NC TIDE

North Carolina Training, Instruction, Development, and Education (NC TIDE)

MARCH 2013

Spring Issue

Volume 2 Issue 1

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Special Interests:

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Attending NC TIDE's 2013 Spring Conference

April 28 – May 1, 2013

Visit www.nctide.org to see which sessions will have CEU's available

A Message from the President

Jill Queen, 2013 NC TIDE President

Greetings,

Spring time has arrived in North Carolina. During Spring, many changes occur in the environment around us. These changes are not just limited to blooming flowers, warm weather, and leaves on the trees. Changes are occurring in the state as the new Governor, Secretary of DHHS, and Director of DMA set their plans for the state and behavioral health into action. Legislators are currently in session making key decisions on the state budget and funding for behavioral health. North Carolina continues to move forward on a course of streamlined government and a mission of customer service. Notwithstanding these changes, the service delivery system in North Carolina continues its' evolution with the final phases of Waiver Expansion to additional areas and emergence of more Managed Care Organizations (MCOs) across North Carolina.

As changes happen, the key to survival and success includes access to information, education and training. NC TIDE offers these survival tools. As an organization, NC TIDE strives to achieve our mission statement of "***A Tradition of Excellence in Providing Training and Promoting Professionalism"***. NC TIDE believes in customer service and strives to meet the training needs of NC TIDE members, consumers, families, providers, MCO staff, board members, advocates, and state government. NC TIDE welcomes your input and feedback on how our organization can better meet the needs of the behavioral healthcare community.

The committee has made a continued effort to listen to your feedback and offer sessions that meet the needs of the behavioral health community and include sessions that interest providers, LME/MCO staff, board members, and advocates. The NC TIDE Planning Committee has worked hard to put together an exceptional conference by offering more sessions with continued education credits, topics related to care coordination, information about the Department of Justice settlement, Institute of Mental Disease and the new personal care service rules along with many more informative session topics. The NC TIDE **Spring 2013 Conference** will be held in Wilmington, NC from April 28-May 1, 2013 at Hilton Wilmington Riverside. The Spring 2013 Conference provides an excellent venue for providers, LME/MCO staff, board members, advocates and, stakeholders to be trained together and to re-connect or establish new professional networking relationships.

NC TIDE is extremely excited about the conference. We are confident that you will want to attend the conference to take advantage of the opportunities to learn together. So, come join us in Wilmington for an informative and successful Spring Conference. Thank you again for all your support; I look forward to seeing each of you in Wilmington!

Jill Queen, President
NC TIDE

NC TIDE would like to thank Daymark Recovery Services for providing the CEU training sessions. If your organization would like to partner with NC TIDE for providing CEU training at future conferences, please see committee members Cathy Macemore, Jill Queen, or Marilyn Brothers.

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NC TIDE NEWS

New for the 2013 NC TIDE Spring Conference: While collaborating with Daymark Recovery Services on a training session for the NC TIDE spring conference, both NC TIDE and Daymark recognized an opportunity to bring CEU awarded training sessions to the participants of NC TIDE. NC TIDE has desired to provide CEU sessions to participants for many years; however, time constraints on a volunteer association and attempts to keep registration fees low have until now prevented this desire from becoming a reality until now. NC TIDE thanks Daymark Recovery Services for assisting in this endeavor. Their sponsorship of the CEU's provides a much requested service to participants. NC TIDE would welcome other partnerships of this nature. If your organization would like to discuss this please see: Cathy Macemore, Jill Queen, or Marilyn Brothers, NC TIDE Committee.

As our Spring conference draws near, NC TIDE appreciates the support of our membership and the continued support from LME/MCOs, consumers, families, provider agencies, advocates, and state offices such as the Division of Mental Health Developmental Disabilities and Substance Abuse Services, Division of Medical Assistance, and UNC School of Government.

The NC TIDE Committee would like to say ***THANK YOU*** to Linda Hawley Isbell for her service to NC TIDE. Linda has resigned as QM Chair. We appreciate all her contributions to NC TIDE and wish her well in all her endeavors.

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NC TIDE is excited to report that the NC TIDE officers and committee members have voted Kim Keehn to serve as the new QM Chair for NC TIDE. Kim has been an integral part of NC TIDE and she is well versed in QM issues.

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NC TIDE welcomes a new Eastern Representative for the NC TIDE Committee. Krissy Vestal, ECBH Data Manager, has been selected as the new Eastern Representative.

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NC TIDE welcomes Mike O'Connor, New Hope Treatment Center to our Training Development Committee. His insight in provider training needs will be an asset to NC TIDE.

NC DHHS Receives $1 million to Extend Successful Program in Robeson County

By Chris Pfitzer, MA, Communications Specialist
N.C. Division of Mental Health, Developmental Disabilities and Substance Abuse Services

North Carolina was one of eight states selected to receive a $1 million grant extension from the U.S. Department of Health and Human Services (US DHHS) from forty-three qualified applicants. The grant will benefit the Robeson County Bridges for Families Program, a regional partnership focused on improving the well-being of children and families affected by parental substance abuse.

