NC TIDE

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

Summer Issue

JUNE 2013

Volume 2 **Issue 2**

Inside This Issue:

Special Interests:

PLAN TO JOIN US FOR THE NC TIDE FALL 2013 CONFERENCE!

CROWNE PLAZA RESORT

ASHEVILLE, NC

NOVEMBER 3 – 6, 2013

A Message from the President

Jill Queen, 2013 NC TIDE President

Greetings,

Can you believe it is June and time for another NC TIDE newsletter designed to increase your awareness of MHDDSA topics? It seems like just last week we were together in Wilmington for the Spring NC TIDE Conference. I hope that each of you who were able to attend the NC TIDE Spring Conference found the conference informative and enjoyable. A special Thank You goes out to all the members, participants, exhibitors and speakers that helped NC TIDE make the Spring Conference such a success!! We received many positive comments on the Spring Conference and we gained a lot of valuable feedback to begin planning the Fall NC TIDE Conference. We are already in the midst of planning the Fall conference for you.

The evolution of change continues with leadership in the state as the MH/DD/SAS Division has selected a new leader, Dave Richard. NC TIDE welcomes Mr. Richard to his new position and looks forward to his leadership, passion and direction.

Just as the weather has brought heat to the state, the general assembly is heating up with their legislative session and reviewing proposed changes that will affect MH/DD/SAS. The outcome of the session may have a profound effect on services and the design of the system. Since NC TIDE strives to be your comprehensive training resource, NC TIDE will continue to monitor these changes in order to ensure the Fall conference contains the most current and up-to-date information on any changes to behavioral health which may affect our members, participants, consumers, providers, LME-MCO's, and stakeholders.

While changes occur all around us, we continue to thrive and meet the needs of consumers, families, providers, LME-MCO's, stakeholders and others as an organization and service system. Your input is a key factor in why NC TIDE consistently provides hands on quality training. We would like to have your input on how NC TIDE can best meet your needs and serve as your resource for providing "***Excellence in Training and Promoting Professionalism***". Please feel free to contact any of your NC TIDE Committee Members or Officers to share your thoughts and ideas.

Thank you again for all your support and allowing us to serve as your training resource. Be on the lookout for exciting information about the NC TIDE Fall Conference and be sure to make plans to attend the Fall Conference in Asheville, NC, scheduled for November 3-6, 2013!

I hope each of you will take time to enjoy the summer weather, much needed vacation and all the other indulgences of summertime in North Carolina. I look forward to seeing each of you in the Fall as we meet again in Asheville, NC to learn and fellowship together.

Jill Queen, President
NC TIDE

NC TIDE Steering Committee:

President:	Jill Queen
Vice President:	Anna North
Treasurer:	Rhonda Brown
Secretary:	Sherry Phillips
Past Presidents:	Beth Brown
	Victor Armstrong
Finance Chair:	Susan Lackey
Reimbursement Chair:	Beth Brown
QI Chair:	Kim Keehn
Provider Liaison:	Gayle Mahl
Facility Chair:	Cathy Macemore
Membership:	Marilyn Brothers
Program/Registration:	Marilyn Brothers
Eastern LME Rep:	Krissy Vestal
Eastern Provider Rep:	English Albertson
Western LME Rep:	Debbie Hatley
Western Provider Rep:	Richard Anderson
Website Development:	Ramon Santiago
Division Consultant:	Cathy Macemore
Newsletter Coordinator:	Alice Matthews

PR Committee:
- Brenda Pittman, Chair
- Cathy Macemore
- Vince Wagner
- Ramon Santiago
- Pat Myers
- Art Harris

Training Development:
- Victor Armstrong
- Kathleen Medlin
- Sharon Stanley
- Mike O'Connor
- Ilene Byrd

NC TIDE NEWS

NC TIDE welcomes ***Dave Richard*** as the new Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse services. Mr. Richard earned his Bachelor of Science degree, with a major concentration in elementary education, from Louisiana State University. Mr. Richard has nearly 25 years as Executive Director of The Arc of North Carolina and has held leadership roles within The Arc of the United States. He previously served as the Executive Director for The Arc of Delaware and The Arc of Louisiana.

