Chapter 8: Mental Health, Substance Abuse and Violence

Mental Health and Substance Abuse

The Rockingham County Area Program is committed to providing quality services to individuals and families affected by mental illness, developmental disabilities and substance abuse, that enhance their potential to live, work and grow in their community.

ACR LME Mission Statement:
"To assist individuals and families affected by mental illness, developmental disabilities, or substance abuse to develop their maximum potential for growth and maturity in dealing with everyday life."

Organization and Authority

In 2001, the North Carolina legislature approved a comprehensive mental health reform plan. The goals of the new plan are to improve access to cost-effective care, choice in treatment and system accountability. The mental health reform also aims to develop a "System of Care"; (clients, families, providers and other stakeholders are actively involved in the process) in an effort to allow clients to transition back into their communities and more normal living conditions. Under the state reform plan, area mental health programs are becoming Local Management Entities (LMEs).

Local Management Entities (LMEs) are agencies of local government-area authorities or county programs who are responsible for managing, coordinating, facilitating and monitoring the provision of mental health, developmental disabilities and substance abuse services in the area served. LME responsibilities include offering consumers access to services 24 hours a day, 7 days a week, and 365 days a year. The LME is also responsible for developing and overseeing providers and handling consumer complaints and grievances.

The LME system results in separation of management and clinical functions, and transitioning many clinicians to other independent or agency based-practice settings. Many services once provided directly by area programs will be offered by qualified community-based providers contracting with the LMEs. Many patients once reliant on care at state facilities will be increasingly served by community-based programs. For more information about the Alamance, Caswell and Rockingham County LME, visit www.acmhddsa.org.

The mental health reform transition has been a continuous process. Identifying the strengths and weaknesses of mental health service in an effort to better serve area clients is of the utmost importance. Therefore, in 2007, the Behavioral Healthcare Resource Program at the School of Social Work, University of North Carolina at Chapel Hill conducted an assessment study funded by the Annie Penn Community Trust. The purpose of the assessment was to determine the range of mental health service needs that were unmet in order to improve the impact of mental health funding. The following pages will explain the assessment process and results.

Introduction

The Annie Penn Community Trust was established in July 2001 as a result of the merger of Annie Penn Hospital with the Moses Cone Health System. The Trust is a private, non-profit organization governed by an autonomous board, and is independent of Annie Penn Hospital and the Moses Cone Health System. Since 2001, the Trust has funded $10 million in projects for Rockingham County, North Carolina. In late 2007, the Trust contacted the Behavioral Healthcare Resource Program at the School of Social Work, University of North Carolina at Chapel Hill and requested assistance with assessing the delivery of mental health services in Rockingham County, North Carolina. The Trust's goal was to determine the range of mental health service needs that were unmet in order to improve the impact of mental health grant making by the Trust.

The needs assessment process included the following steps:

- A series of community group meetings were held with the Trust's mental health stakeholder group which was comprised of a number of mental health service providers, local law enforcement, schools and community representatives. This group met to determine the range of community mental health needs from their prospective
- A series of 6 focus groups were held with community members to discuss the range of challenges each were experiencing related to unmet mental health needs in the county
- A series of interviews with county officials were conducted to gather background information and to gauge their potential investment in the local mental health service system
- A comprehensive interview with the Alamance-Caswell-Rockingham LME (Local Management Entity) was conducted
- Local data on the service delivery system was collected to illustrate the range of services provided and number of county residents who receives assistance with their mental health issues

Rockingham County Demographics and Mental Health Service Characteristics

Rockingham County is located in the Piedmont area of the state at the Virginia/North Carolina Line. The county has a total population of 93,063 residents and the average median household income in 2006 was $39,539. The racial make-up of the county is the following:

74% Caucasian
20% African-America
4% Hispanic
2% other

The county had a long history of textile and tobacco manufacturing as its industrial base until the last 5-10 years when many of the factories closed. The unemployment rate in June 2008 was reported to be 7 percent while the state average unemployment rate was reported to be 5.8 percent for the same time period.

Presentation of Local Related Data

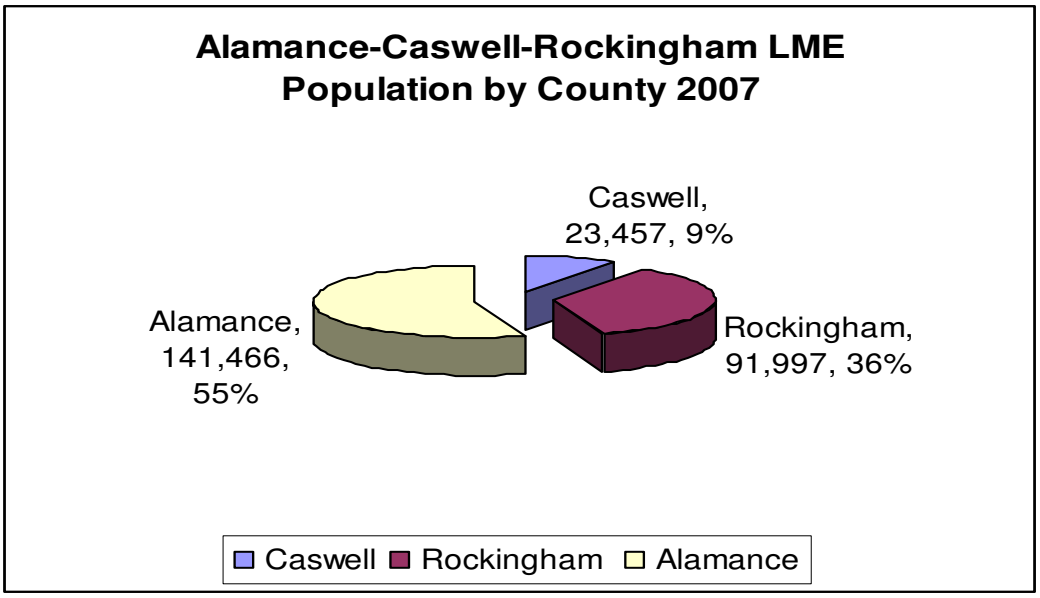
General population statistics for Rockingham County are illustrated in the chart below. For comparison purposes, the other county populations in the LME are also identified. Rockingham County is the second most populous County in the LME service area and its population represents 36 percent of the LME's service population.

Table 41.
Populations Statistics per LME Service Area

County	***2007 Population***	***Percentage under 18***	***Population Under 18 yrs***	***Population Ages 18+***
Rockingham	***91,977***	***0.22***	***20,603***	***71,374***
Alamance	*141,466*	*0.24*	*34,270*	*107,196*
Caswell	*23,457*	*0.22*	*5163*	*18,294*
LME Total	*256,900*	*0.23*	*60,036*	*196,864*

Source: The Behavioral Healthcare Resource Program, July 2008

Figure 67.



