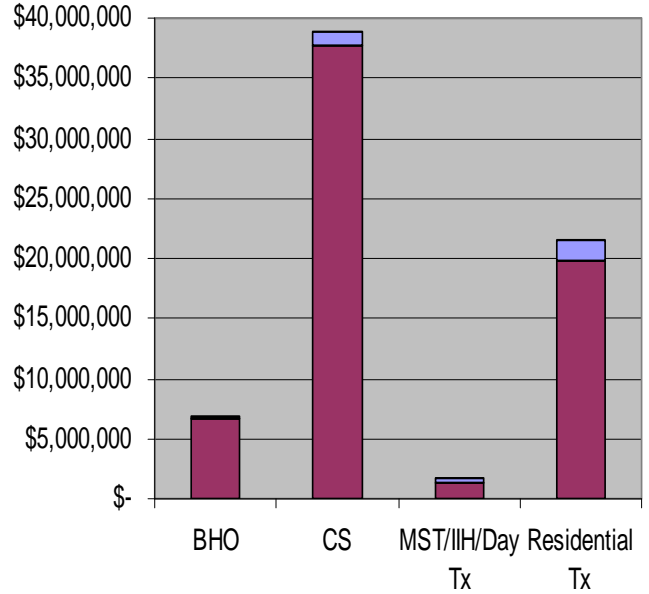
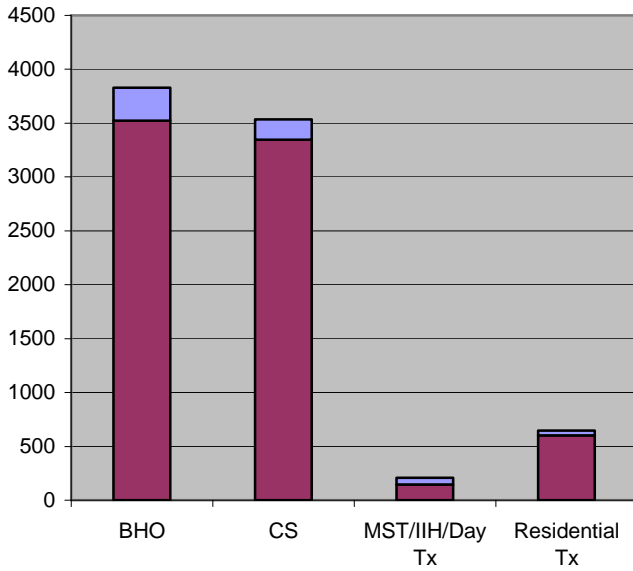
ASA Expenditures

CMH and CSA consumers served and funds expended in FY08 by service type (blue: IPRS; red: Medicaid)

The following charts provide separate illustrations of the number of child MH/SA consumers served during fiscal year 07-08, as well as a breakdown of expenditures by service and fund type.

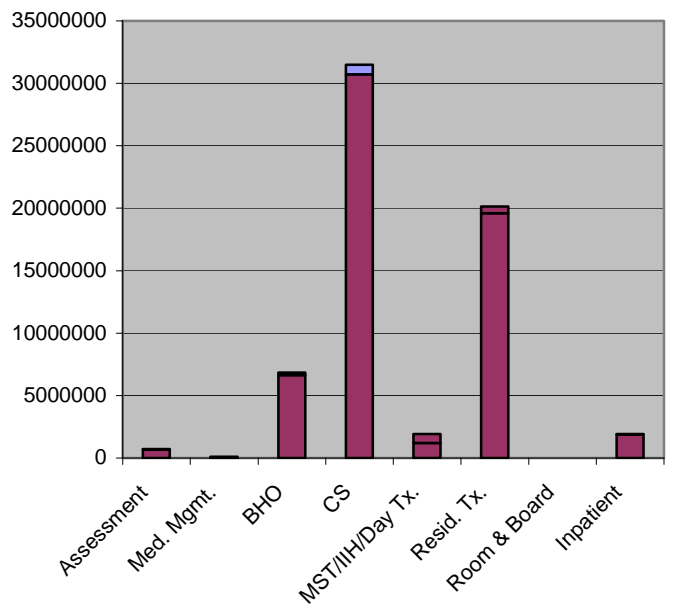
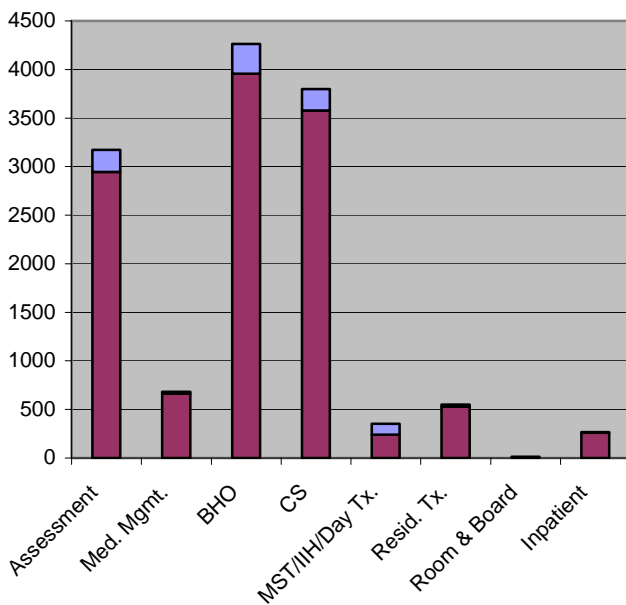
CMH/SA Consumers Served

Expenditures by Service Type FY 08



CMH/SA Consumers Served

Expenditures by Service Type FY 09



Identified Strengths and Gaps in the Service Array

Adult Mental Health/Substance Abuse

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. 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 list of service gap feedback is available in the Appendix.

BHC Forum Survey (N= 31)	Consumer Survey Results (N=50)	World Café Results (N=40)	Wake LME Community Needs Survey (N=111)
<ol style="list-style-type: none"> 1. Housing w/supports 2. Supported Employment 3. Family Psychoeducation 4. Peer Supports 5. Support Groups 6. Local Inpatient (MH) 	<ol style="list-style-type: none"> 1. Transportation 2. Employment 3. Housing / supported housing 4. Affordable medication 5. Staff availability, coverage, crisis response 	<ol style="list-style-type: none"> 1. Education and employment supports 2. Improved transition planning and involvement of others in plans (parents, principals, etc.) 3. Housing and supported housing 4. Transportation 5. Social/recreational activities 6. Facility safety, security, hygiene concerns 7. Medication 	<ol style="list-style-type: none"> 1. Housing w/supports 2. Facility-based crisis 3. Mobile Crisis Response 4. Employment services 5. Short-term local inpatient (MH) 6. Support groups 7. Psychiatry 8. Family psychoeducation 9. 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 (see Appendix D). Survey responses by participants in the Behavioral Health Collaborative and Wake Community

Collaborative for Children were consistent with these results. Further, the BHC/WCCC survey indicated that homeless adults were perceived as being underserved.

Consumer feedback through surveys and World Café forum feedback 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.

Another area of concern pertains to consumer awareness of the LME. The majority (70%) of consumers surveyed were unaware of the LME and its functions and responsibilities. This is of particular concern because most consumers are not aware they can and should contact the LME if they have questions about their services or need to file a complaint.

Child Mental Health/Substance Abuse

In reviewing all of the noted data collected from various sources in conjunction with the following survey results, there are several themes that highlight the strengths and gaps in the current Wake County Child MH/SA system of care. Strengths include a projected trend of decreasing the use of out of home placements and increasing the use of intensive outpatient and evidence-based practices. Another strength in the child MH/SA system is the positive partnership and collaboration with Wake County Public School System (WCPSS) and the Department of Juvenile Justice and Delinquency Prevention (DJJDP) due to the positive work of the Wake County Community Collaborative for Children & Families and the Wake County Juvenile Crime Prevention Council.

Although the child MH/SA service array is extensive, there are trends, disparities, and growing needs that produce challenges, barriers, and gaps for the Wake County Child MH/SA system. Responses from several community surveys describe a sense of a fragmented array of services in a very large county with numerous “generic” service providers. Developing a seamless system of care that consists of specific professional specialty expertise in treating children and adolescents with complex emotional, behavioral, and substance abuse problems continues to be a challenge.

The table below highlights the child MH/SA capacity needs and gaps identified through the various surveys conducted for this assessment.

BHC Forum Survey (N= 31)	Consumer Survey Results (N=50)	World Café Results (N=40)	Wake LME Community Needs Survey (N=111)
<ol style="list-style-type: none"> 1. Partial Hospitalization 2. PRTF 3. Prevention & Support Services 4. Psychiatry 5. Crisis & Hosp. Diversion 6. Residential Tx (Level IV) 7. Inpatient Psych. Tx. 8. Day Treatment 	<ol style="list-style-type: none"> 1. Transportation 2. Education and employment supports 3. Housing 4. Affordable medication 5. Staff availability, coverage, crisis response 	<ol style="list-style-type: none"> 1. Education and employment supports 2. Improved transition planning and involvement of others in plans (parents, principals, etc.) 3. Housing and supported housing 4. Transportation 5. Social/recreational activities 6. Facility safety, security, hygiene concerns 7. Medication 	<ol style="list-style-type: none"> 1. Psychiatry 2. PRTF 3. Crisis & hosp. diversion 4. Prevention & Support Services 5. Inpatient psych. Tx 6. Residential Tx Level IV 7. Day Treatment 8. Transportation

Another significant challenge for the child MH/SA system identified through review of the data is the apparent ongoing disparities in many of the primary public systems serving the youth in Wake County (e.g. mental health/substance abuse services, public school system, and juvenile justice). The following data illustrate the need for further evaluation of disparity issues.

