UNC SCHOOL OF GOVERNMENT

2015 Civil Commitment Conference

January 23, 2015 / Chapel Hill, NC

ELECTRONIC PROGRAM MATERIALS*

*This PDF file contains "bookmarks," which serve as a clickable table of contents that allows you to easily skip around and locate documents within the larger file. A bookmark panel should automatically appear on the left-hand side of this screen. If it does not, click the icon—located on the left-hand side of the open PDF document—that looks like a dog-eared page with a ribbon hanging from the top.

UNC SCHOOL OF GOVERNMENT

2015 Civil Commitment

January 23, 2015 / Chapel Hill, NC

Cosponsored by the UNC-Chapel Hill School of Government & Office of Indigent Defense Services

AGENDA

8:00 to 8:45 am	Check-in
8:45 to 9:00	Welcome Austine Long, Program Attorney UNC School of Government, Chapel Hill, NC
9:00 to 10:00	**Major Mental Illnesses and Treatment** [60 min.] *Brian V. Robbins, M.D., Associate Professor and Medical Director* *UNC WakeBrook Inpatient Unit*
10:00 to 11:00	**The Basics: Memory Loss, Dementia and Alzheimer's** [60 min.] *Peggy Best, LCSW, Associate Director, Alzheimer's Association Eastern North Carolina Chapter, Raleigh, NC*
11:00 to 11:15	*Break*
11:15 to 12:00	**Resources and Strategies for Challenging Clients** [45 min.] *Susan Pollitt, Attorney, Disability Rights North Carolina* *Iris Green, Senior Attorney, Disability Rights North Carolina*
12:00 to 1:00	Lunch *(provided in building)**
1:00 to 2:00	**Substance Use Disorders and Recovery (SA)** [60 min.] *Chris Budnick, VP of Programs, The Healing Place, Raleigh, NC*
2:00 to 2:45	**Traumatic Brain Injury** [45 min.] *Dr. Karla L. Thompson, Assistant Professor* *UNC School of Medicine, Chapel Hill, NC*
2:45 to 3:00	*Break* (light snacks provided)
3:00 to 3:30	**Why It All Matters:** [30 min.] **The Collateral Consequences of Commitment** *Robert Stranahan, Special Counsel, Central Regional Hospital, Butner, NC*
3:30 to 4:30	**Appellate Review** [60 min.] *David Andrews, Assistant Appellate Defender, Durham, NC*

CLE HOURS: 6 (Includes 1 hour of substance abuse /mental health component)

* IDS employees may not claim reimbursement for lunch.

MAJOR MENTAL ILLNESS AND TREATMENT

BRIAN ROBBINS, MD
UNC - WAKEBROOK

DISCLOSURES

- None

LEARNING OBJECTIVES

- Learn some basic facts about mental illness
- Understand categories of major mental illness
- Understand that some behaviors that occur are a reflection of an illness
- Learn about psychiatric medications (how they help, side effects, abuse potential) and other treatments.

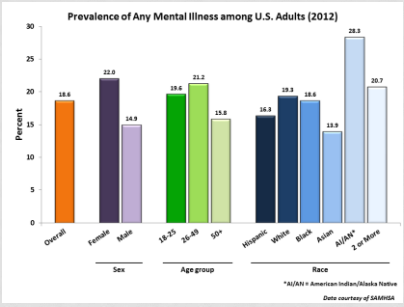
WHY AM I SPEAKING WITH YOU TODAY?

- Many more people with mental illness are incarcerated, than are in hospitals or mental health residential treatment facilities
- Approximately 30-50% of prison populations have a mental illness and if you include substance abuse then the percent increases up to 70%
- Largest provider of inpatient mental health services in Wake County is the Wake County Jail/Central Prison

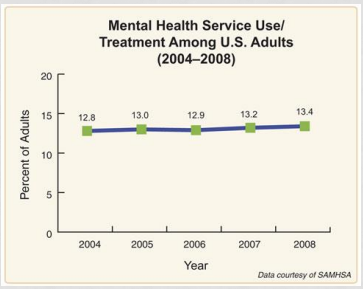
BASIC FACTS ABOUT MENTAL ILLNESS

- About 15% of the adult population will experience severe depression at some time in their life. Anxiety disorders are the most common disorder with substance misuse a very close second.
- Most people with mental illness will not have issues requiring police or legal intervention
- Despite prominent news, TV, and movies, the vast majority of people with mental illness are no more violent then the general population

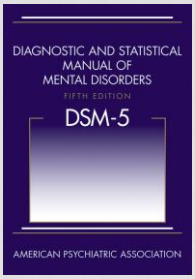
BASIC FACTS ABOUT MENTAL ILLNESS



BASIC FACTS ABOUT MENTAL ILLNESS



DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS



DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

- SYMPTOM BASED
- Important for communication between providers, research and reimbursement
- New DSM-5
  - Has only 1 Axis (verses 5 Axis in the earlier version)
  - Refined Mood Disorder criteria
  - Changes in Bereavement diagnosis
- We will cover Psychotic Disorders, Anxiety Disorders, Mood Disorders, Personality Disorders, and psychiatric medications
- We will briefly touch upon substance abuse and childhood mental illness

PSYCHOTIC, MOOD, ANXIETY AND OTHER DIAGNOSES

Don't forget these symptoms can also result from other things besides a mental illness:

- substance abuse
- **a medical condition**
- a prescribed medication

PSYCHOTIC DISORDERS (**TYPICALLY SOMETHING IS WRONG**)
(HALLUCINATIONS, DELUSIONS, THOUGHT DISORGANIZATION)

- Hallucinations
  - Visual- "see things"
  - Auditory- "hears things; voices"; most connected to mental illness
  - Command
  - Tactile- "formication"
  - Olfactory- "smell"
  - Gustatory- "taste"
  - Not always due to schizophrenia; can happen with other mental health or medical disorders
- Delusions
  - Not always due to schizophrenia
  - Definition: false, fixed belief, not based in reality
    - Paranoid
    - Religious
    - Grandiose
    - Bizarre

NEW PSYCHOSIS OR WORSENING PSYCHOSIS (TYPICALLY THEY NEED HELP)

- **Acute Psychotic Episode**
  - Substance Abuse related
  - Delirium- MEDICAL

Lots of names of psychotic disorders

- Brief Psychotic Disorder
- Schizophrenia
- Schizoaffective Disorder
- Delusional Disorder
- Mood Disorder with Psychotic Features

SCHIZOPHRENIA (DIAGNOSIS OF EXCLUSION)

- **Minimum of 6 months**
- **Two or more symptoms:**
  - Delusions, hallucinations, disorganized speech, disorganized or catatonic behavior, and negative symptoms (flat affect, amotivated, lack of speech)
  - Or two or more voices talking or a running commentary
- **Impairment in work, interpersonal relationships, or self care**

SCHIZOPHRENIA

- **Chronic, relapsing disorder**
- **Usual onset late teens, early 20's**
- Disturbance of thought- thought disorder
- Lack of reality understanding/clarity
- May include thoughts/beliefs that are untrue
- Composed of hallucinations and delusions
- **May present disheveled, impairment in self care**
- **Medications treat, but don't cure**
- **Substance abuse common**

SCHIZOPHRENIA

- Paranoia and paranoid delusions are common
- May have delusions that family members are strangers
- May believe they are someone else
- **May be very scared**
- Delusions may be bizarre, or almost make sense if you accept an underlying premise
- **May be hard to understand. Ask questions and get unusual response**
- **5% of people with schizophrenia kill themselves**
- **People relapse on medications too!**

SCHIZOAFFECTIVE DISORDER

- Often needs medications for both thought disorder (antipsychotic) and mood (mood stabilizer and/or antidepressant)

MOOD DISORDERS

- Very common in the population
- This is NOT equivalent to something bad happened to me recently and I feel lousy about it.

MOOD DISORDERS

- Major Depressive Disorder
- Bipolar Disorder type I
- Bipolar Disorder type II

DEPRESSIVE DISORDERS

- **Over 20 million people annually**
- **Less than ½ seek treatment**
- **15% of all people experience a diagnosable depression during lifetime**
- Most antidepressants are prescribed by primary care providers (family doctor)
- Suicide attempts are not uncommon. Typically it is an attempt to find a solution when they perceive none. **Be concerned about hopelessness.**

MAJOR DEPRESSIVE DISORDER

- Depressed or loss of interest/pleasure **for 2 weeks**
- At least 5 of the following:
  - depressed mood, anhedonia, psychomotor agitation or retardation, fatigue, loss of energy, feeling worthless or guilt, inability to think or concentrate, significant changes in weight and sleep, and recurrent thoughts of death, suicidal ideation with/without specific plan
- **Not due to loss of a close relative or friend**
- Cause distress or impairment in social, occupational, or other areas of functioning
- **Not caused by other causes like medical illness, alcohol or drugs/medication**

MAJOR DEPRESSIVE DISORDER

- Can develop after stressor
- Higher risk of development if family history of depression
- Can be precipitated by medical illness or **substance use**
- Can be a single life time episode or recurrent
- Small percent develop psychotic symptoms while depressed
- Can be seasonally related
- **High rates of suicide. Older males most at risk**

BIPOLAR DISORDER

- **At least one manic episode**
- With or without depression
- More likely to get depressed as get older
- May look "normal" in between episodes
- Medications may help prevent episodes
- **Usual onset late teens, early 20's**
- **Substance abuse common**

MANIC EPISODE

- Elevated, expansive or irritable mood lasting **at least one week**
- Marked impairments in many areas of life
- Symptoms include:
  - **Inflated self-esteem or grandiosity**
  - **Decreased need for sleep (don't sleep and not tired)**
  - **More talkative than usual or pressure to keep talking**
  - Racing thoughts or flights of ideas
  - Distractibility
  - **Increased goal-directed behaviors (rarely good, often problematic)**
- **May have accompanying psychotic symptoms**

HYPOMANIC EPISODE

- Distinct periods of persistently elevated expansive or irritable mood lasting at least 4 days
- **Similar symptoms as mania but period of time more brief and the symptoms are not as severe**
- **Symptoms are not severe enough to cause marked distress or significant impairments in multiple areas of life functioning**
- Symptoms are clearly a change in normal pattern of function and are not the cause of a medical condition or substance usage

BIPOLAR DISORDER

- Cyclic mood swings
- Have to have had at least one manic episode
- May have only manic episodes (no depressions)
- May have episodes of depression, mania, hypomania, or mixed states
- Mixed can be mostly agitated
- **They may seem funny at times BUT high risk for suicide**
  - **Manic- impulsive**
  - **Depressed- hopeless**
  - **Mixed- agitated**

BIPOLAR DISORDER TYPE II

- Depressed episodes plus hypomania
- Depressed episodes often seasonal but not necessarily in winter

ANXIETY DISORDERS

- What we are talking about is not an expected feeling due to an anxiety provoking experience that most people would feel anxious about.