Source: The Behavioral Healthcare Resource Program, July 2008

As indicated by the chart above, during fiscal year 2007, the providers in the Alamance-Caswell-Rockingham LME service area admitted 2,169 children into service that were experiencing severe emotional disorders (SED) which represents about 35 percent of the total population that is estimated to need services in the geographic LME service area. LMEs across the state serve an average of 41 percent of the children with SED in need of services. It is assumed that the number of children with this condition in Rockingham County is similar to the state average which may indicate substantial under service in Rockingham County.

Table 42.
Population of Children in the LME Service Area

County	***Population Ages 3-17***	***12% Estimated SED Population Ages 3-17***
Rockingham	***17,614***	*2,114*
Alamance	*29,112*	*3,493*
Caswell	*4,477*	*537*
Total in Need	***51,203***	***6,144***

Source: The Behavioral Healthcare Resource Program, July 2008

Utilizing the same federal and state prevalence indicators for the adult population, approximately 5.4 percent of the state's adult population will experience a severe and persistent mental illness.

Table 43.
Population of Adults in the LME Service Area

County	***Population Ages 18+***	***5.4% Estimated SPMI Population Ages 18+***
Rockingham	***71,374***	*2,114*
Alamance	*107,196*	*3,854*
Caswell	*18,294*	*988*
Total in Need	***196,864***	***10,631***

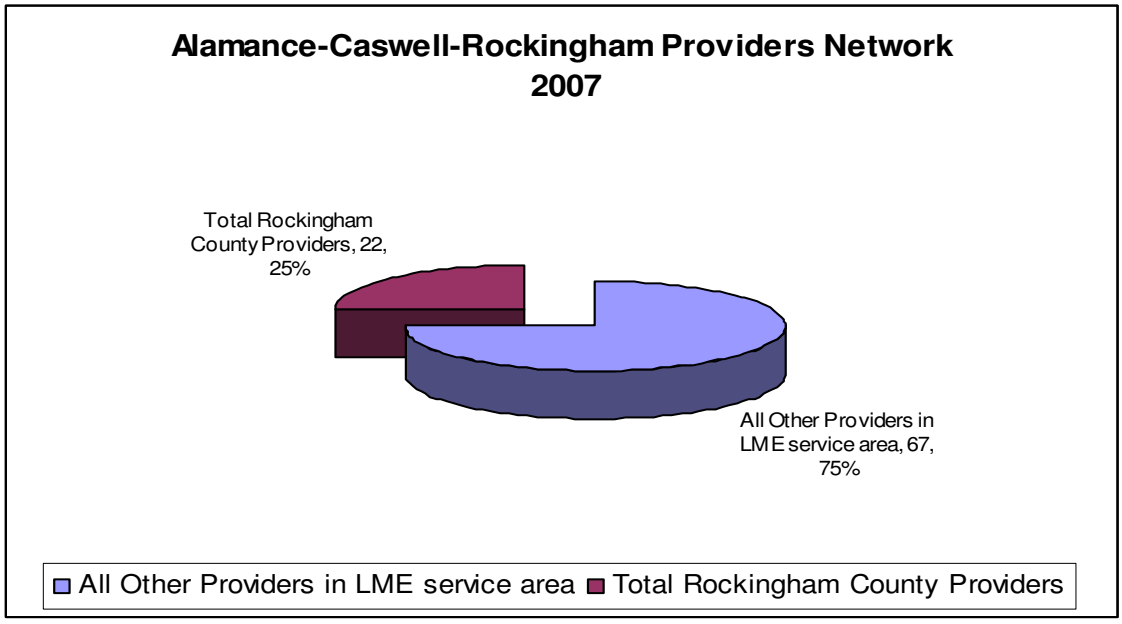
Source: The Behavioral Healthcare Resource Program, July 2008

As indicated by the chart above, during fiscal year 2007, the providers in the A-C-R LME service area admitted 4,531 adults with severely and persistently mental illness (SPMI) into services, representing about 42.6 percent of the total population that is estimated to need services in the geographic area. Statewide, LMEs serve an average of 38 percent of adults with severally mentally ill (SMI). While the LME's admissions are somewhat higher than the state average admissions, it is apparent that it is serving less than half of those adults in need for this type of assistance.

There are a total of 22 providers delivering mental health services in Rockingham County through the LME system. While this seems like it may be a large number given the population in need, when compared to the number of providers in the total LME service area (89) and the

distribution of the population throughout the LME service area, it appears low. The population of Rockingham County in 2007 as per the U.S. Census estimates was 91,977 representing 36 percent of the total population and 22 providers or 25 percent of the total providers in the LME area. Alamance County, which is the most populated County in the LME service area, had an estimated 141,466 residents representing 55 percent of the total LME population and 75 percent of the providers.

Figure 68.



Source: The Behavioral Healthcare Resource Program, July 2008

Summary of Stakeholder Group Discussion

Two meetings with the Annie Penn Community Trust Mental Health Stakeholder group were held. The first meeting identified those issues the stakeholder group felt were paramount to the Mental Health issues facing the County. The second meeting focused on the stakeholder group identifying and prioritizing those Mental Health services imperative to an effective Mental Health system in the County.

<u>Ideal Rockingham County Mental Health System-Adults</u>

- 24 hour crisis response system
- Access to psychiatric medication management which is also affordable for recipients in need
- Accurate assessment and diagnosis
- System needs to recognize disorders and refer to appropriate treatment providers
- Co-occurring disorder services and diagnosis
- Co-occurring capable providers
- Capacity and linkage to medical service who understand Mental Health conditions and disorders
- Ability to coordinate care across diagnosis
- Coordinated care with psychiatrists

- Access to reliable transportation and childcare, particularly when attempting to access Mental Health services
- Providers who are qualified In-home service providers
- Good linkage with housing resources, services that can help with basic needs and vocational retraining needs
- Professional guidance for each client

Ideal Rockingham County Mental Health system-Adolescents

- Basic adolescent assessments and psychological workups
- Participatory cross system team which would include
  - Families
  - Collaborative efforts between school and juvenile justice as well as treatment providers
  - Respite care for families with an adolescent Mental Health case
- Appropriate expedient adolescent crisis response system
- Home based services
  - Intensive in-home
  - Multi-systemic family treatment

Summary of the Focus Groups

Six focus groups were held with citizens in Rockingham County regarding their perception of the alcohol and drug issues facing the County and their perspective of potential solutions. The groups were comprised of the following representatives: Law Enforcement, African-American, Social Services, Healthcare providers, Latino, Schools and Youth issues. Nine questions were asked in each focus group. Themes across the groups are summarized below.

