

Achieving Mental Health Reform: A Legislator's Perspective

Representative Verla C. Insko

TWO YEARS AFTER House Bill 381 Mental Health Reform Act was signed into law, I can now look back on the legislative process and the lessons learned. North Carolina's new mental health law is sound. Credit goes to the diligent work of the many stakeholder groups, an engaged legislative committee, an accomplished project manager and a skilled legislative staff. While the process was often tense, the final product was a true collaborative effort held together by a shared acceptance that the system was not working and change was essential and inevitable.

My First Exposure to Mental Health System Issues

I got my first glimpse of the state's mental health system in 1998 when Speaker Jim Black asked me to chair a study commission on the use of seclusion and restraints in institutional care. As the stakeholders debated the issue, I sensed an atmosphere of acrimony. Jointly forged agreements unraveled and new "critical" issues emerged just as we neared a conclusion. Although a compromise bill finally passed, the level of distrust seemed inordinately high.

The following year, when Senator Jim Phillips and I convened the Study Commission on Mental Health, Developmental Disabilities and Substance Abuse (MH/DD/SA), many of the same people reappeared as Commission members or observers. This time the task was to receive and respond to a report from State Auditor Ralph Campbell and the Public Consulting Group (PCG) on the state's MH/DD/SA system, one of a series of major studies on the system during the past decade.

The Auditor's Report Identified Problems of the Current System

The report was unambiguous: the problems were widespread and serious and the legislature needed to take the lead in reforming the system. The report also identified existing strengths. It rated some of the practices as excellent and noted model services across the state. For the most part, the individuals working in

the system were honorable, hard working professionals who cared deeply for their work and the people they served.

The Auditor emphasized that no single person or group or incident was responsible for the decline of the system. That was my impression also, although the loss of Carolina Alternatives, the only Medicaid waiver in the nation ever to be revoked by the federal government, seemed to have been a major demoralizing factor.

Many of the Auditor's findings and recommendations related to two major issues. One was a lack of accountability among the local Area authorities; the second was the state's excessive reliance on state institutions.

Lack of accountability was a systemic, structural problem. The authorities were subdivisions of the state—much as the counties are subdivisions of the state. Except for funding, the Area authorities were essentially independent of counties and the NC Department of Health and Human Services. With no formal connecting mechanism, the various elements of the system began acting independently. Increasingly, they acted in opposition to one another. This disconnect among the public partners, no doubt, contributed to the distrust I perceived around the restraints and seclusion bill as well as on the Study Commission. Despite the distrust, almost everyone agreed with the major findings in the report. I recognized this shared awareness as a unifying factor among the stakeholders.

Accountability for Performance at the Local Level

To build accountability at the local level, the Auditor proposed eliminating the Area authorities and transferring governance to the counties. Although the county commissioners had endorsed this move at their Legislative Goals Conference in 2001, newly elected officers of the North Carolina Association of County Commissioners eventually rejected the concept and opposed it. The proposal to transform Area authorities into Local Management Entities (LMEs) did not appear in the Auditor's report. It was put forward later by the Council of Community Programs.

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The other key finding was the state's over-reliance on state MH/DD/SA institutions. The major recommendations included closing one of the four mental health hospitals, downsizing the remaining three and transferring at least \$38 million to the local level to pay for new community-based services. A "mental health transfer account" would provide bridge funding and handle cash flow as community services were established and beds were closed at the state level.

Although many of the Auditor's recommendations could have been implemented through administrative action under the existing statute, the Division had been weakened by a turnover of directors and management errors. Department leaders also did not intervene possibly due to their focus on welfare reform and Smart Start and the end of the Hunt administration. A new law would send a strong message to all parties that the legislature was serious about making change.

The Need for New Legislation

The Mental Health Study Commission proposed House Bill 1515 entitled Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse (LOC), to create an oversight committee made up of 16 legislators that would draft a reform bill and monitor the progress of reform over a four-to-five year period. That House Bill passed the General Assembly with little notice did not indicate a lack of interest or concern on the part of legislators. Indeed, as they became more aware of the report, legislators shared personal stories about family members or friends who had one or more of the disabilities targeted by this legislation. Why then was mental health reform difficult to achieve?

I suspect many legislators doubted the system could be improved, at least not without a major infusion of money. The complexity of the human services system is daunting. The issues are thorny and progress is usually a matter of making incremental changes rather than developing true solutions. Most legislators, unaware of new evidence-based treatments and best management practices, did not see the significant potential for improvements.