NC TIDE welcomes Les Merritt as Chief Financial Officer for the Division of Mental Health, Developmental Disabilities and Substance Abuse Services. Les is an accomplished financial and economic strategist with extensive experience in both the private and government sectors. Les is currently a member of the NC State Ethics Commission (appointed by the NC Senate). Among his many accomplishments, Les was the first Certified Public Accountant to serve as North Carolina State Auditor from 2005 to 2009. He also served as Executive Director of the Foundation for Ethics in Public Service from 2009 to 2011. Les earned degrees in Accounting and Economics from North Carolina State University.

As **Jim Jarrard** resumes his role as Assistant Director, our THANKS go out to him for the excellent job he did as Acting Division Director. Jim has been a speaker at NC TIDE Conferences for many years providing valuable insight and information on behavioral healthcare services and policies to its attendees.

Sharon Stanley, Western Highlands Network, will be retiring on July 31, 2013 with over 30 years of service. Sharon has served on the NC TIDE Committee in various capacities for many years. NC TIDE appreciates the support she has provided to the organization. We wish Sharon the best and hopes she enjoys her retirement.

Recycling:

Many of you in attendance at the Spring Conference in Wilmington had asked if the hotel recycled all those plastic drink bottles. We are pleased to say ***YES – the hotel recycles***. Plastic, glass, paper and cardboard is sorted by hotel staff and placed in separate dumpsters.

Words Matter

How to combat stigma associated with mental illness

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

Traditionally, there has been a great deal of misunderstanding, fear, and stigma associated with mental illness. Stigma toward people with a mental illness has a detrimental effect on their choice to seek treatment, their ability to obtain services, the type of treatment and support they receive, their success at recovery and regaining a meaningful life, along with their acceptance in the community.

These stigmas can be reinforced or reduced by media coverage, popular culture and the way we talk about mental illness.

On March 7, 2013, the Associated Press added an entry on mental illness to its influential AP Stylebook.

According to Kathleen Carroll, AP senior vice president and executive editor, "It is the right time to address how journalists handle questions of mental illness in coverage. This isn't only a question of which words one uses to describe a person's illness. There are important journalistic questions, too."

"When is such information relevant to a story? Who is an authoritative source for a person's illness, diagnosis and treatment? These are very delicate issues and this Stylebook entry is intended to help journalists work through them thoughtfully, accurately and fairly," said Carroll.

Recent national and local news coverage involving people with mental illness has been varied and often relied on stereotypes, negative portrayals and reinforced stigmas associated with mental disease.

"It is important to remember that a person living with schizophrenia is a person first and that a child or youth who lives with mental health challenges is a child first," said Susan Robinson, mental health program manager with the N.C. Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS). "Using language that acknowledges the individual or person is very important and can help reduce the stigmas around mental health issues. Mental illness is just an illness affecting the body. In these cases, that body part is the mind."

According to the AP Stylebook:

> Do not describe an individual as mentally ill unless it is clearly pertinent to a story and the diagnosis is properly sourced.
>
> Mental illness is a general condition. Specific disorders are types of mental illness and should be used whenever possible: *He was diagnosed with schizophrenia, according to court documents. She was diagnosed with anorexia, according to her parents. He was treated for depression.*
>
> Do not use derogatory terms, *such as insane, crazy/crazed, nuts or deranged*, unless they are part of a quotation that is essential to the story.
>
> Avoid descriptions that connote pity, such as *afflicted with, suffers from or victim of*. Rather, *he has obsessive-compulsive disorder*.

[Continued on Page 5]

> Double-check specific symptoms and diagnoses. Avoid interpreting behavior common to many people as symptoms of mental illness. Sadness, anger, exuberance and the occasional desire to be alone are normal emotions experienced by people who have mental illness as well as those who don't.
>
> Wherever possible, rely on people with mental illness to talk about their own diagnoses.

While not specifically mentioned, the AP has adopted a person first language philosophy regarding mental illness, as recommended by many advocacy groups. This philosophy, way of speaking, and writing, places the person first and their illness or disability second. Person first language is designed to avoid perceived or subconscious dehumanization when discussing illnesses or people with disabilities.

For example, instead of saying, "He is a crazy person," say "He is being treated for bipolar disorder."

Mental health advocates have also long called for an end to the correlation between violence and mental illness. The Associated Press supports this position.