Race/Ethnicity Breakdown for Wake County Youth in MH/SA Services 7/1/07-6/30/08* :

	Caucasian	African American	Hispanic
CMH (N=652)	16%	74%	8%
Adol MH (N=909)	20%	72%	7%
CSA (N<100)	26%	68%	5%

Source: NC TOPPS Initial Interview Data, 7/1/07 – 6/30/08

*WCPSS data on race/ethnicity for students enrolled in 2007-08 indicate that 26.5% of the student population is African American, 11.1% Hispanic, and 52.6% Caucasian.

The Wake County Public School System (WCPSS) has been very aware of the disparities among students in special education services as well as with students who are long and short term suspended. In the past few years WCPSS has implemented numerous initiatives coordinated with many community partners to address the disparities. The current economic downturn and preliminary budget reductions appear to project a reduction and elimination of many of these initiatives, while the student population continues to grow.

Wake County Public School System Long & Short Term Suspensions 7/1/07-6/30/08:

Gender Breakdown					
Gender	WCPSS total # of Students	# of Suspended Students		# of Violations resulting in Suspension	
		Number	Percentage	Number	Percentage
Female	65,881	3625	5.5%	6470	9.8%
Male	68,026	8542	12.6%	17374	25.5%
Total	133,907	12,167	9.1%	23,844	17.8%

Race/Ethnicity Breakdown					
Race/Ethnicity	WCPSS total # of Students	# of Suspended Students		# of Violations resulting in Suspension	
		Number	Percentage	Number	Percentage
American Indian	358	41	11.5%	74	20.7%
Asian/Pacific Islander	7291	132	1.8%	210	2.9%
African American	35,444	7202	20.3%	15,343	43.3%
Hispanic	14,809	1458	9.8%	2559	17.3%
Multiracial	5696	475	8.3%	875	15.4%
Caucasian	70,309	2859	4.1%	4783	6.8%
Total	133,907	12,167	9.1%	23,844	17.8%

Juvenile delinquency is a known high risk factor for emotional, behavioral, and substance abuse problems among youth. In Wake county the rate of violent crimes among juveniles compared to total crimes has increased by 3% from 2006-2008. DJJDP and other Juvenile Justice officials have noted on numerous occasions that the first offenses of youth in Wake County are increasingly more serious crimes (e.g. armed robbery). Law enforcement and juvenile court officials attribute this increase in violent and serious crimes to the rising number of youth involved with gang activity in Wake County. (Source: Department of Juvenile Justice and Delinquency Prevention (DJJDP) Crime Data)

Emerging gang activity is threatening vulnerable teens in Wake County. The youth involved with juvenile court and/or gang activity overwhelmingly report having observed significant violent acts including shootings and murder. This population has become increasingly difficult to engage in treatment services.

Another discrepancy the data illustrates is a significantly higher rate of behavior disorders than emotional disorders for children and adolescents receiving mental health and/or substance abuse services. National prevalence data from the 1999 Mental Health Report of the Surgeon General note that about 20% of children and adolescents are estimated to have mental disorders with at least mild functional impairment. About 5-9% are estimated to have more severe functional limitations, known as “serious emotional disturbance.” The following table shows the prevalence of specific disorders compared with the most frequent disorders diagnosed among Wake County children and adolescents in mental health services.

Disorder	National Estimated Prevalence	Most Frequent Diagnoses among Wake County youth in MH services
Anxiety disorders	13%	8% Anxiety disorders
Mood disorders	6.2%	9% Major Depressive disorders
Disruptive (behavior) disorders	10.3%	31% Conduct disorder 21% Adjustment Disorder (w/conduct) 19% Attention Deficit Disorder
Any disorder	20.9%	

The national data estimate that 19.2% of children and adolescents in the population have an anxiety or mood disorder, while disruptive behavior disorder is observed at roughly half the rate, or 10.3%. In contrast to this pattern, the Wake County youth appear to be diagnosed with behavior disorders at a much higher rate than would be predicted by national prevalence data. This inconsistency between local diagnostic trends and national prevalence may be affected by a lack of known expertise among providers regarding specific target populations.

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 Co. residents determined eligible and in need of support. In the current State Medicaid Plan, there are essentially no services specific to the DD population approved. There is, however, a Title XIX Waiver (CAP-MR/DD) that provides significant funding to 714 children and adults with DD. There are approximately 746 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 more rural 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 our current child and adult DD/TBI service continuum:

- 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 that have a history of physically acting out
- Retirement services; options in the types of daily activities need to be greater; 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
- TBI clients are extremely difficult to find residential placement for
- Nursing facilities for younger folk with DD and multiple medical issues. They don't 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 w/ how to provide ongoing, long-term support when funding only supports short-term assistance

Emerging Issues

- DD Services and supports are often long-term and even lifelong, meaning once enrolled, people typically do not move out of services
- Family systems are strained leading to caregiver under or unemployment, mental health/substance abuse issues, family disintegration, child/adult abuse/neglect.
- There has been an “explosion” of children and adults with diagnoses of Autism, many of who also have co-occurring mental health diagnoses. These individuals often times present with extremely challenging clinical and safety requirements requiring programmatic and treatment structures that are not readily found in community settings. It takes a professional with expertise in autism and mental health and paraprofessionals who have been specifically trained in implementing behavior management strategies to serve these clients in these settings. Training for staff to serve this population is lacking. There has been a significant increase in the number of state Mental Retardation Center admission requests and subsequent admissions and reliance on psychiatric hospitals and law enforcement.
- Historically there have been few available resources for services to survivors of Traumatic Brain Injury. As medical science and care improves, the survival percentages of people who sustain significant injuries increases, many of who will need long-term and often times costly services that currently do not exist.
- Loss of previously achieved skill levels when adequate adult services are not available upon completion of secondary schooling and people ‘graduate’ to nothing.

- Maladaptive behaviors left unaddressed for long periods of time due to service/funding unavailability are far more intractable and eventually require far more restrictive and costly interventions. Partially concerning herein is the lack of qualified and licensed professionals available to address these clinical needs who also accept Medicaid reimbursement.
- As more individuals have become involved in supported employment & thus more included/integrated in their communities, they find retirement options exceedingly limited. These individuals will want to continue to be as independent as possible and included in their communities. If new opportunities are not developed to support inclusion for seniors with DD, we may be faced with these people reverting to non-integrated settings.
- As the DD population ages so do their caregivers. As parents of disabled adult children age, their ability to adequately care for and meet the needs of that child is diminished sometimes unexpectedly creating crisis situations for families.
- People with Developmental Disabilities are significantly greater risk for developing early onset dementia and Alzheimer's creating a demand for more intense supervision and medical care.

Cultural and Linguistic Competency

Gaps and needs with respect to provider cultural and linguistic competency were assessed through a survey of providers. Survey results suggested a continued need for bilingual/bicultural staff at most agencies, followed by access to interpreters.

Providers were also asked about actions taken by their agency in the past year to address cultural/linguistic competency issues. These results are summarized in the following table:

Actions taken	Response Count (Response %)
Recruitment of bilingual staff	27 (75%)
Translation of written materials	26 (72%)
Use of translation/interpreting	24 (67%)
Cultural competence training	23 (64%)
Organizational assessment of cultural competence	17 (47%)
Consumer and community engagement regarding cultural competency initiatives	14 (39%)
Evaluation of disproportionality and disparities in service delivery	12 (33%)
Use of technology (e.g., TTY, video relay)	11 (31%)
Use of cultural assessment tools in clinical practice	8 (22%)

In review of NC-TOPPS initial interviews data related to race and ethnicity of consumers raised questions regarding the disproportionality of youth represented. See the consumer demographics section for details.

Previously, in December 2006, a special session was conducted with Wake County providers and other stakeholders on the topic of “Improving Access to Services for Latino Consumers.” The purpose of this session was to discuss current resources, gaps, challenges and barriers to the development of services to address the needs of the Latino community. This session noted there are quite a few bilingual therapists in Wake County, as well as Community Support providers. However, because these therapists also serve English-speaking consumers, they have less capacity than is needed. Some of the other gaps noted included the lack of Spanish-speaking psychiatrists to meet medication evaluation and management needs, female bilingual therapists, bilingual therapists with competencies to effectively treat actively psychotic consumers and in-home and family-centered services.

