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The State of Mental Health Reform in North Carolina

North Carolina Center for Public Policy Research

N.C. Center for Public Policy Research

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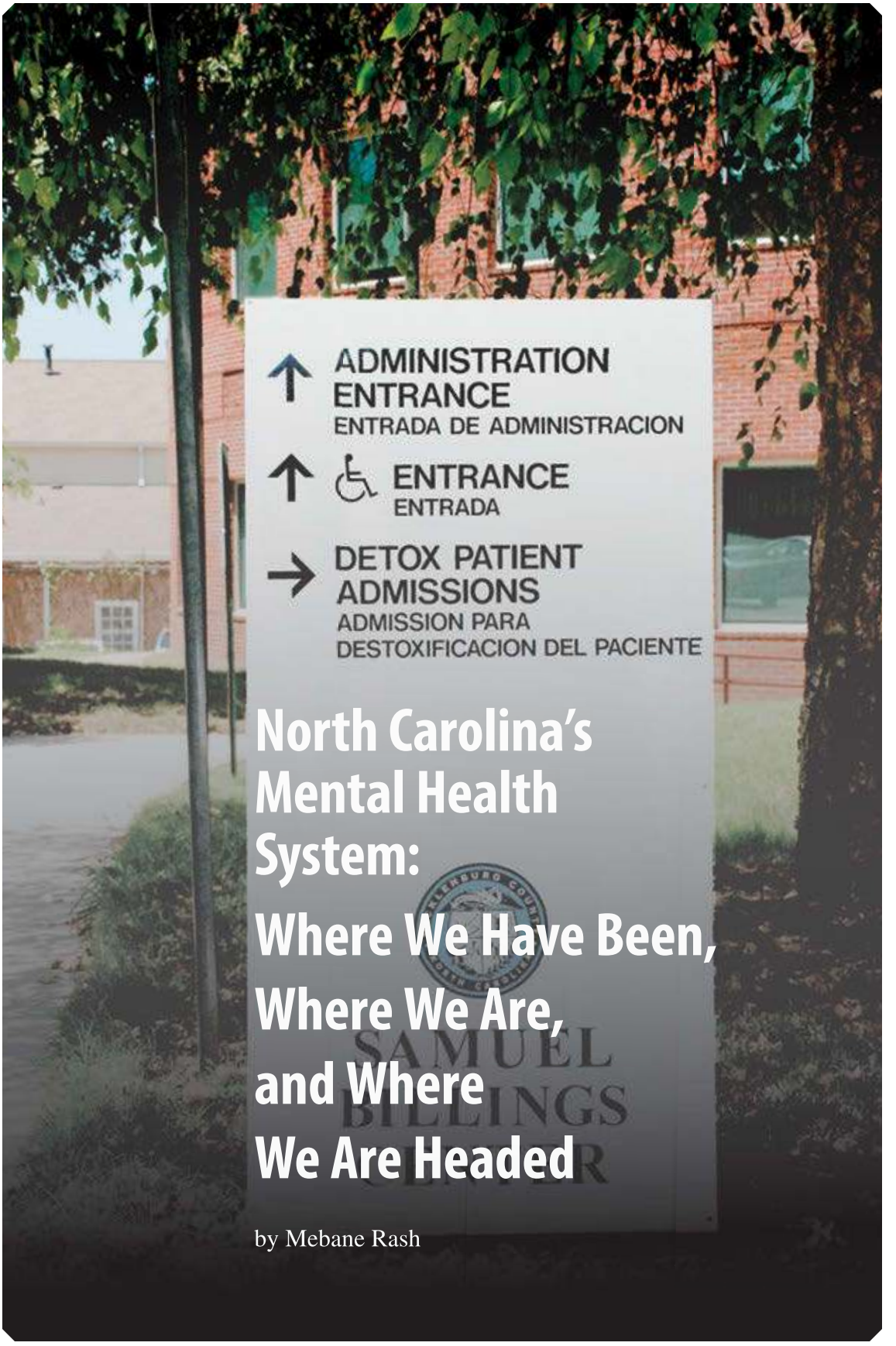

North Carolina's Mental Health System: Where We Have Been, Where We Are, and Where We Are Headed

by Mebane Rash

Aixander Duda

Executive Summary

This article is an overview of North Carolina's mental health system — its past, present, and future. In 1999, the U.S. 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. This decision paved the way for mental health reform nationwide. North Carolina's mental health reform legislation passed in October 2001.

To comply with the Court's decision, the state began to treat more people in the community instead of in institutions. From 2001 to 2011, the number of persons served at the state's psychiatric hospitals declined from more than 17,000 people to fewer than 6,000 people. At the same time, the number of those served in the community increased by 46 percent. A large network of private providers was built up to increase service capacity in local communities across the state, but questions were raised about provider quality. However, the biggest problem with mental health reform in North Carolina has been the state's endless stream of changes in policy, funding levels, and leadership. One national expert described it as "continuous, disconnected change."

More than a decade after mental health reform legislation passed in North Carolina, significant changes are still underway. Changes in policy include the implementation of a **new provider model**, called CABHAs or Critical Access Behavioral Health Agencies, and a **new funding model**, the federal Medicaid waiver. The waiver will move the state from a fee-for-service model to a capitated model, where the state will pay a set amount of money each month for each consumer served. The waiver has thrown the entire mental health system into flux as local mental health management entities consolidate to meet the requirements for managed care organizations. Since reform, the state has shifted its **local governance model** for mental health services from 39 area mental health authorities to 23 local mental health management entities to 11 managed care organizations. The reformed mental health system also has been on a **roller coaster ride of state funding** — from $581 million at the start of the reform effort in 2001–02 to a high of $743 million in 2008–09 to a low of $664 million in 2009–10. **Shifts in leadership** in the state's Department of Health and Human Services and at the legislature further complicate this issue and compromise the stability of the system.

In the 1840s, Dorothea Dix began crusading for the establishment of state psychiatric hospitals to treat mental health patients rather than throwing them in local jails or state prisons with no treatment. Ironically, this issue reverberates into our current policies as patients in need may end up in the criminal justice system instead of the mental health system. Another unintended consequence of mental health reform plays out in hospital emergency rooms across the state and across the nation. Emergency rooms are on the front lines of mental health care, even though they are not funded or staffed to serve that function and even though the chaotic environment of the emergency room is the opposite of what many mental health patients need. As states wrestle with these questions, their answers ultimately will determine the success of the policy established by the U.S. Supreme Court in its *Olmstead* decision — serving people closer to home, in their communities, which almost always is less expensive than the alternatives.

Based on the Center's research and analysis of mental health reform in the 50 states, we conclude 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 mental health system needs to settle on a course and then stay the course long enough to evaluate its success or failure.

The issues of mental illness, developmental disabilities, and substance abuse do not discriminate. They touch the lives of the rich and poor, those living in urban and rural areas, all ages and races, both genders, and people belonging to all political parties. Mental health reform touches all of our lives.

My uncle, Leland Ray, is autistic and developmentally disabled (see pp. 12–15). Born in Oxford, he attended public schools and was placed in the one special education program that was offered there. Sometime after he graduated with a certificate of attendance, he was placed in the Murdoch Developmental Center in Butner. Leland then moved into Person County Group Homes, Inc. — years before the U.S. Supreme Court's *Olmstead* decision would have required the least restrictive setting for him. He lived in a group home in Roxboro, and he worked in a sheltered workshop until he retired. A woman named Queenie ran the group home as if it were her own home, and she was the supervisor the last eight years Leland lived there. After retirement, Leland was moved to a more independent living situation, a boarding house in Roxboro, where he lives today. Leland has had the same case manager, John Noland, for more than nine years, and David Forsythe has been the director of Person County Group

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Mebane Rash is an attorney and the editor of the Center's journal, North Carolina Insight. *The Center has been conducting a study evaluating the state's mental health reforms since 2009. Much of this commentary draws directly from the Center's research, with particular thanks to Alison Gray, author of "The History of Mental Health Reform in North Carolina,"* North Carolina Insight, *N.C. Center for Public Policy Research, 2009, and Christine Kushner for her research on privatization. This commentary was first published in part in the* North Carolina Medical Journal, *Vol. 73, No. 3, May/June 2012, pp. 185–88, by the North Carolina Institute of Medicine and The Duke Endowment.*

Aisander Duda

Homes, Inc. since 1984 — as long as Leland has been in Roxboro. Forsythe's commitment to service is such that he spends his vacations working to repair the homes under his care.