What are some of the strengths in Rockingham County?

Five of the six focus groups identified cooperation and/or collaborative relationships as strengths. One focus group mentioned that the "tight" community enhanced healthcare professionals' willingness to provide services and enabled the county to attract qualified providers. Two focus groups identified the Annie Penn Community Trust as a source of funding. Two focus groups also mentioned that the county was "environmentally pretty"—a plus for attracting industrial development and professionals.

What do you see as the major mental health-related problems in Rockingham County?

Five focus groups thought that some of the challenges were the lack of public transportation and access to services, which were very closely aligned. Five of the focus groups also identified the poor economic outlook of the county, since manufacturers had left the area causing a lack of available jobs and unemployment. Other challenges included the lack of qualified professionals (4 focus groups), particularly psychiatrists; limited resources (4); substance abuse and its associated problems (3); the uninsured not being able to enter programs (2); and stigma associated with seeking mental healthcare (2). Also mentioned were the lack of knowledge about existing resources/services (2), the lack of prevention services (1), the lack of crisis services (1), the length of time to obtain services with wait lists as long as six weeks (2), lack of transitional services post-hospitalization (1), lack of follow-up (2), and lack of translators and

bilingual services (1). The law enforcement focus group, in particular, identified the large number of transports (i.e., 574 in the previous year) of patients to hospitals and the LME and the amount of time that a single transport may take (e.g., up to 48 hours for an involuntary commitment).

How is your community impacted by mental health-related problems?

Focus groups saw the community as negatively affected in the following ways:

- Increase in domestic violence (4 focus groups)
- Untreated mental health disorders (3)
- Increase in crime (3)
- Substance abuse (2)
- Increase in number of children in foster care (2)
- Increase in crisis issues (2)
- Increase in emergency room visits (2)
- Increase in the number of involuntary commitments that require transport by law enforcement (2)
- Paperwork (2)
- Need to make clients aware of existing services and resources (1)
- Need for prevention services (1)
- Need for early intervention (1)
- Decrease in morale of providers (1)
- Delay in getting discharge summaries from inpatient treatment to community providers (1)
- Lack of follow-up services (1)
- Need for bilingual professionals (1)

Where do people in your community go for mental healthcare?

- Focus groups expressed frustration with the lack of community awareness of where to seek help. The Mental Health Center and the emergency room were most frequently mentioned as places where clients sought mental healthcare. Other sources included outpatient clinics, community support services, schools, public health, youth services, private providers, and churches.

What are the strengths of mental health services available in Rockingham County?

Focus groups identified the following strengths:

- Good providers (3)
- Better tracking procedures of the LME (1)
- Collaboration between schools and mental health providers (1)
- Programs for high-risk youths in schools (1)

What are some of the changes in mental healthcare that need to be made in Rockingham County?

Three focus groups mentioned the need to deliver 24/7 crisis services by phone and through mobile units and the need to improve access to services.

- Also identified were the following needs:
  - More funding (2)
  - More licensed providers (2)
  - Better education and publicity (2)
  - More care coordination (1)
  - Enhanced short-term treatment (1)
  - Addition of educational component for youth day treatment programs (1)
  - An intensive outpatient program that offers both individual and group sessions (1); local aftercare programs (1)
  - More transparency regarding funding streams and corresponding services/programs (1)
  - Greater attention to the needs of the unemployed and uninsured (1)
  - and more bilingual professionals (1).

<u>What resources could you/your system bring to help make change in mental healthcare in Rockingham County?</u>

- Three focus groups pinpointed the need to expand crisis services while two focus groups identified the need for more funding, staff training, detox services, and knowledge about the system.

- Focus groups also identified the following:
  - Need to develop a resource list of community services (including a Spanish language translation) (2)
  - To match funds to needs (1)
  - To attract qualified licensed professionals (1)
  - To offer transportation (1)
  - To develop an Assertive Community Treatment Team (1)
  - To engender collaboration, not competition, among providers (1)
  - To conduct performance-based evaluation (1)
  - To establish drop-in centers (1)
  - To create rehab beds (1).

<u>Out of mental health and substance abuse, which do you think is the most pressing issue for Rockingham County at the present?</u>

- Four of the six focus groups thought that substance abuse was the most pressing issue.
- One focus group thought that substance abuse and mental health were intertwined.
- The remaining focus group was uncertain how to answer the question.

Additional focus group comments were also made. These comments reiterated responses to questions asked earlier and include the following:

- Communication and collaboration are key.
- A resource book needs to be developed.
- The county lacks psychiatric services.
- Services are more fragmented than they were prior to the Reform efforts.
- Involuntary commitments and their corresponding mandated transports are a burden to law enforcement.
- Homelessness is an issue for individuals on probation and parole.
- The substance abuse halfway house is always full, with a waiting list.

Summary of County Interviews

Interviews were conducted with significant county stakeholders including the Rockingham County Manager, Rockingham County Chief Finance Officer and newly-appointed Director of Human Services for Rockingham County. The following were the summary from those interviews:

- During the state mental health reform efforts, Rockingham County decided to join with Alamance and Caswell counties to form the Alamance-Caswell-Rockingham LME and to keep its previous Rockingham County mental health service as a service operating under the county's control but funded through the new LME.
- The Rockingham County Commissioners decided to fund the local mental health service over a three-year transition period in addition to the local maintenance of efforts funds to the LME.
- The county management has determined that it cannot continue to subsidize services at the center and is interested in exploring ways in which the operation can be run more efficiently, spun off into its own private non-profit entity or the funds used to contract with an existing provider in the community.

Conclusions and Challenges

- The community stakeholders expressed a high degree of concern and frustration regarding the quality of existing services, lack of 24/7 emergency crisis response availability within their home county and in general unresponsive access and unmet mental health needs existing in the county.
- In particular, the lack of 24/7 mental health crisis response and intervention in the county was mentioned by the stakeholders, majority of focus groups and interviews conducted.
- In addition to the funding provided by Rockingham County to the Alamance-Rockingham-Caswell LME, the local Annie Penn Community Trust has also provided substantial funds to supplement the local mental health service system. The county has a resident population of 93,063 individuals or an average of $21.49 per capita spent on Mental Health, Developmental Disabilities, and Substance Abuse Services (MHDDSAS) in Rockingham County annually from county resources. This does not take into consideration any funds matched by Medicaid, funds provided through private insurance, self-pay or funds provided by the State of North Carolina through the North Carolina Division Mental Health, Developmental Disabilities, and Substance Abuse Services (MHDDSAS).
- There is a need to immediately realign the Rockingham County Mental Health service operation to run more efficiently and effectively to reflect the service needs of the county. Assistance from the Alamance-Caswell-Rockingham LME should be sought by the county for their guidance, assistance and support to make the necessary changes needed to improve the financial and clinical operation of the local service network.