From the AP Stylebook:

> Do not assume that mental illness is a factor in a violent crime, and verify statements to that effect. A past history of mental illness is not necessarily a reliable indicator. Studies have shown that the vast majority of people with mental illness are not violent, and experts say most people who are violent do not suffer from mental illness.

The Associated Press (AP) was founded in 1846 and today delivers unbiased, independent news content around the world. The AP Stylebook was initially published in 1953 and is the most used writing guide for journalists, writers and professionals.

Additional information can be found at this link.

http://www.ap.org/Content/Press-Release/2013/Entry-on-mental-illness-is-added-to-AP-Stylebook

Transitions to Community Living Initiative

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

Traditionally, North Carolinians with mental health support needs have had limited choice in where they receive their services. That is changing with the *Transitions to Community Living Initiative*. This initiative is the result of a settlement agreement between the North Carolina Department of Health and Human Services and the U.S. Department of Justice. The agreement outlines the steps that the Department of Health and Human Services will take to ensure that people living with serious mental illnesses or severe and persistent mental illness can choose where they live.

"Over the next eight years, the *Transitions to Community Living Initiative* will move at least 3000 individuals in North Carolina from a state psychiatric hospital or Adult Care Home to an apartment in their community," says Jessica Keith, Department of Health and Human Services special advisor on the Americans with Disabilities Act. "These transitions into the community will provide long-term housing stability and reduced hospitalizations."

The initiative is based upon the following guiding principles set by the Americans with Disabilities Act of 1990 and the *Olmstead v. L.C.* U. S. Supreme Court decision:

- Individual choice is valued and supported.
- Services should be in the least restrictive and most integrated setting appropriate for the individual.
- Services should be built on resiliency and be recovery oriented.
- Housing setting should enable individuals with disabilities to interact with individuals without disabilities to the fullest extent possible.
- Housing setting should not limit an individual's ability to access community activities at times, frequencies and with people of their choosing.

The Department of Health and Human Services, in partnership with the Local Management Entity-Managed Care Organizations, will administer the initiative and an independent reviewer will evaluate the entire process.

"This initiative is designed to be very individualized," says Keith. "The services and supports are to be wrapped around the individual and help sustain them wherever they choose to live."

The following services and supports are provided by the *Transition to Community Living Initiative*:

- In-reach (information sharing)
- Diversion (screening process)
- Transition Planning
- Housing Slots with rental assistance and transition supports
- Fidelity to the Assertive Community Treatment Team model
- Supported Employment
- Quality Assurance and Performance Improvement
- Crisis Resources

[Continued on Page 7]

In-reach is a series of conversations with the individual, their families, and professionals to help everyone fully understand what options may exist so that an informed choice can be made. These conversations will be coordinated by the Local Management Entity-Managed Care Organizations and be conducted by certified peer specialists. In-reach will begin with residents in adult care homes that have high percentages of individuals with a diagnosis of serious mental illness and will recur at regular intervals to determine if an individual's needs or desires have changed.

Diversion is a screening process intended to identify individuals with potential mental health needs. Individuals who are seeking admission to an adult care home will be evaluated using the Pre-Admission Screening and Resident Review. Those individuals with mental health needs will then be informed of all options available to them. Individuals who choose a community placement rather than an adult care home will be directed to community-based services and will work with their Local Management Entity-Managed Care Organization to develop their transition plan.

Transition Planning assists the individual in developing an effective written plan that will enable them to live independently in an integrated community setting. Transition planning is a person-centered planning process in which the individual has a primary role and is based on the principle of self-determination. The planning is overseen by the Local Management Entity-Managed Care Organization's transition coordinator and should include the individual and the individual's family or guardian.

The planning process will ensure that the individual has the necessary services and supports needed for successful community living, including but not limited to:

- Medical services
- Housing supports
- Educational supports
- Employment supports
- Behavioral health services
- Financial management services
- Other community supports

Transition planning will also ensure that benefits transfer, provide person-specific risk mitigation strategies and crisis planning, along with any necessary adaptive equipment.

"Transition coordination is a critical element of the process," says Trish Farnham, project director for the N. C. Money Follows the Person Demonstration Project. "The transition coordinator works with the participant to make sure that numerous details related to their move into the community are effectively identified and addressed."

The Local Management Entity-Managed Care Organizations will assume the responsibility for assisting on moving day by having a moving company do the heavy lifting if necessary and having someone on-site to assist such as a peer specialist, housing specialist or transition coordinator.