My uncle is fortunate that his community-based care has included appropriate and adequate services provided on the local level in long-term placements, a medical and behavioral health care home, caretakers with experience who stay on the job, and adequate funding for the services he needs. His community-based treatment has been his community-based life. But Leland's experience with the mental health system in North Carolina is not typical. It is hard to find others who have had the positive experience he has had — even after the *Olmstead* decision and the state's mental health reforms. The question is, "Why?"

Person County Group Homes, Inc. provides long-term , community-based care on the local level.

Mental Health Reform in North Carolina: Where We Have Been

President John F. Kennedy and his brother, Attorney General and U.S. Senator Robert F. Kennedy, had a special interest in mental health care because their sister Rosemary was developmentally disabled. In the early 1960s, they helped 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 movement gained further strength in the 1990s as a result of two significant events. In 1990, Congress enacted the Americans with Disabilities Act (ADA) to eliminate discrimination against those with disabilities.[1] The act applies to all public entities and the use of public funds; therefore, it has implications for the provision of publicly-funded Medicaid services to people with mental disabilities.[2] Then in 1999, the U.S. 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.[3] 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, passed in October 2001.[4] Underpinning mental health reform were two ideas: deinstitutionalization and privatization.

Deinstitutionalization

Even after reform, the state has continued to operate 14 inpatient facilities statewide, including three state psychiatric hospitals, three alcohol and drug treatment centers, three developmental centers for people with intellectual and developmental disabilities, two residential programs for children, and three neuro-medical treatment centers. Together, these facilities, served 12,815 persons in FY 2011.[5] The number of persons served at the state psychiatric hospitals has decreased over the past decade. While the state's psychiatric hospitals served 17,160 persons in 2001 — the year mental health reform legislation was enacted — they provided care to just 5,754 persons in 2011.[6]

The intent of mental health reform was to separate management functions from functions of providers of services for area programs providing community-based mental health services and to create local management entities (LMEs), with strong ties to county government and with oversight and assistance from the state. Previously, the 39 quasi-independent area programs, called area mental health authorities, were created in the 1970s to provide direct services to one or more counties and had served both as providers and payers — that is, they both delivered services and oversaw public dollars that were allocated to mental health services. They were autonomous public agencies governed by citizen boards, and they were not accountable to elected county commissioners because their service areas often covered several counties.

Under the 2001 legislation, these area programs morphed into LMEs, shedding their direct services and becoming the local entities that manage both 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.[7] In 2001, 246,039 persons were served through the LMEs, but by 2011, the LMEs were coordinating services for 360,180 persons statewide.[8]

Privatization

Privatization of clinical services — which gathered steam on the national level throughout the 1970s, 1980s, and 1990s — originally was not 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.[9]

In theory, North Carolina's approach was supposed to accomplish four things: to increase administrative efficiency by segregating management and oversight of mental health services from the actual provision of services, to promote innovation and utilize new technologies, to enhance provider quality, and to stimulate competition among providers.[10] 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 watchdogs over quality, expanded their role under reform to provide services, creating a potential conflict of interest for themselves. This led to 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.

Based on the Center's 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 changes in policy, funding levels, and leadership so frequently that often it seems the biggest problem with reform is the state's inability to stay the course — any course. More than a decade after reform legislation passed in North Carolina, significant changes are still underway.

The Mental Health System in North Carolina: Where We Are

Changes in Policy

A New Provider Model: Critical Access Behavioral Health Agencies

Reform created a large network of providers and corresponding service capacity, but there were questions about provider quality.[11] Late in 2009, the N.C. Department of Health and Human Services proposed a new provider classification for mental health services in North Carolina called CABHAs, short for Critical Access Behavioral Health Agencies. These large providers deliver mental health and substance abuse services. This approach was developed to ensure appropriate medical and clinical treatments and to reduce the potential for ineffective or unwarranted services. As of August 2012, there were 210 certified CABHAs statewide.[12]

—continues on page 10

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Mebane Rash

XDS, Inc.: One Provider's Adjustments to the State's Changes in Policy

by Mebane Rash

The story of XDS is a story about providers of mental health services and how they cope with the seemingly constant changes in state policy, how to pay for services, and the real impact on consumers and providers.

Thava Mahadevan (above) is the executive director of XDS in Pittsboro, a nonprofit provider of services to more than 130 consumers. XDS stands for "cross disability services," which means the people Thava serves have both mental illness and developmental disabilities. Consumers with dual diagnoses routinely fall through the cracks because they need long-term care that costs a lot of money, and they are not going to get better. The budget for XDS is $2 million.

Thava is a refugee from the island of Sri Lanka in southeast Asia. Ethnic and political conflict has plagued the island, and Thava's family fled to Southern India after their home was attacked and burned to the ground. With the help of a Hindu monastery, the family began to rebuild their lives. After graduating from Madras Christian College, Thava received a full scholarship to attend Davidson College in 1988 on a music and cultural exchange. After Davidson, he moved to Boone. He worked for a small mental health agency providing direct care at two group homes to the first group of *Thomas S*. patients leaving Broughton Hospital. *Thomas S*. was a lawsuit on behalf of people with mental retardation that had been served in state psychiatric hospitals instead of their communities. Thava says he loved his work there, and so he decided to go to graduate school at UNC-Chapel Hill in rehabilitation counseling. He then went to work at John Umstead Hospital in Butner, as the *Thomas S.* specialist, transitioning patients back to their home counties. Five years later, he became the *Thomas S.* coordinator for the Orange-Person-Chatham local mental health management entity.

After the mental health reform law passed in 2001, XDS was established, and Thava has been there ever since.

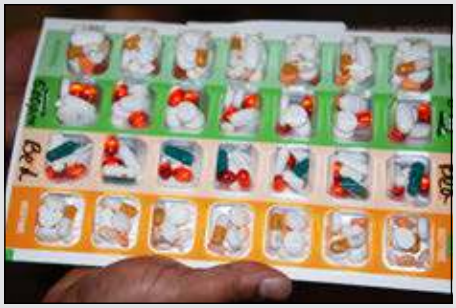
Thava's laugh is infectious. His energy and passion fill the room. He has figured out how to roll with the system. He has decided that serving his clients is all that matters. He figures out what is best for them, and then he figures out how to make that happen.

XDS rents 60 apartments in the Triangle for its clients. Thava knows that without housing he can't keep his clients out of crisis. His clients use a federal government subsidy to pay for rent and food stamps to pay for food. But how were they supposed to pay for utilities? Thava went to the N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and he made sure that their coverage would include the other costs of independent living so his clients could live on their own in the community in an apartment of *their* choice.

When his clients missed appointments over and over again because of transportation issues, Thava bought a fleet of cars for XDS. Now XDS is able to take services to its clients. Even the psychiatrist goes to the homes of those she treats and provides her services there.

To monitor all of the constant changes in billing and coverage, Thava set up a war room. On one screen, he monitors incoming money to provide services. On another screen, he monitors the Division's almost constant communications with providers. He pays bills at the same time with his handheld device. There is a notebook computer on his desk that does everything else. He takes it with him everywhere.

Thava lost hope in 2011 when the state's shift to Critical Access Behavioral Health Agencies (called CABHAs, these are large providers of mental health and substance abuse services) was announced. He stopped laughing, and for the first time he worried about his clients and his staff and whether he could figure out this latest obstacle. He knew the numbers didn't work. Unwilling to shut down, he moved XDS from Durham, where he was paying $8,000 in rent, and bought property in Pittsboro that costs him only $2,500 a month. XDS then was approved as a CABHA. Thava had figured out a way to keep XDS going.



XDS has merged now with the UNC Center for Excellence in Community Mental Health so that together they can provide a true continuum of care for consumers — from hospital emergency room services, to inpatient hospital beds, to mobile crisis teams, to high-level services needed to keep clients living in the community and out of hospitals, to community support. Thava remains the executive director of XDS, and he serves as the Director of Operations for the Center for Excellence.