"The original US DHHS Administration for Children and Families grant was received in 2007 and established the Robeson County Bridges for Families Program," said Jim Jarrard, acting director of the N. C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS). "The grant extension will enable the program to continue and grow for at least two additional years."

The program is made up of a network of service agencies and public officials who are dedicated to supporting families where one or more of the parents or caregivers have issues with substance abuse and the family was referred to the Robeson County Department of Social Services.

Over the course of five years, strong partnerships were built between key state-level agencies and divisions, including but not limited to North Carolina Division of Social Services; DMH/DD/SAS; the North Carolina Administrative Office of the Courts; the Governor's Institute on Substance Abuse; and the University of North Carolina at Chapel Hill.

At the local level parallel partnerships were built and strengthened between social services, the court system, treatment providers, the guardian ad litem program, the local management entity, the domestic violence program, the university and public school systems, the Lumbee Indian Tribe, along with public health and law enforcement.

"A core group of about 15 partners in Robeson County communicate and meet regularly to assure the human service system and its community partners are working effectively on behalf of families," said Starleen Scott Robbins, program coordinator with the DMH/DD/SAS. "On an annual basis, community and elected officials in Robeson County also gather to review the program's progress."

With input from the North Carolina Practice Improvement Collaborative (NC PIC), four evidence-based treatment practices were selected and implemented in Robeson County as part of the project. In addition, a new family drug treatment court was established under the leadership of Judge Stanley Carmical. Community leaders and champions in Robeson County have engaged the whole community and established a collaborative that has received national recognition. More than 50 community businesses, faith groups, and individuals have donated to support events such as health fairs, client graduations, and the Strengthening Families Program partners.

Agencies working with the Robeson County Bridges for Families Program are dedicated to helping parents and children get the treatment and other services they need so that families can be stable and so that the children can live safely with their parents or caretakers. The Robeson County Bridges for Families Program serves as a model for statewide strategic planning efforts to support recovery oriented systems of care that enhance outcomes for children and families affected by parental and caretaker substance abuse.

Over the next two years project leaders and individuals who have graduated from the program will continue to meet to explore ways to improve services and outreach to graduates as part of ongoing recovery support, and will be engaged in sustainability planning for this successful recovery-oriented system of care.

The Shame Associated with Mental Illness

Submitted By: Arelys Chevalier, MSSW, LCSW
Cardinal Innovations Healthcare Solutions

I grew up in a middle class religious environment where mental health problems were a source of shame for the afflicted and embarrassment for the family and even friends. This was even worse for men for whom any affliction was interpreted as weakness and lack of "macho". The presence of any mental health condition was kept in secret as if it were a defect or a punishment for perversity or evil and should be kept buried. That is the reason why even when there were economic means to see a doctor or mental health professional one turned instead to home remedies such as medicinal teas, herbal baths, and or the advice of a close relative or the local folk healer. When none of these brought relief then one would go to a priest, or church pastor. Inevitably these religious officials recommended increased faith and trust that the Almighty would take away these maladies which were making life into a living hell. Then if one did not get relief through faith, prayers, promises and sacrifices, one felt even more desperate, feeling abandoned and with a greater sense of shame, because apparently not even the Almighty and Saints were responding with aid.

Those who have not experience the agony of depression and other mental health issues have no idea of the overwhelming feelings that accompany these illnesses. They cannot imagine what it is like to wake up in the morning feeling exhausted, powerless and hopeless; defeated by self-hatred, and shame. Hope comes only in the form of being able to sleep indefinitely to escape and sometimes death turns into a goal.

The stigma of evil and degradation attributed to emotional and behavioral problems traces back as far back as one wants to research; and it has always been met by fear and disgust. In times past the "treatments" modalities that were used would make even the sane go mad. These beliefs and treatments are not limited to Latino cultures. In Europe during the Middle Ages, mentally ill people were burned at the stake in front of spectators who cheered with enthusiasm and noise. Around 1840 in the United States people with mental illnesses were imprisoned in dark wet and cold cellars, kept naked in near starving conditions and in the company of vile criminals.

Fortunately even as far back as 400 B.C. illustrious people like the Greek doctor, Hippocrates have postulated that mental illnesses have their roots in the physical body. Other celebrated scientists such as Emil Kraepelin, Clifford Beers and Sigmund Freud have theorized and supported their theories with empirical research. Their findings attest to the fact that mental illness is caused by toxic environments, poverty, trauma, physiological disorders and combinations of these. In Modern times it has been demonstrated that brain changes result in abnormal conduct. These breakthroughs challenge beliefs and attitudes rooted in ignorance and fear hundreds of years ago and now.