ANXIETY DISORDERS

- Agoraphobia
- Panic Disorder
- Specific Phobia
- Social Anxiety Disorder
- Obsessive-Compulsive Disorder
- Posttraumatic Stress Disorder
- Generalized Anxiety Disorder
- Unspecified Anxiety Disorder

PANIC ATTACK

- Four or more of the following:
  - Palpitations, pounding heart, increased heart rate
  - Sweating
  - Trembling or shaking
  - Feel short of breath or unable to breath
  - Feeling of choking
  - Chest pain or discomfort
  - Nausea
  - Dizziness, unsteady, faint
  - Derealization or depersonalization
  - Fear of losing control or "going crazy"
  - Fear of dying
  - Numbness or tingling
  - Chills or hot flushes

PANIC ATTACK

- Can look like and feel like a heart attack
- Unless know it is a panic attack, and it gets better quickly (10-15 min) then needs to go to the ED

AGORAPHOBIA

- With or without panic attacks
- Anxiety about being in places or situations for which escape might be difficult
  - Scared to be outside one's home
  - Scared of being in crowds
  - Scared of traveling
- Avoid the situations or need a companion

SPECIFIC PHOBIA

- Persistent excessive fear of a object or situation
- Can trigger anxiety or panic attack
- Person knows it is excessive and unreasonable
- Interferes with person's normal routine, causes distress or occupational or social impairment
- Can be easily treated if not easily avoided
- Things like flying, heights, animals, blood, insects, thunderstorms, water, buses, bridges, tunnels, etc.
- Often onset in childhood or early 20's, rarely later

SOCIAL PHOBIA/SOCIAL ANXIETY DISORDER

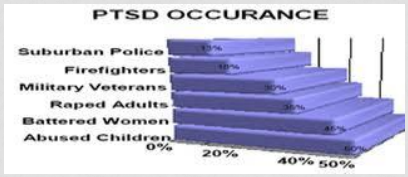
- **Marked and persistent** fear of social or performance situations, fears will act in a way that will be humiliating or embarrassing
- Exposure to setting precipitates anxiety or panic attack
- **Person knows the fear is excessive and unreasonable**
- Interferes with normal routine, social, or occupational functioning
- Medications may help, have side effects

OBSESSIVE-COMPULSIVE DISORDER

- Obsessions
  - **Recurrent and persistent thoughts, impulses, or images**, experienced as intrusive and inappropriate, causing stress or anxiety
  - Not just excessive worries about real life problems
  - Person tried to ignore, suppress, or neutralize thoughts impulses or actions
  - Person knows these thoughts, impulses, or images are created in the own mind

PTSD

- Person has been exposed to a traumatic event in which:
  - The person experienced or witnessed an event that involved actual or threatened death or serious injury
  - The persons response involved intense fear, helplessness or horror
- Traumatic event is persistently re-experienced
  - Recurrent and intrusive distressing recollections of the event with images, thoughts or perceptions
  - Recurrent distressing dreams of the event
  - Acting or feeling as if the traumatic event were recurring
  - Intense psychological distress when exposed to cues related to the traumatic event
  - Physiological reactivity when exposed to cues related to traumatic event



PTSD

- Persistent avoidance of stimuli associated with the trauma, and numbing of general responsiveness
  - Efforts to avoid thought, feelings, or conversations associated with the trauma
  - Efforts to avoid activities, places, or people that arouse recollections of the trauma
  - Inability to recall an important aspect of the event
  - Marked diminished interest or participation in significant activities
  - Feelings of detachment or estrangement from others
  - Restricted range of affect
  - Sense of a foreshortened future

PTSD

- Persistent symptoms of increased arousal
  - Difficulty falling or staying asleep
  - Irritability or anger outbursts
  - Difficulty concentrating
  - Hyperviligence
  - Exaggerated startle response

- **Substance Abuse often an attempt to self medicate**

PERSONALITY DISORDERS

- Longstanding, permanent, and inflexible patterns of behavior and mental experience that deviate from the expectations of a person's culture and that impair social and occupational functioning and may cause emotional distress. "STRESS SENSITIVE"

- Patterns present in at least 2 areas:
  - Cognition
  - Emotions
  - Relationships
  - Impulse control

PERSONALITY DISORDERS

- Cluster A: Odd/eccentric
  - Schizoid
  - Schizotypal
  - Paranoid
- Cluster B: Dramatic
  - Borderline
  - Antisocial
  - Narcissistic
  - Histrionic
- Cluster C: Anxious/fearful
  - Avoidant
  - Dependent
  - Obsessive-compulsive

BORDERLINE PERSONALITY

- Impulsive
- Unstable, stormy, intense relationships
  - *Splitting*
- Emotional reactivity
- Frantic efforts to avoid abandonment
- Unstable sense of self
- Anger control problems
- Recurrent suicidal gestures (cutting wrists)
- **Abuse substances (frequent presentations to EDs)**

BORDERLINE PERSONALITY

- **Comorbidity high with PTSD, MDD, substance usage, and eating disorders**
- Suicide rates high
  - *Self-mutilation* also a problem

NARCISSISTIC PERSONALITY

- Grandiose view of self
  - Preoccupied with fantasies of success
- Self-centered
  - Demand constant attention and adulation
- Lacks empathy
- Envious of others
- Arrogant
- Little concern for needs and well being of others
- Sensitive to criticism
- Seeks out high-status partners

ANTISOCIAL PERSONALITY

- Pervasive disregard for the rights of others since age 15
  - Lies
  - Aggressive
  - Impulsive
  - Breaks the law
  - Irresponsible
  - Lacks remorse
- **Conduct disorder before age 15**
  - Truancy, running away, lying, theft, arson, destruction of property

ANTISOCIAL PERSONALITY

- **Psychopathy (sociopathic)**
- Focuses on internal thoughts and feelings
  - Poverty of emotion
    - Negative emotions
      - Lacks shame and anxiety
      - Emotional detachment
      - Lacks remorse
    - Positive emotions
      - Useful because they are a means to manipulate others
  - Antisocial behaviors
  - Impulsivity
    - Behave irresponsibly for thrills

ADDRESSING THOSE WITH MENTAL ILLNESS

- Try to establish some rapport
- Talk slowly and use a calm voice
- **Be respectful and patient**
- Listen for what they are saying/needing
- Do not rush the process
- Keep questions simple
- Repeat your words if necessary
- Handle all situations with compassion

CHILDHOOD DISORDERS

- Specific Disorders of Childhood
  - Learning Disabilities
  - Pervasive Development Disorder (now called Autistic Spectrum disorders)
    - Asperger's Disorder (not in DSM-5)
    - Autism
  - **Attention Deficit and Hyperactivity Disorder**
  - Oppositional Defiant Disorder
  - Conduct Disorder

AUTISM SPECTRUM

- Higher functioning (**Asperger's Disorder**) and lower functioning (**Autism**)
- Symptoms typically show within the **first 3 years of life**
- Impairments in **communication, socialization, and restrictive or repetitive patterns of behaviors**
- May have other brain disorders such as seizure disorders, cerebral palsy, mental retardation, etc.
- Often time autistic children are seen when hyperactive, can't sleep, or self injure

DEVELOPMENTAL DISABILITIES

- Intellectual Disability or Intellectual developmental Disorder (formerly known as mental retardation)
  - Significantly below average IQ on a test of mental ability or intelligence and limitations in the ability to function in areas of daily life (self-care, communication, social situations, etc.)
- May have other areas of disabilities such as cerebral palsy, vision and hearing impairment, seizure disorder, other mental health issues (ADHD, depression, etc.)
- **Have about 3x risk for a serious mental illness**
- In adulthood substance abuse may also co-occur

COMMUNICATION WITH THOSE WITH DEVELOPMENTAL DISABILITIES

- To communicate effectively and sensitively with persons with developmental disabilities
  - Be patient
  - **Use clear direct phrases that are short and to the point (no long stories)**
  - Communicate on a person's level
  - Speak calmly and in a low voice
  - Be alert for verbal/behavioral outbursts
  - Repeat simple questions if needed
  - Give praise and encouragement
  - Always be compassionate

QUESTIONS???

MEDICATIONS

- Antipsychotic
- Antidepressant
- Anti-anxiety
- Mood Stabilizers

THE SAME MEDICATIONS TYPICALLY HAVE AT LEAST 2 NAMES

- Generic – chemical name (1 name)
- Brand - Can have more than one name since made by multiple companies
- Examples:
  - Ibuprofen (generic) = Advil, Motrin (brands)
  - Guaifenesin (generic) = Robitussin, Mucinex
  - Fluoxetine (generic) = Prozac, Sarafem
  - Haloperidol (generic) = Haldol
  - Lorazepam (generic) = Ativan

MEDICATIONS

- **Informed consent** and communicate information
  - With patient
  - With family/parent/guardian
- People are often prescribed a lot of different medications
- They also take the medications multiple times a day
- People often do not discard older medications when new ones are prescribed
- Most people (not just people with a mental illness) do not always take their medication when they should

ANTIPSYCHOTIC MEDS

- Old/First generation
  - More neurologic side effects
    - Parkinsonism, tardive dyskinesia
  - Inexpensive (typically)
- New/Second generation ("atypical")
  - More metabolic side effects
    - Weight gain, diabetes, high cholesterol
    - Can be very expensive ($800-900/month)

ANTIPSYCHOTIC MEDS

- First generation
  - Chlorpromazine (Thorazine)
  - Fluphenazine (Prolixin)
  - Haloperidol (Haldol)
  - Trifluoperizine (Stelazine)
  - Thiothixene (Navane)
  - Perphenazine (Trilafon)
  - Loxapine (Loxitane)
  - Thioridazine (Mellaril)
- Long-acting: Haldol decanoate (every 4 weeks), Prolixin decanoate (every 2 weeks)

FIRST-GEN

- Tardive dyskinesia
- Anticholinergic: sedation, constipation, dryness, urinary retention
- **Extrapyramidal (EPS): cogwheeling, oculogyric crisis, tremor, shuffle, tongue thickens**
  - Can be easily treated with Cogentin, Benadryl, and others

SECOND-GEN (ATYPICAL)

- Clozapine (Clozaril, Fazaclo)
- Risperidone (**Risperdal**, Risperidal- M, Risperdal Consta, Invega, Invega Sustenna)
- Olanzapine (**Zyprexa**, Zyprexa Zydis, RelPrevv)
- Quetiapine (**Seroquel**, Seroquel XR)
- Aripiprazole (**Abilify**, Abilify ODT, Maintena)
- Ziprasidone (Geodon)
- Iloperidone (Fanapt)- new
- Asenapine (Saphris)- new
- Lurasidone (Latuda)- new

SECOND-GEN (ATYPICAL)

- Risperidone, Olanzapine, Quetiapine, and Clozapine in generic form
- Others can be very expensive
- Many insurance companies starting to require trial of less expensive medications first
- **Seroquel has street value (sedating/anti-anxiety)**
- Long acting injectable:
  - Risperdal Consta (every 2 weeks)
  - Invega Sustenna (every 4 weeks)
  - Zyprexa RelPrevv (every 2-4 weeks)
  - Abilify Maintena (every 4 weeks)

SECOND-GEN SIDE EFFECTS

- Metabolic:
  - Marked weight gain
  - Diabetes with or without weight gain
  - Increased cholesterol and triglycerides
- What helps:
  - Drink water
  - Healthy diet/nutrition
  - Exercise

ANTIDEPRESSANTS

- SSRI
  - Fluoxetine (Prozac), Paroxetine (Paxil), Citalopram (Celexa), Sertraline (Zoloft), Escitalopram (Lexapro), fluvoxamine (Luvox)
- SNRI
- Venlafaxine (Effexor IR/XR), desvenlafaxine (Pristiq), duloxetine (Cymbalta)
- Mirtazapine (Remeron)
- Bupropion (Wellbutrin IR/SR/XL)

ANTIDEPRESSANTS

- Newer ones much safer in overdose
- High risk of suicide as someone starts to have increased energy but still having significant depressed mood/depressive symptoms
- Young people may be more prone to side effects

SSRI SIDE EFFECTS

- Nausea (if with food take on an empty stomach, if without food then take with food)
- **Sexual dysfunction**
- Sleep (if too sleepy move to pm; if trouble sleeping either wait, take non-prescription sleep aids or add sleep medication)
- GI disturbance, headaches, irritability/agitation
- Body needs to adjust
- If any side effects getting worse after 7-10 days then stop
- 2-3 weeks at each dose for maximum benefit

OTHER SIDE EFFECTS

- Mirtazepine (Remeron) weight gain, sedation
- Buproprion (Wellbutrin) may be too activating, can be used to stop smoking
- Duloxetine (Cymbalta) can be helpful with chronic pain
- Venlafaxine (Effexor) can elevate blood pressure
- Venlafaxine (Effexor) and Paroxetine (Paxil) are the hardest to stop

MOOD STABILIZERS

- Lithium
- Valproic Acid/Divalproex Sodium/Divalproex Sodium ER (Depakote)
- Carbamazepine (Tegretol) and Oxcarbazepine (Trileptal)
- Lamotrigine (Lamictal)
- Topiramate (Topamax)
- Gabapentin (Neurontin)
- Atypical and typical antipsychotics

MOOD STABILIZERS

- Lithium still the oldest and the best
- Lithium best for mania and best at preventing further episodes and suicide
- Lithium, Depakote, and Tegretol require blood monitoring
- **In hot weather people may become lithium toxic**
- Lamotrigine best to help depression
- Topamax and Neurontin are not FDA approved for mood stabilization

ANTI-ANXIETY MEDS

- Benzodiazepines- lorazepam (Ativan), clonazepam (Klonopin), alprazolam (Xanax), diazepam (Valium), clorazepate (Tranxene), temazepam (Restoril), oxazepam (Serax)
- SSRI antidepressants
- Buspirone (Buspar)
- Hydroxyzine (Vistaril, Atarax)
- Diphenhydramine (Benadryl)
- Gabapentin (Neurontin)- not FDA approved
- Quetiapine (Seroquel)- not FDA approved