Thava now wants to establish a clinic on the XDS property so that medical and behavioral services are integrated, at least for his clients. He wants to create a therapeutic farm on his 35 acres and build a music, art, and pottery therapy center for his consumers.

Thava wants mental health reform to work. The alternative, he says, is unthinkable —for his clients, for his organizations, for his state.

"Thava now wants to establish a clinic on the XDS property so that medical and behavioral services are integrated at least for his clients. He wants to create a therapeutic farm on his 35 acres and build a music, art, and pottery therapy center for his consumers."

"And if the dam breaks open many years too soon
And if there is no room upon the hill
And if your head explodes with dark forbodings too
I'll see you on the dark side of the moon
The lunatic is in my head
…
You lock the door
And throw away the key
There's someone in my head but it's not me."

— *Brain Damage* by Pink Floyd

CABHAs may be for-profit, nonprofit, or public health agencies, but they are required to provide three core services — comprehensive clinical assessment, medication management, and outpatient therapy — and at least two additional services from a list of 14 services, 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.

The interplay of the federal Medicaid waiver (see below) and CABHA policies is worth watching closely. One of the goals of the waiver is to allow LMEs to pick providers based on performance and to give the providers incentives to provide needed services. But the CABHA policy eliminates many smaller providers in favor of fewer, larger providers. Some areas of the state do not have many CABHAs. Whether local management entities will be able to encourage competition and lower prices in areas where a few providers essentially have a monopoly on services is unclear. Also, this provider network is still in flux with the number of CABHAs likely to come down. If further budget cuts are made by the 2013–14 N.C. General Assembly that affect the provision of mental health services, then the CABHAs that are operating close to the margin of profitability may go out of business.

—continued from page 7

A New Funding Model: The Federal Medicaid Waiver

Medicaid is the state-run federal program providing health insurance for individuals with low incomes, long-term care for the elderly, and services for person with disabilities. It is the largest funder of mental health services nationwide. In North Carolina, it is also the fastest-growing program in our state budget.[13]

North Carolina is currently trying a new funding model — a federal waiver for our Medicaid program. Federal waivers allow states to operate programs outside normal federal Medicaid guidelines. The federal Medicaid guidelines are *waived*, thus the name of the program. Particularly since the economic downturn began in 2008, the waiver is a crucial element in running an effective and cost-conscious system. According to David Swann, chief clinical officer for Partners Behavioral Health Management, "The objective is not to limit services for individuals, but to manage a system so that a person is guided to the *appropriate* level of care."[14]

The waiver eventually will apply to all mental health, developmental disability, and substance abuse services in North Carolina funded by Medicaid. The technical name of the 1915(b) waiver is the N.C. Mental Health, Substance Abuse, and Developmental Disabilities Health Plan. 1915 is the section of the federal Social Security Act that authorizes these waivers.[15] The (b) part of the waiver allows the state to contract with a managed care vendor, a local management entity-managed care organization (LME-MCO),[16] for oversight of mental health, developmental disability, and substance abuse services in their counties. In theory, this will save money allowing for expanded services. The technical name of the 1915(c) waiver is N.C. Innovations. The (c) part of the waiver allows for home- and community-based services to be provided in lieu of institutional care for those with developmental disabilities. Through this part of

the waiver, the state will be able to offer habilitation — the teaching or training of a person to be independent in their daily living.

Initially, the state had planned to expand the waiver to one or two LMEs each year, allowing expertise to be provided to each LME and giving the state time to learn from each implementation. But in 2011, with Medicaid costs rising and the state revenues down due to the recession, the North Carolina legislature passed a bill to expand the waiver statewide by July 1, 2013, in hopes of saving $10.5 million in fiscal year 2012 and $52.5 million in fiscal year 2013.[17]

This has thrown the entire mental health system into flux as local management entities consolidate to meet the requirements for managed care organizations (MCOs). State officials currently expect the 23 LMEs to merge into 11 MCOs.[18] For this model to work, each MCO has to cover a sufficient number of consumers to be financially stable. From area agencies to LMEs to LME-MCOs, North Carolina needs to stick with a local governance model. "Don't hit reset too soon," cautions Mike Hogan, the Commissioner of Mental Health in New York.

Not unexpectedly, implementing the waiver statewide this quickly has been difficult. The Mecklenburg County LME requested a 90-day reprieve from working towards an anticipated July 1, 2012 start date of the waiver as the leadership and financial management of the LME was reorganized. The waiver in Mecklenburg now is scheduled to be implemented in January 2013. The Western Highlands Network began administering services in January 2012. By July 2012, it had amassed a $3 million deficit, and its board of directors fired the CEO.

There are pros and cons to the waiver approach. On one hand, it allows the state to use Medicaid and state funds more effectively by giving the state the ability to predict and control costs. Instead of receiving a fee for a service provided, LMEs will receive a set amount of money each month for each consumer served. The federal waiver also gives the LMEs the ability to pick providers and set rates. The hope is that LMEs will be able to create incentives for providers to make available the mix of services consumers need in their region, including services for consumers who may have been undertreated historically. According to Kelly Crosbie, who is in charge of implementing the waiver statewide for the Division of Medical Assistance, waivers can be used to:

- increase access to preventive and maintenance care;
- decrease the use of avoidable inpatient care;
- expand provider networks and services;
- shift the emphasis to recovery, rehabilitation, and work;
- provide more focused and goal-oriented treatment; and
- increase reliance on best practices.[19]

On the other hand, the waiver approach continues to carve out separate provision of mental health services for consumers in North Carolina instead of following a national trend to integrate the provision of mental and physical health care services through one health care provider.[20] Under the waiver, LME-MCOs also will assume the risk. If services cost more to provide than projected, the LME-MCOs will have to use risk reserves to cover those costs. Furthermore, the promise of additional services depends on three variables. First, LME-MCOs need to be able to save money, which may prove difficult now that the primary source of savings — moving people out of institutions and into the community — has occurred.[21] Second, the federal government will have to approve any extra services provided with savings, a process that does not always happen quickly. Third, although the waiver moves LME-MCOs to a capitated system where they receive a set amount for each consumer served, the providers remain in a

—continues on page 16

Leland Ray: Living a Community-Based Life in Roxboro

by Aisander Duda

Nestled on a small hill in Roxboro, surrounded by ancient oaks and pecan trees, is a beautiful 1930s-era farmhouse with a long front porch, occupied by well-worn rocking chairs. On one bright and sunny morning, the front door is wide open, and "Hot Stuff" by Donna Summer is blasting into the carefully-tended garden on the front lawn. Inside, gathered in a long, spacious dining room, "Mama Jo" Shotwell is leading a group of a dozen developmentally-disabled men and women in dance. Mama Jo is a bubbly and vibrant woman who has been working with this group for more than 15 years. As she dances around the room clapping and singing, she calls out each person's name, pulling them further into the activity. Those that can stand up are shaking their hips and swinging their arms. Those who are wheelchair-bound raise their hands into the air and smile and laugh with their companions. This is Generations Adult Day Services, which provides care and therapies for Roxboro residents with developmental disabilities and severe dementia. At Generations, those with mental retardation, autism, and dementia get a mix of socialization, physical therapy and activity, and education from 8 a.m. until 4 p.m.

After Mama Jo gets the group's blood flowing with some dancing and stretching, she immediately jumps into the first activity of the day, which varies from one person to the next. A young man in a mechanized wheelchair is shown flash cards with images of different animals by an aide, which prompts him to try and name the creature. While the young man cannot verbalize his answers well, the aide continues to prompt him and then gives him the correct answer if he misses. Sitting across the table from him is a quiet woman in her 70s who has severe Alzheimer's disease. Her activity is a word-finding puzzle. She glances around the room smiling at everyone.

Aisander Duda

Just down the table sits another older gentleman. He is working on the same type of puzzle as the woman, but his focus is intense. This is Leland Ray (above), who has mental retardation and autism. Leland is an avid walker, making his way to many of the local shops and public spaces in Roxboro, often catching a ride home with anyone from the police, to the fire department, to local store employees, and even other shoppers. Leland lives just up the hill from Generations, a short walk for him. He lives in a small house with four other developmentally disabled men, part of the independent living program of Person County Group Homes, Inc.