Recommendations

- At a minimum, Rockingham County residents should expect the following basic mental health services provided within the county's borders:
  - 24/7 Live telephone and in-person mental health crisis response with appropriate and effective referrals for intervention services that meet the needs of the adolescent and adult county residents who have mental health issues.

- Both adult and adolescent mental health assessment, diagnostic services and referral services to be available and easily accessible within the county with no substantial waiting periods.
- A serious attempt at linkage with the various local law enforcement units and the crisis service should be made to reverse the current trend of transporting those with serious mental health crises outside the county. However, in order for this trend to occur, effective and accessible local mental health intervention services must be present and easily accessible within Rockingham County.
- County located Assertive Community Treatment Team (ACTT) to assist Rockingham County residents who have the Serious and Persistent Mental Illness diagnosis and who need assistance with day to day life and illness management issues to either cope effectively in the community or make a transition from institutional care back to their home community in the county.
- Adolescent mental health services comprised a minimum of a home based service which can respond to the adolescent in the home and school setting and which provides services for the adolescent in combination with families to insure that the family unit is dealing with the day-to-day challenges of an adolescent who has a serious emotional disorder. Services of this type which should be offered in Rockingham County include Intensive In-home services, Community Support and Community Support Team Services.
- Medication Management should be available for any Rockingham County Resident in need of medications to assist in stabilizing his or her mental health condition. However, offering Medication Management should not be offered as the only service available without the earlier referenced services.

- Serious consideration needs to be given to the ongoing operation and management of Rockingham County Mental Health services under the county's purview. If the service is continued under county management, then in order for the Rockingham County Mental Health not to operate at a loss, then the financial system must be brought in line with recognized accounting practices and principles and the service array must be redesigned to insure that services offered in the county by the county's service operate with minimal loss and write off annually. Another option would be for the county to seriously consider spinning off the county Mental Health service into its own private non-profit organization at which time it would be required to answer to its own Board of Directors and would have to revamp its business and service infrastructure to insure its ongoing livelihood. A third option could potentially be to seek out a merger of the county mental health service with an existing provider.

Violence

Violence is defined as intentional use of physical force or power directed toward oneself, another person, a group of people, or a community, which includes interpersonal violence such as homicide, child abuse, youth violence, domestic violence, and other types of assaults. It also includes self-directed violence such as suicide, suicide attempts, and self-mutilation. Violence is a significant problem in the United States. It affects people in all stages of life, from infants to the elderly. In 2006, there were 41,363 violent crimes committed in North Carolina, which increased .9 percent from 2005 (NC-SBI, 2006).

Violence erodes communities by reducing productivity, decreasing property values, and disrupting social services as well as negatively affects the health and welfare of all Americans through premature death, disability, medical costs, and lost productivity. The total costs associated with violence (injuries and deaths) in 2000 were more than $70 billion. Most of this cost was loss of productivity (64.8 billion or 92 percent). Another 5.6 billion was spent on medical care for self-inflicted violence. These costs do not include the costs associated with victims of violence. Many more survive violence and are left with permanent physical and emotional scars like post-traumatic stress disorder and depression (Corso, Mercy, Simon, Finkelstein, & Miller, 2007).

Homicide

According to the Bureau of Justice Statistics, homicide is an accurate predictor of all violent crime. Based on data from 1976-2005, the demographic characteristics of homicide victims and offenders differ indicating racial, gender, age disparities (Fox, Zawitz, 2007).

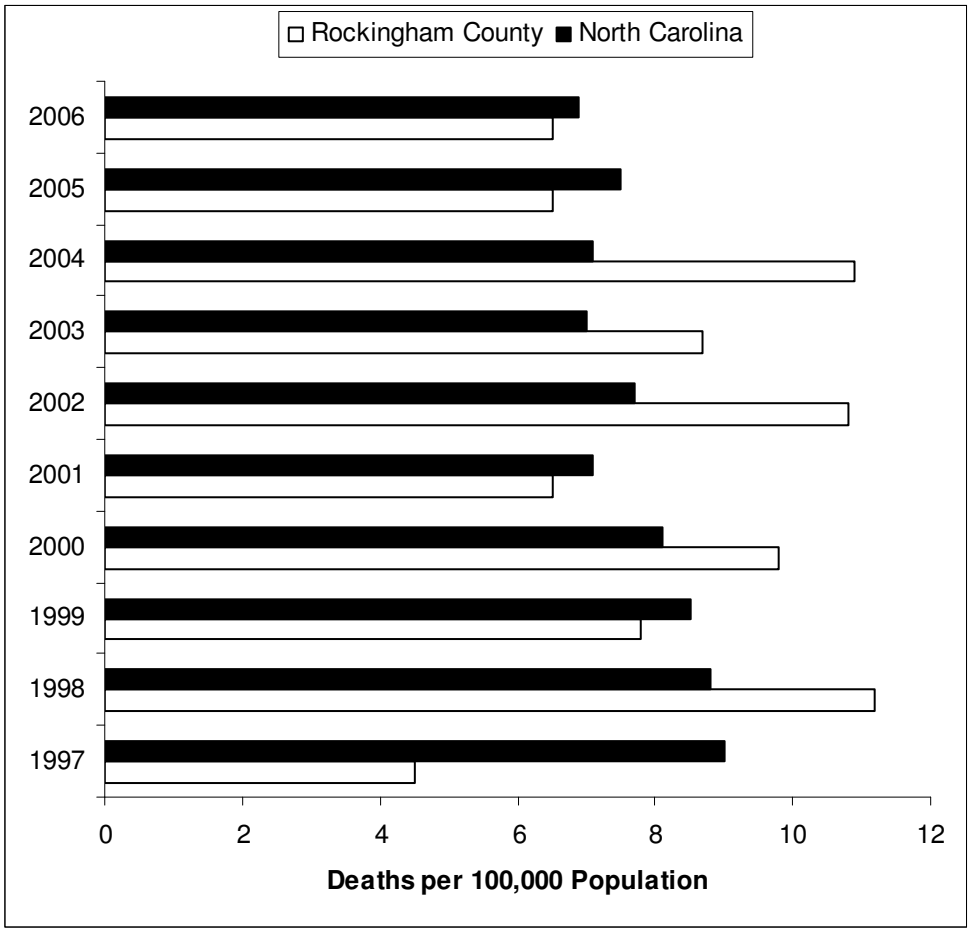
- Black people are disproportionately affected as both victims and offenders of homicide. The victimization rates for black people were 6 times higher than those who are white. The offending rates for those who are black were more than 7 times higher than the rates of white persons.

