

North Carolina's Behavioral Health Delivery System: A Historical Perspective

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This commentary provides an overview of the mental health system in North Carolina. It suggests that the key to building a mental health system is settling on a strategy, implementing it, evaluating it, and funding it. More than a decade after reform was passed in North Carolina, this state still has not settled on a strategy.

Joshua is autistic. He has an IQ of 36. He can only speak a few words, such as "Ma" and "hurt." In January 2010, after violently attacking his mother and little brother at home, Joshua spent 8 days at Wake County Crisis and Assessment Services waiting for a bed in a facility to open up. He slept in a chair. He did not have access to a shower. He was 13 years old.

At the time, there were open beds at Central Regional Hospital in Butner, 35 miles away. Only 13 children were there, and they have the capacity for 34. But there were not enough workers to care for Joshua. After his 8-day wait, he was transferred to Broughton Hospital in Morganton, 200 miles west of Raleigh. It was the first time he had ever been away from his mother for more than two days.

This story illustrates that our mental health system still has many problems, even after a major reform in 2001. Key issues that remain unresolved are how to make sure state and local responsibilities are clear, how to identify who needs services and what services they need, how to address work force shortages, and how to fund the system in these tough economic times.

Mental Health Reform

President John F. Kennedy and his brother Robert had a special interest in mental health care because their sister Rosemary was developmentally disabled. In the early 1960s, they used their influence to help get legislation passed that encouraged a nationwide move toward deinstitutionalization—an effort to move those with mental disabilities out of state institutions and into local, community-based treatment.

The community-based treatment movement gained further strength in the 1990s as a result of two significant events. In 1990, Congress enacted the Americans with Disabilities Act to eliminate discrimination against those

with disabilities [1]. The act applies to all public entities and to the use of public funds; therefore, it has implications for the provision of publicly funded Medicaid services to people with mental disabilities. Then in 1999, the US Supreme Court handed down the *Olmstead* decision, which required states to place people with mental disabilities in the least restrictive setting possible and in community settings rather than in institutions [2]. This decision paved the way for mental health reform nationwide.

North Carolina's mental health reform legislation, An Act to Phase in Implementation of Mental Health System Reform at the State and Local Level [3], was passed in October 2001. Underpinning mental health reform were two ideas: deinstitutionalization and privatization.

Deinstitutionalization. Even after this reform, the state has continued to operate 15 inpatient facilities statewide, including 4 state psychiatric hospitals, 3 alcohol and drug treatment centers, 3 developmental centers for people with intellectual and developmental disabilities, 2 residential programs for children, and 3 neuro-medical treatment centers. Together, these facilities, served 12,815 persons in fiscal year 2011 [4]. The number of persons served at the state psychiatric hospitals has decreased over the past decade. While the state's 4 psychiatric hospitals served 17,160 persons in 2001—the year of mental health reform—in 2011, they provided care to just 5,754 persons [5].

The intent of mental health reform was to separate management from provider functions for area programs providing community-based mental health services, to create local management entities (LMEs) with strong ties to county government, and to mandate state oversight and assistance. The 39 quasi-independent area programs created in the 1970s to provide direct services to one or more counties served both as providers and as payers—that is, they both delivered services and oversaw public dollars that were

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allocated to mental health services. They were autonomous public agencies governed by a citizen board, and they were not accountable to elected county commissioners because their service areas often covered several counties.

These area programs morphed into LMEs, shedding their direct services and becoming the local entity that manages providers and public funds for local consumers. Many individuals who had been staff members of the area programs became contractors with the newly formed LMEs. Consolidation also occurred: The 39 area programs were replaced initially by 33 LMEs, resulting in savings in administration costs and overhead. By July 2010, there were only 23 LMEs serving all 100 counties [6]. In 2001, 246,039 persons were served through the LMEs, and by 2011, the LMEs were coordinating services for 360,180 persons statewide [7].