Housing Slots are a state-supported package of subsidies that include rental assistance, one-time transition supports, and community services. The *Transitions to Community Living Initiative* will create over 3000 Housing Slots during the life of the program on a first-come, first-served basis and will be based upon geographic availability and individual preferences.

[Continued on Page 8]

Housing Slots include tenancy support services to assist in overcoming the barriers to obtaining and maintaining housing. The Housing Slots will be located at scattered site locations with no more than 20 percent of the units occupied by a person with a disability.

"This will enable individuals with disabilities to interact with non-disabled people to the fullest extent possible," says Martha Are, director of housing and homelessness with the Department of Health and Human Service's Division of Aging and Adult Services. "The preference for housing slots is in a non-licensed, single occupancy apartment-style setting. This type of location will allow for choice in everyday activities."

Assertive Community Treatment Team is a service-delivery model that provides comprehensive, locally-based treatment to people with a serious mental illness or a severe and persistent mental illness. Assertive Community Treatment Team recipients receive the around the clock availability of multidisciplinary, behavioral health staffing within the comfort of their own home and community. There will be 33 teams serving 3,225 individuals by July 2013 and by July 2019 there will be 50 teams serving 5,000 individuals.

Supported employment is a service to assist individuals with job training, job coaching and finding employment opportunities. This service will be based upon the Dartmouth Individual Placement and Support Model. The initial target for supported employment services is 100 individuals by July 2013 and increasing to 2,500 individuals by 2019. Supported employment does not mean sheltered workshops, employment in segregated settings, group employment models or sub-minimum wages.

Using **Quality Assurance and Performance Improvement**, North Carolina will ensure that services provided by the state are of good quality and are sufficient to help individuals achieve increased independence, gain greater integration into the community, obtain and maintain stable housing, avoid harms, and decrease the incidence of hospital contacts and institutionalization.

This will be done by tracking length of stay, readmissions and tenure in the community. Personal outcomes will also be tracked, including:

- Incidents of harm
- Repeat admissions
- Use of crisis beds and community hospital admissions
- Repeat Emergency Department visits
- Time spent in congregate day programming
- Number employed, attending school, maintaining living arrangement, engaged in community life

Quality Assurance and Performance Improvements will also conduct *Quality of Life Surveys* with the individuals that are part of the initiative and will evaluate the in-reach and discharge activities for the program. An *External Quality Review* will also help ensure that the state is meeting its responsibilities under the agreement.

The agreement creates an eight year timeline for the *Transitions to Community Living Initiative*, during which at least 3000 individuals across North Carolina will begin living in their community instead of in an institution. Transition efforts are being supported during the first year with an allocation of $10.3 million in the state budget.

For additional information regarding the *Transitions to Community Living Initiative*, please visit the program website at http://www.ncdhhs.gov/mhddsas/providers/dojsettlement/.

The Golden Rule

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

If you lived in the tri-state area of NY, Connecticut, and NJ there is no denying that if you were a student or a school teacher, one of the compulsory field trips was to the United Nations. There are many gifts on display from the various member nations. In 1985, as a representative of the United States, then first lady Nancy Reagan presented a mosaic to the United Nations from the United States to celebrate the organization's 40th anniversary. The *Golden Rule* mosaic was a creation of Venetian artists and was based on a painting by Norman Rockwell. Depicting people of all races, religion, creed and hue, the mosaic imparts the message to "do unto others as you would have them do unto you". (http://en.wikipedia.org/wiki/United_Nations_Art_Collection)

Ethics is essentially concerned with our moral obligations to other people. This does not mean that self-respect and self-esteem are not valid goals of personal development, or that the pursuit of self-interest and personal happiness is unethical. It does mean, however, that ethics requires us to recognize a duty beyond self-interest and accept the responsibility to treat others in a moral manner. It also means that an ethical person is willing to exercise self-restraint and self-sacrifice in deference to the interests and needs of others. This, after all, is the basis of one of the oldest and most powerful formulations of moral duty, the Golden Rule.

The most famous statement of the rule, at least in western civilization, is derived from the Sermon on the Mount (Matthew 7:12), popularized as “Do unto others as you would have them do unto you.” Yet this simple moral maxim, sometimes called the rule of reciprocity because it is based on the idea of mutuality of interest, has roots in many other cultures.