- Males represent 77 percent of homicide victims and nearly 90 percent of offenders. The victimization rates for males were 3 times greater than the females' rate. The offending rates were 8 times higher than the rates for females.

- Approximately 33 percent of murder victims and almost 50 percent of the offenders were under the age of 25. For both victims and offenders, the rate per 100,000 peaks in the 18-24 year-old age group.

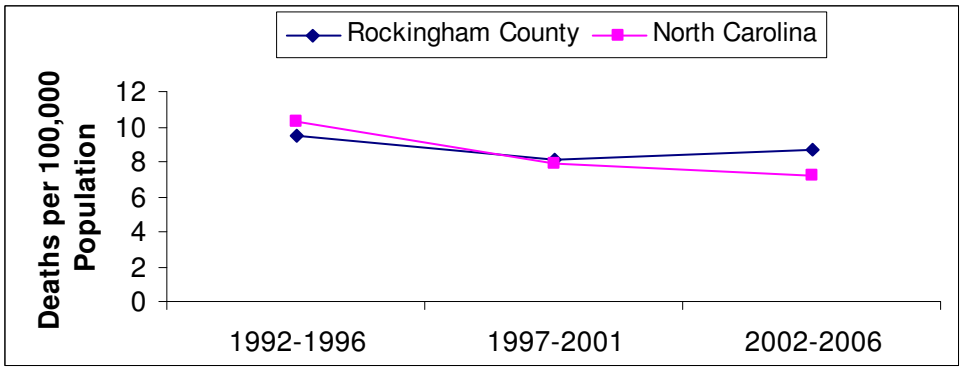
In 2006, 611 people died in North Carolina as a result of homicide. In the same year, Rockingham County had 6 homicides (NC-SCHS 2008[b]). However after examining both yearly (1997-2006) and four-year homicide trends (1992-2006) for North Carolina and Rockingham County; North Carolina yearly rates have decreased from 1997-2000 and then remain steady until 2006. Although the four-year trend indicates a reduction in homicide rates from 10.3 to 7.2. Rockingham County yearly rates have escalated since 1997 although it has varied year to year with several jumps in homicide deaths which is also evident in the four-year trend (Figure 69 and Figure 70). During 2002-2006, Rockingham County had a rate of 8.7 compared North Carolina's rate of 7.2. During that period of time, Rockingham County had 40 homicide deaths, which included 34 males and 6 females; 18 minorities and 22 white people.

Figure 69.
Homicide Rates for Rockingham County Compared to North Carolina, 1997-2006



Source: NC-SCHS, 2008

Figure 70.
Age-Adjusted Homicide Rates for Rockingham County vs. NC, 1992-2006 Trends



Source: NC-SCHS, 2008[d]

Youth Violence

Youth violence is a disturbing and important issue that all communities face. According to the CDC (2007[f]):

- In 2005, 5,686 young people ages 10 to 24 were murdered in the United States, an average of 16 deaths per day.
- Nationally, homicide was the 2nd leading cause of death for young people ages 10 to 24 years old.
- Among that age group, 86 percent (4,901) of homicide victims were male and 14 percent (785) were female.
- Also among that age group, 82 percent were killed with a firearm.

The current trend in youth violence is cyber bullying. Electronic aggression is the term that accurately depicts all types of violence that occurs electronically. Teenagers use the internet or cell phones to send embarrassing, harassing, or threatening messages to their peers. Increasing numbers of adolescents are becoming victims of this new form of violence. Like traditional forms of violence, electronic aggression is associated with emotional distress and behavior problems at school (CDC 2007[f]).

According to the CDC, research has identified some populations that are more vulnerable to victimization and perpetrations. These risk factors are often the same because of the overlap among victims and perpetrators of violence.

The more risk factors a child or young person is exposed to, the greater the likelihood that he or she will become violent. No single risk factor or combination of factors can accurately predict violence. Most young people exposed to a single risk factor will not become involved in violent behavior; similarly, many young people exposed to multiple risks will not become violent. The risk factors for youth violence include (2007[f]):

Individual Risk Factors

History of violence victimization or involvement
ADHD, or learning disorders
History of early aggressive behaviors
Involvement with drugs, alcohol, or tobacco
Low IQ
Poor behavioral control
Deficits in information-processing abilities
High emotional distress
History of treatment for emotional problems
Antisocial beliefs and attitudes
Exposure to violence and conflict in the family

Peer/School Risk Factors

Association with delinquent peers
Involvement with gangs
Social rejection by peers
Lack of involvement in conventional activities
Poor academic performance
Low commitment to school and school failure

Family Risk Factors

Authoritarian childrearing attitudes
Harsh, lax, or inconsistent disciplinary practices
Low parental education and income
Parental substance abuse or criminality
Poor family functioning
Poor monitoring and supervision of children
Low parental involvement
Low emotional attachment to parents or caregivers

Community Risk Factors

Diminished economic opportunities
High concentration of poor residents
High level of transiency
High level of family disruption
Low levels of community participation
Socially disorganized neighborhoods

During 2007, Rockingham County had an undisciplined rate of 5.95 per 1,000 youth age 6-17 compared to North Carolina's rate of 3.25. During that same year, Rockingham County had a delinquent rate of 33.33 per 1,000 youth ages 6-15 compared to the statewide delinquency rate of 34.08. Table 44 is an overview of youth-related violence data (NCDJJDP, 2007)

Table 44.
Youth Violence Statistics for Rockingham County Compared to North Carolina, 2004-2007

Rockingham County Databook		Trend Data			
		2004	2005	2006	2007
Juvenile Ages 6-17	Rockingham	14,161	14,054	13,988	14,280
	NC	1,380,084	1,392,855	1,419,257	1,461,851
Juvenile Ages 6-15	Rockingham	11,876	11,790	11,784	12,061
	NC	1,155,767	1,165,446	1,185,239	1,217,196
Juvenile Ages 10-17	Rockingham	9,501	9,467	9,396	9,512
	NC	928,201	934,862	947,271	968,150
Complaints Received Violent-Felony Class A-E	Rockingham	0	8	3	8
	NC	1,014	1,048	1,207	1,119
Complaints Received Serious - Felony Class H-I, A-1 Misdemeanor	Rockingham	126	112	163	81
	NC	10,187	10,033	10,445	10,281
Complaints Received Misdemeanor Class 1-3	Rockingham	340	297	374	310
	NC	29,299	29,238	30,920	29,776
Infractions	Rockingham	5	1	2	3
	NC	323	314	348	311
Total Delinquent Complaints	Rockingham	-	418	542	402
	NC	-	40,633	42,920	41,487
Total Complaints	Rockingham	583	499	638	487
	NC	46,041	45,389	48,089	46,231
Undisciplined Rate per 1,000 Ages 6-17	Rockingham	7.91	5.76	6.86	5.95
	NC	3.78	3.41	3.64	3.25
Delinquent Rate per 1,000 Ages 6-15	Rockingham	39.66	35.45	45.99	33.33
	NC	35.32	34.86	36.21	34.08
Juveniles Transferred to Superior Court	Rockingham	-	1	0	2
	NC	-	50	27	49
Distinct Juveniles Served Detention	Rockingham	49	58	65	54
	NC	-	5,200	5,420	5,026
Number of Detention Admissions	Rockingham	68	84	93	77
	NC	7,854	7,654	8,311	7,792
Youth Development Center (YDC) Commitments	Rockingham	2	7	5	4
	NC	473	428	486	437
YDC Commit. Rate per 1,000 Ages 10-17	Rockingham	-	0.74	0.53	0.42
	NC	-	0.46	0.51	0.45
Eckerd Camp	Rockingham	7	8	5	2
	NC	405	371	436	386