Privatization. Privatization of clinical services—which gathered steam on the national level throughout the 1970s, 1980s, and 1990s—was not initially a central premise of North Carolina’s 2001 reform legislation. Private providers already were involved in delivering some services. Only after the reform bill passed in 2001 did private providers and LME staff begin to say that the goal was to privatize.

In theory, North Carolina’s approach was supposed to accomplish 4 things: to increase administrative efficiency by segregating management and oversight from the provision of services, to promote innovation and utilize new technologies, to enhance provider quality, and to stimulate competition among providers [8]. But the transition has not been easy. For consumers, the loss of a one-stop shop has been tough. Many consumer advocacy groups, who had served as a watchdog over quality, expanded their role under reform to provide services, creating a potential conflict of interest for themselves. There have also been concerns that the private sector might not be sufficiently responsive to the needs of people with mental illness and that the profit motive could result in a reduction in the quality or quantity of services, particularly for those with severe and persistent mental illness.

Reform created a large provider network and corresponding service capacity, but there have been questions about provider quality. Late in 2009, the North Carolina Department of Health and Human Services proposed a new provider classification for mental health services in North Carolina: CABHAs, short for Critical Access Behavioral Health Agencies. These large providers deliver mental health and substance abuse services. Currently, there are 202 certified CABHAs statewide [9].

CABHAs may be for-profit, nonprofit, or public health care companies, but they are required to provide three core services—comprehensive clinical assessment, medication management, and outpatient therapy—and in addition, at least 2 other services from a list of 14, creating a continuum of care. The goal is to establish a strong clinical foundation on which to build community capacity. To that end, the state

also requires certain staffing for CABHAs—a medical director (full-time for CABHAs serving more than 750 consumers), a clinical director, and a quality management/staff training director.

Based on our research and analysis of mental health reform in the 50 states, we have found that the key to building a solid mental health system is settling on a strategy, implementing it, evaluating it, and funding it. North Carolina’s reform effort has seen major policy shifts so frequently that often it seems the biggest problem with reform may be the state’s inability to stay the course. More than a decade after reform legislation passed in North Carolina, significant changes in policy are still under way.

Opportunities and Challenges Ahead

As we have looked at what other states around the country are doing to comply with the US Supreme Court’s *Olmstead* decision and serve those with mental disabilities, three trends are apparent.

A new funding model: the waiver. First, there is a need for new funding models. Medicaid is the largest funder of mental health services nationwide. In North Carolina, it is also the fastest growing program in our state budget. The provision of mental health services is big money and big business.

North Carolina is currently trying a new funding model—a federal waiver for our Medicaid program (the 1915(b)/(c) Medicaid waiver). Particularly in the current economic environment, this waiver is a crucial element in running an effective and cost-conscious system. Federal waivers allow states to operate programs outside the federal guidelines.

The waiver eventually will apply to all mental health, developmental disability, and substance abuse services in North Carolina that are funded by Medicaid. There are pros and cons to this approach. It allows the state to more effectively use Medicaid and state funds by giving it the ability to predict and control costs. Instead of getting a fee for a service provided, LMEs will get a set amount each month for each consumer served. The waiver gives the LMEs the ability to pick providers and set rates; the hope is that the LMEs will be able to create incentives for providers to make available the mix of services consumers need in their region, including for those that may have been undertreated historically. But LMEs also will assume risk. If services cost more to provide than projected, the LMEs will have to use risk reserves to cover the additional cost.

In 2011, needing to find ways to save money, the North Carolina legislature passed a bill to expand the waiver statewide by July 1, 2013, in the hope of saving \$10.5 million this fiscal year and \$52.5 million in the next fiscal year [10]. This has thrown our entire system into flux as local management entities consolidate to meet the requirements for managed care organizations (MCOs). North Carolina’s 23 LMEs currently have merged into 21 LMEs, and ultimately we expect the LMEs to merge and collapse into 12 LME/MCOs [11]. For this model to work, each MCO will have to cover a sufficient

number of consumers to be financially stable.