Mama Jo looks over at him and says, "Leland, tell me what time it is?" Leland pauses and refocuses his attention on the clock in front of him. "One minute past 10, Mama Jo," he says quietly, flashing her a big smile.

Joyce Riley, who is the Program Director of Generations Adult Day Services, says that each member of this group has a set of tasks and goals that they must complete. All of their tasks are set up to challenge them and improve their ability to take care of their own life needs. Some of Leland's

tasks include serving and cleaning up breakfast, helping cook some of the lunches, planning the event and activity calendar with Mama Jo, and working on his ability to tell time, among others. Riley says that on a typical day, the Generations staff tries to provide five types of activities to challenge individuals in the program; passive activities, such as watching TV; active tasks, such as working on a puzzle or game; exercise, such as dancing; communication, such as working with a staff member on a project; and educational activities, such as being read a short article about health and wellness.

Leland and the Generations group will spend the morning hours in this large, old dairy farmhouse participating in these types of activities, watching "The Price is Right" on TV, and cooking a family-style lunch. Once a month, they have the Roxboro Fire Department over for a few games of bingo, and just recently the group donated a rose bush to a local retirement home. When Mama Jo and the other staff mention the fish fry they are planning for Father's Day, the whole room buzzes with excitement. "I try to mix things up for them, to get them excited, and to provide variety," says Shotwell. "This place is their whole world. For most of them, after they leave here in the morning, they go home and get dinner and a bath and that's it. At [Generations] these folks at least have a chance to be part of a close group, learn skills, and to interact in a way they may not normally."

After Leland Ray finishes a busy morning at Generations, he walks up the hill and returns to his home, but his day is far from over. On this particular afternoon, Leland is late returning home from Generations and John Noland, the qualified professional that oversees the operation of several independent living programs and adult care homes, is worried Leland might have gone out for one of his famous long walks. Noland, a retired high school teacher from West Virginia, has been with Person County Group Homes for nearly eight years and knows Leland's habits well.

"I used to worry about Leland walking around on his own," says Noland. "But he's pretty careful about where he goes, and now people all over Roxboro know him and know where he lives. I've followed him home in my car on several occasions just to be sure he's all right."

Noland says that Leland is just one of more than 80 Roxboro residents living in Person County Group Homes, Inc., and 50 in their day services programs. The five men in this particular group home receive funding at various levels from the N.C. Community Alternatives Program for the Developmentally Disabled (CAP MR/DD) as a means of paying for their services, says Noland. Each individual in the home also is employed in the community, earning their own money to spend on food, hobbies, and vacations. Employment for the members of this group can range from working in a restaurant to a supportive workshop at Person Industries, a county-sponsored work program which recently began handling the processing of all of Person County's recyclable materials. The other four members of the home work either full- or part-time jobs. Leland, at age 64, is what Noland terms "retired."

"He still does some work around the house apart from his normal tasks, and he gets paid for doing things like raking leaves in the yard," says Noland.

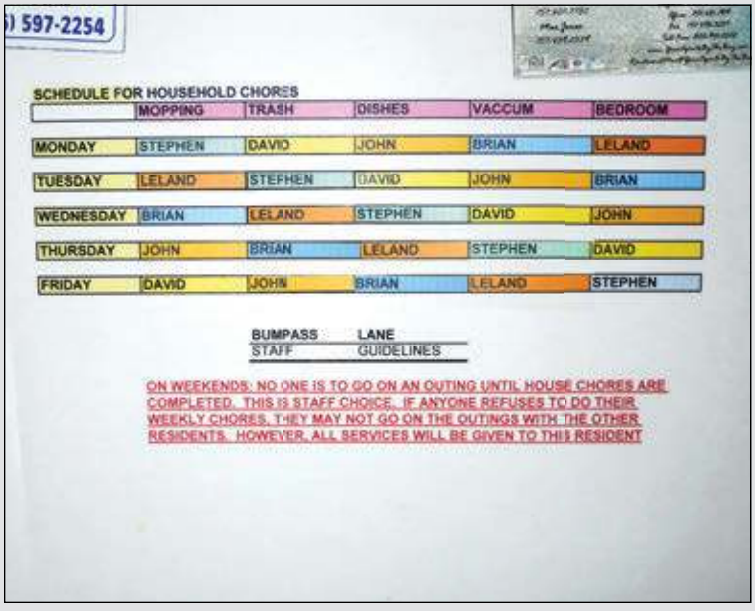
Noland then turns away and cups his hand over his furrowed brow as he scans the road leading toward the house for any sign of Leland. Then, a red pickup truck comes rolling up to the house. John Noland smiles wide, and out pops Leland and Mike Jones, a supervisor, who oversees the daily activities in Leland's house. "Sorry we're late. Leland was getting his glasses fixed," says Mike, a middle-aged man with a Southern drawl and neatly trimmed, graying mustache.

Mike has been working with the developmentally disabled for more than 18 years. In his current position with Person County Group Homes, Inc., Mike oversees the daily activities of the five men in Leland's home, including helping them learn and develop life skills, assisting them with their finances, and transporting the group to doctor appointments and shopping. Mike only stays through dinnertime, making sure everyone in the house has completed their tasks and chores and has received any one-on-one time they need. At night, the residents are on their own, but rarely call upon Mike or John Noland for assistance. "I've had only a few serious incidents at night in the time I've been here," says Mike. "Usually if there's an issue, it's because someone has switched medications and is having an adverse reaction or something like that."

Aisander Duda

Leland Ray shows Mike Jones, right, pictures from the group's recent trip to the beach.

Leland leads the way into the house, a small brick ranch home divided into five individual suites — each with a living area, bedroom, large closet, and shared bathroom. Leland's suite is clean and well-kept except for the small hobby table in his living room, which is covered by countless batteries, broken electronics, and tools. Mike says that Leland is enormously interested in the inner-workings of everyday electronics like clocks, radios, and small toys. In fact, Leland carries a handheld radio in his pocket everywhere he goes. The rest of his suite is sparsely furnished with a TV, couch, bed, dresser, refrigerator, and homemade art that Leland has crafted during his time at Generations.



The house is old and worn but also quite homey, with a large communal kitchen and dining area. In the kitchen hangs a small laminated list of chores that each member of the house must complete daily, such as vacuuming the common areas or cleaning the kitchen. On one wall of the kitchen, from floor to ceiling, is a mural of geese flying over an expansive lake and forest. Mike says that the mural is something to brighten the room up, and Leland smiles and nods approvingly. It is here in the kitchen that

Leland has recently been doing a lot of work, learning how to cook new dishes with Mike's help.

"I've been trying to teach Leland how to cook scrambled eggs for a couple months now," says Mike. "He's gotten better, but we're not quite there. I try to keep him from burning himself or flipping the eggs onto the burner." Along with these skills, Mike has been helping Leland improve his verbal communication as well. Due to Mike's poor hearing, he says that Leland has been forced to speak louder and more clearly when they work together. Mike chuckles and says, "I never intended to work on that with him, so that's a happy accident."

Sitting down at the kitchen table, Leland immediately begins pulling out picture albums and souvenirs from the group's latest vacation — a trip to Myrtle Beach. John Noland says that every year they give each individual in their communities an opportunity to go on a vacation. Everyone saves up the wages they earn throughout the year to afford the trips.

Closer to home, the staff of Person County Group Homes makes sure there are plenty of opportunities for fun. Some residents enjoy barbecues. Others

have a membership in a sports club. Still others try out for the Special Olympics. Leland, prior to his retirement, was on the Person County Special Olympics Equestrian Team and also possesses several trophies from local bowling clubs. Each resident of the group homes is offered opportunities to live a full, active life.

With this blend of oversight and autonomy, structure and independence, Leland Ray has been given the opportunity to live his life as an integrated, active member of the Roxboro community. This was the goal of mental health reform, but it's not everyone's experience.

Leland Ray has been given the opportunity to live his life as an integrated, active member of the Roxboro community. This was the goal of mental health reform, but it's not everyone's experience.