JCPC Admission	**Rockingham**	450	520	363	353
	NC	23,083	25,970	24,348	23,441
JCPC Admissions Rate per 1,000 Ages 10-17	**Rockingham**	-	54.93	38.63	24.7
	NC	-	27.78	25.7	16.0
SOS Admission	**Rockingham**	112	94	213	125
	NC	16,077	17,535	15,568	13,760

Source: NCDJJDP, 2007

Child Abuse

Federal legislation identifies minimum standards for states to incorporate in their statutory definitions of child abuse and neglect. These definitions determine the grounds for state intervention in the protection of a child's wellbeing. States recognize the four different types of abuse in their definitions, including physical abuse, neglect, sexual abuse, and emotional abuse. There are some states that also define parental substance abuse and/or abandonment as child abuse. Although any of the forms of child maltreatment may be found separately, they often occur in combination.

- Physical abuse is physical injury, ranging from minor bruises to severe fractures or death, as a result of punching, beating, kicking, biting, shaking, throwing, stabbing, choking, hitting (with a hand, stick, strap, or other object), burning, or otherwise harming a child.

- Neglect is failure to provide for a child's basic needs. Neglect may be:

  Physical: Failure to provide necessary food or shelter, or lack of appropriate supervision
  Medical: Failure to provide necessary medical or mental health treatment
  Educational: Failure to educate a child or attend to special education needs
  Emotional: Inattention to a child's emotional needs, failure to provide psychological care, or permitting the child to use alcohol or other drugs

- Sexual abuse includes activities by a parent or caregiver such as fondling a child's genitals, penetration, incest, rape, sodomy, indecent exposure, and exploitation through prostitution or the production of pornographic materials.

- Emotional abuse is a pattern of behavior that impairs a child's emotional development or sense of self-worth. This may include constant criticism, threats, or rejection, as well as withholding love, support, or guidance. Emotional abuse is often difficult to prove and Child Protective Service (CPS) may not be able to intervene without evidence of harm to the child. Emotional abuse is almost always present when other forms are identified (Child Welfare Information Gateway, 2007).

According to the CDC, a combination of individual, relational, community and societal factors contribute to the risk of child maltreatment. Children are not responsible for the harm inflicted upon them, although individual characteristics have been found to increase their risk of being maltreated. Risk factors are those characteristics associated with child maltreatment; they may or may not be direct causes. The risk factors for perpetration are (2007[f]):

Individual Risk Factors

- Parents lack of understanding children's needs, development, and parenting skills
- Parental mental health
- Substance abuse in the family
- Young, single parents
- Parental supporting abusive behaviors

Family Risk Factors

- Poor parent-child relationships and negative interactions
- Poverty, unemployment, or lack of education
- Family disorganization, dissolution, and violence
- Social isolation of families

Community Risk Factors

- Community Violence

Risk Factors for Victimization

- Children younger than 4 years are at greatest risk for severe injury or death
- Disabilities in children that may increase caregiver burden

Protective Factors are conditions in families and communities that, when present, increase the health and well-being of children and families. These attributes serve as buffers, helping parents to find resources, supports, or coping strategies that allow them to parent effectively, even under stress. Research has shown that the following protective factors are linked to a lower incidence of child abuse and neglect (CDC, 2007[f]):

- Nurturing and attachment
- Knowledge of parenting and of child and youth development
- Parental resilience
- Social connections
- Concrete supports for parents

State and Local Data

According to North Carolina Division of Social Services, the number of investigated child maltreatment cases varies from year to year. In the fiscal year of 2004-2005, Rockingham County Department of Social Services (DSS) investigated 1,111 cases of maltreatment, 232 (20.9 percent) of those cases were substantiated and 879 cases (79.1 percent) were unsubstantiated. During the same year, North Carolina had 26,670 cases (23.9 percent) of substantiated cases of maltreatment. Throughout the fiscal year of 2005-2006, DSS investigated 770 cases of maltreatment, 163 (18.9 percent) of those cases were substantiated while 631 cases (81.9 percent) were unsubstantiated. North Carolina had a higher substantiated rate of 22.1 percent (24,597 cases) (NC-DSS, 2007).

Table 45.
Total Number of Children Found Substantiated or In Need of Services

	Rockingham County		**North Carolina**	
Year	Number of Children	Percent	Number of Children	Percent
2001-2002	309	NA	32,883	NA
2002-2003	329	NA	30,016	NA
2003-2004	236	NA	27,310	NA
2004-2005	232	20.9%	26,670	23.9%
2005-2006	163	18.9%	24,597	22.1%

Source: (NC-DSS, 2007)

Table 46.
Type of Maltreatment (Substantiated Cases Only) for Rockingham County and North Carolina, 2004-2006

	2004-2005				2005-2006			
	Rockingham Co		North Carolina		Rockingham Co		North Carolina	
Type of Maltreatment	Children	Percent	Children	Percent	Children	Percent	Children	Percent
(Substantiated Cases)								
Physical Abuse	2	0.9%	942	4.7%	3	2.2%	980	6.0%
Emotional Abuse	0		68	0.0%	0	0.0%	107	0.7%
Sexual Abuse	10	4.4%	1,021	5.1%	4	2.9%	1,016	6.2%
Moral Turpitude	3	1.3%	211	1.1%	5	3.6%	201	1.2%
Improper Supervision	38	16.9%	3,042	15.3%	23	16.8%	2,368	14.5%
Improper Care	67	29.8%	4,440	22.3%	30	21.9%	1,650	10.1%
Improper Discipline No Physical Injury					13	9.5%	1,244	7.6%
Abandonment	0		117	0.6%	0	0.0%	104	0.6%
Improper Medical Remedial Care	3	1.3%	369	1.9%	0	0.0%	309	1.9%
Injurious Environment	102	45.3%	9,693	48.7%	52	34.9%	5,691	34.7%
Adoption Law Violation	0		5	0.0%	0	0.0%	3	0.0%
Improper Discipline Physical Injury					1	0.7%	491	3.0%
Injurious Environment Domestic Violence					5	3.6%	1,343	8.2%
Injurious Environment Substance Abuse					1	0.7%	871	5.3%
Total	**225**		**19,908**		**137**		**16,378**	