We can start with Confucius who in about 500 B.C. said, “What you do not want done to yourself, do not do to others.”

Some hundred years later in a different part of the world, Aristotle advanced the same essential message: “We should behave to our friends as we wish our friends to behave to us.”

In one of the Hindu holy books from about 150 B.C., the Mahabharata says, “Do nothing to thy neighbor which thou wouldst not have him do to thee.”

Islamic writ referred to as the Traditions says “No one of you is a believer until he loves for his brother what he loves for himself.”

Buddhist thoughts expressed in the Udanavarga prescribe: “Hurt not others with that which pains thyself.”

And in the Jewish literature, the Apocrypha puts it simply: “And what you hate, do not do to anyone.”

John C. Maxwell author of *There is no such thing as “Business” Ethics: There is only one ethics...If you desire to be ethical; you live it by one standard across the board.”*

He makes a clear distinction between those leaders who go for the gold and those who go for the Golden Rule. He concludes that “*people who go for the gold and are very lucky, they get some gold. People who live by the Golden Rule give themselves a chance to have it all.”*

www.josephsoninstitute.com

Mindful Eating

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

We are often in a rush throughout the day, completing tasks, crossing off items as they are completed and adding new things to a seemingly never-ending to-do list. We often try to accomplish as much as we can with the minimal amount of time in an effort to accomplish the task so we can "be done." Organizations frequently reward individuals for being efficient and effective and getting more done in less time. Because we often have so much to do and not enough time to do everything, we resort to multi-tasking both in our professional and personal lives. At work, we talk on the phone while making a to-do list or checking our emails, and we eat our lunch at our desks while we continue to work. At home, we talk on the phone and fold laundry, and we listen to our children tell us about their day while we go through the mail. This type of multi-tasking can lead to mindlessness or an unawareness of what we are doing because our minds are off some place else cultivating a split attention to what we are really doing. Eating is one example.

We eat in front of the television, in our cars, at our desks at work, when we are stressed, angry, sad, or bored. Despite the fact that we consume food many times throughout the day, we often do this mindlessly. The other task, whether it's completing paperwork, driving, talking on the phone or being consumed by our thoughts, takes center stage while the actual act of eating is secondary. I know I have sat in front of the television eating mindlessly and then suddenly realizing I have eaten the entire pizza. I was completely absent from the experience of eating the pizza as I was too engrossed in what was on television. We also eat with gusto, placing more food in our mouths before we swallow what we already have in our mouths. We take bite number 10, when bite number 9 is still being worked on, yet we keep shoveling more of what we are already tasting in our mouths. Something interesting to consider.

Sometimes we eat in an effort to distract us from uncomfortable thoughts or feelings we may be experiencing in the moment; similar to smoking or having a drink. Just with using cigarettes or alcohol to help us manage what is currently going on in our minds, chronic eating can lead to undesirable consequences that affect our overall health and wellbeing. Over eating can lead to weight problems and can affect self-confidence and self-esteem. Not feeling good about ourselves can then influence how often we eat if we are using food to distract us from uncomfortable thoughts or feelings. This can lead to a cycle; a vicious habit. In these cases eating is no longer associated with reducing hunger or providing nutrients to our bodies, it's about avoidance, an attempt to push away what is actually happening in the mind.

So, eating mindfully is simply another way to give the gift of being in the present moment to yourself. Nothing else to do but eat, nourishing the body, being fully present with taking care of yourself through mindful eating.

CFAC CONNECTIONS

NC TIDE values the input, perspective and involvement of CFAC. As a result, NC TIDE will feature a CFAC related article, upcoming trainings or state issues/meetings effecting CFAC. Stay tuned for more information and this exciting new section of the newsletter. The next state CFAC meetings are:

July 11, 2013
September 12, 2013

Visit the state CFAC website at:
http://www.ncdhhs.gov/mhddsas/services/advocacyandcustomerswervice/localcfac.html