—*continued from page 11*

fee-for-service system. According to Marvin Swartz of the Duke University School of Medicine, this may "misalign incentives between the MCO and providers, undermining joint planning."[22] Ultimately, Swartz warns the waiver may shift the incentives for LMEs-MCOs from over-treating to under-treating consumers.[23] The cost to treat these consumers may end up just being shifted to the criminal justice system, for instance.[24]

To increase the likelihood that the implementation of the waiver statewide will be successful, Swartz has three recommendations. First, despite the political consequences or feasibility, the state should slow down its implementation of the federal waiver. Second, the state should engage *private* MCOs to teach the *public* LME-MCOs the business and then exit after implementation. Third, the state should extend the current pilot[25] and try different approaches.[26]

Michigan's experience provides another cautionary tale about waivers and the risk of relying exclusively on Medicaid to fund mental health services. Michigan also implemented its waiver statewide, but with mixed results. As hoped, 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 the auto industry's troubles and the state's damaged economy during the recession. To receive Medicaid 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."

Foreshadowing yet another policy change, in April 2012, North Carolina requested approval from the federal government to provide personal assistance services (services that assist with daily living skills, such as eating, bathing, and dressing) to mental health consumers through a 1915(i) State Plan Personal Assistance Services (PAS) program. If approved, these services will be available beginning on January 1, 2013.

Unstable Funding

The funding for the public mental health system in North Carolina comes from Medicaid, state appropriations, county funds, and other sources. More than $3 billion annually is spent on services.

But the reformed system has been on a roller coaster ride of state funding, with the Great Recession taking its toll on North Carolina's state budget revenues and thus funding for the system. State funding for the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services totaled $581 million in fiscal year (FY) 2001–02, increased to $743 million in 2008–09, decreased to $664 million in 2009–10, increased to $705 million in 2010–11, decreased to $666 million in 2011–12, and increased to $696 million in 2012–13.

Three years ago in FY 2010, the state had a revenue shortfall of $4.6 billion dollars. The Governor had to impose cuts after the legislature adjourned to keep the budget in balance. Overall, the Division of Mental Health's budget was cut during that year from $820 million[27] to $664 million, or by 19 percent. Two years ago, the state had another revenue shortfall of $1.2 billion. In FY 2011, $40 million in funding for community services administered through the LMEs was restored. But, this increase was more than offset by cuts in other parts of the budget — in particular, the budget for the Division of Medical Assistance (DMA), which runs the Medicaid program in North Carolina and pays for a lot of mental health services. To save $41 million, the legislature required DMA to use rate and utilization management for mental health services — that means lower rates paid to providers and fewer services for consumers. To save an additional $7.7 million, independent assessments were required for some mental health services paid for with Medicaid funds. The upshot of this was also fewer services for consumers. And, to save an additional $51 million, the in-home personal care services program now will provide care at home only to those individuals at the greatest risk of being sent to more expensive institutional care.

Freedom House Recovery Center in Chapel Hill: The Need for Stable State Funding

by Mebane Rash

A man undergoing substance abuse detoxification for heroin addiction groans as the drug works its way out of his system. A teenager's addiction to alcohol is treated in a chair where he may sit for 23 hours under medical observation because beds for adolescents who need long-term substance abuse treatment are few and far between in North Carolina. In another building, a 30-year-old woman sits in a halfway house crying with gratitude. After going through detox three times and being discharged back to the streets, she is ashamed of her struggle but thankful for the support she is finally getting to overcome her addiction. Here, she will learn basic living skills, get her first job, and find permanent housing. Recovery is about much more than being drug-free.

> *"As one of the state's best private providers of mental health services, Freedom House employs 252 people, and it served almost 10,000 mental health and substance abuse consumers in 2011. Their outcomes are better than both state and national outcomes."*

These life-altering services are provided at Freedom House Recovery Center in Chapel Hill, a mental health provider for 37 years. Three years ago, Freedom House had built up almost $1 million in cash reserves—enough to ensure adequate cash flow when the state's payments were delinquent. But, those reserves were reduced as the economy tanked. Feeding their residential clients costs one-third more than it did a year ago due to the rising costs of groceries. Then, they had to reorganize as a Critical Access Behavioral Health Agency (or CABHA), the state's new designation for large providers of mental health services. This required having a full-time medical director on staff. And, the organization has suffered through three years of state budget cuts—cuts both to the services they can provide, and the amount they are paid to provide them. Providers are feeling the effects of the economy, changes in state policy, and state budget cuts in a way that could undermine their ability to provide services going forward.

As one of the state's best private providers of mental health services, Freedom House employs 252 people, and it served almost 10,000 mental health and substance abuse consumers in 2011. Their outcomes are better than both state and national outcomes. Clients who received long-term treatment at Freedom House were surveyed after 90 days and again after 180 days: 82 percent reported being drug or alcohol free, 62 percent had full- or part-time employment, 91 percent of those with prior involvement in the criminal justice system because of their addiction reported no criminal activity or charges, and 86 percent were living in permanent housing. It's an investment of state dollars that makes good business sense.

Trish Hussey is the director of Freedom House.

Yet Marvin Swartz of the Duke University School of Medicine notes that most provider organizations are already under financial strain with severe cash flow problems. Providers like Freedom House have had to ask themselves hard questions during the past several years. How will we make payroll? Should we cut services? In a speech in August 2012, Swartz cautioned that additional cash flow problems created by the transition to the federal Medicaid waiver could send provider organizations into insolvency.[1]

Trish Hussey, the executive director of Freedom House, says the transition to Cardinal Innovations, formerly Piedmont Behavioral Healthcare (PBH) and one of the new LME-MCOs, "has been a positive experience for us financially so far. They are paying quickly and efficiently for the services we provide, and this has made all of the difference in the world to us."

Karen Tam

Endnote

[1] Marvin Swartz, "The Promise and Pitfalls of North Carolina's Medicaid 1915 b/c Waiver Program," N.C. Institute of Medicine, Annual Meeting on the Evolving Mental Health System, Aug. 23, 2012, Slide 11.

In FY 2012, the state was short $2.5 billion. Despite this shortfall, some of the mental health dollars cut in FY 2010 continue to be restored, so for FY 2013, the Division's budget increased to $696 million. Some important provisions of the FY 2013 state budget as it pertains to mental health reform include:

- A $20 million reduction in funding to the state's LMEs. $345 million remains in the budget for this purpose;
- An $8.5 million reduction in funding for the *administrative* budgets of the LMEs;
- A $2.25 million reduction in funding for drug treatment court services;
- $9 million in additional funding for the three-way contracts to purchase 45 more beds;[28] and
- 124 additional beds funded at Cherry Hospital, and 19 additional beds funded at Broughton Hospital, both of which are state psychiatric hospitals.

Shifts in Leadership

Just keeping up with who the policymakers are in this field can be challenging for those interested in the issue. Lanier Cansler was Secretary of the Department of Health and Human Services (DHHS) from January 2009 until he stepped down in February 2012. Al Delia, formerly the Governor's senior advisor on policy, is now the acting Secretary — probably until a new governor takes office in January 2013.

On June 19, 2012, Delia announced a re-organization of his leadership team. Dr. Craigan Gray, the former director of the Division of Medical Assistance, the state's Medicaid office, was fired. Mike Watson, formerly the chief deputy secretary of DHHS, is the new state Medicaid director. Beth Melcher, formerly the assistant secretary for the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS), is now chief deputy secretary of DHHS. Soon after these changes, Steve Jordan, the director of MH/DD/SAS, was killed by a logging truck while riding his bicycle. Jim Jarrard has been named acting director of the Division. Jarrard has been deputy director of the division since October 2010. The elections in November 2012 are likely to precipitate another round of changes.

Turnover at the North Carolina General Assembly further complicates the issue. In the 2011–12 legislature, there were 46 freshman legislators (27 percent). And, 61 more legislators serving in 2011–12 will not be returning at all or to the same chamber in 2013 as a result of deaths, resignations, redistricting, or defeats in the 2012 elections. In the 2013–14 General Assembly, 102 legislators (60 percent) will not have been there just three years ago.[29] This will result in a loss of institutional memory around the goals of mental health reform and create another hurdle for stable funding and consistent policies. For example, the 2011–12 legislature allowed the Joint Legislative Oversight Committee on Mental Health, Developmental Disability, and Substance Abuse Services to expire. Thus, the most prominent forum for discussing mental health policy issues no longer exists. And, when bills affecting mental health services were discussed in committee meetings, legislators did not even realize that they needed committee rooms that would accommodate people with disabilities.