Mental illnesses/behavioral problems are not character defects, laziness, drama or deserved punishment for evil deeds. People of good moral character, hardworking and religious develop mental problems at the same rate as the rest. Expecting to be cured by deepening one's spirituality, strengthening one's personality or repenting from sins is a grave mistake. Anyone experiencing behavioral problems needs professional treatment by qualified and compassionate professional(s). Modern medicines have "miraculous" effects and most are not addictive. If you or a loved one is experiencing a problem of this sort, please seek professional services.

Immigrants are more vulnerable to emotional problems due to the multiple stressors and changes that are required to survive and strive in a new environment. We have to face a way of life totally different to what we are used to. Even the "small" things turn into huge struggles, things like shopping for food, transportation, school system for our children, the different climate, different language, the separation from country and family, and discrimination and more. Trauma, isolation and loneliness are major contributors to mental illness yet they are part and parcel of everyday life for immigrants. Additionally, immigrants who are here without the proper visas ("papers") have an additional insurmountable burden and live under stress and panic to be deported or jailed simply because they are here searching for a better life. Hispanics/Latinos and people of all races, countries and socioeconomic backgrounds experience mental illness; however, these individuals often let myths based on ignorance keep them from being well.

Cardinal Communications Handedness

Submitted By: Patrick Chang, Cultural Competence Practice Manager
Cardinal Innovations Healthcare Solutions

As a righty, I was drawn to the left side by a Time magazine cover story about a study that Lefties had a shorter life span than righties. The article went into great detail about how our right-handed world, only 10-15% of the population is left handed, discriminates against lefties. As someone who wears glasses, I ask others with a visual impairment, if they ever paid attention to their prescription and whether or not they knew the significance of the letters O.D. and O.S.? Most say "No." The O is Oculus = eye, The D is Dexter = Right. And, the S is Sinister = Left. The very origin of the word in Latin conjures up a negative connotation. Let's look at a few other languages. In Spanish, some may be familiar with izquierda for left but not many know the word zurdo. In French it is understood that if you are gauche, you are crude or awkward.

The Mandarin Chinese character for *left* is 左 (pronounced zuǒ). It is composed of two elements - the radical 工 (gōng - meaning *worker* or *work*) and a stylized version of the character for *hand* - 手 (shǒu). The character 工 is a pictograph representing a carpenter's square. So you could interpret 左 as a left hand holding a square. Compare this character with 右 (yòu), which means *right*. Both of these characters depict a hand, in the case of 右 combined with a mouth, which reminds us that it is common to eat with the right hand. (Wikipedia.org)

In many societies, the left hand is used for cleansing oneself and the right hand is for eating. There are Biblical references to the left hand. In Matthew 25:32-33 *Before him all the nations will be gathered, and he will separate them one from another, as a shepherd separates the sheep from the goats. He will set the sheep on his right hand, but the goats on the left.* There is also the story of Ehud a left-handed Benjamite who personally killed Eglon the fat king of Moab (Judges 3:21-22) He led in the slaying of 10,000 Moabites (3:29). The story goes that Ehud went to meet his enemy Eglon. They shook right hands, but since Ehud was a Lefty, he pulled his sword and took Eglon's life. Therein also lays the origin of the handshake. It was a gesture of peace demonstrating that the two parties did not have a weapon in their right hands.

Every time I do a presentation about lefties, invariably, there is one person who tells the story of having his/her left hand tied or a nun beating him/her to force him/her to use the right hand. In the game of baseball, lefties are limited to first base, pitcher and the outfield. I always ask if a Lefty had designed the game of baseball, to which base would a Lefty run after hitting the ball?

These are the names of some noteworthy Lefties and their contributions:

Jimi Hendrix – first to rearrange the strings on a guitar to suit Lefties

Leonardo DaVinci – wrote his manuscripts from right to left to maintain secrecy

Michelangelo – painted the Sistine Chapel and as one hand tired he changed to the other

Golf – Only about 2-3% of golfers are Lefties. Such well-known professional golfers as Nick Price, Johnny Miller, and Curtis Strange are natural left-handers, but learned to play the game right-handed! Bob Charles was the first Lefty to win a major. Charles who hails from New Zealand won the 1963 British Open Championship. Canadian Mike Weir became the second left-handed player to win a major when he won the 2003 Masters. (www.phil-fanatics.com)

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Handedness, as the dominance of one hand over the other is called, provides a window into the way our brains are wired, experts say. And it may help shed light on disorders related to brain development, like dyslexia, schizophrenia and attention deficit hyperactivity disorder, or ADHD, which are more common in left-handed people.

Other recent research suggests that mixed-handedness—using different hands for daily tasks and not having a dominant one—may be even more strongly linked than left-handedness to ADHD and possibly other conditions.

About 10% of people are left-handed, according to expert estimates. Another 1% of the population is mixed-handed. What causes people not to favor their right hand is only partly due to genetics—even identical twins, who have 100% of the same genes, don't always share handedness.

More important, researchers say, are environmental factors—especially stress—in the womb. Babies born to older mothers or at a lower birth weight are more likely to be lefties, for example. And mothers who were exposed to unusually high levels of stress during pregnancy are more likely to give birth to a left-handed child. A review of research, published in 2009 in the journal Neuropsychologia, estimated that about 25% of the variability in handedness is due to genetics.