According to the most recent Wake County survey regarding cultural and linguistic needs and gaps, the Latino population was identified, both children and adults, as having the greatest unmet needs in terms of mental health, substance abuse and developmental disabilities. Of those responding to this category on the survey, the majority noted the need for an “increased service array, capacity and workforce development to serve the Latino population.” The second most popular response noted the need for “interpreters and funding for interpreters for languages other than Spanish.” It is important to note however that several respondents agreed with best practice standards in indicating the preference to utilize bilingual therapists whenever possible, rather than interpreters.

Provider Community Emergency Response Availability

Below is a compilation of the responses submitted by providers to the March 2009 survey regarding agencies' willingness and preparedness to participate in community disaster or emergency response efforts. The following table summarizes survey responses:

Provider Emergency Response Capacity	Response Count (Response %)
Emergency plan for agency's consumers	30 (81%)
Community-based MH/DD/SA services	22 (60%)
Assistance with staffing shelters	12 (32%)
Short-term pro bono services	12 (32%)
Critical Incident Stress Debriefing capacity	11 (30%)

Over 80% reported that they have a plan in place to serve their own consumers, representing a significant improvement over last year's responses (56%). Nonetheless, our target is 100%, and further plans will be developed to improve provider network emergency response capacity.

Provider Network Training Needs

The Wake County Behavioral Health Collaborative, made up of providers, consumers, advocates, and other stakeholders, completed a training needs assessment in August 2008. The training needs have been broken out into two categories, clinical, and business practices. The detail results can be provided upon request. The top priorities are noted in the following table:

Top Clinical Training Needs	Top Business Related Needs
<ol style="list-style-type: none"> 1. Enhance communication among providers; Seamless transitions between services; develop agreed upon expectations for transitioning clients; Best practice procedures for collaboration between services 2. Information regarding access to public health and social services resources; Improve the integration of MH/DD/SA services with other community resources; Improve understanding and coordination of systems involved in addressing the needs of children and families (i.e. early intervention, schools, child welfare, juvenile court) 3. Identify therapy models with proven effectiveness for specific populations; Evidenced-based practices; Effective psychosocial treatments; Integrated treatment approaches; Recovery-oriented services 	<ol style="list-style-type: none"> 1. Effective and affordable automated billing systems; Streamline County billing procedures to improve timely payments 2. Sustainability in an ever-changing industry; Budgeting to provide highest quality, best practice level of services with state rates 3. Effective QI - new models of evaluation – evaluation of service delivery models; Individual outcomes (i.e. service testing); Proper methods for data collection

The Wake County Behavioral Health Collaborative (BHC) has organized itself into sub-committees that will address the top needs identified above. The BHC will work with the LME to implement strategies to develop and implement training and other interventions that will address the system’s needs.

The Wake County Community Collaborative for Children and Families (WCCCCF), Wake County Human Services Local Managing Entity and Wake AHEC collaborated to survey the Wake community regarding their opinions about training needs related to mental health, developmental disabilities and substance abuse services in the community. The survey, conducted 2nd quarter to January 2008 through the on-line survey tool Zoomerang, yielded 271 responses from the community. The highest rated topics are summarized in the chart below. Respondents work with all disability areas, children, adolescents, adults and geriatric populations, and, represent people from all types of professions and systems.

Survey Question Category	Non-LME Respondents' Highest Rated Topic for Training Importance	LME Respondents' Highest Rated Topic for Training Importance
General Practice	Identifying community resources and/or informal supports - 46%	Identifying community resources and/or informal supports - 48%
Clinical Issues	Behavioral Disorders in Children & Adolescents - 46% Grief and loss for families - 43%	Substance related and personality disorders - 50% Personality disorders - 48%
Treatment Strategies	Evidence based practices - 44% Teaching anger management - 41%	Crisis intervention - 48% Suicide intervention - 37%
Ethics Issues	Ethics and documentation - 44% Ethics and client rights - 43%	Confidentiality - 44% HIPAA rules and strategies - 37%
Cultural Competence	Cultural implications when accessing services - 38% Becoming culturally competent - 38% Gang awareness - 37%	Becoming culturally competent - 39% Gang awareness - 37%

The WCCCCF will address the identification of community resources and informal supports during its annual System of Care conference in May 2009.

2009 - 2010 Network Development Priorities

Based on the results and findings of the various needs assessments, surveys and focus groups, as well as the availability of funding, the following services and initiatives have been identified for potential implementation or are in the development phase. The Wake LME will continue to analyze the impact of the economic crisis, changing demographics and demand trends as we move into the new fiscal year and develop plans and services based on those realities.

There are however, some things the Wake LME can do regardless of the economy and funding. For example, we will identify ways to better inform consumers and increase community awareness of the functions and responsibilities of the LME. Wake LME intends to focus efforts on aiding consumers in better understanding how their services are funded, how they can file a concern or complaint, how they can more easily navigate our provider network, etc. We will also continue to improve our community provider and stakeholder awareness of the LME, community services and local resources, as we attempt to develop a more seamless and responsive system of care.

We will also focus efforts on improving our provider agencies' plans for response in the event of community/natural disasters. While the majority of the respondents to a survey reported they would be able to serve their own consumers, more robust plans for the community at-large are desired.

Wake County has continued to focus efforts on the development of a comprehensive continuum of crisis services. This preparation will continue, with ground-breaking scheduled for the summer of 2009, for the development of a new Facility-Based Crisis/Secure Detox facility to be built and ready for utilization in late 2010. Plans include 16 crisis beds and 16 secure detox beds. Additional expansion of crisis continuum services will include implementation of Mobile Crisis Team and walk-in crisis services, and we will continue efforts underway to improve continuity of care and timely access to services, both for routine referrals and consumers being discharged from inpatient care.

Enhancement of provider network cultural competency and accessibility of bilingual/bicultural services will remain a priority. In addition to development of additional service capacity, we will examine disparities in referral and service utilization patterns. Additional priority areas for specific age/disability areas are described below:

Adult Mental Health/Substance Abuse

Wake County in many respects is fortunate to enjoy a myriad of services, although the demand currently outweighs the depth of the system. The challenge for the Wake LME is two-fold: to develop more evidence-based and enhanced services to adequately address the needs of the adult mental health/substance use population and to also better collaborate with non-traditional partners to meet all of the consumers' needs.

Network development efforts to address identified gaps in the Adult MH/SA Services continuum will include:

- ❑ **Transformation of the current array of mental health and substance abuse services into a system of care.** This will require increased and improved communication, collaboration and integration between the providers of services, other community partners and all stakeholders. Wake LME will focus efforts on identifying methods that will enable us to move toward a recovery-oriented system of care that supports person-centered and self-directed approaches. This includes a comprehensive five-axis approach for all consumers that addresses not only mental health and substance use issues, but also housing, healthcare, transportation, employment, etc. Some elements of this can be accomplished by increased collaboration between the private provider network and services delivered by Wake County Human Services public health (which includes behavioral health services) and social services departments. We will continue our pilot project with Community Care of Wake and Johnston Counties, which is focusing on integrating primary and behavioral health care for an identified subset of the MH/SA population.
- ❑ **Full implementation of the approved alternative services definition, Assertive Engagement.** This will improve providers' abilities to maintain contact with consumers who have been hospitalized or incarcerated and participate more fully in discharge planning. It also provides agencies with a mechanism by which they can attempt to locate and engage consumers who are not yet open to their services, but have a history of hospitalizations, incarcerations, utilization of crisis services, etc.
- ❑ **Development of both inpatient treatment and hospital diversion capacity.** Although the closure of Dorothea Dix Hospital has been delayed, Wake County Human Services has sought to secure a more local resource for those individuals needing psychiatric hospitalization. A contractual agreement between the state and Wake County has been implemented that will provide for 60 beds to remain available for the community, even after the closure of DDH. Additionally, Wake County also contracts with Holly Hill Hospital for crisis and short-term inpatient care for adults and children with mental illness and/or co-occurring substance use. In addition to development of inpatient capacity, we will continue development of hospital diversion capacity, including our new Mobile Crisis Team, development of a walk-in crisis clinic, and improved provider network crisis prevention and response efforts.

Child Mental Health/Substance Abuse

The priorities for the child and adolescent mental health/substance abuse population are not that different from adults. The need to develop more evidence-based and other effective interventions, while improving integration of services with and among other community partners and stakeholders is necessary to assure a comprehensive system of care.