Source: (NC-DSS, 2007)

Table 47.
The Number and Percent of Children in Foster Care in Rockingham County, (1997-2007)

	1997-1998	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005	2005-2006	2006-2007
Number of Children in Foster Care	6	12	9	8	5	16	11	30	34	36
Percent of Children in Foster Care	30%	46%	39%	53%	42%	46%	32%	49%	59%	63%
Number of Children Initially Placed	20	26	23	15	12	35	34	61	58	57

Source: (NC-DSS, 2007)

Elder Abuse

Older adults today are more visible, more active, and more independent than ever before. They are living longer and in better health. But as the population of older Americans grows so do the hidden problems of elderly abuse, exploitation, and neglect.

According to National Center for Elderly Abuse, roughly two-thirds of all elder abuse perpetrators are family members, most often the victim's adult child or spouse. Research has shown that the abusers in many instances are financially dependent on the elder's resources and have problems related to alcohol and drugs.

Elder abuse is the infliction of physical, emotional, or psychological harm on an older adult. Elder abuse can also take the form of financial exploitation or intentional/ unintentional neglect by the caregiver.

Physical abuse is the use of physical force that may result in bodily injury, physical pain, or impairment. Physical abuse can include injuries, ranging from minor bruises to severe fractures, as a result from hitting, beating, pushing, slapping, shoving, kicking, biting, pinching, or burning. It can also include inappropriate use of medication, depriving the elder of food, or exposing the person to severe weather- deliberately or inadvertently.

Emotional or psychological abuse is the infliction of anguish, pain or distress though verbal or nonverbal acts. This type of abuse includes name-calling, insults, threats, intimidation, humiliation, and harassment. It also includes isolating the person from family, friends, or regular activities and giving the older person the "silent treatment".

Neglect is the refusal or failure to fulfill obligations or duties of an elder. Neglect typically means refusal or failure to provide for basic needs such as food, water, clothing, medications, shelter, personal safety, comfort, and personal hygiene. It can also include failing to meet the physical, social, or emotional needs of the older person.

Sexual abuse is non-consensual sexual contact of any kind with an elderly person. Sexual contact with any person incapable of giving consent is also considered sexual abuse. It includes inappropriate touching, rape, sodomy, indecent exposure, coerced nudity, any unwanted sexualized behavior, or explicit photographing. Sexual abuse is the least reported form of abuse toward the elderly.

Financial exploitation is the illegal or improper use of an older person's money, property or assets. This includes stealing or misusing an older person's money or possessions, forging signatures, and includes improper use of conservatorship, guardianship, or power of attorney. Financial exploitation also includes a variety of financial scams targeting older adults (National Center for Elder Abuse, 2008).

Elder abuse is a growing problem that every community faces. There is no one explanation for elderly abuse and neglect. Elderly abuse, like other types of domestic violence, is a complex problem with multiple factors such as psychological, social, and economics; along with the mental and physical conditions of the victim and the perpetrator.

Table 48.
Rockingham County Department of Social Services Adult Protective Service

Adult Protective Services Calls For:		
Infraction	**2006-2007**	**2007-2008 (May YTD)**
Abuse	18	19
Neglect	122	210
Exploitation	27	43
Multiple	15	27
Cases in Community	142	246
Cases in Facilities	10	26
Total Complaints Investigated	167	272
Total Complaints Received	231	405
Total Complaints Substantiated	85 (51%)	145 (53%)
Statewide Substantiation Rate is 20%		

Source: RC-DSS, 2008

According to Rockingham County Department of Social Services, the increase in Adult Protective Service calls and substantiation rates are due to:

- Economic Times
  - Choices between medication, utilities, food, and other necessities.
- Mental Health Transformation (Reform)
  - Consumers are having more difficulty accessing services.
  - There are no real outreach efforts and care coordination is too fragmented.
  - Client has to arrange or give written permission.
- Financial Exploitation
  - Family members taking vulnerable adult's assets to supplement drug use or their financial situations.
  - Increase in paid caregivers cases exploiting the consumers they are paid to serve.
- Life Expectancy has Increased
  - People are living longer with more complex medical needs.
  - Caregivers either over-estimate their own ability to care for the ailing adult or under-estimate the amount of time and skill needed to care for the vulnerable adult.
  - Caregivers are having more stress caring for persons with these complex medical issues.
  - There are also more instances of self-neglect because the person may not be educated appropriately about the illness or may refuse outside supports.
- Developmental Disabilities
  -Some guardians or parents have not made arrangements for their continued care.
  - There is a lack of community support for caregivers in the community caring for adults with cognitive disorders like dementia.
  - People with developmental disorders are living longer due to medical advances in treatments.

Domestic Violence

Domestic violence occurs when one person in a relationship or marriage tries to dominate and control the other person. An abuser doesn't "play fair." The abuser uses fear, guilt, shame, and intimidation to wear down the victim and gain complete power over him or her. An abuser may threaten the victim and hurt other family members or friends (Domestic Violence, 2007). Examples of abuse are:

- name-calling/insults
- withholding money
- stalking
- isolating partner from friends and family
- keeping partner from getting a job
- actual or threatened physical harm
- intimidation
- sexual assault

Victims of domestic violence may be men or women, although women are more commonly victimized. This abuse happens among heterosexual couples and in same-sex partnerships. Except for the gender difference, domestic abuse doesn't discriminate. It happens within all age ranges, ethnic backgrounds, religion, education and financial levels. The abuse may occur during a relationship, while the couple is breaking up, or after the relationship has ended.

Violence is a deliberate choice made by the abuser in order to take control over the spouse or partner. Violence takes many forms and can happen all the time or once in a while. Physical abuse is only one part of a system of abusive behaviors.

Rockingham County Domestic Violence Facts:

Table 49.
Rockingham County Total Ex Parte and Protective Orders Filed 2004-2008

Year	Total Ex Parte & Protective Orders	No Contact Orders
2004	403	NA
2005	446	38
2006	401	46
2007	499	98

Source: Rockingham County Clerk of Court
* 2005 data reflects No Contact Order which includes stalking and sexual assault

Table 49 gives the total number of Ex Parte (temporary protective order) and Protective Orders (at least 1 year petition) filed for Rockingham County for 2004-2007. Table 50 shows the total number of Protection Orders granted in Rockingham County, since numerous protective orders are dismissed or denied for various reasons.