• Left-handed people make up about 10% of the population, while 1% of the population appears not to be dominant with either hand, known as mixed-handed.

• Being left-handed is only partially genetic.

For reasons not clearly understood, handedness depends mainly on how a baby's brain develops while in the womb.

• On average there is no difference in intelligence between right-and left-handed people. But lefties do better on an element of creativity known as divergent thinking.

• Six of the last 12 U.S. presidents, including Barack Obama and George H. W. Bush, have been lefties.

• Left-handed people earn on average 10% lower salaries than righties, according to a recent study. Findings of some earlier studies on income have been mixed.

• Despite popular misperceptions, lefties aren't more accident prone than right-handed people and don't tend to die at a younger age.

• Left-handedness has been linked to increased risk of certain neurodevelopmental disorders like schizophrenia and ADHD. Mixed-handedness is even more strongly associated with ADHD.

• Most people's brains have a dominant side. More symmetrical brains of mixed-handed people may explain the link to some neural disorders. On average there is no significant difference in IQ between righties and lefties, studies show, belying popular perceptions. There is some evidence that lefties are better at divergent thinking, or starting from existing knowledge to develop new concepts, which is considered an element of creativity. And left-handed people have salaries that on average are about 10% lower than righties, according to recent research.

(As reported in the Wall Street Journal -Tuesday, December 6, 2011)

The Good Lives Model as Best Practice for the Treatment of Sexually Aggressive Youth

Submitted By: Sam E. Phifer, LCSW, Executive Director
New Hope Carolinas

The Good Lives Model (GLM) of offender rehabilitation, initially developed by Tony Ward and his colleagues in 2003, is now emerging as a best practice model for the treatment of sexual offenders. This model, which is now integrated with Ward and Hudson's Self-Regulation Model (SRM), offers a unique and comprehensive approach to the rehabilitation of sexual offenders. Since its introduction, the GLM has quickly gained international attention as a useful theory and practice model for general offender rehabilitation. New Hope Treatment Centers began incorporating both models into practice in 2006, and now views this integrated, strength- based approach as the cornerstone of treatment for adolescents with sexually offensive behavior problems.

Over the past 25 years or so, the predominate practice approaches used with juvenile sexual offenders consisted of traditional risk-based approaches, primarily Relapse Prevention (RP) and the Risk Needs Responsivity (RNR) models. While the GLM acknowledges the value of traditional risk-based approaches, it also recognizes that a risk-focused approach is insufficient to address all of the treatment needs commonly seen in this population. For decades, RP and RNR approaches to treatment were seen as best practice and few providers questioned their efficacy or bothered to venture beyond their limitations. The GLM outlines a patient-centered, holistic approach to rehabilitation, which emphasizes the qualities of life that are important to the client. Ward defines these qualities as" Primary Goods". The model also examines the concrete activities one uses to obtain these Primary Goods. These activities are defined as "Secondary Goods". The goal(s) of therapy when utilizing the GLM include; determining the Primary Goods that are important to the client and reinforcing their importance, helping the client see and overcome barriers to obtaining these goods, helping the client understand the relationship of primary goods to their offending behavior, and ultimately building each client's capacity to attain the goods they want in socially acceptable, non-offensive ways.

This client-centered process draws upon the strengths of the client, which is counter to the traditional problem focused, or diagnosis-driven approach to care and treatment. In our experience at New Hope, clients appreciate this radical shift in how they are approached in treatment, and as a result are more motivated to engage and participate in treatment. From a research and common sense approach, we know that the level of internal motivation or engagement in the treatment process is directly related to positive outcomes, so in that regard alone, the GLM starts out light years ahead of the traditional risk-based models. This model also promotes a Rogerian style by promoting autonomy, focusing on strengths, and maintaining unconditional positive regard for the client. The style and underpinnings for the Good Lives model are not only a very comfortable fit for most clinicians, but we know from research and practice that clients respond better to this type of approach. In addition, the GLM allows practitioners to move beyond the traditional, stigmatized risk-based approach, which focuses solely on preventing the problematic behavior of sexual offending. The Good Lives Model challenges