BENZODIAZEPINES

- Best for short-term use (i.e. needing to sleep in the context of acute grief, anticipatory surgery, agitation with cause)
- Can be addictive
- Sold on the street
- Prescriptions "lost" especially alprazolam (Xanax)
- Withdrawal seizures are a concern
- As people age: cognitive problems, falls

MEDS TO TREAT SIDE EFFECTS

- Anti-Parkinsonian
  - Benztropine (Cogentin)
  - Trihexphenidyl (Artane)
  - Amantadine (Symmetrel)
  - Diphenhydramine (Benadryl)

ADHD MEDS

Stimulants: 2 types
Methylphenidate (ritalin, concerta, focalin)
Amphetamines (adderal, dexadrine, vyvanse)
Non-stimulants:
1) Strattera
2) Intuniv/tenex, Kapvay/clonidine

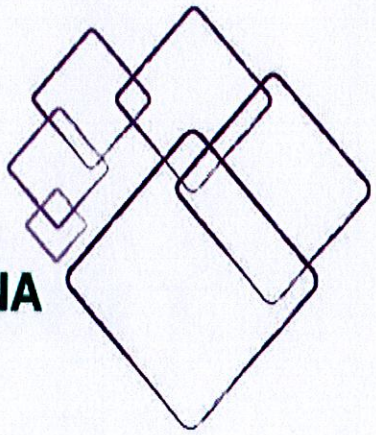
PSYCHOTHERAPY

- Supportive therapy
- Cognitive behavioral therapy
- DBT (dialectical behavioral therapy)
- Psychoanalysis (couch therapy)

QUESTIONS

DISABILITY RIGHTS
NORTH CAROLINA

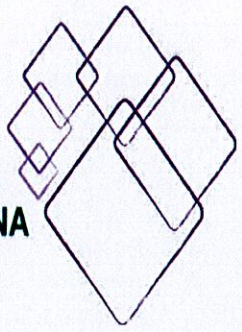
Champions for Equality and Justice



2015 COMMITMENT INFORMATION PACKET

DISABILITY RIGHTS
NORTH CAROLINA

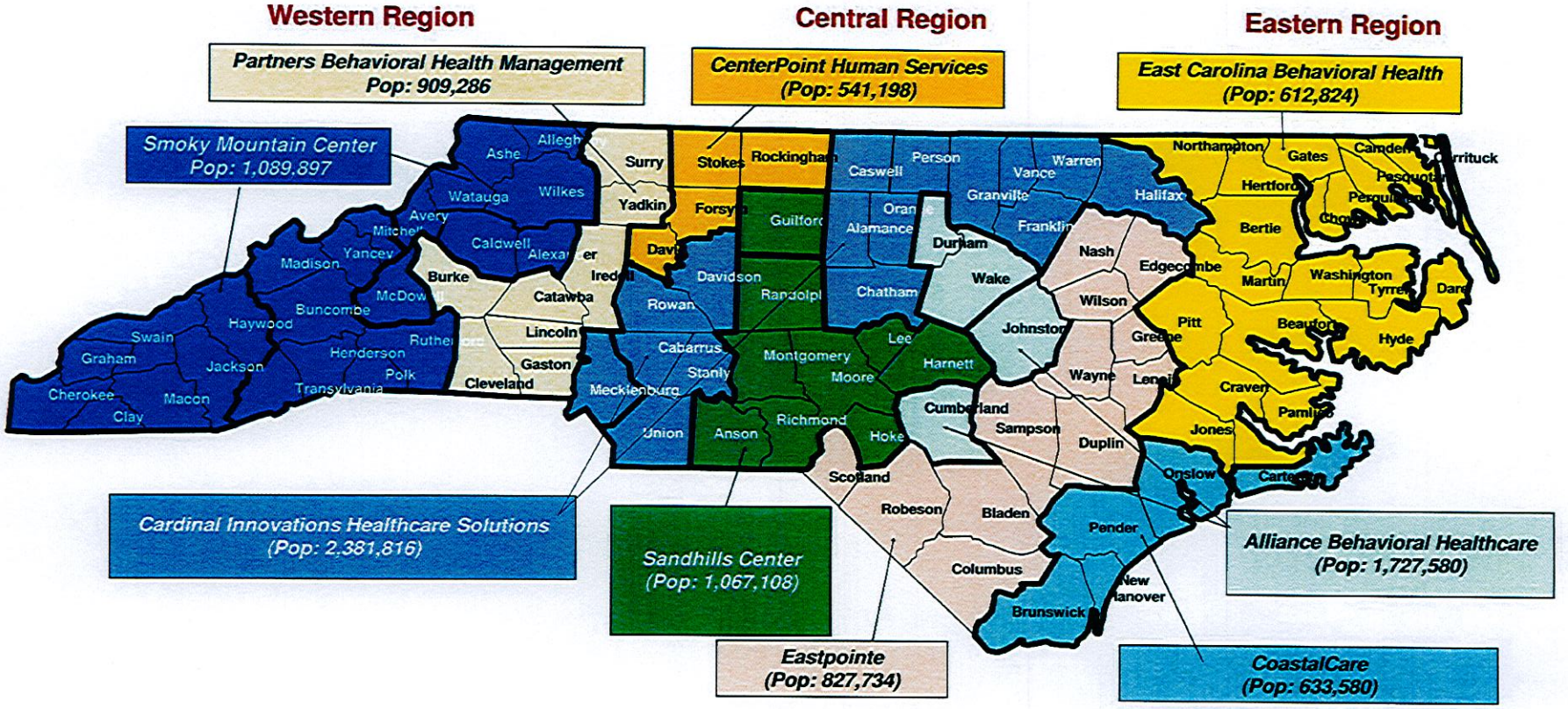
Champions for Equality and Justice



2015 CIVIL COMMITMENT

INDEX

April 17, 2014
DHHS currently has -- Nine -- LME-MCOs operating under the 1915 b/c Waiver



- *SMC now manages WHN catchment area*
- *Cardinal Innovations now managing Mecklenburg County catchment area*
- *Cardinal Innovations is the first of the four regions coming together*

NC Council of Community Program

LME/MCO Members

http://www.nc-council.org/about/

- **ALLIANCE BEHAVIORAL HEALTHCARE**
  Area Director: Rob Robinson, MA, LCAS
  4600 Emperor Blvd.
  Durham, NC 27703
  Phone: (919) 651-8401
  Emergency: (800) 510-9132
  www.AllianceBHC.org
  Serving Durham, Cumberland, Johnston and Wake counties

- **CARDINAL INNOVATIONS HEALTHCARE SOLUTIONS**
  CEO: Pamela Shipman, M.Ed.
  4855 Mileston Ave.
  Kannapolis, NC 28081
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  Access Call Center: (800) 939-5911
  Fax: (704) 939-7903
  www.cardinalinnovations.org
  Serving Alamance, Cabarrus, Caswell, Chatham, Davidson, Frankiln, Granville, Halifax, Orange, Person, Rowan, Stanly, Union, Vance and Warren counties

- **CENTERPOINT HUMAN SERVICES**
  Area Director/CEO: Betty Taylor, Esq.
  4045 University Parkway Ave
  Winston-Salem, NC 27106
  Phone: (336) 714-9100
  Emergency/ ACCESS/STR: (888) 581-9988
  Fax: (336) 714-9111
  www.cphs.org
  Serving Davie, Forsyth, Rockingham and Stokes counties

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  Area Director: Foster Norman
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  Wilmington, NC 28406
  Phone: (910) 550-2600
  Emergency/ Access to CARE: (866) 875-1757
  Fax: 3910) 550-2623
  www.coastalcarenc.org
  Serving Brunswick, Carteret, New Hanover, Onslow and Pender counties

- **EAST CAROLINA BEHAVIORAL HEALTH**
  Director: Leza Wainwright
  1708 E. Arlington Blvd.
  Greenville, NC 27858-5872
  Phone: (252) 695-6400
  Emergency: (877) 685-2415
  Access: (877) 685-2415
  Fax: (252) 215-6881
  www.ecbhlme.org
  Serving Beaufort, Bertie, Camden, Chowan, Craven, Currituck, Dare, Gates, Hertford, Hyde, Jones, Martin, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, and Washington Counties

- **EASTPOINTE**
  CEO: Kenneth E. Jones, MPA
  PO Box 396
  Beulaville, NC 28518
  Phone: (800) 513-4002
  TTY: (888) 819-5112
  Emergency: (800) 913-6109
  Fax: (919) 731-1333
  www.eastpointe.net
  Serving Bladen, Columbus, Duplin, Edgecombe, Greene, Lenoir, Nash, Robeson, Sampson, Scotland, Wayne and Wilson counties

- **PARTNERS BEHAVIORAL HEALTH MANAGEMENT**
  CEO: W. Rhett Melton
  901 South New Hope Rd.

Gastonia, NC 28054
Phone: (704) 884-2501
Emergency/ Access to Care: (800) 235-4673
Fax: (704) 854-4809
www.partnersbhm.org
Serving Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Surry and Yadkin counties

- **SANDHILLS**
  CEO: Victoria Whitt
  PO Box 9
  West End, NC 27376
  Phone: (910) 673-9111
  24 Hour Access Line: (800) 256-2452
  Fax: (910) 673-6202
  www.sandhillscenter.org
  Serving Anson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, and Richmond counties

- **SMOKY MOUNTAIN CENTER**
  CEO: Brian Ingraham, MSW, CSW
  Area Administrative Office:
  44 Bonnie Lane
  Sylva, NC 28779
  Phone: (828) 586-5501
  Fax: (828) 586-3965
  Northern Region Office
  895 State Farm Road, Suite 404
  Boone, NC 28607
  Phone: (828) 265-5615
  Fax: (828) 262-1859
  www.smokymountaincenter.org
  Serving Alexander, Alleghany, Ashe, Avery, Caldwell, Cherokee, Clay, Graham, Haywood, Jackson, Macon, McDowell, Swain, Watauga, and Wilkes counties

LME/MCO ADATC Liaisons for Admissions and Discharge Planning
Updated 5/23/14

ADATC Region	LME/MCO	Liaison	Telephone #	Fax #	Email	Address
Julian F. Keith	**Partners Behavioral Healthcare**	Shenitra Turner	704-928-4563 704-657-0411 (c)	336 527-3321	sturner@partnersbhm.org	200 Elkin Business Park Drive Elkin, NC 28621
	Cardinal Innovations	Adrienne Dekay Tracy Sherrill (back-up)	704-310-6860 (c) 704-213-2735 ACCESS: 704-939-7950	704-939-7998 866-836-7539 Corporate: 704-939-7998	Adrienne.dekay@cardinalinnovations.org tracy.sherrill@cardinalinnovations.org	4855 Milestone Avenue Kannapolis, NC 28081
	Smoky Mountain Center	Beth Schore Rocky Morris Judy Keuhn (re-auth)	828-586-5501 x1195 919-605-6259 (c) 828-586-5501 x5214 828-586-5501 x1147	828-452-3473 (auths)	beth.schore@smokymountaincenter.com rocky.morris@smokymountaincenter.com	356 Biltmore Avenue Asheville, NC 28801
R. J. Blackley	**Sandhills**	Sandra Reiman Terry Wicker (back-up)	336-389-6159 910-220-7702	336-389-6127	Sandrar@sandhillscenter.org	201 North Eugene Street Greensboro, NC 27401
	Alliance Behavioral Healthcare/ Wake	Gabriel Campbell Jessica King (back-up)	919-651-8748 919-651-8759	919-651-8776	gcampbell@allianceBHC.org jking@allianceBHC.org	5000 Falls of Neuse Road Suite 304 Raleigh, NC 27609
	Alliance Behavioral Healthcare/ Durham	Julie Kellermeier	919-651-8823 919-808-2491 (c)	919-651-8668 (RRF/auths) 919-651-8683 (CCPs/face sheets)	jkellermeier@allianceBHC.org	414 E. Main St. Durham, NC 27701
	CenterPoint	Wallace Rutledge	336-778-3590 336-705-8921 (c) Provider ACCCESS# 888-220-5280	336-714-9327 (auths, appt, etc.) 336-778-3548	jrutledge@cphs.org	4025 University Pkwy. Winston-Salem, NC 27106
	Cardinal Innovations	Larron Lee Chanda Lee (back-up)	336-380-5194 919-794-1145	866-249-7407 866-232-7038 or (Corporate) 704-939-7998	larron.lee@cardinalinnovations.org Chanda.lee@cardinalinnovations.org	4855 Milestone Avenue Kannapolis, NC 28081