Nationwide Trends: Where We Are Going

As the Center has looked at what other states around the country are doing to comply with the U.S. Supreme Court's *Olmstead* decision and serve those with mental disabilities, two trends are apparent.

Dealing with Mental Illness and Substance Abuse: In the Criminal Justice System or the Mental Health System?

One trend is for states to deal with mental illness and substance abuse in jails and prisons rather than in the mental health system. This is an echo of the policies in place when Dorothea Dix began crusading for the establishment of state psychiatric hospitals to treat mental patients rather than throw them in local jails or state prisons. There is no better example of this trend than the state of Georgia, where one in every 13 adults is under correctional control.[30] It is estimated that 75 to 80 percent of those inmates require either mental health or substance abuse services, and some require both.[31]

Dr. Tony Frasca, a psychiatrist who works in western North Carolina, says that state governments have two options when it comes to serving their mentally ill populations: Either the Department of Correction 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 Correction, with citizens being served at a much lower cost in the community with treatment that prevents them from ending up in jail. He asked, "Which system do we as a state want to fund?"

Hospital Emergency Rooms on the Front Lines

Another trend that emerged in our 50-state study is that visits to hospital emergency rooms by patients with mental illness or substance abuse are increasing. This unintended consequence of mental health reform plays out in emergency rooms (ERs) across our state every day. In 2011, at one community hospital with 24 beds in the emergency room, there were about 2,000 visits by patients with mental illness or substance abuse — on average, about five visits each day. In June 2011, things got so bad that for two weeks, there were nine or more patients in this ER at all times with mental health or substance abuse issues. Patients also are staying in the hospital emergency rooms longer and longer as they wait for beds in mental health facilities to become available. There have been as many as 15 people held in this particular ER for mental health issues, taking up more than half the capacity of the emergency room. The longest stay has been 10 days. Just imagine waiting in a hospital emergency room for 10 days.

Emergency rooms 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 a hospital emergency room is the opposite of what many mental health patients need, and even though many ERs are unable to initiate treatment.

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

Stay the Course

"Y'all never stick with one thing," said Mike Hogan, the Commissioner of Mental Health in New York, of North Carolina's mental health system, during his keynote address at a mental health care conference sponsored by the N.C. Institute of Medicine in August 2012. He described one of North Carolina's long-standing challenges with mental health reform as "continuous, disconnected change." He said there was "lack of agreement on the playlist." His advice? "Problems will occur. Expect them, deal with them. Stay the course."

Endnotes

[1] U.S. Public Law 101–336, codified as 42 U.S. Code § 12132.

[2] The Social Security Act of 1965, 42 U.S. Code Chapter 7, Subchapter XIX, §§ 1396–1396v. Generally, Medicaid provides health insurance for individuals with low incomes, long-term care for the elderly, and services for persons with disabilities.

[3] *Olmstead v. L.C.*, 527 U.S. 581 (1999).

[4] N.C. Session Law 2001–437 (House Bill 381).

[5] Jeanette Barham, *Annual Statistical Reports: N.C. Alcohol and Drug Abuse Treatment Centers, N.C. State Developmental Centers, N.C. Neuro-Medical Treatment Centers, N.C. Psychiatric Hospitals, and N.C. Wright and Whitaker Residential Programs for Children,* Fiscal Year 2011, N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Jan. 2012. On the Internet at *http://www.ncdhhs.gov/mhddsas/statspublications/Reports/Financialandstatisticalreports/Statisticalreports/index.htm*, accessed on March 29, 2012.

[6] Jeanette Barham, *Annual Statistical Report: North Carolina Psychiatric Hospitals*, Fiscal Years 2010 and 2011, N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Table 1, Dec. 2010 and Jan. 2012. On the Internet at *http://www.ncdhhs.gov/mhddsas/statspublications/Reports/Financialandstatisticalreports/Statisticalreports/index.htm*, accessed on March 29, 2012.

[7] Local Management Entities by Name Website, on the Internet at *http://www.ncdhhs.gov/mhddsas/lmeonbluebyname.htm*, accessed March 29, 2012.

[8] Jeanette Barham, *Annual Statistical Report: North Carolina LMEs*, N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, State Fiscal Year 2011, Figure 1, Jan. 2012. On the Internet at *http://www.ncdhhs.gov/mhddsas/statspublications/Reports/Financialandstatisticalreports/Statisticalreports/AREAPROGRAMS/2011lmeannualrpt.pdf*, accessed on March 29, 2012.

[9] Alison Gray, "The History of Mental Health Reform in North Carolina," *North Carolina Insight*, the N.C. Center for Public Policy Research, Raleigh, N.C., 2009, p. 76, quoting Rep. Verla Insko, "But it was only after House Bill 381, Mental Health System Reform, passed that private providers and LME staff began to say the goal was to privatize, so that became 'the truth.'" Insko sponsored House Bill 381.

[10] Marvin Swartz and Joseph Morrissey, "Mental Health Care in North Carolina: Challenges on the Road to Reform," *North Carolina Medical Journal*, Vol. 64, No. 5, North Carolina Institute of Medicine and The Duke Endowment, Morrisville, NC, Sept./Oct. 2003, p. 208.

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[11] See Pat Stith and David Raynor, "Reform Wastes Millions, Fails Mentally Ill," *The News & Observer*, Raleigh, NC, Feb. 24, 2008; p. A1.

[12] CABHA Certification List Website, on the Internet at *http://www.ncdhhs.gov/mhddsas/providers/CABHA/cabha_certificationlist_03–02–12.pdf*, accessed on August 21, 2012.

[13] Christine Kushner, "Medicaid and North Carolina's Aging Population," *North Carolina Insight*, Vol. 23, Nos. 2–3, N.C. Center for Public Policy Research, Raleigh, N.C., March 2010, p. 121.

[14] David Swann, "Implementing the Medicaid Managed Care Plan," N.C. Institute of Medicine, Annual Meeting on the Evolving Mental Health System, Aug. 23, 2012, Slide 5.

[15] Title XIX of the Social Security Act §1915(b)(c), 42 U.S. Code Chapter 7, Subchapter XIX, § 1396n.

[16] Local mental health management entities (LMEs) are the agencies responsible for managing, coordinating, facilitating, and monitoring the provision of mental health, developmental disability, and substance abuse services in the area served. Many LMEs are in flux as they merge into the 11 managed care organizations (MCOs) that are expected to exist after the state's implementation of the federal waiver of Medicaid regulations governing mental health services.

[17] N.C. Session Law 2011–264 (House Bill 916).

[18] Proposed LME-MCO Map Website, on the Internet at *http://www.ncdhhs.gov/mhddsas/lmemcomap2–9–12.pdf*, accessed on March 29, 2012.

[19] Kelly Crosbie, "Medicaid Plan for *Quality*, *Access*, *Services*," N.C. Institute of Medicine, Annual Meeting on the Evolving Mental Health System, Aug. 23, 2012, Slide 4.

[20] Marvin Swartz, "The Promise and Pitfalls of North Carolina's Medicaid 1915 b/c Waiver Program," N.C. Institute of Medicine, Annual Meeting on the Evolving Mental Health System, Aug. 23, 2012, Slide 9.

[21] *Ibid*., Slide 10.

[22] *Ibid*.

[23] *Ibid*.

[24] *Ibid.,* Slide 9.

[25] For instance, one LME, Piedmont Behavioral Healthcare, has been operating as a pilot under the waiver since fall 2004. PBH is now an LME-MCO and operating as Cardinal Innovations.

[26] Swartz, note 20 above, Slide 12.

[27] This figure is from the adjusted continuation budget for 2009–10.

[28] See also in this issue of *North Carolina Insight*, by John Quinterno with Mebane Rash, "Serving Mental Health Patients in Crisis: A Review of the State's Program To Buy Beds and Build Capacity in Local Hospitals," pp. 54–113.

[29] See also in this issue of *North Carolina Insight*, by Ran Coble, "Retirements and Republicans' Redistricting Bring High Legislative Turnover for 2013," pp. 121–24.

[30] The Pew Center on the States, One in 31 Website for Georgia, on the Internet at *http://www.pewcenteronthestates.org/uploadedFiles/wwwpewcenteronthestatesorg/Fact_Sheets/PSPP_1in31_factsheet_GA.pdf*, accessed on March 29, 2012.