Network development efforts to address this and other identified gaps in the Child MH/SA Services continuum will include:

- ❑ **Transformation of the current array of mental health and substance abuse services in the child and adolescent system of care to a comprehensive five-axis approach** – This approach will address not only mental health and substance use issues, but also housing, healthcare, transportation, employment, and education supports, along with continued partnership with Wake County Public School System (WCPSS) and the Department of Juvenile Justice and Delinquency Prevention (DJJDP). The LME will work with the Behavioral Health Collaborative to improve communication, collaboration and integration between the providers of services, other community partners and all stakeholders. This will include a focused effort to increase awareness and collaboration between the private provider network and services delivered by Wake County Human Services public health (which includes behavioral health services) and social services departments.
- ❑ **Development of specific services, initiatives, and interventions to address system needs and gaps** – These will include:
 - Continued identification, implementation, and monitoring of evidenced-based practices, particularly those that integrate effective treatment approaches and encourage recovery-oriented and family empowerment services. We will also continue education of parents and community stakeholders regarding the efficacy of evidence-based treatments to encourage service utilization
 - Services for children who are dually diagnosed with mental health disorders and developmental disabilities - Day Treatment for autistic children will be developed and coordinated with the specialized Intensive In-Home services working with the same population
 - Crisis Respite – To be implemented using Therapeutic Foster Care Homes in coordination with Mobile Crisis Management
- ❑ **Increase and formalize Assertive Engagement and Outreach for youth and families that are high risk and difficult to engage in services** – This includes an ongoing partnership and collaboration between the Wake County Gang Prevention Partnership Intervention Team, Gang Outreach Services, and appropriate mental health/substance abuse service providers (i.e. Multisystemic Therapy). We will also implement the use of the approved alternative services definition, Assertive Engagement. This will improve providers' abilities to maintain contact with consumers who have been hospitalized, placed in juvenile detention, jail, or Youth Development Centers in order to participate more fully in discharge planning.

- ❑ **Investigation of disproportionality and disparity issues** - In 2008, the Wake County Community Collaborative for Children and Families sponsored several trainings and workshops related to cultural competency. The collaborative followed up with a January 2009 session with participants of the prior workshops to dialogue about the advancement of cultural competency in Wake County. Due to continued data that illustrates significant disparities for the child mental health/substance abuse population, the collaborative will continue to investigate avenues for further exploration of cultural competence and its relationship to disparate outcomes for Wake County youth.

Adult and Child Developmental Disabilities

Network development efforts to address identified gaps in the DD Services' continuum include:

- ❑ An Intensive In-Home RFP for the young child MH/DD (autism) population has been issued and a new provider selected
- ❑ Increased funding to adults through Residential Subsidy, which will contribute to movement from residential facility-based services (or avoidance of placement in residential facility-based services) and increasing consumer independence
- ❑ Continued advocacy efforts to increase Medicaid Waiver slot allocation for Wake County consumers
- ❑ Continued collaboration with Raleigh Parks and Recreation to increase leisure and retirement activities for older persons with DD
- ❑ Negotiation with the Arc of Wake County to begin planning expansion of existing Supported Retirement Services
- ❑ Increased affordable housing options for Wake County residents with DD by supporting the development through a HUD-funded project of The Serving Cup and Lutheran Family Services called the Green Level Apartments. These 6 two bedroom semi-independent living apartments will open in Spring 2009.

APPENDICES

APPENDIX A: WCHS 2006 Community Assessment – February 2007

The Wake County Human Services Community Assessment is a report, prepared every four years, that serves as the first step in the development of a community action plan that addresses documented and prioritized needs in Wake County. It is a process that helps to identify factors affecting our County, determine resources needed to address these factors and develop a plan of action to address community needs. A group of community members across Wake County representing county and local governments, schools and universities, health care, financial institutions, public safety, faith organizations and the media conducted the Community Assessment in 2006. The group collected this information from people who live and/or work in Wake County to identify this community's resources, strengths and needs. This was done by focus groups, and by using data from the State Office of Health Statistics, Census 2000 and other sources. Information was also gathered by a survey. It is prepared by a Steering Committee comprised of more than 60 community, faith, business, hospital, nonprofit and government representatives, who direct the activities of the assessment process and provide input on issues of interest.

A Core Staff Team was formed to ensure consistent data collection and engagement of community partners. Work groups composed of topic experts from the community, as well as Wake County staff, reviewed data and produced the chapters of the Community Assessment report covering six areas:

- 1) Behavioral and Social Health
- 2) Economic Health
- 3) Environmental Health
- 4) Lifelong Learning
- 5) Physical Health
- 6) Safety

Relevant information from the Community Assessment is included in the Summary section of the report above. The full version of the assessment is available on the Wake County web page at: <http://www.wakegov.com/humanservices/about/communityassessment/2006/default.htm>

APPENDIX B: Community Needs Assessment - November 2007

During the Fall of 2007, the Network Development Team conducted an assessment of provider network capacity and community needs, which was summarized in a presentation to Ramon Rojano, Wake County Human Services Director, on November 21, 2007. The presentation, entitled “A System of MHDDSA Services For Wake County Consumers: Strategies for Developing, Managing and Enhancing the Continuum of Care,” is available upon request. Relevant excerpts that address community capacity and needs analysis have been incorporated in the report.

APPENDIX C: Quarterly Updates to 2008 Wake LME Community Need and Provider Capacity Assessment

Community Capacity Development – FY07-08 4th Quarter Update

- ❑ A Peer Advocate program was implemented with Oxford House of NC. Oxford House is a self-run, self-supported recovery house program for individuals with addiction. There are currently 15 houses in Wake County that provide affordable housing and supportive services for more than 125 people. Funding was provided to recruit, hire and train six recovering individuals to function as liaisons for residents of the 15 Oxford Houses. The responsibilities of these peer advocates include facilitating applicant interviews, assisting with moving in to an Oxford House and helping new residents identify, navigate and access needed supportive services in the community.
- ❑ In collaboration with the Child Developmental Disabilities Care Coordinators, the Young Child Intensive In-Home services for the treatment of consumers with co-occurring MH/DD disorders was implemented through the use of Mental Health Trust Funds.
- ❑ In collaboration with Wake County Public School System, the LME has begun conversations with an established provider about implementing a Day Treatment program specifically for young children with co-occurring MH/DD, especially those with Autism.
- ❑ Start-up funding was provided to Grandfather Home Community Services for a specialized level III facility for adolescent females with sexually reactive treatment needs.
- ❑ In collaboration with stakeholders such as local emergency departments and the Gold Coalition, the Wake LME conducted a Request for Proposals (RFP) for a Geropsychiatric Mobile Crisis Response Team and has selected a vendor to provide the service. The objective of this team is to reduce our utilization of state geropsychiatric inpatient beds, decrease frequency of crisis episodes, and increase residential stability for older adults with MH/SA problems. State Crisis Funds in the amount of \$300,000 are available in FY09 for start-up of this team. This project is currently on hold pending LME reorganization and prioritization of funding by the Director's office.
- ❑ The LME has also begun conversations with an established provider about providing a Forensic Assertive Community Treatment Team (Forensic ACT or F-ACT) and has identified partners for program development and implementation. This team will support the ongoing development of the continuum of services needed for adults with severe and persistent mental illness (and often co-occurring addictions disorders) who have encountered the criminal justice system. The team will initially serve as a treatment option for those leaving the Wake County Jail and will be expanded when possible to work with those released from prison as well. Mental health trust funds in the amount of \$621,800 are available for start-up of the F-ACT Team in FY09. This project is currently on hold pending LME reorganization and prioritization of funding by the Director's office.

To address training needs the following activities transpired within the children's system of care.

- Person Centered Planning: A Child and Family Team Approach was facilitated for 26 provider agency personnel. In addition, 2 provider agency facilitators and 2 LME facilitators completed the train-the-trainer course for this 3-day program, increasing training delivery capacity within the service network.
- A seminar entitled A Delicate Balance: Integrating Cultural Competency into Person Centered Planning and Service Implementation was facilitated for 47 individuals including members of the Wake Community Collaborative for Children and Families, service agencies and other stakeholders.
- The 2nd Annual System of Care conference was held at the McKimmon Center on April 22, 2008, the theme being Youth: Our Future in Progress, and was attended by 110 participants including parents, service agencies, and other stakeholders.

Additionally, the Quality Management Team facilitated Incident Report training each month within the 4th quarter for a total of 69 staff personnel from 41 provider agencies.

APPENDIX C: Quarterly Updates to 2008 Wake LME Community, cont.

Community Capacity Development – FY08-09 1st Quarter Update

The Network Development Team has focused more time this quarter on maintenance of capacity in the provider network, as opposed to expansion. This is due in part to several agencies discontinuing Community Support services because they were unable to meet staffing requirements, as well as the closure of one large provider for financial reasons. It should also be noted that the LME received a reduction of funding for Cross Area Services Programs (CASP). This reduction was distributed across all LMEs in order to fulfill a legislative mandate and fund new CASP services. This reduction will primarily affect those individuals from other counties who were receiving opioid treatment and/or methadone maintenance therapy.

However, there has been some progress towards expansion, based on the identified gaps from the March 2008 assessment, as indicated by the following:

- ❑ Wake received funding from the Division of MH/DD/SA Services to develop and implement a Mobile Crisis Management team that would serve all ages and disabilities.
- ❑ Wake is partnering with Durham and OPC LMEs to initiate a regional S.T.A.R.T. program in order to divert people with co-occurring DD and mental illness from state hospital admission.
- ❑ Wake has been contacted by Strategic Behavioral Health, LLC, a Tennessee based provider, planning to build and offer Psychiatric Residential Treatment Facilities (PRTF) for children and adolescents. They are interested in opening one of these facilities in Wake County. Location of this type of facility in Wake County would lessen the numbers of youth going out of Wake County or out of North Carolina for this most restrictive level of residential treatment.
- ❑ Mental Health Trust Fund money was used for start up of a specialized Intensive In-Home team serving young children (ages 4-13) with mental health and developmental disorders. Family Based Strategies has implemented the team and served seven children and families since the beginning of the fiscal year.
- ❑ A new IPRS contract has been implemented with El Futura to better meet the mental health needs of Spanish-speaking adults and children.