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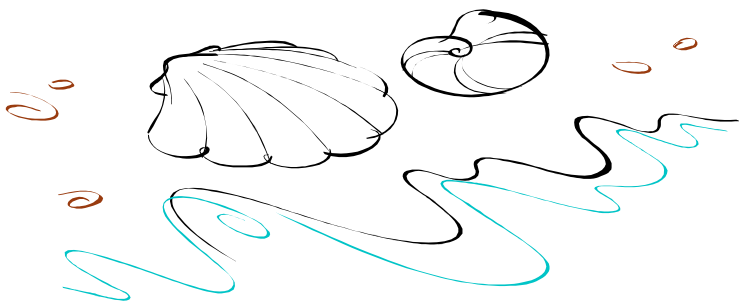
clients to look at core schemas and the ways in which clients go about getting their needs met in general. By shifting away from constant attention in therapy being paid to the highly stigmatized deviant sexual behaviors, and instead looking at more general beliefs and problem- solving techniques, practitioners at New Hope report being better able to keep clients engaged in and motivated for treatment. This a critical leap forward in ensuring clients complete treatment and benefit from the experience. Adolescents in treatment at New Hope demonstrate excitement when discussing their life ambitions, and enjoy working with their families to develop better "Good Lives Plans". The improved motivation and comfort with therapy is a fresh change for those of us who struggled for years in helping adolescents get comfortable discussing relapse prevention strategies, particularly when we require them to discuss their sexual deviance with parents and caregivers. The Good Lives Model gives us a positive window into therapy, and offers a therapeutic route to help our clients explore their lives in great detail, without needing to pay constant attention to the problem behavior which typically brought them to treatment.

Best practice is typically defined as "the methods or techniques which are widely accepted by the experts in the field of study". It's easy to see how the basic underpinnings of the GLM fit this definition of best practice. Nowadays, therapists almost universally embrace a Rogerian style and strength-based approach. For example, Motivational Interviewing is gaining widespread attention as a best- practice technique, by emphasizing the value of getting and keeping clients engaged in treatment by simply focusing on the ambivalence they are experiencing regarding change. Using a holistic model that helps clients change core beliefs and build better coping strategies intuitively makes sense as best practice. The Good Lives Model incorporates all of these well-accepted philosophies and strategies. It provides a comprehensive theory, guides clinical practice, embraces client's strengths, and works to help each person develop a comprehensive plan for improving his/her life.

Sam E. Phifer, LCSW

Sam is the Executive Director at New Hope Carolinas, a 150-bed Psychiatric Residential Treatment Facility located in Rock Hill SC. New Hope Carolinas is accredited by the Joint Commission, and specializes in behavioral healthcare for adolescents. For more information on New Hope Treatment Centers, visit our website at www.newhopetreatment.com



MINDFULNESS

By Karen S. Holst, MSW, LCSW, EdD and Jude Johnson MA, LMFT
Monarch

Jon Kabat-Zinn, the founder of the Mindfulness Based Stress Reduction (MBSR), defines mindfulness as a particular way of paying attention; on purpose, in the present moment, nonjudgmentally. MBSR takes a holistic approach to health and wellness by embracing the mind/body connection through teaching participants the practice of mindfulness, meditation, and gentle yoga which have shown to reduce the impact of stress and illness. The research on MBSR shows significant benefits to those with mental illnesses, medical conditions, chronic pain, and substance abuse. While the literature shows promise in reducing symptoms with a variety of mental and medical conditions, it also has shown to be effective with non-symptomatic individuals. Research conducted using brain imaging technology such as functional magnetic resonance imaging, have demonstrated changes in gray matter concentration in the areas of the brain involved in learning, memory processing, emotion regulation, and perspective taking. In other words, practicing mindfulness regularly is associated with structural changes in the brain which lead to emotional stability and a more positive outlook. Other benefits include an increase in the immune system's ability to ward off disease, a reduction in stress and stress hormones, such as cortisol, and an improvement in one's overall happiness and well-being.

According to the Centers for Disease Control, up to 90% of all doctor's visits in the United States are stress-related. Stress has a direct impact on physical and mental health, quality of life, and over-all well-being. Stress directly impacts individual's performance in the form of absenteeism, litigation, grievances, accidents, errors of judgment, conflict, interpersonal problems, violence, and customer-service difficulties. The current demand for employers to "do more with less," facing economic uncertainty, and being tasked to be more effective with less funding, have forced many in the healthcare system to revisit current practices. Mindfulness has proven successful in corporate wellness programs and has been adopted by companies such as Apple, Google, AstraZeneca Pharmaceuticals, and General Motors. MBSR has recently been added to the SAMHSA's National Registry of Evidenced Based Programs and Practices for an evidenced based preventive intervention." MBSR is a preventative, cost-effective intervention designed to assist individuals in recognizing and nurturing one's own capacity for self-healing. MBSR is an intervention which can be applied to businesses and employees experiencing stress but is also equally suited to engage the community as a whole. Mindfulness is utilized by a variety of populations including, but not limited to, medical students, health care professionals, business professionals, military personnel, caregivers, students, prisoners and those with mental or physical illnesses.