[31] Georgia Governor's Office of Planning and Budget, "Factors that influence incarceration rates," Oct. 2008, p. 8. On the Internet at *http://opb.georgia.gov/vgn/images/portal/cit_1210/58/3/162698065incarceration_rate_final_11–18–2008.pdf*, accessed on March 30, 2012.

Brianna's Story

by Mebane Rash

Brianna came to live with Linda McDonough when she was seven weeks old, gaining a family, including a big sister, and a home. Linda then adopted her at age two. McDonough adopted Brianna even though by then it was clear Brianna's mental health issues would shape the life the family would share. Brianna is 13 now.

In some ways, Brianna is lucky. Medicaid pays for Brianna's treatment, thanks to an adoption insurance package for families taking in high-risk children. And, she has a mother that loves her for the beautiful, challenging child that she is. "I love my daughter," says Brianna's mom. "But I can't cure her, nor can I fix her. I can only love her as she is and work to shape her world so that she can be successful. Sometimes it works. Much of the time it doesn't."

Brianna was expelled from her first day care center. Her first interaction with the mental health system in North Carolina was through her local mental health management entity, which placed her in therapeutic day care. Brianna has been mainstreamed — where students with special needs are educated in regular classes. And she has been pulled out of regular classes and educated in a self-contained educational environment. She has attended public and private schools. Her first psychiatric hospitalization was in third grade at UNC Hospital in Chapel Hill.

Brianna personally has experienced most of the options our mental health system has to offer children her age. She spent eight months at the Wright School, a state-operated facility offering residential treatment for children aged 6–12 with serious behavioral and emotional disorders (see p. 45). She spent five months in a therapeutic level II foster care facility with a caretaker she called Aunt Jackie. She spent six weeks

Brianna's mom sits with her in an emergency room, waiting for a bed to open up.

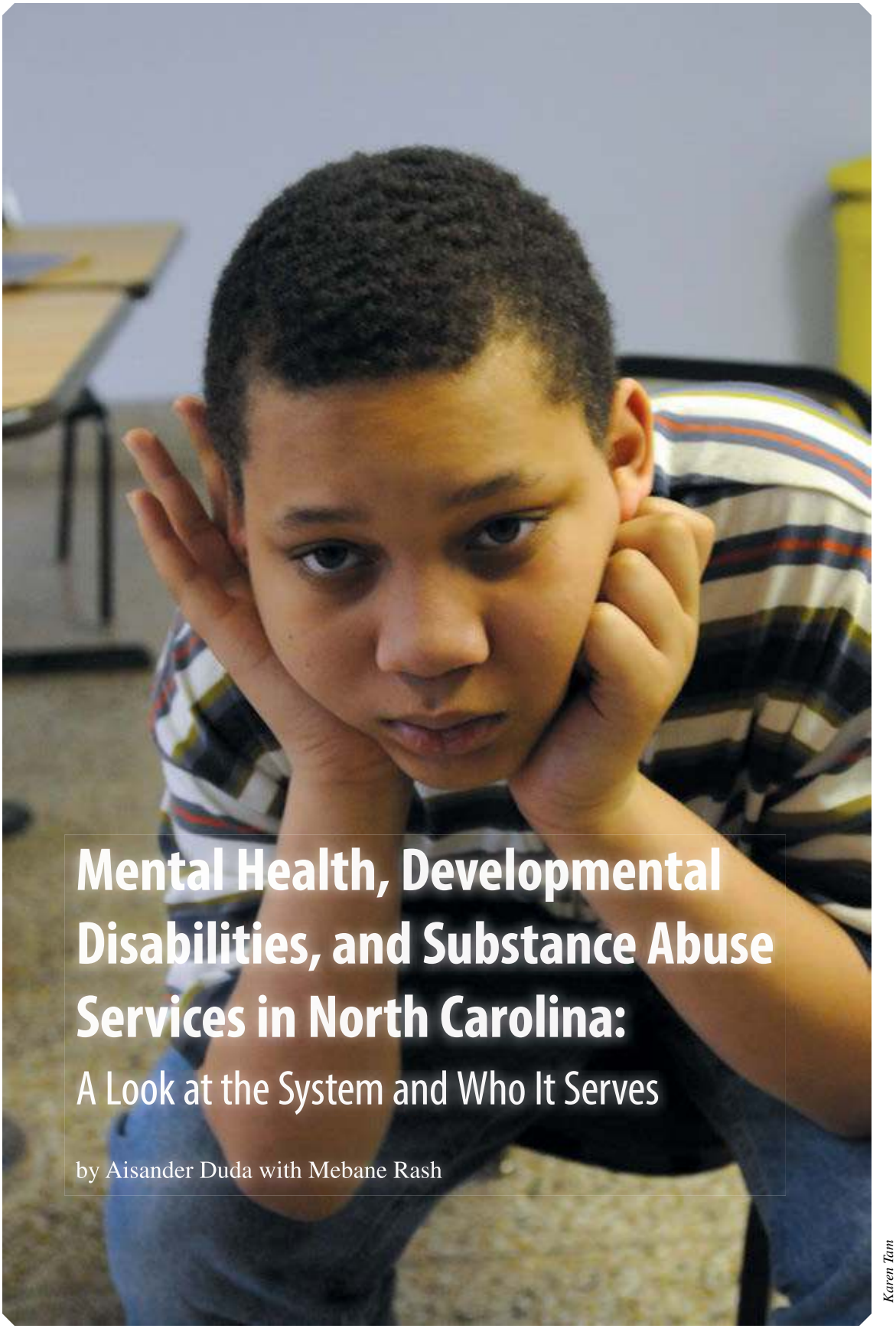
Karen Tam

at Central Regional Hospital in Butner. She has been in more than one psychiatric residential treatment facility (PRTF). She has spent time in multiple emergency rooms across the state. She knows that sheriffs in the criminal justice system take her from one place to another.

In March 2011, Brianna spent 6½ days in a hospital emergency room, 80 miles away from her hometown and her mom. Staff from a psychiatric residential treatment facility had dropped her off and left her in the ER. She was given medication, but she still needed to be restrained at times. She did not have access to books or school work or exercise — because these things just aren't possible in an ER. She began to self-mutilate, and her hand had to be bandaged. Finally, it was Brianna herself that picked up the phone and called 911. She told the operator she needed a ride to Butner.

Brianna's primary diagnosis is Disruptive Behavior Disorder, a little worse than attention deficit hyperactivity disorder (ADHD), but not quite so bad as conduct disorder, according to her mom. She also has Anxiety Disorder, NOS (not otherwise specified), which means it doesn't look like most people's anxiety. And, complicating it all is a brand new diagnosis of severe receptive-expressive language disorder. "When people talk, Brianna drowns in an ocean of words," says her mom. "Kids with this disorder have a very hard time in classrooms because teachers talk so dang much. You know how the adults in the Charlie Brown videos sound? That's how she hears language."

Brianna's mom hopes to find a PRTF that is able to treat her daughter for an extended period of time, maybe a year or two, and that Brianna then will be able to come home and live with her. "The truth is that I am proud of both my daughters. I have no desire to trade either one of them in. They are who they are, and I am honored to share their journeys. Even the one who tells me she likes Butner because their padded room is nicer."



Mental Health, Developmental Disabilities, and Substance Abuse Services in North Carolina:

A Look at the System and Who It Serves

by Aisander Duda with Mebane Rash

Karen Tam

Executive Summary

In North Carolina, there are 1.37 million people in need of mental health, developmental disability, and/or substance abuse (MH/DD/SA) services—almost 14 percent of the state population. Of those, 609,087 need mental health services, 122,813 need developmental disability services, and 639,512 need substance abuse services. There are 313,910 children in need of services. These numbers are calculated by the N.C. Division of MH/DD/SAS using national estimates of prevalence—the occurrence of chronic and serious mental health, developmental disabilities, and substance abuse problems in the population—and then applying them to North Carolina's population.