APPENDIX C: Quarterly Updates to 2008 Wake LME Community, cont.

Community Capacity Development – FY08-09 2nd Quarter Update

- ❑ Subsequent to the closure of a large provider agency in the 1st Quarter of FY09, two other large agencies have closed this quarter and several others have reduced service scope significantly. In response to concerns about the financial status of providers, the Wake LME convened a Business Forum on 11/4/08 to provide information and assistance to providers regarding “business practices in times of economic crisis.” This event was well attended and generated suggestions for further action that are being pursued by the Behavioral Health Collaborative Business Subcommittee.
- ❑ The Wake LME has received funding from the Division of MH/DD/SA to establish a Mobile Crisis Team for Wake and Johnston counties. This program is funded as a Cross Area Services Program (CASP) serving both Wake and Johnston counties, with Wake designated as the lead county for the project. In collaboration with the Division of MH/DD/SA, Wake LME has contracted with Therapeutic Alternatives to develop a MCT that will provide 24/7 mobile crisis services. They are in the process of hiring staff, with plans to be operational by mid-February. This team will serve adults and children with MH/DD/SA problems who are experiencing crisis, in an attempt to divert consumers from inpatient psychiatric treatment.
- ❑ The Division of MH/DD/SA has also allocated new funding to establish Walk-In Crisis and immediate psychiatric aftercare services for Wake and Johnston counties. These funds will be used in Wake County to improve psychiatric aftercare for homeless mentally ill consumers, with plans in progress to add psychiatric services at the South Wilmington Street Center and possibly other sites serving homeless adults.
- ❑ Wake County Public School System (WCPSS) continues to report an increase of autistic children with significant behavioral problems that are unmanageable in their school settings. This has caused an increase in numbers of autistic children who are being placed on Home Hospital status. Wake LME is using Mental Health Trust Funds to collaborate with WCPSS and a community provider to implement a specialized Day Treatment program for children who are dually diagnosed with autism and mental health behavioral disorders. This program is scheduled to be open early FY 09-10.
- ❑ The capacity for services for the Latino population continues to be a problem. The Wake LME Network Development Team has been working with a provider agency that specializes in mental health services for this population in Pennsylvania to expand their services to North Carolina, especially Wake County.
- ❑ Wake LME Network Development is working with a community provider to implement an Intensive In-Home team utilizing Functional Family Therapy (an evidence based treatment model for youth with significant behavioral problems) in order to prevent out of home placements for adolescents.

- ❑ The Wake County Juvenile Crime Prevention Council has completed their annual plan data collection for FY 09-10 and will be sharing the relevant data regarding juvenile crime, WCPSS suspensions, and delinquency/gang activity with Wake LME for assessing and identifying the MH/SA service needs for the juvenile justice and gang involved population in Wake County.

- ❑ A Peer Advocate Program was implemented with Oxford House of NC last fiscal year. Funding was provided to recruit, hire and train six recovering individuals to function as liaisons for residents of the Wake County Oxford Houses. During the past quarter, Oxford House has trained another peer advocate, increasing the number to seven. The responsibilities of these peer advocates include facilitating applicant interviews, assisting with moving in to an Oxford House and helping new residents identify, navigate and access needed supportive services in the community. Due to the success of this model, several other LMEs are considering implementing this program in their catchment areas.

- ❑ The provider network pharmacy has been in operation for five years as of this quarter. Since 2003, this program has enabled uninsured adults with mental illness and substance use disorders to obtain free medication through patient assistance programs and other sources. Latest data indicate that the program has obtained over \$8.5 million in patient assistance medication since 2005 and is currently serving over 1,400 consumers.

APPENDIX D: Wake LME Community Needs Survey (March, 2009)

The Wake LME conducted a community needs survey by e-mail in March 2009, using a web-based (Survey Monkey) survey tool. The survey was sent to all LME MH/DD/SA providers and LME staff. Survey items included assessment of provider capacity, service gaps, quality of care and barriers to treatment.

Information about respondents

Most responses came from community providers (57%), with participation from 63 respondents representing 32 separate provider agencies.

Community provider (including WCHS programs)	57%	63
Wake LME	40%	44
Other	4%	4
	<i>TOTAL</i>	111

With regard to age/disability representation of provider agencies, adult mental health and substance abuse were endorsed most highly, with child SA and DD populations being least represented in the survey.

Populations served by providers completing survey		
Answer Options	Adult	Child
Mental Health	39	31
Substance Abuse	25	7
Developmental Disabilities / Traumatic Brain Injury	18	16

**Adult Mental Health/Substance Abuse Services
Ratings of provider network capacity for adult MH/SA services**

The following table lists services in order of their rated supply capacity need, based on the percentage of respondents who rated each as having either critically low capacity, needing more capacity or having no capacity.

Type of Service	% Rating Capacity as ‘Critically Low, None or More Capacity Needed’
Housing with supports	88%
Facility-based crisis	74%
Mobile crisis response	74%
Employment services (e.g., supported employment)	72%
Short-term local inpatient treatment (MH)	72%
Support groups	70%
Psychiatry	70%
Family psychoeducation	70%
Outpatient psychotherapy	69%
Partial hospitalization	68%
Peer Supports	68%
Wellness Management/Recovery	68%
Assertive Community Treatment	63%
Short-term local inpatient treatment (SA)	62%
Psychosocial Rehabilitation	57%
Residential Treatment	57%
Substance Abuse Intensive Outpatient Program (SAIOP)	55%
Inpatient detoxification	54%
Substance Abuse Comprehensive Outpatient Treatment (SACOT)	47%
Community Support Team	42%
Community Support	28%

Ratings of Quality of Care

The following table lists services in the order by which respondents expressed concerns about quality of care, based on the percentage of respondents who rated each as having poor, very poor or variable quality of care.

Type of Service	% Rating Quality as 'Poor, Very Poor or Variable'
Community Support	51%
Housing with supports	38%
Community Support Team	30%
Assertive Community Treatment	28%
Residential Treatment	25%
Facility-based crisis	24%
Peer Supports	18%
Short-term local inpatient treatment (MH)	18%
Employment services (e.g., supported employment)	17%
Outpatient psychotherapy	14%
Family psychoeducation	14%
Psychosocial Rehabilitation	14%
Mobile crisis response	13%
Inpatient detoxification	12%
Short-term local inpatient treatment (SA)	12%
Support groups	10%
Substance Abuse Comprehensive Outpatient Treatment (SACOT)	10%
Partial hospitalization	10%
Psychiatry	9%
Wellness Management/Recovery	5%
Substance Abuse Intensive Outpatient Program (SAIOP)	5%

Additional Feedback about Service Gaps

The following areas were the most frequently cited services that are not present, populations being underserved and barriers to received care by our current adult MH/SA service network.

Services missing from the Adult MH/SA continuum	Underserved populations	Barriers to accessing care
<ul style="list-style-type: none">❑ Housing❑ Transportation	<ul style="list-style-type: none">❑ Dually diagnosed MH/SA and MI/DD❑ Spanish-speaking consumers❑ Substance abuse populations	<ul style="list-style-type: none">❑ Limited transportation❑ Limited funding❑ Services for Spanish-speaking clients

**Child Mental Health/Substance Abuse Services
Ratings of provider network capacity for child MH/SA services**

The following table lists services in order of their rated supply capacity need, based on the percentage of respondents who rated each as having either critically low capacity, needing more capacity or having no capacity. .

Type of Service	% Rating Capacity as 'Critically Low, None or More Capacity Needed'
Psychiatry	76%
Psychiatric Residential Treatment Facility (PRTF)	65%
Crisis and hospital diversion	63%
Prevention and support services	59%
Inpatient psychiatric treatment	57%
Residential Treatment-Level IV	57%
Intensive In Home	55%
Day Treatment	52%
Planned respite	50%
Emergency respite	50%
Residential Treatment-Group (Level II)	43%
Partial Hospitalization	37%
Residential Treatment-Group (Level III)	35%
Outpatient psychotherapy	33%
Multisystemic Therapy (MST)	28%
Therapeutic Foster Care	26%
Community Support	23%
Residential Treatment (Level I)	14%

Ratings of Quality of Care

The following table lists services in the order by which respondents expressed concerns about quality of care, based on the percentage of respondents who rated each as having poor, very poor or variable quality of care. Three services, Intensive In Home (56%), Psychiatry (52%), and Residential Treatment-Group, Level II (50%), were rated by most respondents as having 'very good' or 'good' quality.