Another barrier was the stigma associated with these disabilities. Many people still consider mental illness to be a defect rather than a treatable illness. They view substance addiction as a moral failure rather than a disease. And many regard people with developmental disabilities, while innocent, as "different."

In addition to these uniformed perceptions, a two-year election cycle forces legislators to give attention to short-term results that can be readily understood by the voters back home. The Auditor was recommending a five-year process and while most people agreed on the Auditor's findings, no consensus existed about how to solve the problems.

Sen. Steve Metcalf and I, as LOC co-chairs, retained Dr. Alice Lin, who brought expertise, neutrality and strong negotiating skills to her role as project manager. The 26-member Governance Subcommittee we appointed and co-chaired was not as unwieldy as we feared. Dr. Lin and our legislative staff kept us on track, summarized the sense of the meetings and

translated it into bill language. We kept the process open and fluid, which produced some ups and downs. During an early meeting, one Area Director walked out, unhappy about a proposal to transfer governance of the system to the counties. He declared he would see us during session. True to his word, he and other Area directors eventually forced a revision of the bill that, though important, did not substantially alter the direction of reform.

Engagement, Cooperation and Trust: The Essential Ingredients of Reform

Despite the unhappiness of a few Area program directors, it was during this time of open debate that we began to see the stakeholders engage in problem solving and developing the capacity to collaborate with trust and dedication. After more than 50 revisions, the Legislative Oversight Committee (LOC) had a draft bill that incorporated the Auditor's recommendation to transfer governance to the counties but required first a state strategic plan to lay the foundation for local governance.

Soon after the bill was introduced in the House and Senate, several Area program directors and their board members descended on the General Assembly, determined to prevent counties from subsuming the Area programs. County commissioners concerned they would be left with funding responsibility also opposed this feature of the bill. As much as anything, the ensuing committee debate brought reform to the attention of legislators.

At that point, the concept of the LME was discussed in more depth. We could leave governance with Area authorities if we increased their responsibility for managing the local system and required them to divest most services to the private sector. The Department would develop a state plan to ensure a more uniform statewide system; Area staff, consumers and county commissioners would jointly develop a local plan. We addressed advocates' demands for a state-level ombudsman and a focus on consumer empowerment. Suddenly, we had a package that looked appealing to most parties. The bill passed and was signed by the Governor. When the budget bill was passed with partial funding for the Mental Health Trust Fund, it was time to transfer responsibility for implementation onto the Department.

The reform process had a successful beginning. Credit must go to our new Division Director, Dr. Rich Visingardi. We must also applaud the determination of Secretary Carmen Hooker Odom to find and then support a director who could meet the challenge. The General Assembly has helped by holding the line on budget cuts and partially funding the Mental Health Trust Fund. An invaluable ingredient to success is the ongoing involvement of the stakeholder groups: consumers, advocates, Area program leaders, providers and county commissioners.

Reform is not without risk. Some consumers and public providers believe the private sector cannot and will not respond to the needs. They predict that private providers will seek control through the legislative or regulatory process, and the profit motive will inevitably lead to the reduction in the quality or

quantity of services. Other people fear a repeat of earlier hospital downsizings that resulted in thousands of homeless people across the nation. Most advocates and providers alike worry that legislators will peel off savings to support other programs or to provide tax cuts rather than build community capacity. All those who care about these populations must work to prevent any one of these scenarios.

The Promise of System Reform

If reform progresses on course, we will have resolved some fundamental and serious system-level problems; but we will still be far from reaching the vision articulated in the state plan. We have yet to address the many people in our prison system with a mental illness and/or substance addiction. We have yet to develop a way to divert at-risk youth from the juvenile justice system into appropriate treatment. We have yet to consider the

state's responsibility to mental health consumers who reside in our publicly-funded adult care homes, receive few or no services and are often integrated with the frail and fearful elderly. We have too many gaps in services for children and too many children in group homes or state institutions. With appropriate wrap-around services and other evidence-based practices such as intensive home visitation and interagency coordination, many of them could stay at home or in their own community.

These problems can be solved if we have the patience and the will and if we respect the current balance of power among the stakeholders. The system is now working for the good of the consumer rather than expending energy protecting turf and the status quo. As long as this is true, as long as the will and commitment to improve is present, I will remain optimistic about the future, committed to seeing reform through and determined to address related issues.

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