Mindfulness Corner

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

So perhaps just for fun try eating a meal mindfully. Eliminate distractions to the greatest extent possible. Turn off the television or radio, put away books or newspapers, and sit at the table with the intention of simply eating. Think about your intention (eating) and give yourself the gift of being present in the moment to yourself. Being aware of any thoughts about taking the time to only eat, and any thoughts you may have about the other things on your "to-do list" while eating. Sitting in silence for a moment and then observing the food before you, notice the colors, the textures, the smells coming from the plate. Thinking about all the hands and resources it took for this food to be where it is now. Thinking about the effort it took for you to prepare the food. As you begin to eat, notice how your hand can gather the food, either by picking it up, or using a utensil to capture the food and bring it to your mouth. Sitting for a moment in the miracle of this ability. Notice your body's reaction to the anticipation of tasting the food and perhaps some thoughts that arise in the mind in preparation for eating. As you bring the food into your mouth and begin to chew, notice the taste and the texture of the food. Is it salty, or sweet, or sour? Is it soft, or chewy, or crunchy? Notice how your body knows how to chew; your tongue moving the food around to make it available to your teeth. Continue to simply chew, noticing any desire to swallow before the food is completely ready to be swallowed, or your mind already anticipating the next bite. When the food is ready to be consumed, notice how you don't have to tell your muscles in your throat to contract and move in order to swallow, your body knows what to do all on its own. Continue with eating until you no longer experience hunger, eating at a pace that embodies a sense of stillness. Being aware of, but not reacting to, any desires to finish quickly and move on to the next item on your to-do list.

The NC TIDE Committee would like to say THANK YOU to our *June* contributors of articles for the NC TIDE Newsletter. Their valuable insight and information that they provide to our membership is appreciated.

- **Chris Pfitzer, Division of MHDDSAS**
- **Patrick Chang, Cardinal Innovations**
- **Karen Holst, Monarch**
- **Jude Johnson, Monarch**

We would love to have YOU provide an article for the fall issue of our newsletter. Our target due date for articles is August 21, 2013. Contact Alice Matthews at abmcms@aol.com.

CONFERENCE NEWS

THANK YOU!

The NC TIDE Committee thanks everyone who submitted an evaluation form on our spring conference sessions and activities. Your comments and ideas are appreciated and greatly assist with future conference planning.

The NC TIDE Committee is now in the planning stages for our 2013 fall conference. The suggested topics you provided on your evaluations have been compiled and your ideas will provide much insight in session planning.

For additional topic/speaker suggestions, contact Marilyn Brothers at marilynbrothers@earthlink.net or Jill Queen at Jill.Queen@cardinalinnovations.org.

Make your reservations now for the upcoming NC TIDE Fall 2013 Conference to take advantage of the special rates.

Crowne Plaza Resort
One Resort Drive
Asheville, NC 28806

The Crowne Plaza Resort - Asheville NC has provided a customized website to make your hotel reservation.

https://resweb.passkey.com/go/NCF2013NOV

You may also call in for reservations to 888-233-9527, 7 days, 7 am – 11 pm through the contracted cutoff date of October **2, 2013** and mention the group name or block code: **NCF**. After October 2, 2013, you must call 800-733-3211 Monday – Friday, 9 am – 5 pm for reservations assistance as the link will no longer be active.

NOTES

- There is still time to become a NC TIDE member and take advantage of reduced fall conference rates. Contact Marilyn Brothers at marilynbrothers@earthlink.net .
- ***COMING SOON!*** Watch your email – the target date for the registration agenda is September 5, 2013.
- The NC TIDE Committee is looking for an IT representative as a volunteer for our committee. If you are interested, contact Jill Queen at Jill.Queen@cardinalinnovations.org.
- NC TIDE is working on offering CEU's again at the fall conference. Stay tuned for more information as we develop our fall conference agenda. If your agency is interested in sponsoring the CEU sessions, contact Jill.Queen@cardinalinnovations.org.

Cornerstone Treatment Facility, Inc.,
Premier Healthcare Services, Inc. & CTFP
3620 Legion Road
Hope Mills, NC 28348

WOULD YOU LIKE TO SEE YOUR LOGO HERE?

Go to www.nctide.org for sponsorship options

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. Sponsorship opportunities for the NC TIDE 2013 Fall Conference will be available shortly. Make sure your company responds quickly to the sponsorship opportunities because exhibitor slots are available on a first-come, first-served basis. The NC TIDE Fall Conference will be held at the Crowne Plaza Resort, One Resort Drive, Asheville, NC November 3-6, 2013.

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.*