While MBSR is an excellent vehicle to learn, implement and maintain a mindfulness practice, you don't have to take a MBSR course to practice mindfulness. It should be noted that if you are going to practice present moment awareness or mindfulness, that it is equally important to do so with an attitude that is friendly and kind towards yourself. Our minds are often avoiding the present moment by forecasting the future or rehashing the past. The mind's tendency to frequently want to be somewhere other than here can cause stress, especially when one is making an effort to cultivate present moment awareness. This constant wandering of the mind highlights the importance of practicing self-compassion when bringing the attention back to the present moment, over and over again. You can see how this process could easily become very self-critical. Beginners to mindfulness tend to think they are not doing it right because their minds are wandering. The good news is that it is normal for your mind to wander and this even happens to the most experienced mindfulness practitioners. The practice of mindfulness asks that you notice where your attention has wandered, and invite yourself to return to the intended object of awareness e.g. feeling of the breath, hearing, seeing, eating, etc. Here are a couple of practical ways you can apply mindfulness in your daily life.

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STOP exercise

1. S: Stop
2. T: Take a breath
3. O: Observe what is happening in the moment non-judgmentally e.g. thoughts, feelings, bodily sensations, other senses (touching, tasting, seeing, hearing and smelling)
4. P: Proceed with presence moment awareness

Let's say you are at your computer and you read an email evoking feelings of stress and tension. Before responding to the email, stop what you are doing, bring awareness to the feeling of your breath coming in and out, and observe what is happening with thoughts, feelings and senses. Notice any areas of unnecessary tension in the body (where are your shoulders? Up around your ears?). Proceed with present moment awareness while paying particular attention to the transitions in thinking and feeling states. You can practice the STOP exercise as often as you can remember throughout the day. A stressor is not a prerequisite for practicing mindfulness and most wisely implemented as often as possible. Some people have found mindfulness to be so valuable that they set an alarm on their cell phone or computer at set time intervals in the day as a reminder to practice presence moment awareness.

Another activity which can be practiced is mindful eating. The next time you sit down to eat a meal, simply eat a meal. Leave multi-tasking for another time. Turn off the television, put away reading materials, and give this time to yourself to allow the focus to be on eating. One way to bring mindfulness to eating is to use your non-dominate hand to eat. Notice the difference you feel while eating in this manner. Bringing awareness to possible feelings of awkwardness or frustration and allowing space for the feelings that emerge. See if you can practice patience with the process and yourself, allowing the moment to unfold naturally, not attempting to add or take anything away from the experience. If this does not appeal to you, you may just want to take a mindful bite of food. To take a bite mindfully, pick up your fork or utensil of choice, observe the food, and thoughtfully pick up a moderate portion. While moving the food to your mouth, notice how your arm and hand work effortlessly to place the food in the exact location to be received by the mouth. It may be helpful to remind yourself of how difficult feeding one's self can be. Think of toddlers or those with neurological problems who have difficulty feeding themselves as a way of practicing gratitude for the capacity to feed yourself. Remembering all the human hands and effort it took for the food to reach your plate is another way to bring awareness to the food we have at our disposal that we often take for granted. Slowly place the food in your mouth, remove the utensil and allow the food to naturally rest in your mouth. Notice the sensations experienced in the mouth, body and mind when holding the food in the mouth. Take a moment as you notice any impulses to start chewing your food and then observe how your tongue seems to know to place the food in between your teeth. Observe the texture of the food, flavors, and sensations in the mouth as you slowly chew the food. Chewing the food thoroughly, approximately 20 to 30 bites before swallowing. You can eat an entire meal in this fashion or simply take a bite to experience mindfulness. The practice of mindfulness can be brought to any activity; and can be practiced with present moment awareness that fosters a kind and friendly attitude towards one's self.

Investigate the practice of using mindfulness and notice any impact it may have on how your experience of the present moment. Use the acronym STOP and mindful eating as reminders to practice present moment awareness. If you are interested in learning more about mindfulness you may want to consider the following resources:

~Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness by Jon Kabat-Zinn (May 1, 1990)
~Wherever You Go, There You Are (ROUGH CUT) by Jon Kabat-Zinn (Jan 5, 2005)
~Coming to Our Senses: Healing Ourselves and the World through Mindfulness by Jon Kabat-Zinn
http://www.umassmed.edu/cfm/stress/index.aspx

Look for more information on mindfulness and ways to incorporate it into daily life beginning next quarter in the `Mindfulness Corner'.

March is Brain Injury Awareness Month

By Chris Pfitzer, MA, Communications Specialist
N.C. Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Governor Pat McCrory has declared March as Brain Injury Awareness Month in North Carolina. During 2010, there were 68,859 traumatic brain injuries reported to the N.C. Department of Health and Human Services' Traumatic Brain Injury Program. Health officials say that number may just be the tip of the iceberg.

According to Jim Jarrard, acting director of the DHHS Division of Mental Health, Developmental Disabilities and Substance Abuse Services, there are many cases each year that go undiagnosed and, as a result, never receive treatment. Each year in the Unites States, 1.7 million people including 475,000 children will sustain a traumatic brain injury (TBI).

"Brain injuries can happen anytime, anywhere, and to anyone," Jarrard said. "Brain injuries are a serious, national public health epidemic which can result in long-term or permanent disability or death."

Traumatic brain injury is caused by a bump, blow, jolt or penetration to the head that disrupts the normal functions of the brain. In North Carolina, the leading cause of TBI is falls. Other causes include motor vehicle crashes, assaults, sports-related or occupational injuries.