Type of Service	% Rating Quality as 'Poor, Very Poor or Variable'
Community Support	43%
Residential Treatment-Group (Level III)	38%
Therapeutic Foster Care	29%
Crisis and hospital diversion	23%
Day Treatment	20%
Planned respite	19%
Inpatient psychiatric treatment	19%
Prevention and support services	17%
Outpatient psychotherapy	14%
Intensive In Home	14%
Residential Treatment-Group (Level II)	14%
Psychiatric Residential Treatment Facility (PRTF)	13%
Multisystemic Therapy (MST)	12%
Emergency respite	10%
Residential Treatment (Level I)	6%
Residential Treatment-Level IV	6%
Partial Hospitalization	5%
Psychiatry	3%

Additional Feedback about Service Gaps

The following areas were the most frequently cited services that are not present, populations being underserved and barriers to received care by our current child MH/SA service network.

Services missing from the Child MH/SA continuum	Underserved populations	Barriers to accessing care
<ul style="list-style-type: none">❑ Mentoring services	<ul style="list-style-type: none">❑ Latino children and families❑ Dually diagnosed (MH/SA)	<ul style="list-style-type: none">❑ Complexity and fragmentation of system❑ Language barriers

**Child and Adult Developmental Disabilities Services
Ratings of provider network capacity for child and adult DD services**

The following table lists services in order of their rated supply capacity need, based on the percentage of respondents who rated each as having either critically low capacity, needing more capacity or having no capacity.

	% Rating Capacity as ‘Critically Low, None or More Capacity Needed’
Facility-based respite	93%
Semi- and/or independent living	88%
In-home respite	86%
In-home support services (e.g., Developmental Therapy)	84%
Non-Work Day Activity	83%
Leisure/recreational/retirement services	80%
Developmental Daycare	77%
Supported Employment	72%
Group living situations	64%
Sheltered employment	63%
Institutional care	60%
Case Management	53%

Ratings of Quality of Care

The following table lists services in the order by which respondents expressed concerns about quality of care, based on the percentage of respondents who rated each as having poor, very poor or variable quality of care. Two services, Institutional Care (52%) and In-home respite (50%), were rated by most respondents as having ‘very good’ or ‘good’ quality.

	% Rating Quality as ‘Poor, Very Poor or Variable’
Case Management	39%
In-home support services (e.g., Developmental Therapy)	37%
Group living situations	30%
Supported Employment	29%
Non-Work Day Activity	26%
Facility-based respite	23%
Sheltered employment	22%
Developmental Daycare	20%
In-home respite	19%
Leisure/recreational/retirement services	19%
Semi- and/or independent living	14%
Institutional care	13%

Additional Feedback about Service Gaps

The following areas were the most frequently cited services that are not present, populations being underserved and barriers to received care by our current child and adult DD service network.

Services missing from the Child & Adult DD continuum	Underserved populations	Barriers to accessing care
<ul style="list-style-type: none"> <input type="checkbox"/> Transportation <input type="checkbox"/> Respite <input type="checkbox"/> Crisis diversion 	<ul style="list-style-type: none"> <input type="checkbox"/> Dually diagnosed (DD/MI) <input type="checkbox"/> Adolescents with behavioral problems <input type="checkbox"/> Children in crisis 	<ul style="list-style-type: none"> <input type="checkbox"/> Funding and eligibility limitations

Priority Areas

The following priority areas were identified by survey respondents for further LME attention (listed in order of frequency of endorsement)

1. Network capacity development: Latino services, inpatient, crisis/hospital diversion, psychiatry, housing, transportation, day activities, etc
2. Improve continuity of care, discharge planning and aftercare
3. Funding stability and financial viability of providers
4. Ensuring accessibility, prioritization of care as funds are cut
5. Improved system of care integration, collaboration and communication
6. LME management of Medicaid funds
7. Improve quality of community support

APPENDIX E: Endorsed Provider Data

Selected Wake LME Endorsed Provider Network Data: July – December 2008

SERVICE TYPE	Endorsement Status as of 12/31/08		
	Fully Endorsed	Withdrawn by LME	Voluntarily withdrawn by Provider
Community Support Child	40	8	26
Community Support Adult	30	9	30
Community Support Team	23	1	13
Multi-systemic Therapy	4	0	1
Assertive Community Treatment Team	2	0	1
Diagnostic Assessment	34	6	23
Mobile Crisis*	0	0	0
Intensive In Home	21	3	20
Partial Hospitalization	0	0	0
Child Day Treatment	5	0	1
Opioid Treatment Program	1	0	0
Substance Abuse Intensive Outpatient	5	1	1
Substance Abuse Comprehensive Outpatient	4	1	5
Psychosocial Rehabilitation	4	1	3
Child Residential	29	3	4

*Currently Wake LME has a Memorandum of Agreement with a Provider who is endorsed by another LME to provide Mobile Crisis services in Wake County

APPENDIX F: Consumer Survey Responses

Survey for Individuals Receiving MH/DD/SA Services (March 2009)

By taking a few moments to fill out this survey, you will be giving us important information that will help us to more accurately respond to the needs of Wake County consumers.

Do you...

	Yes	No
1) Think your service provider understands your needs?	42	8
2) Feel you are treated with respect and dignity?	34	5
3) Relate well with counselors and other staff members?	46	3
4) Receive your services in a reasonable amount of time?	39	9
5) Need more information about what services are provided?	28	20
6) Need any services that you do not get?	21	28

7) Are your service needs covered when your service staff are not available?

- No because medicine refills are not automatically called into pharmacy
- No because of lack of funding across the board when it comes to Personal Care and Developmental Therapy. However, my supported employment through the same company has been excellent this year
- Yes, my services are covered when staff are not here
- Yes, but they lack information on my case and conditions. They don't know how to treat me sometimes because they lack my history and information (medical information).
- Yes (26 responses)
- No (8 responses)
- Yes, I still receive my service
- Transportation, paying taxi cab drivers \$2 per ride or \$1
- Staff perform important job functions. The needs are not as well cared for when they are not in place
- Yes, for the most part. We need more group home referral
- No – staff are not available even when I'm in crisis except if I go to Crisis and Assessment, which it isn't life or death, but I really need to communicate with a therapist
- No! No coverage on weekends, county holidays and after business hours!

8) What is the most frustrating part about the services or care you receive?

- My medicines are not affordable
- Not having backup when my regular PC or DT worker is not available
- Getting able to communicate with my current doctor and therapist during an emergency
- Not being able to take a bus
- The most frustrating part about the services is when a client needs to talk about client rules, then staff is there
- That when frustrated people can't take a break when they need a cigarette
- Learning how to get along with different personalities in the program and standing your grounds

- Not having enough time spent to talk to your facilitator
- Other kids bring up things in my past life that I don't agree with
- The hours, I just think we wake up too early
- Medicaid – more than just \$65
- Difficulty finding employment, support to move towards independent living, difficulty with transportation
- Money
- Getting the same goals to be met by all staff in your case
- They don't provide a job skills training tract with information on resumes, job interviews and role playing
- The amount of time it takes when a change is scheduled
- Dealing with negative people
- Limited effectiveness of medicines
- Not receiving services when therapist has to cancel because of his/her own issues and people not covering for them for clients in crisis mode!
- No appointment for two weeks or more
- Sometimes not having a ride
- No one listens
- The amount of time I have to wait to be seen and time between appointments
- Sometimes I need transportation so I can meet my appointment
- My workers are too protective
- I wait too long for everything
- Lack of transportation
- When I have to change my medicine – I hate the side effects
- I have no problems with my services. Every time I reach out for help I find someone with a hand up
- Sometimes not enough information

9) What do you like most about the services or care you receive?

- Getting care in caring manner
- Discussing problems and try to reflect what happened last session
- I have had the same staff for several years now
- I like the services when my staff helps me run errands when I need to and take me to my doctors appointments
- I get most my services free and the people really work with me on my ability to pay
- Everything
- I like the staff, they treat me right
- That when client is wanting to leave program successfully staff can help them and are good at it
- They are real nice to all the clients and have one-on-one's when they need it, and when frustrated or mad take a few minutes in the hallway, so it's a really good program
- The people give care in a caring manner
- The facilitator listening to me helping me to understand more about my illness and medication
- My care is the top
- Everything except the level system

- Everything
- SSI
- Food stamps
- Support
- Day programs available
- The staff is kind and supportive
- How good the case managers do their jobs
- The qualify of staff and supervisors and their care and concern
- The care is great through Fellowship. Many people are knowledgeable and activities and services are geared toward the health and recovery of the client
- Fairly accessible
- I like my therapists then they are available
- My psychiatrist of 32 years, Dr. Morton Meltzer
- Very good people
- I get free samples when I don't have money for medicine
- I like the group home I live in. The food is good
- Nice people
- Workers are very nice
- Everything
- Staff are nice and patient
- The structure, fellowship and the principles
- Relationships with good people
- Great workers willing to help as much as they can
- I get information that I need with a quick call
- Unity minded
- Clean environment
- I like the diversity, caring and sharing the willingness and respect
- A clean and safe place to live
- They help us to help ourselves
- Unconditional support

10) List any services you need but do not get

- Affordable medicines
- Sometimes I need help getting information on food vouchers and other charities
- Help in preparing and getting a job
- Transportation services to therapy or group or day program
- Reliable transportation – for eyeglasses
- Supported housing/moving towards independent/semi-independent living, employment, transportation
- Jobs
- Living care of group home to be monitored better
- Job skills need to be provided. We play a lot of games and color a lot
- Help with employment
- Bus passes – so vital for a job search
- More socialization – 24/7 drop in center – lower cost housing