ADATC Region	LME	Hospital Liaison	Telephone #	Fax #	Email	Address
Walter B. Jones	**Eastpointe/ Goldsboro**	Suzanne Nix Kristiann Herring Libby Dukay Patricia Turner Venessia Hill Claire Edwards Mike Disieno	919-587-0342 919-587-0318 919-587-0317 919-587-0349 919-587-0382 919-587-0373 919-587-0361	910-298-7187	snix@eastpointe.net kherring@eastpointe.net ldukay@eastpointe.net pturner@eastpointe.net vhill@eastpointe.net cedwards@eastpointe.net mdisieno@eastpointe.net	100 S. James St. Goldsboro, NC 27530
	Eastpointe/ Lumberton	Cheryl Harris Elsa Shaw Makisha Hunt Diane Nelson	910-272-1218 910-272-1274 910-272-1267 919-272-1261	910-298-7187	charris@eastpointe.net eshaw@eastpointe.net mhunt@eastpointe.net dnelson@eastpointe.net	450 Country Club Rd. Lumberton, NC 28360
	Eastpointe/ Rocky Mount	Lou Ann Simmons Lynn Winstead Michelle Kirby	252-407-2472 252-407-2455 252-407-2169	910-298-7187	lasimmons@eastpointe.net lwinstead@eastpointe.net mkirby@eastpointe.net	500 Nash Medical Arts Mall Rocky Mount, NC 27804
	East Carolina Behavioral Health	Amber Balent Jennifer Cox (back-up) Rob Heubel (back-up)	1-866-998-2597 ACCESS: 1-877-685-2415	ACCESS: 252-215-6878 CCPs: 252-215-6873	abalent@ecbhlme.org jcox@ecbhlme.org rheubel@ecbhlme.org	1708 Arlington Boulevard Greenville, NC 27858
	Coastal Care	Tony Welch	910-550-2600	910-550-2720	tony.welch@coastalcarenc.org	P.O. Box 4147 Wilmington, NC 28406
	Alliance Behavioral Healthcare/ Cumberland	Shenethia Hebert	910-491-4815	910-323-0096	shebert@alliancebhc.org	711 Executive Place Fayetteville, NC 28302
	Alliance Behavioral Healthcare/ Johnston	Adolpha Bassett	919-989-5551	919-989-5532	adolpha.bassett@johnstonnc.com	521 N. Brightleaf Blvd. Smithfield, NC 27577

Facility Contacts:
http://www.ncdhhs.gov/dsohf/

Julian F. Keith ADATC
828-257-6200 main #
201 Tabernacle Road
Black Mountain, N.C. 28711
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828-257-6362
melissa.couser@dhhs.nc.gov

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debra.hughes@dhhs.nc.gov

Walter B. Jones ADATC
252-830-3426 main #
2577 W. Fifth Street
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mike.howard@dhhs.nc.gov

Division of State Operated Healthcare Facilities **1/12/2015**
Contact for this Document: Jenny Wood – 919-855-4700 or Jenny.Wood@dhhs.nc.gov

System of Care Coordinators

Updated 10-20-14

LME/MCO	Name	Agency	Phone	E-mail	Counties Served
Alliance Behavioral Healthcare	Dawn Manus	Alliance BH (formally Durham Center)	919- 651-8847	DManus@alliancebhc.org	Durham
	Catherine Stephenson	Alliance BH (formerly Wake County Human Services)	(919) 651-8704	CStephenson@alliancebhc.org	Wake
	Felecia Ferrell	Johnston County LME	919- 989-5584	felecia.ferrell@johnstonnc.com	Johnston
	Sharon Glover	Cumberland County LME	910-491-4813	sglover@alliancebhc.org	Cumberland
Cardinal Innovations Healthcare Solutions	Beth Pfister	Cardinal Innovations-Corporate Officce	704-305-0196 cell	Beth.pfister@cardinalinnovations.org	SOC Manager
	Fran Harvey	Alamance Caswell/ OPC - COC	919-913-4011	Fran.harvey@cardinalinnovations.org	Alamance, Caswell, Orange, Person, Chatham
	Clarette Hill	Five County -COC	252-430-1330	clarette.hill@cardinalinnovations.org	Franklin, Granville, Vance, Warren, Halifax
	Diana Moser-Burg	Meckenburg COC	704-939-7608	diana.moser-burg@cardinalinnovations.org	Mecklenburg
	Noel Thomas-Lester	Piedmont - COC	704-918-8928	noel.thomas-lester@cardinalinovations.org	Cabarrus, Rowan, Stanly, Union, Davidson
Centerpoint Human Services	Kathi Perkins	CenterPoint Human Services	336-778-3501	kperkins@cphs.org	Davie, Forsyth, Stokes & Rockingham
Coastal Care	Karen Reaves	Coastal Care	910.459.4859	karen.reaves@coastalcarenc.org	Onslow and Carteret
	Amy Horgan	Coastal Care	910- 550-2599	Amy.Horgan@coastalcarenc.org	New Hanover, Pender, and Brunswick

System of Care Coordinators

Updated 10-20-14

LME/MCO	Name	Agency	Phone	E-mail	Counties Served
East Carolina Behaviorall Health	Adam Leggett	East Carolina Behavioral Health	252-287-4339	aleggett@ecbhlme.org	SOC Director
	Amy Bryant	East Carolina Behavioral Health	252-636-1510 or 1-877-685-2415	abryant@ecbhlme.org	Craven, Jones, Pamlico, Martin, Beaufort
	Sarah Massey	East Carolina Behavioral Health	252-636-1510 or 1-877-685-2415	samassey@ecbhlme.org	Dare, Camden, Currituck, Pasquotank
	Hope Eley	East Carolina Behavioral Health	252-636-1510 or 1-877-685-2415	heley@ecbhlme.org	Bertie, Gates, Hertford, and Northampton
	Tracey Webster	East Carolina Behavioral Health	252-636-1510 or 1-877-685-2415	twebster@ecbhlme.org	Washington, Chowan, Perquimans, Hyde, Tyrell
	Chinita Vaughan	East Carolina Behavioral Health	252-636-1510 or 1-877-685-2415	cvaughan@ecbhlme.org	Pitt
Eastpointe	Angela Wilson	Eastpointe Human Services	919-587-0314 919-920-8429 cell	awilson@eastpointe.net	SOC Lead
	Tamiko Loftin	Eastpointe Human Services	919-587-0368	tloftin@eastpointe.net	Duplin, Sampson, Lenoir, Wayne Counties
	Vacant	Eastpointe			Greene, Wilson, Edgecombe, Nash
	Rikki Bullard	Eastpointe	910-272-1543	rbullard@eastpointe.net	Columbus, Bladen, Scotland, Robeson
Partners Behavioral Health Management	Tara Conrad	Partners Behavioral Health Management	828-323-8093 828- 323-8049 cell	tconrad@partnersbhm.org	SOC Manager
	Kim Sorrell	Partners Behavioral Health Management	828-323-8049 828- 446-5687 cell	ksorrell@partnersbhm.org	Catawba, Burke
	Rebecca Harris	Partners Behavioral HM	704-772-4278	rharris@partnersbhm.org	Lincoln, Gaston, Cleveland
	Candice Moore	Partners Behavioral HM	336- 527-3215 336- 466-0192 cell	cmoore@partnersbhm.org	Iredell, Surry, Yadkin

System of Care Coordinators

Updated 10-20-14

LME/MCO	Name	Agency	Phone	E-mail	Counties Served
Sandhills	Lucy Dorsey	Sandhills Center	336-389-6353	lucyd@sandhillscenter.org	Anson, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond
	Lisa Salo	Sandhills Center (formerly Guilord Center)	336- 389-6091 919- 975-5326 cell	lisas@sandhillscenter.org	Guilford
Smoky Mountain Center	Ann DuPre Rogers	Smoky Mountain Center	828- 225-2785 ext. 5146	ann.rogers@smokymountaincenter.com	Community Outreach Director
	Melissa Ledbetter	Smoky Mountain Center	828- 586-5501 ext. 3340	Melissa.ledbetter@smokymountaincenter.com	Alexander, McDowell, Caldwell
	Vacant	Smoky Mountain Center	828-586-5501 ext. 1229	heather.james@smokymountaincenter.com	Jackson, Swain, Macon, Cherrokee, Haywood, Qualla Boundry, Graham
	Robin Winkler	Smoky Mountain Center	828- 586-5501 ext. 4433	Robin.winkler@smokymountaincenter.com	Ashe, Allegany, Avery, Wilkes, Watauga
	Ashley Edmonds	Smoky Mountain Center	828-225-2785 ext. 5324	ashley.edmonds@smokymountaincenter.com	Buncombe, Yancey, Mitchel, Madison
	Marilyn Kaylor	Smoky Mountain Center	828-225-2785 ext. 5908	marilyn.kaylor@smokymountaincenter.com	Rutherford, Polk, Henderson, Transylvania
State SOC Coordinator: Heather McAllister , 919-715-2774, heather.mcallister@dhhs.gov					

LME-MCO HOUSING CONTACTS

Updated: Jan. 5, 2015

LME-MCO	Contact Name	Title	Catchment	Address	City_ST_Zip	Phone	E-mail	Counties Served
Alliance Behavioral Healthcare	Stephanie Williams	Community Relations Supervisor	Alliance BH	414 E. Main St.	Durham, NC 27701	(919) 651-8854	swilliams@allianceBHC.org	Durham
	Valaria Brown	Housing Coordinator	Durham	414 E. Main St.	Durham, NC 27701	(919) 651-8825	vbrown@alliancebhc.org	Durham
	Malcolm White	Housing Specialist	Wake	5000 Falls of the Neuse Rd., Suite 304	Raleigh, NC 27609	(919) 651-8756	MWhite@alliancebhc.org	Wake
	Melissa Payne	Housing Specialist	Johnston	PO Box 411	Smithfield, NC 27577	(919) 989-5587	Melissa.payne@johnstonnc.com	Johnston
	William H. Robinson	Housing Specialist	Cumberland	711 Executive Place	Fayetteville, NC 28302	(910) 222-6105	wrobinson@alliancebhc.org	Cumberland
Cardinal Innovations Healthcare Solutions	Suzanne Storch	Housing Program Administrator	Cardinal Innovations Healthcare Solutions	4855 Milestone Avenue	Kannapolis, NC 28081	(704) 939-7607	suzanne.storch@cardinalinnovations.org	Alamance, Cabarrus, Caswell, Chatham, Davidson, Franklin, Granville, Halifax, Mecklenburg, Orange, Person, Rowan, Stanly, Union, Vance & Warren
	Joel Rice	Housing Specialist	Five County, OPC & AC COC	134 S. Garnett Street	Henderson, NC 27536	(252) 430-3073	Joel.Rice@cardinalinnovations.org	Franklin, Granville, Vance, Warren, Halifax, Orange, Person, Chatham and Alamance-Caswell
	Natalie Allen	Housing Specialist	Piedmont - COC	245 LePhillip Court	Concord, NC 28025	(704) 721-7066	Natalie.Allen@cardinalinnovations.org	Cabarrus. Rowan, Stanly, Union, Davidson
	Robert "Craig" Weaver	Housing Specialist	Mecklenburg	4855 Milestone Avenue	Kannapolis, NC 28081	(704) 783-5998	robert.weaver@cardinalinnovations.org	Mecklenburg
	Xiocomara "Cici" Ebanks	Housing Specialist	Mecklenburg	10150 Mallard Creek Rd.	Charlotte, NC 28262	(704) 783-6079	xiocomara.ebanks@cardinalinnovations.org	Mecklenburg
CenterPoint Human Services	Leona Williams	Community Operations Manager	CenterPoint Human Services	4025 University Parkway	Winston-Salem, NC 27106-3325	(336) 714-9131	lwilliams@cphs.org	Davie, Forsyth, Stokes & Rockingham
	DeShanna Johnson	Housing Coordinator	CenterPoint Human Services	4025 University Parkway	Winston-Salem, NC 27106-3325	(336) 778-3561	djohnson@cphs.org	Davie, Forsyth, Stokes & Rockingham
	Rahim N. Skinner	Peer Care Assistant Housing	CenterPoint Human Services	4025 University Parkway	Winston-Salem, NC 27106-3325	(336) 714-9380	rskinner@cphs.org	Davie, Forsyth, Stokes & Rockingham
CoastalCare	Brett Wells	Housing Specialist	Southeastern Center	2023 South 17th Street	Wilmington, NC 28406	(910) 550-2732	brett.wells@coastalcarenc.org	Brunswick, New Hanover, Pender
	Brian Fike	Housing Specialist	Onslow Carteret	165 Center Street	Jacksonville, NC 28546	(910) 459-4858	Brian.Fike@coastalcarenc.org	Onslow, Carteret
East Carolina Behavioral Health	Amy Modlin	Housing Director	East Carolina Behavioral Health	1708 E. Arlington Blvd.	Greenville, NC 27858	(252) 695-6400	amodlin@ecbhlme.org	Beaufort, Bertie, Craven, Gates, Hertford, Jones, Northampton, Pamlico, Pitt
	Talaika Goss-Williams	Housing Coordinator	East Carolina Behavioral Health	1708 E. Arlington Blvd.	Greenville, NC 27858	(252) 695-6400	tgwilliams@ecbhlme.org	Camden, Chowan, Currituck, Dare, Hyde, Martin, Pasquotank, Perquimans,
Eastpointe	Vacant	Housing Manager	Eastpointe Human Services	100 S. James Street	Goldsboro, NC 27530		vacant	DOJ Housing Manager for Eastpointe
	Vacant	Housing Specialist	Eastpointe Human Services	100 S. James Street	Goldsboro, NC 27530		vacant	Shelter Plus Care Program Specialist for Eastpointe
	LaTasha McNair	Housing Specialist	Beacon	500 Nash Medical Arts Mall	Rocky Mount, NC 27804	(252) 407-2413	ltmcnair@eastpointe.net	Wilson, Greene, Edgecombe, Nash, Wayne & Lenoir