It is estimated as many as 3.8 million concussions occur in the United States each year during competitive sports and recreational activities; however, as many as 50 percent of concussions may go unreported because a concussion, or mild brain injury, does not necessarily result in loss of consciousness.

Thirty percent of sports-related brain injuries happen among youth between 5 and 19 years old. Because the signs of brain injury are not always well recognized, youth may put themselves at risk for another injury.

Traumatic brain injury has also been the signature injury of the wars in Iraq and Afghanistan and is complicated by PTSD and suicide, presenting new challenges for members of the military and their families in North Carolina.

"An injury that happens in an instant can bring a lifetime of physical, cognitive and behavior challenges, said Janice White, Traumatic Brain Injury program coordinator with DMH/DD/SAS. "Early, equal and adequate access to care will greatly increase overall quality of life, and will enable individuals to return to their homes, school, work and communities."

How Do You Know If It's a Concussion?

Most people with a concussion recover quickly and fully. But for some people, symptoms can last for days, weeks, or longer. In general, recovery may be slower among older adults, young children, and teens. Those who have had a concussion in the past are also at risk of having another one and may find that it takes longer to recover if they have another concussion. Symptoms of concussion usually fall into four categories:

- Thinking/Remembering
    - Difficulty thinking clearly
    - Feeling slowed down
    - Difficulty concentrating
    - Difficulty remembering new information

[Continued on Page 13]

- Physical
  - Headache
  - Fuzzy or blurry vision
  - Nausea or vomiting
  - Dizziness
  - Sensitivity to noise or light
  - Balance problems
  - Feeling tired, having no energy
- Emotional/Mood
  - Irritability
  - Sadness
  - More emotional
  - Nervousness or anxiety
- Sleep
  - Sleeping more than usual
  - Sleeping less than usual
  - Trouble falling asleep

If you or someone you know might have a concussion or brain injury, seek the guidance of a health care professional.
Additional information and resources are available online at:
http://www.ncdhhs.gov/mhddsas/services/TBI/

The NC TIDE Committee would like to say THANK YOU to the contributors of newsletter articles for their valuable insight and information that they provide to our membership.

We would love to have YOU provide an article for the summer issue of our newsletter. Our target due date is May 22, 2013. Contact Alice Matthews at abmcms@aol.com to discuss.

NC TIDE 2013 SPRING CONFERENCE

April 28 – May 1, 2013

HOTEL INFORMATION

Wilmington Hilton Riverside
301 N. Water Street
Wilmington, NC 28401

A block of rooms have been reserved for April 27, 2013 – May 1, 2013. The special room rate will be available until March 27th or until the group block is sold out, whichever comes first.

Room Rates:
2 Double Beds Riverview – rates from 128.00 USD/Night
1 King Bed Historic View – rates from 128.00 USD/Night

Reservations can be made at: http://www.hilton.com/en/hi/groups/personalized/I/ILMNCHF-FIN-20130427/index.jhtml?WT.mc_id=POG

Group Name:	NC TIDE (Training, Instruction, Development & Education)
Group Code:	FIN
Check-in:	27-APR-2013
Check-out:	01-MAY-2013
Hotel Name:	Hilton Wilmington Riverside
Hotel Address:	301 North Water Street
	Wilmington, North Carolina
	28401-3934
Phone Number:	910-763-5900

Current Parking Fees:

Daily Parking	$5.00/Day
Overnight Parking	$7.00/Day (Group Discount)
Valet Parking	$12.00/Day

For Hotel/Reservation Questions contact: Cathy Macemore
Cathy.Macemore@dhhs.nc.gov, 910-298-7158

EXHIBITOR INFORMATION

Take advantage of the opportunity to highlight new products and services and gain beneficial marketing exposure as you speak to 325+ behavioral healthcare professionals from all over the State of North Carolina. Make sure your company is represented at the NC TIDE Spring Conference that will be held April 28-May 1, 2013 at the Wilmington Hilton Riverside in Wilmington, North Carolina.

Learn more about the various exhibitor opportunities contact: Brenda Pittman
bpittman@eastpointe.net, 910-298-7158

***Thank You** to all NC TIDE Exhibitors! The NC TIDE Conference would not be a success without the resources and financial support of our exhibitors.*

SPONSORS/EXHIBITORS

WOULD YOU LIKE TO SEE YOUR LOGO HERE?

Go to www.nctide.org for sponsorship options or contact Brenda Pittman at bpittman@eastpointe.net

CONFERENCE REGISTRATION/MEMBERSHIP INFORMATION

REGISTER EARLY FOR BEST RATES!

The 2013 Spring Conference Registration Agenda will be e-mailed mid-March. Please share the registration agenda with others in your agency and with those agencies in your network. Registration form will be included with the agenda and available on NC TIDE's website.