Table 50.
Rockingham County One-Year Petition Granted for Protective Orders, 2002-2007

Fiscal Year	Protection Order Granted In Whole or Part
2002-2003	189
2003-2004	182
2004-2005	163
2005-2006	190
2006-2007	175

Source: The North Carolina Court System, n.d.

The Help, Inc., shelter for battered women and their children provide a safe place to live, counseling, safety planning, skills training, client outreach assistance, and children's counseling services. According the Help, Inc. of Rockingham County, on average a woman will leave an abusive relationship seven times before actually making the final break.

Table 51.
The Help, Inc. Shelter Served:

	Women ~ Bed Nights	***Children ~ Bed Nights***
2004-2005	72 ~ 987	92 ~ 1,175
2005-2006	64 ~ 959	76 ~ 1,123
2006-2007	56 ~ 711	52 ~ 599
2007- March 2008	35 ~ 658	56 ~ 1,008

Source: Help, Inc.

Domestic violence affects married and unmarried couples, young and old. Studies show that nearly 20 percent of teenage girls are victims of dating violence. According to Help, Inc., 379 elderly Rockingham County residents were victims of domestic violence from 2005-2006 and there were 348 elderly victims in 2006-2007.

For the victims of domestic violence, Help, Inc., offers counseling sessions and support groups. Through the years, numerous clients have taken advantage of these Family Support Services.

Table 52.
The Help, Inc. counseling sessions and support group participants

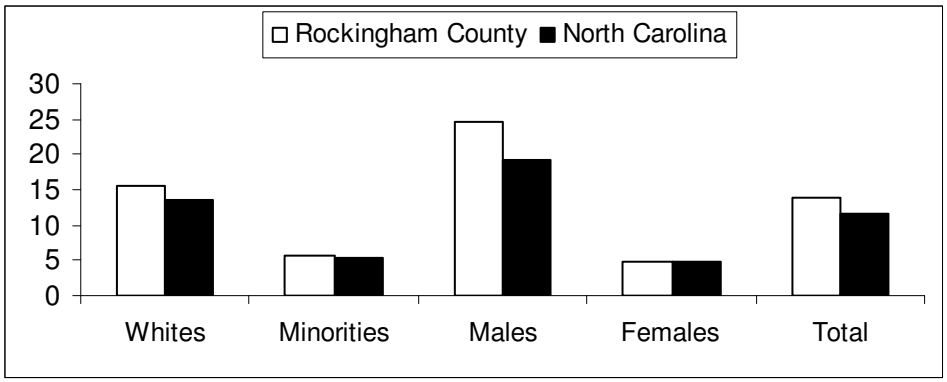
Year	Counseling Participants	Number of Sessions	Witness Support Group Participants
2004-2005	115	219	490
2005-2006	282	662	421
2006-2007	202	431	304
2007-March 2008	172	376	NA

Source: Help, Inc.

Suicide

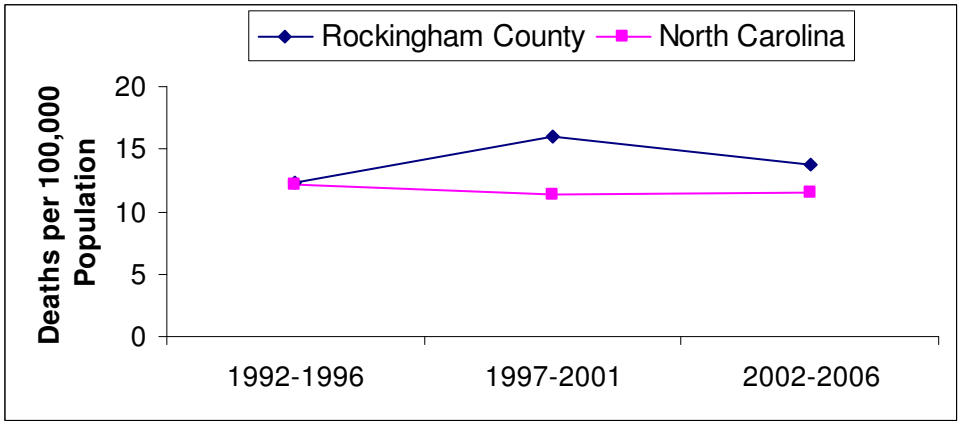
Suicide is the act of intentionally ending one's own life. According to the CDC, for every 25 attempted suicides, there is one suicide (2007[d]). More people survive suicide attempts than actually die. They are often seriously injured and need medical care. In 2006, there were more than 31,000 suicide deaths in the United States. This is equivalent to 89 suicides per day, one suicide every 16 minutes or 11.05 suicides per 100,000 population (CDC, 2007[d]). In 2006, Rockingham County had 15 suicide deaths (16.3 death rate) and 67 deaths from 2002-2006 (13.8 death rate). North Carolina had 1,093 deaths related to suicides, with a death rate of 12.3, in 2006. The total North Carolina suicide deaths from 2002-2006 was 5,027 or a death rate of 11.6 (NC-SCHS, 2008[b]). Figure 71 compares Rockingham County to North Carolina, for 2002-2006 years, in race and gender age-adjusted suicide mortality rates. Figure 72 compares Rockingham County to North Carolina in age-adjusted mortality rates with trend data of fifteen years.

Figure 71.
Race-Sex-Specific Age-Adjusted Suicide Mortality Rates for Rockingham County Compared to NC, 2002-2006 (per 100,000)



Source: NC-SCHS, 2008[a]

Figure 72.
Age-Adjusted Suicide Trend Rates for Rockingham County vs. NC, 1992-2006



Source: NC-SCHS, 2008[c]

Suicide Facts: (CDC, 2007[d])

- Suicide affects everyone, but some groups are at higher risk than others.
    - Men are 4 times more likely than women to die from suicide and represent 78.8 percent of all suicides.
    - Women are 3 times more likely to attempt suicide
    - Suicide rates are higher among males, adults 65 years and older (37.4 per 100,000)
    - Among females, those in their 40s and 50s have the highest rate of suicide (8.0 per 100,000)
    - 15 to 24 year olds account for 12.9 percent of suicide deaths
    - The rate of suicide for older adults, 65 years and older, was 14.3 per 100,000
- More than 425,000 people with self-inflicted injuries are treated in emergency rooms each year.
- Some risk factors for suicide include:
    - Previous suicide attempts
    - History of mental illness or depression
    - Alcohol or drug abuse
    - Family history of suicide or violence
    - Physical illness
    - Feeling alone
- Firearms are the most commonly used methods of suicide among males.
- Poisoning is the most common method of suicide for females.