NC Housing Search at: http://www.nchousingsearch.org/
Bed Availability Database - Public View at: http://www.ncdmh.net/bedavailability/

LME-MCO HOUSING CONTACTS

Updated: Jan. 5, 2015

LME-MCO	Contact Name	Title	Catchment	Address	City_ST_Zip	Phone	E-mail	Counties Served
	Rhoda Emanuel	Housing Specialist	Southeastern Regional	450 Country Club Rd.	Lumberton, NC 28360	(910) 272-1257	rhodaemanuel@eastpointe.net	Bladen, Columbus, Duplin, Robeson, Scotland & Sampson
Partners BHM	Kenneth Gehrig	Housing Coordinator	Partners Behavioral Health Management	901 S. New Hope Road	Gastonia, NC 28054	(704) 884-2514	KGehrig@partnersbhm.org	Gaston, Lincoln, Cleveland
	Kim Maguire	Housing & Service Development	Partners Behavioral Health Management	901 S. New Hope Road	Gastonia, NC 28054	(704) 884-2504	kmaguire@partnersbhm.org	Gaston, Lincoln, Cleveland
	Teena Willis	Housing Specialist	Mental Health Partners	1985 Tate Blvd. SE, Suite 529	Hickory, NC 28602	(828) 323-8084	TWillis@partnersbhm.org	Catawba & Burke
	Mollie Tompkins	Housing Specialist	Crossroads	200 Elkin Business, Park Dr	Elkin, NC 28621	(336) 527-3259	MTompkins@partnersbhm.org	Iredell, Surry, Yadkin
Sandhills	Donna McCormick	Housing Specialist	Sandhills Center	P.O. Box 9	West End, NC 27376	(910) 673-7229	DonnaM@sandhillscenter.org	Anson, Hoke, Montgomery, Moore, Richmond, Randolph, Harnett, Lee
	Mary Pat Buie	Housing Specialist	Sandhills Center	P.O. Box 9	West End, NC 27376	(910) 673-7202	maryb@sandhillscenter.org	Anson, Hoke, Montgomery, Moore, Richmond, Randolph, Harnett, Lee
	Salima Thomas	Housing & Community Relations Manager	Partners Ending Homelessness in Guilford	201 Church Ave.	High Point, NC 27262	(336) 553-2715 ext. 103	Salima@PartnersEndingHomelessness.org	Guilford
	Katy Manganella (backup)	CoC Program Manager	Partners Ending Homelessness in Guilford	1500 Yanceyville Street	Greensboro, NC 27405	(336) 553-2715 ext. 105	Katy@PartnersEndingHomelessness.org	Guilford
Smoky Mountain LME/MCO	Kristi Case	Housing Manager	SM for MH/DD/SAS	44 Bonnie Lane	Sylva, NC 28779	(828) 586-5501 x 1202	casekristi@smokymountaincenter.com	Housing Manager for SMC
	Andrew Romines (Western Region)	Housing Coordinator	SMC for MH/DD/SAS	44 Bonnie Lane	Sylva, NC 28779	(828) 586-5501 ext. 1272	andrew.romines@smokymountaincenter.com	Cherokee, Clay, Graham, Haywood, Jackson, Macon & Swain
	Lynne DeLuca (All SM counties)	I/DD Housing Coordinator	SMC for MH/DD/SAS	1207 East Street	Waynesville, NC 28786	(828) 586-5501 ext. 1181	Lynne.DeLuca@smokymountaincenter.com	Mitchell, Yancey, Buncombe, Henderson, Madison, Polk, Rutherford, Transylvania, Cherokee, Clay, Graham, Haywood, Jackson, Macon, Swain, Alexander, Caldwell, McDowell, Alleghany, Ashe, Avery, Wilkes & Watauga
	Tammy Gray (Central Region)	Housing Coordinator	SMC for MH/DD/SAS	825 Wilkesboro Blvd, SE, Lenoir, NC 28645	Lenoir, NC 28645	(828) 759-2160 ext. 3352	tammy.gray@smokymountaincenter.com	Alexander, Caldwell, McDowell
	Lori Watts (Northern Region)	Housing Coordinator	SMC for MH/DD/SAS	895 State Farm Rd, Suite 507	Boone, NC 28607	(828) 265-5315 ext. 4409	lorelei.watts@smokymountaincenter.com	Alleghany, Ashe, Avery, Wilkes, Watauga, (eff. 10/2013 added Mitchell & Yancey)
	Sarah Lancaster	Housing Specialist	WHN	356 Biltmore Ave.	Asheville, NC 28801	(828) 225-2785	sarah.lancaster@smokymountaincenter.com	Buncombe, Henderson, Madison, Polk, Rutherford & Transylvania

DMH/DD/SAS-Housing Specialist-Angela Harper at: angela.harper@dhhs.nc.gov
DMH/DD/SAS-Housing Administrator-Ken Edminster at: ken.edminster@dhhs.nc.gov
DMH/DD/SAS-PATH Program Manager-Debbie Webster at: debbie.webster@dhhs.nc.gov

NC Housing Search at: http://www.nchousingsearch.org/
Bed Availability Database - Public View at: http://www.ncdmh.net/bedavailability/

LME/MCO CONTACTS FOR THE TRANSITION TO COMMUNITY LIVING INITIATIVE		
MCO/LME NAME AND ADDRESS	**NAME OF CONTACT**	**CONTACT INFORMATION**
Alliance Behavioral Healthcare **5000 Falls of Neuse Road, Ste 304** **Raleigh, N.C. 27609**	Sherisse Bailey – Transition to Community Living Team Lead Jessica King – DOJ Coordinator	919-651-8738 sbailey@alliancebhc.org 919-651-8759 jking@alliancebhc.org
Cardinal Innovations Healthcare Solutions **4855 Milestone Avenue** **Kannapolis, N.C. 28081** **Fax: 704-939-7998**	Larry Swabe - MS – Community Living Manager	919-358-0114 larry.swabe@cardinalinnovations.org
Centerpoint Human Services **4045 University Parkway Avenue** **Winston-Salem, N.C. 27106** **Fax: 336-778-3547**	Sharonda Patrick – Lead Care Coordinator of Mental Health	336-778-3523 spatrick@cphs.org
Coastal Care **3809 Shipyard Boulevard** **Wilmington, N.C. 28406** **Fax: 910-550-2720**	Darlene Webb – Director of Care Coordinator	910-550-2600 darlene.webb@costalcarenc.org
East Carolina Behavioral Health **1708 E. Arlington Boulevard** **Greenville, N.C. 27858-5872** **Fax: 252-695-6400**	Lindsay Henson – Transition to Community Living Director	252-695-6400 lhenson@ecbhlme.org
Eastpointe **PO Box 396** **Beulaville, N.C. 28518** **Fax: 919-731-1333**	Angela Keith – Housing Transition Coordinator	919-587-0363 akeith@eastpointe.net
Partners Behavioral Health Management **901 South New Hope Road** **Gastonia, N.C. 28054**	Regina Hayes –LCSW MH/SA Care Coordinator Supervisor	704-884-2501 rhaynes@partnerbhm.org

LME/MCO CONTACTS FOR THE TRANSITION TO COMMUNITY LIVING INITIATIVE		
MCO/LME NAME AND ADDRESS	**NAME OF CONTACT**	**CONTACT INFORMATION**
Sandhills **PO Box 9** **West End, N.C. 27376** **Fax: 910-673-7993**	Teresa McLean – Lead Transition to Community Living Coordinator	910-673-7230 teresam@sandhillcenter.org
Smoky Mountain Center **356 Biltmore Avenue** **Asheville, N.C. 28801** **Fax: 828-225-2801**	Karol Gebbia –LPC, Transitions to Community Living Manager	828-335-2185 Karol.gebbia@smokymountaincenter.com

NORTH CAROLINA'S *MONEY FOLLOWS THE PERSON* PROJECT
Summer, 2010

PERSON in INPATIENT FACILITY
- hospital
- skilled nursing facility
- intermediate care facility

FOR AT LEAST THREE MONTHS
- Medicare considerations

MEDICAID ELIGIBLE
- Mindful of deductible status

TRANSITION PROCESS

- **CAP SLOT or PACE**
- **TRANSITION YEAR STABILITY RESOURCES**
- **ENHANCED CASE MANAGEMENT**
- **TRANSITION COORDINATION**

MOVES BACK INTO OWN HOME AND COMMUNITY
- Own house or apartment
- Family's home
- Group home of four people or fewer*

*For folks with I/DD only

OBJECTIVES:
- Increase the Use of Home and Community-Based, Rather than Institutional, Long-Term Care Services
- Eliminate Barriers or Mechanisms, Whether in State Law, the State Medicaid Plan, the State Budget, or Otherwise Which Prevent or Restrict the Flexible Use of Medicaid Funds to Enable Medicaid-Eligible Individuals to Receive Support for Appropriate and Necessary Long-Term Services in the Settings of their Choice
- Increase the Ability of the State Medicaid Program to Assure Continued Provision of Home and Community-Based Long-Term Care Services to Eligible Individuals Who Choose to Transition from an Institution to a Community Setting
- Ensure Strategies and Procedures are in Place to Provide Quality Assurance for Eligible Individuals Receiving Medicaid Home and Community-Based Long-Term Care Services and to Provide for Continuous Quality Improvement for Such Services.

Our Website: http://www.ncdhhs.gov/dma/MoneyFollows/

THE TARGETING PROGRAM

Affordable Housing for Persons with Disabilities

THE TARGETING PROGRAM

Over 1,800 low-income persons with disabilities have successfully obtained housing through the Targeting Program – a partnership between the NC Department of Health and Human Services (DHHS) and the NC Housing Finance Agency (NCHFA). Another 1000 units are under development. Benefits of Targeting Program housing include:

- Access to newly constructed or rehabbed independent apartments.
- Integration in communities of choice.
- Rent that does not exceed 30% of household income.
- Required access to supports and services by Referral Agency.

TARGETING PROGRAM APPROVED REFERRAL AGENCIES

The Targeting Program provides housing linked to supports and services by virtue of commitment from referral agencies. DHHS and NCHFA look to local human service agencies to make referrals for persons receiving their services and to provide access to supportive services for Targeted Unit tenants. Basic responsibilities of referral agencies include:

1) Making referrals based on professional assessment of each individual's ability to live in independent housing with the supports and services available.
2) Providing access to supportive services for persons referred to Targeted units and being a point of contact should tenants need assistance.
3) Collaborating with other community partners to support tenants and build local housing knowledge.

BUILDING HOUSING KNOWLEDGE

Ensuring that persons with disabilities have access to affordable housing and to the supportive services they need requires collaboration at the local level. Local Housing Support Committees provide:

- A venue for referral agencies and other community partners to network, learn about housing and share information and resources to support persons with disabilities.
- An opportunity for agencies to get involved at the community level in housing and human service related issues.

HOW TO GET INVOLVED

To become a referral agency, review the Targeting Program Referral Agency Agreement to Participate to see if the program is a good fit with your agency's mission. All agencies interested in supporting persons with disabilities are welcome to join their local Housing Support Committee. Agencies considering becoming a referral agency or those that would like to get involved with a Housing Support Committee should contact:

Kay Johnson
Field Operations Manager
NC Dept. of Health & Human Services
Division of Aging and Adult Services
kay.r.johnson@dhhs.nc.gov
(704) 619-6716.

Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8
Russell Cate	**Gillian Hampton**	**Tonya Rathbone**	**Frank Bryant**	**Stacy Hurley**	**Thea Craft**	**Monica Jones**	**Lamar Johnson**
Cherokee	Avery	Gaston	Rowan	Alamance	Wake	Northampton	Nash
Swain	Watauga	Lincoln	Cabarrus	Caswell		Hertford	Edgecombe
Macon	Ashe	Cleveland	Union	Person		Gates	Wilson
Clay	Wilkes	Mecklenburg	Stanly	Orange		Camden	Wayne
Graham	Alleghany		Davidson	Halifax		Currituck	Greene
Jackson	Surry		Anson	Granville		Pasquotank	Lenoir
Haywood	Yadkin		Richmond	Vance		Perquimans	Sampson
Madison	Davie		Montgomery	Franklin		Chowan	Duplin
Buncombe	Stokes		Randolph	Warren		Bertie	Pender
Transylvania	Forsyth		Moore			Martin	New Hanover
Henderson	Rockingham		Hoke			Washington	Brunswick
Polk	Guilford		Lee			Tyrrell	Johnston
Rutherford			Harnett			Dare	
McDowell			Chatham			Pitt	
Yancey						Beaufort	
Mitchell						Hyde	
Burke		**Region 9**				Craven	
Catawba		**Thea Craft**				Pamlico	
Caldwell		Cumberland				Jones	
Alexander		Bladen				Onslow	
Iredell		Columbus				Carteret	
Durham		Robeson					
		Scotland					

Russell Cate
919-480-9273
1-888-331-8455 fax
russell.cate@dhhs.nc.gov

Gillian Hampton
336-982-2392
1-888-570-2290 fax
gillian.hampton@dhhs.nc.gov

Tonya Rathbone
704-530-9896
1-888-591-4410 fax
tonya.rathbone@dhhs.nc.gov

Frank Bryant
919-215-1880
1-888-419-7783 fax
frank.bryant@dhhs.nc.gov

Stacy Hurley
919-401-6850
1-888-510-4487 fax
stacy.hurley@dhhs.nc.gov

Thea Craft
919-855-4985
1-888-426-9964 fax
thea.craft@dhhs.nc.gov

Monica Jones
252-686-6941
1-888-560-9088 fax
monica.jones@dhhs.nc.gov

Lamar Johnson
919-374-7173
1-888-548-0041 fax
lamar.johnson@dhhs.nc.gov

Field Operation Manager: Kay Johnson, 704-619-6716, 1-888-524-7121 fax; kay.r.johnson@dhhs.nc.gov
Regional Housing Manger: Ellen Blackman, 919-855-4992, ellen.blackman@dhhs.nc.gov
Supervisor: Martha Are, 919-855-4994, martha.are@dhhs.nc.gov

North Carolina Coalition
securing resources ▪ encouraging public dialogue ▪ advocating for public policy change
to End Homelessness
NC SOAR: SSI/SSDI, Outreach, Access and Recovery
soar@ncceh.org www.ncceh.org 919.755.4393

As of December 31, 2014

NC SOAR Outcomes

Total usable outcomes reports received*	1,608
Total Approved	1,287
Total Denied	313
Total Death Before Decision	8
Average time between completion of application and determination for initial applications	100 days
Median number of days between completion of application and determination on initial applications	88 days
Percentage of caseworkers becoming the 1696	96%
Average length of time homeless	2 years, 8 months
Percentage of applications approved (not including deaths before decisions)	80%
Percentage that required CE	38%
Amount of income brought into state since June 2, 2010 **(includes first year of annual income and back pay awarded to applicants)**	**$17,068,185.21**

*Outcome reports are cumulative and are based on data received since 2008. Some outcomes forms are received and do not have enough completed fields to be considered 'usable' for the purposes of data collection. Appropriate follow-up is done with submitting caseworkers, but when no further information is available we consider these submitted forms to be unusable. Outcomes include cases at three stages: Initial Applications, Reconsiderations, and Appeals.

County	# of Outcomes	Approval Rating	Dedicated staff?
Alamance	5	100% (5/5)	N
Beaufort	1	100% (1/1)	N
Bladen	1	0% (0/1)	N
Brunswick	4	50% (2/4)	N
Buncombe	317	81% (255/316); 1 Death Before Decision	Y: 4 FTE
Burke	2	100% (2/2)	N
Cabarrus	1	0% (0/1)	N
Caldwell	1	100% (1/1)	N
Carteret	1	100% (1/1)	N
Catawba	22	73% (16/22)	N
Cumberland	14	79% (11/14);	Y: 1 FTE
Davidson	6	83% (5/6)	N
Durham	215	86% (185/214); 1 Death Before Decision	Y: 3 FTE
Edgecombe	4	50% (2/4)	N
Forsyth	135	87% (118/135)	Y: 3 FTE
Gaston	5	100% (5/5)	N
Granville	3	67% (2/3)	Y: 1 PTE
Guilford	40	78% (31/40)	Y: 2 FTE
Haywood	1	100% (1/1)	N
Henderson	39	55%(21/38); 1 Death Before Decision	Y: 1 FTE
Iredell	46	89% (41/46)	Y: 1 FTE
Jackson	1	0% (0/1)	N
Lenoir	1	100% (1/1)	N
Martin	2	50% (1/2)	N
McDowell	1	100% (1/1)	N
Mecklenburg	203	86% (172/201); 2 Deaths Before Decision	Y: 4 FTE, 1 PTE
Nash	1	100% (1/1)	N
New Hanover	267	72% (193/267)	Y: 1 FTE
Orange	36	89% (31/35); 1 Death Before Decision	N
Pasquotank	2	50%(1/2)	N
Pender	4	25% (1/4)	N
Person	1	100% (1/1)	N
Pitt	65	56% (36/64); 1 Death Before Decision	Y: 2 FTE, 1 PTE
Robeson	3	33%(1/3)	N
Rockingham	2	100% (2/2)	N
Rowan	1	100%(1/1)	N
Sampson	1	100%(1/1)	N
Stanly	1	100% (1/1)	N
Surry	3	0% (0/3)	N
Union	1	1 Death Before Decision	N
Vance	4	100% (4/4)	N
Wake	132	93% (123/132);	Y: 2 FTE
Watauga	3	50% (1/3)	N
Wayne	9	89% (8/9)	Y: 2 FTE
Wilkes	1	100% (1/1)	N

North Carolina
Coalition to End Homelessness
NC SOAR: SSI/SSDI Access, Outreach and Recovery
soar@ncceh.org www.ncceh.org 919.755.4393

In order to transition a person out of homelessness, we know that one will need affordable housing, access to appropriate services and an adequate income. For many North Carolinians who are homeless, working a full-time job is not an option because of some type of disability.

For these, federal disability benefits will be their ticket out of homelessness. Disability Benefits, including a monthly check and health insurance, can help individuals and families access affordable housing, access needed healthcare and mental health services, and provide some income to help pay for living expenses. In shelters across North Carolina, we see people hoping to receive disability benefits. They are often frustrated and confused by what can be a long, disappointing process.

National rates of approval for disability (SSI/SSDI) applications are approximately 35% for first time applicants. Among the homeless population, however, the approval rates are significantly less – closer to 15%, despite the high percentage of homeless persons who are prominently disabled.

Caseworkers are often perplexed by the denials from disability. It is often so clear that a person has some sort of condition that renders them unable to work. So why can't Social Security see that? Do people really have to be denied three times? It just doesn't make any sense.

The truth is, applying for disability benefits can be a tough process. For persons experiencing homelessness, it can prove even more difficult. Lack of access to a phone or an address and the transitory nature of homelessness make it difficult for SSA and DDS to communicate with applicant. Obtaining copies of records or even simple identification can be a struggle for a homeless person. Even the nature of one's disability may make it impossible to follow the process for applying for disability.

But the real truth is, the process has seemed difficult because we have not understood how the it works. Until now.

Over the past 4 years SAMHSA has contracted with Policy Research Associates to develop and facilitate a training called **SOAR – SSI/SSDI Outreach, Access and Recovery**. Communities that have participated in the training and implemented the SOAR technology fully have had similar results, documenting up to 95% approval rates within 3 months for homeless persons.

So what does it take to see similar results in North Carolina? The next page details the difference that SOAR makes, as compared to the usual process of applying for SSI/SSDI benefits. Caseworkers have been trained to complete disability applications using SOAR methods--it is important to support them by creating the community infrastructure to ensure their success. To apply the critical components of success in your community, learn more about the NC SOAR Community Certification process today!

Comparison of Usual SSI/SSDI Application Process and SOAR Process

Week(s)	Usual Process	SOAR Process
1	Make initial assessment to determine whether applicant needs assistance to apply for benefits.	Make initial assessment to determine whether applicant needs assistance to apply for benefits.
1-2	❖ Establish Protective Filing Date by calling SSA ❖ Take applicant to SSA to file SSI and SSDI applications	❖ Establish Protective Filing Date-fax in SOAR form from Module 16. ❖ Have applicant sign Appointment of Representative form (SSA-1696) and duplicate releases for previous treatment providers (one for assisting agency and one for SSA). ❖ Review SSA Disability Report (SSA-3368) and use as a guide (do paper version) to create complete list of agencies/others for whom releases are needed. ❖ Fax/mail/phone requests for medical and other records. ❖ Continue gathering medical records and assessing applicant.
3-8	❖ Receive requests for completion of SSA Disability Report (SSA 3368) by psychiatrist. Complete and return to SSA. ❖ Receive requests for completion of ADL form by applicant or staff. Complete forms and return to SSA. ❖ Applicant may not respond to requests for information by SSA; case manager may not know this; SSA can't locate applicant and the application is denied for lack of follow-up.	❖ Continue gathering medical records and assessing applicant. ❖ Write Medical Summary Report using medical records received; integrate personal treatment history in narrative; include your observations, assessment, and quotes from the individual so DDS' four functional areas of concern are clearly addressed. ❖ Have Medical Summary Report co-signed by physician or psychologist who has seen the person ❖ Complete on-line forms: SSDI application (SSA-16) and disability report (i3368pro) ❖ Make appointment with SSA to complete SSI application (SSA-8000) which is not available online. This form must be completed within 60 days of establishing the protective filing date.
9-16	❖ Wait for applicant to tell you that they have received a letter from SSA with a decision. ❖ Applicant may be sent for consultative exam (CE); he/she may not show up for exam and the application is denied.	❖ Find out name of examiner at DDS and call to establish relationship. Ask if he/she received a copy of the 1696 Appointment of a Representative form. ❖ Get bar code information identified with applicant and fax supporting documentation to examiner. ❖ Continue to gather information as needed and send to DDS examiner.
16-20	❖ Continue waiting for decision.	❖ SSA decision regarding disability status mailed to applicant and you as the Representative.
20 or longer	❖ SSA decision regarding disability status mailed to applicant. ❖ Typically, the application is denied. ❖ The applicant appeals and may wait 2-3 years for a hearing OR ❖ Applicant is discouraged and does not appeal	❖ Applicant is able to be placed in housing, receive treatment and supports; begins process of recovery…

Additional Resources

Below is a list of referrals to other North Carolina organizations (advocacy and professional organizations) that may assist you in your work.

- **Disability Rights NC** - is a 501(c)(3) nonprofit organization based in Raleigh. Its team of attorneys, advocates, paralegals and support staff provide advocacy and legal services at no charge for people with disabilities across North Carolina. As the state's federally mandated protection and advocacy system, Disability Rights North Carolina is charged with protecting the rights of children and adults with disabilities living in North Carolina.

  Disability Rights NC
  3724 National Drive
  Suite 100
  Raleigh, NC 27612
  919-856-2195
  877-235-4210

- **The Arc of North Carolina, Inc.** – is a statewide advocacy and service organization committed to securing for all people with intellectual and developmental disabilities the opportunity to choose and realize their goals of where and how they learn, live, work, and play. The Arc of North Carolina is an affiliated chapter of The Arc of the United States.

  The Arc of North Carolina
  343 E Six Forks Rd
  Raleigh, NC 27609
  info@arcnc.org
  800.662.8706 | 919.782.4632

- **National Alliance on Mental Illness (NAMI)** - is NAMI NC is a non-profit organization, whose mission is to provide support, education, advocacy, and public awareness so that all affected by mental illness can build better lives.