Remember your annual membership renewal – reduced conference rates are available for its members……so register early and become a NC TIDE member. Membership forms are available on NC TIDE website at www.nctide.org.

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Conference Registration/Membership Questions contact: Marilyn Brothers
marilynbrothers@earthlink.net, 919-740-9435

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Highlights of sessions planned for Spring 2013 conference:

- P.L.A.Y Project: Parent Training and It's Outcomes
- Healthcare Payment Reform-The North Carolina Opportunity for Better Care
- LME/MCO Performance Measurement – Community System Progress Report Measures – Details of Revised Measures
- Mindfulness and Stress Reduction – Session 1 & Session 2
- DMHDDSAS Performance Contract Reporting Requirement of LMEs: Summary of Highlights and How the Data Is Utilized
- "Gap Analysis and Need Assessments – Using Raw Data and Outcome Measurements to Create Meaningful Change in your Local MH/DD/SA Service System"
- Maintaining Consumer's Records: What you Need to Know Before you Scan Medical Records and Requirements for Retaining Consumer Records
- Successful Models of Care Coordination
- NC TRACKS Updates and Information
- DOJ Settlement – Transitions to Community Living
- I/DD Care Coordination – Success and Challenges
- IMD (Institution for Mental Disease) Determination Process
- IBNR Revisited: Educating the Board on the Big Accrual
- MH/SU Care Coordination – Being Innovative to Make an Impact
- Consolidated Personal Care Services (PCS)
- You are a MCO, Now What: What to Expect the First Year in the Clinical Functions
- Using a Carrot When You Don't Have a Stick
- ICF-I/DD in the MCO World
- Budgeting for Service Costs – A Cross Functional Responsibility
- MCO Networking
- Provider Networking

- Plus other great sessions being developed

WILMINGTON HIGHLIGHTS: Come early, stay late and enjoy what Wilmington has to offer.

Places to eat while you are in Wilmington:

Fat Tony's Italian Pub – N Front St https://fatpub.com/
Front Street Brewery – N Front St http://www.frontstreetbrewery.com/
Indochine – off Market St on Wayne Drive http://www.indochinewilmington.com/
Kilwins Ice Cream & Candy - Market St https://www.kilwins.com/
Copper Penny – Chestnut St http://www.copperpennync.com/
Cape Fear Wine & Beer – N Front St http://www.capefearwineandbeer.net/
Ruth Chris Steakhouse –located in the Hilton http://www.ruthschris.com/Restaurant-locations/
The Riverboat Landing – Market St http://www.riverboatlanding.com/
Elijah's Seafood - http://elijahs.com/index.php
The Pilot House – 2 Ann St http://www.pilothouserest.com/
Black Sea Grill – S Front St http://blackseagrill.com/
Paddy's Hollow Restaurant and Grill – located across from the Hilton in the Cotton Exchangehttp://www.paddyshollow.com/
The George on the Riverwalk – S Water St http://www.thegeorgerestaurant.com/
Caffe Phoenix – S Front St http://www.caffephoenix.com/
Firebelly Lounge – N Front St http://www.thefirebellylounge.com/Home_Page.html
Reel Café – S Front St http://www.reelcafe.net/index.php?page=Home
HIRO Japanese Steakhouse –Old Eastwood Road http://www.hirojapanesesteakhouse.com/ordereze/default.aspx
Hell's Kitchen – Princess St http://www.hellskitchenbar.com/
Oceanic Restaurant – Wrightsville Beach http://www.oceanicrestaurant.com/
BlueWater Grill – Wrightsville Beach http://www.bluewaterdining.com/events.html
Port City Chophouse – Eastwood Drive http://www.chophouse.com/

Fun Things to Do While in Wilmington:

Costello's Piano Bar – Princess Street http://www.costellospianobar.com/CosPages/CostellosCalendar.xhtml
USS North Carolina Battleship http://www.battleshipnc.com/
Arlie Gardens- Arlie Road http://airliegardens.org/
Brown Coat Theatre – Grace St http://www.browncoattheatre.com/
Ten Pin Alley Bowling – S. College Rd http://www.breaktimetenpin.com/tenpinalley.php
Cape Fear Museum of History and Science – Market St http://www.capefearmuseum.com/index.php
Cape Fear Tattoo & Arts Expo – Cape Fear Convention Center – April 26-28, 2013http://www.capefearexpo.com/
North Carolina Aquarium at Fort Fisher – Kure Beach http://www.accesswilmington.com/directory/nc-aquarium-at-fort-fisher/
Cape Fear Riverboat Cruises –Henrietta III - http://www.cfrboats.com/aboutus.html
Nutt Street Comedy Room http://www.nuttstreet.com/
Ghost Walk of Wilmington - Front & Market St http://www.wilmingtondowntown.com/go/ghost-walk-of-old-wilmington
For More Hours of Fun visit this website: http://www.wilmingtondowntown.com/explore/attractions
For Shopping in Wilmington visit this list of wonderful retail therapy:
http://www.wilmingtondowntown.com/explore/shopping