- Longer session sometimes and maybe I like to see weekend and night sessions offered for those who can't come during the day or went into crisis – also more handicapped parking up front
- Day hospital (partial hospitalization) – I have been in day hospital five times since 1970 – each time it averted inpatient hospitalization
- Sometime need transportation
- Housing, Medicaid, information, education
- Cost of medicine and transportation
- Transportation
- I need help paying for medicine
- I get all I need from Oxford House

APPENDIX G: World Café Consumer Forum Responses

North Carolina Consumer Advocacy
Networking & Support Organization (NC-CANSO)
Wake LME
Wake Consumer and Family Advisory Committee (CFAC)

World Café Event

March 6, 2009

Consumer Survey Summary

1. What would a well-designed service system look like to all who needed to use it?

- Has to be an inter-connected system of components that fit and work together
- Sub-system group to meet localized needs
- MH/DD/SA – needs to be more universal and person-centered and use self-advocate language
- Seamless transition from LME to LME (administrative system)
- All needs should be met through the system framework, like transportation, housing, medication, peer support, recreation opportunities, socializing
- Adequate pay and career ladder with areas of specialization offered (encourage college of direct work, peer specialized)
- Better transportation
- Good health care
- CAP services (Medicaid)
- Speedy supportive employment
- Micro enterprise
- Community college education opportunities
- Similar in that it provides from the same list of services to all of those in need and meets all their needs
- Social Services needs to be more consumer-friendly and not invasive of privacy
- Be able to start services within seven days
- Services must fit each individual's schedule
- Need consistent transportation services (that pick up on time)
- Treatment needs to focus on each person's individual needs
- Doctors that listen to the patient's feedback and concerns about medication
- More state involvement
- Treatment divided upon level of need
- A system where people could be processed quicker; not having to divulge their life history – a “one-stop shop” system (a system where there doesn't have to be fundraising)
- The well designed system is the system that provides assistance such as employment, housing, education and health services for the consumers
 - job training for consumers
 - case management after you get discharged from hospital
 - support and recovery
 - seamless transition from hospital to community support
 - educate non-consumers about mental illness through T.V., films or brochures
 - housing for the mentally ill who are pregnant

- Hospitalization
 - Stay in the company of others sometimes to not feel so isolated
 - Short Term (address issues by personalized care -- moving around a lot is not good – have control of your bearing)
 - Long Term (Day program outpatient – during the day work, volunteer, or go to some kind of supportive group)
- Consumer/Family Empowerment Choice
 - Support and Recovery/MH/DD/SA Services
 - Insurance
 - Hospitals
 - Doctors
 - Rehabilitation
 - Therapies
 - Peer Mentoring
 - Social/Recreational/Spiritual
 - Counseling
 - Medications
 - Transportation
 - Housing
 - Employment
 - Qualities: interconnected – fit and work seamlessly together – interdependent – adequate pay and career opportunities
- Mental Health System
 - Psychiatric access
 - Be prepared for emergencies
 - Home help services (when leaving hospital)
 - Transportation to therapy and group session – paying fee
 - Insurance – Medicaid/Medicare pay 100% medications
 - More senior programs
 - More PSR programs
 - Health and wellness and fitness
 - Meals on Wheels Program
 - Be mentors
 - Respect others and have good manners

2. What services or supports are needed, but not available?

- Be able to work more for financial gain without risk of losing benefits
- More daily activities within each group home
- Transportation
- Section 8 housing
- Supportive housing
- Affordable housing near work
- Capable and trained support staff with career opportunities
- Supported employment including volunteering support
- Transition support and services (staff transitions and life transitions)
- Proven alternative therapies
- Advocacy trainings
- Talk to the principal(s) of the school before transitioning back
- Do more community outreach activities
- Program to keep spare medication for consumers (in case they forget theirs)

- Educational TV programs
- Dress code
- Hygiene code
- Safe and pleasant location
- Live people answering the phones
- Diverse staff to meet various/specific needs
- Relevant/engaging treatment
- Searching people entering facility to keep clients safe
- Security systems
- Solid doors
- No funding put aside for mid wives to do at-home births
- One stop services
- Easier access to doctor/psychiatrist – more opportunities or availability to answer questions
- Having more information on individual rights and on services available
- Reduced fare for public transportation (bus/van/taxi fares)
- More peer specialists
- Meals on Wheels Program being cut
- Ask Medicaid to increase the number of medications
- Supporters to give us bus passes
- More school support
- Additional direct care staff
- More physical activities to help prevent medical conditions
- More parent involvement
- Follow through “people doing what they say they are going to do”
- More education support through tutoring
- Plan more for transition and discharge
- Need support professionals that truly understand our needs
- More emphasis on career exploration, career evaluation (inventories) and guidance (job skills training and supporters to furnish bus passes/job representative to speak on how many hours you can work and still get your disability)

3. What do you consider critical supports to the quality of life for users of local services?

- Providing daily activities for people in need
- Group homes have to have oversight for daily activities
- Transportation
- Good health care
- CAP services
- Wait list
- Community outreach and integration
- Seamless and speedy supportive employment
- Community college education opportunities
- Encourage peer mentoring by establishing a coding for billing via peer specialist
- Unify or completely divide MH/DD/SA system so it truly works
- Recreational/social opportunities
- Spiritual
- Quality
- Transportation easier to access
- Monitor on transportation
- Free at home tutoring

- Assistance getting part-time jobs
- Not allow kids to drop out of school early
- Start a program allowing teenagers from underprivileged families to get cars
- Free home care for people that are sick
- Frustrated clients should be allowed to smoke
- Job opportunity stigma
- Help for individuals who don't have insurance
- Group homes monitored! (abuse in group homes by workers toward residents – mediators/advocators to help clients residing in group homes for mistreatment)
- Federal funding
- Public transportation in more remote areas
- Job skills training
- Group homes – healthy food and drinks, getting my mail and not having someone else go through it
- People that are willing to listen
- Parents involved in treatment
- Monthly meetings and feedback from treatment team schedule to be the same as the traditional school schedule (day treatment services)
- Continue with summer treatment services
- Include social and recreational activities
- Services that are offered close to home
- To be able to get help (access) from psychiatrist, therapist, etc., quicker and easier
- Access to affordable transportation for life functions i.e., grocery store, laundry mat, hair appointments

APPENDIX H: LME Consumer Survey Results - October 2008

	YES	NO	Response Count
Have you heard of the Wake County Local Management Entity (LME)?	30.0% (131)	70.0% (306)	437
Did you know if you have a complaint about the services you are receiving that you can make a complaint to Wake County Local Management Entity?	32.6% (141)	67.4% (291)	432
If you have ever made a complaint to the Wake County LME has it been responded to in a timely fashion?	43.5% (37)	56.5% (48)	85
If you have ever made a complaint to the Wake County LME have you been satisfied with the results?	47.4% (36)	52.6% (40)	76
Did you know that there is a Wake County Consumer and Family Advisory Committee (CFAC)?	28.3% (123)	71.7% (311)	434
Do you know how to access crisis services in Wake County?	65.7% (281)	34.3% (147)	428
Do you know how to contact Wake Local Management Entity if you have a question about your services?	30.4% (131)	69.6% (300)	431
Has your current service provider given you a copy of the Wake County LME Consumer Handbook?	38.8% (160)	61.2% (252)	412

APPENDIX I: Provider and Stakeholder Responses from Wake Behavioral Health Collaborative and Wake Community Collaborative for Children

Wake County LME Community Needs Assessment – February 2009

1. Which of the following best describes your agency/organization?

- 19 Mental health/developmental disabilities/substance abuse services provider
- 3 Other community provider
- 3 Advocacy organization
- 2 Consumer/family member/interested citizen
- 4 Other (Community Collaborative for Children, Juvenile Court, W.C. Public School System, Wake LME)

2. If applicable, with which population(s) is your agency/organization affiliated? (Check all that apply)

- 13 Adult Mental Health
- 17 Child Mental Health
- 7 Adult Developmental Disability
- 10 Child Developmental Disability
- 11 Adult Substance Abuse
- 13 Child Substance Abuse

3. Service Capacity for Adult Mental Health and Substance Abuse

(a) For adult mental health and substance abuse consumers, please rate the quantity of the following services, in terms of supply, consumer choice and accessibility:

Service	% rating as low capacity
Housing w/supports	100%
Supported Employment	100%
Family Psychoeducation	90%
Peer Supports	89%
Support Groups	86%
Local Inpatient (MH)	86%
ACT	83%
Mobile Crisis	83%

(b) Please tell us about any services that were not listed above that could benefit adults with mental health or addictions needs:

- Mental health stabilization for homeless
- Transitional SA housing for Spanish speaking client
- Local residential SA care
- Considering the amount of SA funding available that does not get used compared to the amount of people who need the service, we seem to be missing or under serving this group
- Transportation
- Housing

