North Carolina's Community Hospitals and Mental Health Reform

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LAST OCTOBER A NEWSPAPER REPORTED that South Carolina's Richland County sheriff's deputies were taken off the streets to escort mentally ill patients being transferred to health facilities. Richland County Sheriff Leon Lott said, "Our policy is we have to handcuff them. We're treating them like criminals and they haven't committed a crime."

At the time, Lott estimated that law enforcement agencies in South Carolina spent $1.5 million a year escorting mentally ill patients to community hospitals and that as many as 50 patients were sitting in hospital emergency rooms on any given day.

At about the same time, the Raleigh *News & Observer* reported that the Wake County, North Carolina sheriff estimated that 80 percent of the inmates in his jail had mental health problems, often in combination with addictions and substance abuse. That, in effect, made the Wake County jail the largest mental institution in the state.

Almost one out of every five adults in the United States has a diagnosable mental disorder—one characterized by alterations in thinking, mood or behavior associated with distress and/or impaired function. In fact, in the magnitude of disease burden, major depression alone ranks second, behind only ischemic heart disease.

The sheer volume of incidence of mental illness, with the accompanying costs for treatment and lost productivity, justifies major attention, as well as appropriate care and funding. But in North Carolina there is great risk that we are stepping backward. Not only is our system broken, if we do not bring all concerned parties to the table to work together to achieve a better solution, we risk entering a state of bedlam in the original meaning of that word.

The North Carolina Mental Health Reform Plan, calling for closure of 854 state psychiatric hospital beds through 2006, proposes to re-direct operational funds for these beds into community-based programs. Management of those programs is to be done by Local Management Entities under the direction of county governments. Care is to be limited to "target populations" who are very sick with the Local Management Entities serving as assessment centers and gatekeepers.

The challenge is that patients who do not fit into "target populations" will no longer be eligible for services. Already the "target population" of those qualifying for state funding has been trimmed by the state. That means an even greater number of patients will have no access to state-funded behavioral care. It is unrealistic to expect that charitable organizations or private clinicians will be able to serve all of those who do not qualify for state funding. This will have major effects on emergency services, inpatient hospital care, jails and law enforcement agencies and, most importantly, human beings in North Carolina.

Providing mental healthcare for North Carolinians cannot be left to jails or hospital emergency departments—it will overwhelm an already overcrowded system and it will not assure the appropriate services for those who are suffering from mental illness. And more and more it has been shown that people with mental illness can lead productive lives in their communities if they receive help with treatment, housing and education. Often that means taking services to the patients, rather than waiting for a crisis that requires police intervention or emergency hospital care.

Although very few state acute psychiatric beds have actually been closed at this point, community hospitals already report difficulties and delays in transferring patients to state psychiatric hospitals. As patients fall outside the "target populations" or are displaced by the closure of state hospital psychiatric beds, they will not have access to needed services at the community level and will be forced to seek care in already stressed hospital emergency departments. Hospital emergency departments are not equipped with the staffs or physical resources needed to care for persons having psychiatric emergencies while simultaneously addressing their rapidly growing regular ED caseloads. The state must ensure that it does not close state psychiatric beds until adequate community services are available and appropriately funded.

As state funding for mental health services moves from state institutions to the community, the need for community-based behavioral hospital beds will also increase. Yet, many community-based inpatient psychiatric beds are also closing or the existing hospital programs are small. They will not be able to

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accommodate the displaced state hospital patients. If hospitals are to consider developing or maintaining inpatient psychiatric services, significant improvement in capital and operational funding will be needed. Hospitals are already facing increased costs for providing care, shortfalls in reimbursement and increased charity care obligations. It is very difficult to manage psychiatric hospitals so that they break even. That is why we are seeing so many psychiatric bed closures—hospitals no longer can absorb the losses from their psychiatric services.

Hospital officials statewide have repeatedly posed questions to the state regarding a number of funding issues including rate updates, continuation of direct billing to Medicaid, utilization management and the funding of indigent care, but answers have not been forthcoming. If the state expects community hospitals to develop and maintain the inpatient psychiatric services that are necessary for the Mental Health Reform effort to be successful, resources must be there to assure hospitals' financial stability.

The state has recognized the important goals of availability of patient choice and appropriate levels of community-based care. It will be very important for area mental health providers and health departments to work with their local hospitals, churches, mental health advocates, law enforcement agencies and other community partners to develop a capable, community-based infrastructure with crisis centers and other services designed to provide appropriate, effective care in settings other than hospital emergency departments and jails.

Although mental illness is a chronic condition, it is increasingly considered a disease from which people can recover and lead independent lives—but they must be assured of medication and community treatments, appropriate housing and sufficient vocational training. To fix what is a very broken system, community hospitals, the state, county health agencies and law enforcement agencies must engage in dialogue and work together. The state must ensure that the reformed system provides incentives for healthcare and social services professionals, hospitals and treatment centers to work together to develop and maintain services needed by their communities.