  NAMI
  309 W. Millbrook Road Ste. 121, Raleigh, NC 27609 |
  919-788-0801
  Helpline (NC Only) 1-800-451-9682
  Fax: 919-788-0906 | Email: Mail@Naminc.Org

- **The Autism Society** – is an organization that works to directly improve the lives of individuals and families affected by autism through advocacy, training and education, and direct services. They can be contacted at:
  1 800-442-2762 *(NC only)*
  +1 919-743-0204

Autism Society of North Carolina, Inc.
505 Oberlin Road, Suite 230
Raleigh, NC 27605, USA

info@autismsociety-nc.org

- **NC Families United** - is the Statewide Family Network whose mission is to support and unite the voices of children, youth, and families with mental health concerns to educate, support and advocate for improved services and lives. Their vision is for North Carolina to have a family driven, child focused System of Care to ensure their independence, safety, happiness and success in their homes, schools, and their communities.

North Carolina Families United
206 East Elm Street
Graham, NC 27253
Phone: (336) 395-8828
Fax: (336) 395-8830
Twitter: @GailCormier

National Service Inclusion Project:

Fact Sheet

Person-First Language

The words we use to describe one another can have an enormous impact on the perceptions we and others have, how we treat one another, mutual expectations, and how welcome we make people feel. The following are guidelines for talking with, and about, a person with a disability. While these guidelines can be helpful, keep in mind the following:

- If you're unsure of the proper term or language to use, ask!
- The best way to refer to someone with a disability is the same way we all like to be referred to: by name.

Outdated or Offensive	Reason(s)	Currently Accepted
"The" anything: The blind The disabled The autistic	Views people in terms of their disability. Groups people into one undifferentiated category. Condescending; does not reflect the individuality, equality, or dignity of people with disabilities.	• People with disabilities • Deaf people* • People who are blind • People with autism
Handicapped	Outdated; connotes that people with disabilities need charity. Disabilities don't handicap: Attitudes and architecture handicap.	• People with disabilities

National Service Inclusion Project:

Fact Sheet

Admits she/he has a disability	Disability is not something people have to "admit" to or needs to be disclosed.	• Says she/he has a disability
Normal, healthy, whole (when speaking about people without disabilities as compared to people with disabilities)	People with disabilities may also be normal, healthy, and whole. This implies that a person with a disability is not normal.	• Person without a disability
Courageous	Implies the person has courage because of having a disability	• Successful, productive

* All currently accepted terms should be used with "people-first" language, i.e., "people with…." The exception to this are the terms "deaf people" and "deaf community," which are fine.

Adapted from material developed by Mid-Hudson Library System Outreach Services Department, 103 Market Street, Poughkeepsie, NY 12601, 914/471-6006.

www.serviceandinclusion.org

DISABILITY RIGHTS NORTH CAROLINA

Champions for Equality and Justice

Resources and Strategies for Challenging Clients

2015 Civil Commitment
January 23, 2015

Iris Green and Susan Pollitt, Senior Attorneys

Disability Rights NC is North Carolina's P&A

- NC's "Protection and Advocacy" system
- Provide advocacy and legal services to people with disabilities.
- By federal law, each state and US territory has a P&A

Who is Disability Rights NC?

- **Our Mission:** To protect the ***legal rights*** of people with disabilities through individual and systems advocacy.
- **Our Vision: Disability Rights NC** values the dignity of ALL people and their freedom to ***control*** their own lives. We work for justice, upholding the fundamental rights of people with disabilities to ***live free from harm*** in the ***communities of their choice*** with the opportunity to participate fully and equally in society.

What We Plan to Cover…

- Basic Structure of NC Mental Health, Developmental Disabilities and Substance Abuse (MH/DD/SA) System
- Resources
  - Department of Justice Settlement
  - Money Follows the Person
  - Housing
  - SOAR
  - EPSDT
    - Communication Bulletin # 72
- Other Resources

4

N.C.'s Behavioral Health Service System

- N.C. DHHS is the single state agency for Medicaid.
- N.C. DHHS contracts with 9 "Local Management Entities/Managed Care Organizations" ("LME/MCO"), arranged geographically, to manage the provision of publicly funded behavioral health services.
- The LME/MCOs receive a per-member/per-month rate to "manage care" in their communities.

LME/MCO Role in Hospital Discharges

By contracts with Divisions of N.C. DHHS and through statute and the Administrative Code, the LME/MCOs must:

- be aware of hospital admissions and discharges including discharge planning;
- Develop engagement strategies including identification of barriers to treatment, treatment needs and referral needs;
- Provide linkage to needed psychological, behavioral, educational and physical evaluations;
- Oversee the development of the Person Centered Plan ("PCP");
- Monitor the PCP and health and safety of the consumer;
- Coordinate Medicaid eligibility and benefits;
- and monitor connectedness to services until the person is no longer at risk for crisis. (DMA-LME/MCO contract.)

LME/MCO Resources

1. Hospital and ADATC Liaisons
2. Care Coordinators
3. "System of Care" Coordinators for kids
4. Housing Contacts/Coordinators
5. DOJ/Transition to Community Living Team Leads or Managers

(also can email community@dhhs.nc.gov and we are told someone WILL respond.)

History of the DOJ Settlement

- In 2010, Disability Rights NC complained to the U.S. DOJ that N.C. relies on institutional settings, specifically Adult Care Homes, to provide services to people with mental illness. These settings are segregated from non-disabled people and isolated from the community.
- In July, 2011, the U.S. DOJ issued a Findings Letter that N.C. structures and funds its mental health service delivery system to serve people in Adult Care Homes rather than in integrated settings. Reliance on institutional settings violates the Americans with Disabilities Act, the U.S. Supreme Court's *Olmstead* decision and the civil rights of people with disabilities.
- After a year of negotiation, in August, 2012, the parties settled the case.

DOJ Settlement - By July 2020…

- NC must house 3,000 people in the community with tenancy supports
- Improve community mental health services so there are 50 ACT Teams serving 5,000 people
- Improve crisis services
- Provide employment support

How The DOJ Settlement Works

- The LME/MCOs are the point of contact.
- PASSAR Screening prior to admission to an ACH (identifies people with SMI and may divert people from ACHs).
- An independent reviewer will monitor the state's progress.
- LME/MCO staff will conduct "in-reach" in ACHs, in state operated psychiatric hospitals and with people diverted from ACHs to identify people who want to transition to the community.

Eligibility for a DOJ Housing Slot

- The Agreement prioritizes people with serious mental illness (SMI) as follows:

1. People in ACHs;
2. People in State Psychiatric Hospitals who are homeless or with unstable housing; and
3. People diverted from ACHs.

Contact The LME/MCO "Transition To Community Living" Team Leader

- If you represent someone with SMI who is homeless or has unstable housing, contact the LME/MCO Transition to Community Living Team Leader or Manager.
- Contact community@dhhs.nc.gov and DHHS staff will respond.
- N.C. DHHS has a web-page with lots of information at:

http://www.ncdhhs.gov/mhddsas/providers/dojsettlement/index.htm

Money Follows The Person

Goal of the project is to increase use of Home and Community Based services rather than long-term institutional care. Participants receive transition support.

- Must be 22 years old or younger or over 65
- Must be in hospital/PRTF for 3 months
- Must be eligible for the Innovations (IDD) Waiver
- Must be transitioning to own home and community

HOUSING – Two Kinds

1. Licensed Facilities (either under NCGS 122C or 131D)
   - ACHs. If less then 7 beds, called Family Care Homes ("FCH") (131D license)
   - Group Homes and Alternative Family Living ("AFL") (122C license)
     - Group homes are operated by providers including non-profits (called ".5600" group homes)

Housing con't

2. Affordable Supported Housing/Independent Living
   - The Targeting Program, a state program providing housing linked with supports and services (Ellen Blackman at N.C. DHHS: 919 855-4992)
   - See N.C. DHHS Supported Housing page: http://www.ncdhhs.gov/mhddsas/services/housing/index.htm
   - DMA Bed Availability Listing at http://www.ncdmh.net/bedavailability/ a bed availability listing by County kept in real-time every month (AFL, FCH, Group Home and Permanent Supported Housing options)

Housing con't

- N.C. Housing Coalition has a county listing of affordable housing at: http://www.nchousing.org/need_help/housing_location/county-resource-guides
- See N.C. Housingsearch at: http://nchousingsearch.org/index.html
  A free service listing affordable housing

N.C. SOAR – SSI/SSDI Outreach, Access and Recovery

SOAR is a program sponsored by SAMHSA (Substance Abuse and Mental Health Services Administration) to increase access to Social Security Administration (SSA) disability benefits (SSI and SSDI) for people who are homeless and at risk of homelessness.

- NC Coalition to End Homelessness ("NCCEH") serves as the state lead for SOAR in North Carolina.
- email Emily Carmody with NCCEH or call her at (919) 755-4393 and she will link your client with a SOAR trained caseworker in your area.

What is EPSDT?

- **E**arly and **P**eriodic **S**creening, **D**iagnosis and **T**reatment
  - **EPSDT** is a part of the Medicaid Act that
    - provide a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children and adolescents under age 21, as specified in Section 1905(r) of the Social Security Act (the Act)all medically necessary health care services to Medicaid-eligible children under the age of 21.

18

Goal of EPSDT

- Assure that individual children get the health care they need when they need it, the right care to the right child at the right time in the right setting.
- States have an affirmative obligation to make sure that Medicaid-eligible children and their families are aware of EPSDT and have access to required screening and necessary treatment services.

19

What is the Process for Requesting EPSDT Services?

- The Medicaid Act requires North Carolina to inform all Medicaid eligible children under age 21 about EPSDT. If eligible, a child is entitled to medically necessary services, and have every right to demand those services under EPSDT.

20

Continued…What is the Process for Requesting EPSDT Services?

- One important step is to speak with the physician, licensed practitioner, or clinician. The child's clinician knows the specific nature of the child's health and is in the best position to show the State that a service is a medical necessity for the child. Also, as stated earlier, the reviewer should give deference to a child's physician/clinician in determining whether a particular treatment or procedure will correct or ameliorate a health issue for the purposes of EPSDT. If the child's physician or clinician is unfamiliar with EPSDT or would like additional information, the following resources may prove helpful:
- http://www.ncdhhs.gov/dma/epsdt/index.htm.

21

Continued…What is the Process for Requesting EPSDT Services?

- The child's service provider (physician or other licensed clinician) should then submit a request for Medicaid services to the assigned care coordinator at the LME/MCO.
- See list of LME/MCO in attachments.
- A parent/child has appeal rights if the service is denied.

22

Other Resources

- Autism Society
- NC Start
- NC Families United
- Legal Aid of North Carolina
- The Arc
- NAMI
- Remember to use people first language.

23

Questions?

24

Appellate Review: Lessons from Commitment Appeals

Civil Commitment Conference
January 23, 2015

David Andrews, Assistant Appellate Defender

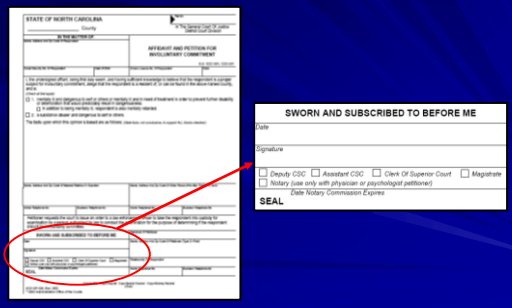
All the Process that is Due…

- "Civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection." *Addington v. Texas*, 441 U.S. 418, 426, 60 L. Ed. 2d 323, 300-31 (1979).
- Juvenile respondents in commitment hearings are "entitled to the protection of due process…." *In re Long*, 25 N.C. App. 702, 707, 214 S.E.2d 626, 629 (1975).

The Affidavit and Petition

- The affidavit must be confirmed by oath or affirmation.
- The affidavit must contain facts indicating that the respondent is mentally ill, and:
  - Dangerous to herself or others, or
  - Would predictably become dangerous without treatment.
- The petition and affidavit can be based on hearsay.