(c) Are there currently adult mental health or substance abuse populations that are underserved or have particular difficulty accessing appropriate services? If so, please describe:

- Homeless, those without transportation and/or telephone
- Latinos and those released from prisons/jails
- Dual diagnosis, MH/SA
- SA services for Latino population
- Services for veterans
- Integrated mental health/physical health for chronic diseases
- Mobile crisis/outreach for homeless
- Homeless
- Spanish-speaking
- HIV/AIDS consumers and ex-offenders
- There are many in all populations and economic situations who are not aware of where to obtain help for adult and children mental health problems

4. Service Capacity for Child Mental Health and Substance Abuse

(a) For child mental health and substance abuse consumers, please rate the quantity of the following services, in terms of supply, consumer choice and accessibility:

Service	% rating as low capacity
Partial Hospitalization	80%
PRTF	80%
Prevention & Support	79%
Psychiatry	79%
Crisis & Hosp. Diversion	71%
Residential Tx (Level IV)	60%
Inpatient Psych. Tx.	60%
Day Treatment	50%

- (b) Please tell us about any services that were not listed above that could benefit children with mental health or substance abuse needs:
- Need quality intensive periodic services that can respond quickly. Families are more receptive in a time of crisis
 - Prevention and support
 - Preventative group work – teen forum about care and health
 - Clinically appropriate SA services that are not guided by the research done with adults
 - Transitional living for kids aging out of foster care (17-21)
 - High quality accredited residential treatment
 - Home-based services for DD population
 - High quality accredited community support
 - Vocational training
 - Funding for community activities (sports, clubs, hobbies, interests)
 - Alternatives to suspension programs
 - Crisis therapeutic foster care – it is less cost than hospitalization and consumers do better and get better connected with family, community and schools
 - We need more inpatient/residential SA providers; more Level 4's and PRTFs; more sex offender level 3's, level 4's and PRTFs
- (c) Are there currently child mental health or substance abuse populations that are underserved or have particular difficulty accessing appropriate services? If so, please describe:
- Those without transportation
 - We still lack capacity/skills to address the social/emotional needs of children under the age of 5, particularly if there are also developmental problems
 - Very young pre-school population
 - Children who are diagnosed with MH and DD type diagnosis. This is especially true if children do not qualify for DD services
 - Wendell area
 - Long-termed suspended, violent and aggressive youth
 - Youth who need a child psychiatrist (big problem in rural areas)
 - The consumers that experience housing issues with their families due to gang involvement and/ or activities. The consumer wants to go back home but gang will not let them or the family is scared to let them
 - Yes, there is a great need for school staff to be educated about children problems and how to deal with them. Many teachers (and staff) are not sympathetic or helpful in dealing with children behavior problems
 - Substance abuse populations that need residential treatment are not properly served and/or there is a long waiting list for services

5. Service Capacity for Child and Adult Developmental Disabilities/Traumatic Brain Injury

- (a) For child and adult consumers with developmental disabilities and/or traumatic brain injury, please rate the quantity of the following services, in terms of supply, consumer choice and accessibility:

Service	% rating as low capacity
In-Home Respite	100%
Leisure/Rec/Retirement	100%
Center-Based Respite	100%
Day Activity	100%
Group Living Situations	88%
Semi-Independent Living	83%
Developmental Daycare	83%
Institutional Care	83%

- (b) Please tell us about any services that were not listed above that could benefit children or adults with developmental disabilities or traumatic brain injury:

- Availability of cognitive testing for those with history of traumatic brain injury
- CPI provides services specifically for adults with traumatic brain injuries
- Brain injury support services
- Day support services (like day services for residents of ICF-MR group homes) – may differ from ADVP, CTVS or related CAP services in that ratios and service focus may differ
- Long-term volunteer supports – in this economic environment it is easier to place people in volunteer roles than jobs – these people often need the same kind of supports available through LTVS
- More senior/retirement services – focus should be maintaining social network
- I am not aware of any services for TBI

- (c) Are there currently child or adult developmental disabilities or traumatic brain injury populations that are underserved or have particular difficulty accessing appropriate services? If so, please describe:

- People with Asperger’s or individuals that have a degree of independence which disqualify them for needed services
- Need more structured day services for people with significant behavioral or personal hygiene assistance and intervention needs
- TBI patients do not fit neatly in MH or DD services but could benefit from a blend of both

6. Please specify the most important issues you believe should be addressed in the upcoming year (irrespective of any disability):

- Funding / budget cuts /financial stability
- Development of full continuum / filling gaps
- Community awareness of services
- Provider financial feasibility
- Provider communication & collaboration
- Accountability/oversight of provider network
- LME standardization, streamlining IPRS funding, authorization, STR functions

APPENDIX J: DD Services Wait List

WCHS DD SERVICES WAIT LIST MARCH 2009			
SERVICE	CHILDREN (3 – 17)	ADULTS (18+)	TOTAL
NON-MEDICAID CASE MANAGEMENT	51	50	101
ADULT DEVELOPOMENTAL VOCATIONAL PROGRAM (ADVP)	NA	23	23
LONG TERM VOCATIONAL SUPPORT	NA	0	0
SEMI-INDEPENDENT LIVING (BOARDING HOME)	NA	0	0
GROUP LIVING (DDA)	NA	29	29
ICF-MR	15	26	41
CAP-MR/DD FUNDING	533	215	748
TOTAL (Unduplicated)	555	298	853

	Apr-05	Jun-06	Jul-07	Nov-07	Feb-08	Mar-08	Jul-08
CM	481	361	514	546	179	100	56
ADVP	108	96	48	53	33	18	23
LTVS	268	283	312	292	0	0	0
BDG HM	37	34	36	38	0	0	8
GRP LVG	137	121	93	85	46	27	27
ICFMR	158	169	94	71	35	31	30
CAPMRDD		530	650	601	601	623	664
TOTAL		1172	1272	1208	902	725	741

ADDED	FY0405	FY0506	FY0607	FY0708
	355	259	272	291

APPENDIX K: Wake Community Collaborative for Children and Families World Café Responses (January 6, 2009)

1. What steps/actions must we take to build and expand cultural competence awareness, knowledge and skills of all agencies?
 - Increase our knowledge of cultural competence issues
 - Sharing data
 - Sharing workshop/training information/dates
 - Be more inclusive (to trainings/workshops) (increase marketing)
 - Include cultural competence as an agenda item at the Collaborative
 - Act as foot soldiers for cultural competence
 - Provide trainings to agencies
 - Provide opportunities to share resources/information
 - Encourage agencies to train their staff
 - Train the trainers (train the agencies to train their staff)
 - Collect data on what's already happening
 - Are we READY to be a center of influence? Are we passionate about this? Is it a priority? Are we going to step to the plate? What are we willing to do? Set target dates for action plan. (Do more than lip service!)
 - Become experts at group facilitation
 - Model cultural competency and mentor agencies in network
 - What happens if commitment is lacking?

2. What actions must we take to fully and authentically engage consumers and community voice and needs into all levels of our organizations and system?
 - Recognize importance of them being at table (consumer)
 - Make sure group is diversified and fully represented and engaged
 - Provide consumer with tools to express themselves/needs
 - Who is determining the consumer's identified needs?
 - Getting sidetracked by other agendas/distractions, etc.
 - **TAKE ACTION!!** Not just talk about
 - Empower consumers to advocate for selves and emerge as community leaders
 - Providers to go to consumers/meet them where they are to help reduce barriers
 - Providing incentives/resources to help engage consumers in process (food, transportation, child care, etc.)
 - Using empathy in/during process
 - Building social capital
 - Ensuring accountable
 - ***Providers must commit** to help to bring about the support and changes
 - Reducing barriers for providers (funding/being billable)
 - Independent consumer education/leverage knowledge, experience of current consumers
 - Become **EXPERTS** at **group** process and dynamics
 - How do we identify "community voice"?
 - Reach out to community to further develop community resources (informed as well as formal)
 - Who is identifying who the consumer is?
 - Solicit feedback from community
 - Identify specific items of interest for consumers/parents

3. What does the system need to do in order for the community and stakeholders to believe that we value and are committed to becoming a culturally competent organization?

- Doing Person Centered Planning as it was meant to be done
- The Collaborative has to do the work to make sure that we're committed to being a center of influence
- The system has to be diligent in reflecting the population it serves –staff, intervention, etc.
- The LME, private providers and partners commit to cultural competence skill building
- The Collaborative needs to establish and demonstrate indicators of becoming culturally competent
- Devote energy to educating and empowering families in cultural competence
- Act individually in a culturally competent way
- Be more inclusive of all ethnicities and don't single out individual ones
- Make sure collaborative itself is diverse – meeting time, place, location – are we really marketing and engaging – is product/agenda worth their while?
- Need to get all voices in the room (think done some better this year)
- Ongoing culturally competency education – keep doing
- Reach out more – school system especially – get in Google search system
- Represent all cities and towns in Wake County
- Work more with schools – suspensions
- Need more parents/families involved
- Will be needed more with economic downturn
- Drugstores, talk with doctors
- Transportation is a big problem
- Faith-based groups – use for marketing and collaboration