A cautionary tale about waivers and the risk of relying exclusively on Medicaid to fund mental health services: Michigan has implemented its waiver statewide with mixed results. The state has been able to save money and increase provider quality, but it has struggled to match federal dollars with state dollars because of its economy and the recession. To get on the Medicaid rolls and obtain coverage, a consumer must be in dire circumstances. As one Michigan area mental health director told us, "We've had to tell people who ask for help to come back to us when they've lost their job, their house, and their support—because at that point they will qualify for Medicaid and get the services they need."

Funding the system: corrections or mental health? Another emerging trend is for states to deal with mental illness and substance abuse in jails and prisons rather than in the mental health system. There is no better example of this than the state of Georgia, where 1 in every 13 adults is under correctional control [12]. It is estimated that 75 to 80 percent of those inmates require either mental health or substance abuse services, and some require both [13].

A psychiatrist who works in western North Carolina told us that state governments have two options when it comes to serving their mentally ill populations: Either the Department of Corrections can be the unseen arm of mental health system, housing people in prisons with little or no treatment, or the mental health system can be the unseen arm of the Department of Corrections, with citizens being served at a much lower cost in the community with treatment that prevents them from ending up back in jail. Which system do we as a state want to fund?

Emergency departments on the front lines. The third trend that emerged in our 50-state study is that visits to hospital emergency departments (EDs) by patients with mental illness or substance abuse are increasing. This unintended consequence of mental health reform plays out across our state each and every day. In 2011, at one community hospital that has 24 beds in the ED, there were about 2,000 visits by patients with mental illness or substance abuse—on average, about 5 visits each day (M.R., unpublished data). Last June, things got so bad that for two weeks, there were 9 or more patients in this ED at all times with mental health or substance abuse issues. Patients are also staying in EDs longer and longer as they wait for beds to open up. There have been as many as 15 people being held in this particular ED for mental health issues, taking up more than half the department's capacity. The longest stay has been 10 days. Imagine waiting in an ED for 10 days!

Emergency departments like this one are on the front lines of mental health care in North Carolina—even though they are not funded and staffed to serve that function, even though the environment in the ED is the opposite of what many mental health patients need, and even though many EDs are unable to initiate treatment.

By contrast, in New York, the mental health system was designed to put EDs on the front lines. Each of their regions has a psychiatric ED for the provision of mental health services; it provides a single portal of entry into the mental health system. Psychiatric EDs are the home base for Assertive Community Treatment teams, which are designed to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support. These EDs are funded and staffed to identify who needs help the most, what help they need, and where they should get it.

Community-Based Treatment, Community-Based Lives

In his 30 years as a consumer of mental health services in North Carolina, Mark Long has seen it all. He has been admitted to every state psychiatric hospital and many local community hospitals. He has lived in group homes and on the street. He has tried nearly every treatment available, often with painful side effects.

Diagnosed with paranoid schizophrenia as a young man, Long spent most of the 1970s and 1980s in and out of psychiatric hospitals. Of the shift to community services in the 1990s, he says, "I felt like a yo-yo. I would bounce into one situation and then I would bounce back out. I went from being in a hospital to being back in the community every few months."

After making a third attempt to take his own life, Long left the family care home where he was living, walked down the street, and found Residential Treatment Services of Alamance. He later enrolled in the University of North Carolina at Greensboro, graduating with a degree in social work in May 2009. He went on to become one of the first Peer Support Specialists in our state. These specialists are people in recovery from mental illness or substance abuse who provide support to others by sharing their experiences. There are now 652 certified Peer Support Specialists in North Carolina [14].

Long has finally found the right treatment, a place to call home, and a vocation. His community-based treatment is his community-based life. The Court in Olmstead got the policy right. It is the implementation of this decision by the state that continues to need reform. **NCMJ**

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