The Affidavit and Petition



STATE OF NORTH CAROLINA

County

AFFIDAVIT AND PETITION FOR INVOLUNTARY COMMITMENT

SWORN AND SUBSCRIBED TO BEFORE ME

Date

Signature

☐ Deputy CSC ☐ Assistant CSC ☐ Clerk Of Superior Court ☐ Magistrate

☐ Notary (use only with physician or psychologist petitioner)

Date Notary Commission Expires

SEAL

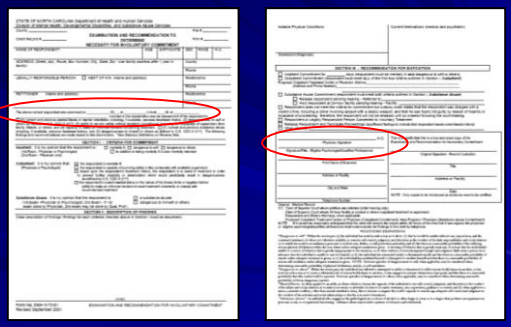
The Affidavit and Petition

- Be sure to scrutinize the affidavit for defects.
- If the respondent does not challenge the affidavit at the first commitment hearing, he may not challenge the affidavit on appeal or at a re-commitment hearing. *In re Moore*, ___ N.C. App. ___, 758 S.E.2d 33 (2014).

The Examination Process

- First Examination: The respondent must be examined by a doctor or psychologist within 24 hours of arrival at a facility.
- Second Examination: The respondent must be examined by a doctor within 24 hours of arrival at a 24-hour facility.
- If the State fails to complete the second examination, the case is subject to dismissal under *In re Barnhill*, 72 N.C. App. 530, 325 S.E.2d 308 (1985).

The Examination Process



The Examination Process

- If you do not receive both reports, file a motion to dismiss based on a defect in the examination process.
- Be sure to argue about prejudice. In *In re Spencer*, ___ N.C. App. ___, 762 S.E.2d 637 (2014), the Court of Appeals found no prejudice from the lack of a report.
- You have a right to examination reports under N.C. Gen. Stat. § 122C-54.
- Prejudice could include the inability to prepare for the commitment hearing.

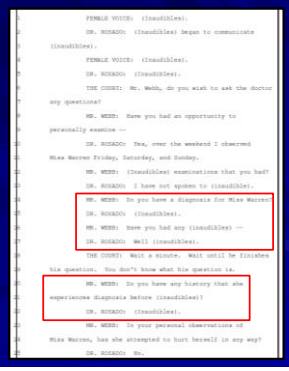
An Expert for the Respondent

- Respondents can request funds for their own expert. *In re A.N.B.*, ___ N.C. App. ___, 754 S.E.2d 442 (2014).
- You must show either that (1) the motivations of the testifying experts are suspect or (2) there is a specific reason, apart from standard reasons, for the expert.
- A respondent can request an expert if he believes the State's experts are "biased and prejudiced." *People v. Burns*, 209 Ill. 2d 551, 569, 809 N.E.2d 107, 119 (2004).

The Commitment Hearing

- Remember to speak clearly and loudly during the commitment hearing.
- Please help ensure that the recording equipment works properly.
- If the equipment is old or broken, the transcripts of commitment hearings will be incomplete.

The Commitment Hearing



FEMALE VOICE: (Inaudible).

DR. ROSADO: (Inaudible) began to communicate (inaudible).

FEMALE VOICE: (Inaudible).

DR. ROSADO: (Inaudible).

THE COURT: Mr. Webb, do you wish to ask the doctor any questions?

MR. WEBB: Have you had an opportunity to personally examine --

DR. ROSADO: Yes, over the weekend I observed Miss Warren Friday, Saturday, and Sunday.

MR. WEBB: (Inaudible) examinations that you had?

DR. ROSADO: I have not spoken to (inaudible).

MR. WEBB: Do you have a diagnosis for Miss Warren?

DR. ROSADO: (Inaudible).

MR. WEBB: Have you had any (inaudible) --

DR. ROSADO: Well (inaudible).

THE COURT: Wait a minute. Wait until he finishes his question. You don't know what his question is.

MR. WEBB: Do you have any history that she experiences diagnosis before (inaudible)?

DR. ROSADO: (Inaudible).

MR. WEBB: In your personal observations of Miss Warren, has she attempted to hurt herself in any way?

DR. ROSADO: No.

HOW TO SAVE YOURSELF FROM

ETERNAL HELLFIRE

Preserving Errors for Appeal

- Object to any evidence that you suspect is inadmissible.
- Provide specific grounds for your objections.
- Constitutionalize your objections, motions, and arguments.
- Make an offer of proof if the court prevents you from presenting evidence.

Preserving Errors for Appeal

- "Heretofore, this Court has limited the application of the plain error doctrine to appeals in criminal cases, and we decline to apply it in appeals in civil cases." *Durham v. Quincy Mut. Fire Ins. Co.*, 311 N.C. 361, 367, 317 S.E.2d 372, 377 (1984).
- Bottom Line: If you fail to properly object to errors in district court, the client will not be able to raise those errors on appeal.

Do the Rules of Evidence Apply to Commitment Hearings? Yes

- Evidence Rule 1101: "Except as otherwise provided in subsection (b) or by statute, these rules apply to all actions and proceedings…."
- Subsection (b) does not discuss commitment hearings.
- N.C. Gen. Stat. § § 122C-224.3 and 122C-268 do not address the Rules of Evidence.
- Compare to N.C. Gen. Stat. § 15A-1345 (Probation Revocation Hearings): "Formal rules of evidence do not apply at the hearing."

Common Evidentiary Objections

- Hearsay
- Relevance
- Lack of Personal Knowledge
- Improper Opinion

The Right to Confrontation

- Under N.C. Gen. Stat. § § 122C-224.3, 122C-268, and 122C-286, the respondent's right to confrontation "may not be denied."
- If a court admits a report, it must permit the respondent to cross-examine the author.

The Right to Confrontation

- *In re Benton*, 26 N.C. App. 294, 215 S.E.2d 792 (1975).
- *In re Hogan*, 32 N.C. App. 429, 232 S.E.2d 492 (1977).
- *In re Mackie*, 36 N.C. App. 638, 244 S.E.2d 450 (1978).
- *In re C.W.F.*, No. 84PA14.

The Right to Confrontation

- If you decide not to subpoena the author, that does not mean that you waive the right to question the author.
- The State or facility carry the burden of proof and, thus, the burden of issuing subpoenas.
- The power to subpoena witnesses "is no substitute for the right of confrontation." *Melendez-Diaz v. Massachusetts*, 557 U.S. 305, 324, 174 L. Ed. 2d 314, 330 (2009).

The Right to Confrontation

- Subpoenas are governed by Rule 45 of the NC Rules of Civil Procedure.
- The AOC has created a fillable subpoena form available on the AOC website under the number: AOC-G-100.
- Objections to subpoenas include the lack of reasonable time to comply with the subpoena, undue burden, and procedural defects associated with the subpoena.

The Right to Confrontation


STATE OF NORTH CAROLINA

SUBPOENA

Limiting Expert Testimony

- Purpose of Expert Testimony: To help fact-finders decide questions based on the expert's "specialized knowledge."
- Do not let the expert testify outside of her area of expertise.
- Do not let the expert convey hearsay statements as substantive evidence.
- Do not let the expert testify that the respondent is dangerous.

Limiting Expert Testimony

- An expert may rely on hearsay statements to formulate an opinion, but the court may not rely on the statements for their truth.
- Out-of-court statements relied on by an expert are admissible "to show the basis for the expert's opinion." *State v. Huffstetler*, 312 N.C. 92, 107, 322 S.E.2d 110, 120 (1984).
- "We emphasize again that such testimony is not substantive evidence." *State v. Wade*, 296 N.C. 454, 464, 251 S.E.2d 407, 412 (1979).

Limiting Expert Testimony

(11) "Dangerous to himself or others" means:

a. "Dangerous to himself" means that within the relevant past:

1. The individual has acted in such a way as to show:

I. That he would be unable, without care, supervision, and the continued assistance of others not otherwise available, to exercise self-control, judgment, and discretion in the conduct of his daily responsibilities and social relations, or to satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety; and

II. That there is a reasonable probability of his suffering serious physical debilitation within the near future unless adequate treatment is given pursuant to this Chapter. A showing of behavior that is grossly irrational, of actions that the individual is unable to control, of behavior that is grossly inappropriate to the situation, or of other evidence of severely impaired insight and judgment shall create a prima facie inference that the individual is unable to care for himself; or

2. The individual has attempted suicide or threatened suicide and that there is a reasonable probability of suicide unless adequate treatment is given pursuant to this Chapter; or

3. The individual has mutilated himself or attempted to mutilate himself and that there is a reasonable probability of serious self-mutilation unless adequate treatment is given pursuant to this Chapter.

Previous episodes of dangerousness to self, when applicable, may be considered when determining reasonable probability of physical debilitation, suicide, or self-mutilation.

b. "Dangerous to others" means that within the relevant past, the individual has inflicted or attempted to inflict or threatened to inflict serious bodily harm on another, or has acted in such a way as to create a substantial risk of serious bodily harm to another, or has engaged in extreme destruction of property; and that there is a reasonable probability that this conduct will be repeated. Previous episodes of dangerousness to others, when applicable, may be considered when determining reasonable probability of future dangerous conduct. Clear, cogent, and convincing evidence that an individual has committed a homicide in the relevant past is prima facie evidence of dangerousness to others.

Limiting Expert Testimony

- A social worker can be qualified as an expert in the diagnosis and treatment of mental illness. *In re A.N.B.*, ___ N.C. App. ___, 754 S.E.2d 442 (2014).
- Be sure the social worker has sufficient experience or knowledge to testify about mental illness.
- Be sure the social worker was able to form an independent opinion based on reliable sources.

The Old Rule 702

An expert opinion is admissible if:

- The expert's proffered method of proof is sufficiently reliable as an area for expert testimony.
- The witness testifying at trial is qualified as an expert in that area of testimony.
- The expert's testimony is relevant.

The New Rule 702

An expert opinion is admissible if:

- The testimony is based upon sufficient facts or data.
- The testimony is the product of reliable principles and methods.
- The witness has applied the principles and methods reliably to the facts of the case.

The New Rule 702

- The standards under the old rule were flexible.
- The standards under the new rule are exacting and stringent.
- *State v. McGrady*, No. 72PA14.

The New Rule 702

- Testimony is excludable under the new Rule 702 if the witness merely parrots the opinion of another person.
- If the witness forms an independent opinion by applying well-established criteria to the respondent's symptoms, it is admissible under the new Rule 702.
- Reliable sources for expert opinions likely include the DSM, empirical studies, and peer-reviewed articles.

Constitutional Arguments

- The doctrine of waiver applies to involuntary commitment cases. *See In re Hayes*, 139 N.C. App. 114, 120, 532 S.E.2d 553, 557 (2000).
- "[A] constitutional question which is not raised and passed upon in the trial court will not ordinarily be considered on appeal." *State v. Hunter*, 305 N.C. 106, 112, 286 S.E. 2d 535, 539 (1982).
- If you do not include due process in motions, objections, and arguments, the respondent cannot raise due process in the Court of Appeals.

Offers of Proof

- An offer of proof enables the appellate court to determine what the excluded evidence was.
- Without an offer of proof, the appellate court can only guess as to what the evidence might have shown.
- Summarizing what the evidence would have shown is no substitute for an offer of proof.

Sufficiency of the Evidence

- Dangerous to self: There is a reasonable probability the respondent will suffer serious physical debilitation within the near future unless adequate treatment is given.
- Dangerous to others: There is a reasonable probability that the respondent's behavior will be repeated.
- *In re Whatley*, ___ N.C. App. ___, 736 S.E.2d 527 (2012).

Disposition

- When the court enters judgment, make sure that the commitment period is proper.
- Challenging an improper period on direct appeal will be deemed moot.
- Challenging an improper period at a re-hearing is prohibited. *In re Webber*, 201 N.C. App. 212, 222, 689 S.E.2d 468, 476 (2009).

Disposition

- If the commitment period is too long, ask the judge to order a proper commitment period.
- File a motion for a supplemental hearing to correct the commitment period.

Notice of Appeal

- It must be entered within 30 days of judgment.
- It must be written.
- It must specify the judgment from which the appeal is taken
- It must specify that the respondent is appealing to the Court of Appeals.
- It must contain proof of service.

Order of Appellate Entries


STATE OF NORTH CAROLINA

_____ County

In The General Court Of Justice
District Court Division

IN THE MATTER OF:

APPELLATE ENTRIES
INVOLUNTARY COMMITMENT

INITIAL APPEAL ENTRIES


ORDER OF TRANSCRIPT

RECEIPT AND NOTICE

THIRTY DAY EXTENSION OF TIME TO PREPARE TRANSCRIPT

THIRTY DAY EXTENSION OF TIME TO SERVE PROPOSED RECORD ON APPEAL

CERTIFICATION