To evaluate access to mental health treatment, it also is important to look at the number of people that received services through the state's *public* system of care. Overall, the state treated 52 percent of adults needing mental health services, 40 percent of adults needing services for developmental disabilities, and 12 percent of adults needing substance abuse services. In fiscal year 2010–11, the state's system treated 372,995 people: 360,180 (97 percent) were served in the community, and 12,815 (3 percent) were served in state-operated facilities.

State-Operated Facilities for the Treatment of MH/DD/SA

State Psychiatric Hospitals:

Treating People with Mental Illness

The state operates 14 facilities serving the MH/DD/SAS population in North Carolina. There are three psychiatric hospitals: Broughton Hospital in Morganton, Central Regional Hospital in Butner, and Cherry Hospital in Goldsboro.

The three state psychiatric hospitals served 5,754 people in FY 2010–11. Of those served, Broughton Hospital treated 1,352 people; Central Regional Hospital treated 2,119 people; Cherry Hospital treated 1,563 people; and Dorothea Dix Hospital in Raleigh treated 720 people before it closed.

Developmental Centers:

Treating People with Intellectual and Developmental Disabilities

There are three state-operated developmental centers that treat those with profound or severe mental retardation or related developmental disabilities: Caswell Developmental Center in Kinston, J. Iverson Riddle Developmental Center in Morganton, and Murdoch Developmental Center in Butner. In FY 2010–11, the facilities served 1,355 people, including 1,312 residents and 43 people in respite beds. The Caswell Center served 417 people, the Riddle Center served 337, and the Murdoch Center served 601.

The Neuro-Medical Treatment Centers:
Treating People with Disabilities Needing Long-Term Care

There are three state-operated neuro-medical treatment centers, serving 1,000 disabled adults needing long-term care in FY 2010–11: Black Mountain Neuro-Medical Center serving 426 people, O'Berry Neuro-Medical Center in Goldsboro serving 299, and Longleaf Neuro-Medical Treatment in Wilson serving 275.

Alcohol & Drug Abuse Treatment Centers:
Treating People Addicted to Alcohol or Drugs

North Carolina has three state-operated alcohol and drug abuse treatment centers (ADATCs) that treated 4,590 people in FY 2010–11 for alcohol or drug addictions: Julian F. Keith ADATC in Black Mountain serving 1,610 people; R.J. Blackley ADATC in Butner serving 1,296; and Walter B. Jones ADATC in Greenville serving 1,684.

Residential Programs for Children:
The Wright and Whitaker Schools

There are two state-operated facilities that offer residential programs for children with serious emotional and behavioral disorders: the Wright School in Durham serving 62 children, and the Whitaker School in Butner serving 54 children. The Wright School provides residential mental health treatment for children aged 6–12. The Whitaker School is a long-term treatment program for emotionally handicapped adolescents aged 13–17. The Whitaker School has been converted into a psychiatric residential treatment facility (PRTF) so that services provided there will be covered by Medicaid.

Community-Based Services for the Treatment of MH/DD/SA

Local management entities (LMEs) are the agencies responsible for managing, coordinating, facilitating, and monitoring the provision of mental health, developmental disability, and substance abuse services in the area served. LME responsibilities include offering consumers access to services 24 hours a day, seven days a week, 365 days a year, as well as developing and overseeing providers and handling consumer complaints and grievances. They are the basic building block for the state's provision of community-based services, providing referrals to both public and private providers of care.

In 2010–11, there were 23 LMEs statewide serving 360,180 people. Of those served in the community, 257,364 were mentally ill; 20,637 had developmental disabilities; and 82,179 were treated for substance abuse. Many LMEs are in flux

as they merge into the 11 managed care organizations (MCOs) that are expected to exist after the state's implementation of a federal waiver of Medicaid regulations governing mental health services.

Leza Wainwright knows North Carolina's mental health system inside and out. In August 2010, she retired from her position as Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services after working in the Division for almost 27 years. She says, "The system served more than 140,000 more people in 2009 than in 1991 because the number of people with all three disabilities served in the community increased by more than 88 percent. This shift toward community services follows national trends and also creates a more consumer-friendly type of care. People can stay at home in their communities and receive most of the services they need."

Conclusion: Three Important Changes in the System over the Past 30 Years

As Wainwright looks back on her career in mental health in North Carolina, she sees three important changes: the consumer movement, the changes in local service delivery and management, and the evolving role of the state facilities. She believes that the consumer movement changed the provision of mental health services in this state. "Recovery is now the expected outcome for people with mental health and substance abuse issues. For people with developmental disabilities, the goals are self-determination and learning self-advocacy skills. Treatment plans have been replaced by Person Centered Plans, and . . . [c]onsumers' goals and dreams guide the plan."

Wainwright says that 30 years ago, practically all community mental health and substance abuse services in North Carolina were delivered by area mental health programs that were part of local governments. She says, "The state's reform plan, which changed the area programs from service providers to managers of the system at the local level, created a good environment for the growth of private providers. Now there are literally thousands of providers. This has given people needing services a greater choice of provider agencies and has made access to services easier. It also has increased concerns about the quality of the services being delivered since the system is challenged to monitor such a large provider community effectively. And, it has made the system more complicated for some people since there are so many providers and since so many of them deliver only a few services."

The third change Wainwright notes is the role of the state facilities. In 1991, a large number of the people served by the mental health, developmental disability,

and substance abuse services system still were being served in state institutions. "That has changed dramatically over the past 30 years," says Wainwright. "In 2009, the number of people with developmental disabilities served in the state developmental centers had decreased since 1991 by more than 53 percent. The number of people with mental illness and substance use disorders served in state psychiatric hospitals decreased by more than 10 percent over the same period."

But advocates think this paints too rosy a picture. Vicki Smith is the Executive Director of Disability Rights NC, a nonprofit advocacy agency working to protect the right of individuals with mental illness or developmental disabilities. She says, "While I agree with the concept of the system being owned by the people it serves, the current system lacks the infrastructure to support such a concept. Unfortunately, the bag with the pretty bow tied around it that was handed to consumers is empty." Advocates say it is extremely hard to find providers willing to treat the most difficult consumers, and because of the lack of appropriate community-based treatment, many people with acute needs are stuck in limbo—between poor ongoing support and inadequate or non-existent crisis services.

The mental health system in North Carolina is anything but static. The changes in the system can be seen in the numbers of those served and where they are served, but also in the experiences—good and bad—of the consumers.

Editor's Note: A longer version of this article was published online in March 2011. It is available at *http://www.nccppr.org/drupal/content/insightarticle/4072/mental-health-developmental-disabilities-and-substance-abuse-services-in*

Leza Wainwright knows North Carolina's mental health system inside and out. In August 2010, she retired from her position as Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services after working in the Division for almost 27 years.

Wainwright says, "The biggest change I have seen over my career is the increased ownership of the system by the people it serves. It should have always been that way, but it wasn't. Too often, those served were viewed as people who had to be protected. Consumers were not encouraged to be active participants in their own treatment. Treatment plans focused on the individual's symptoms or problems, rather than their strengths and goals. The consumer movement changed all of that. The mission of the system now is to support consumers in living, working, and playing in communities of *their* choice."

But advocates think that paints too rosy a picture. Vicki Smith is the Executive Director of Disability Rights NC, a nonprofit advocacy agency working to protect the right of individuals with mental illness or developmental disabilities. She says, "While I agree with the concept of the system being owned by the people it serves,

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Aisander Duda is a policy analyst and writer living in Durham, N.C. During the day, he works as the Center's development director.

the current system lacks the infrastructure to support such a concept. Unfortunately, the bag with the pretty bow tied around it that was handed to consumers is empty."

Debra Dihoff, Executive Director of the National Alliance on Mental Illness–North Carolina, says that though everyone wants the system to be consumer-focused, it is not that way yet. She gives an example of a committee formed in 2010 to look at how long consumers have to wait before obtaining services. The committee included sheriffs, the North Carolina Council on Development Disabilities, providers, local management entities, and hospital association members. Dihoff says, "But where were the consumers and families most affected? No one thought to invite them."

The Number of People in Need of Mental Health Services in North Carolina

In North Carolina, there are 1.37 million people in need of mental health, developmental disability, and/or substance abuse (MH/DD/SA) services (see Table 1, p. 32)—almost 14 percent of the state population.[1] Of those, 609,087 need mental health services, 122,813 need developmental disability services, and 639,512 need substance abuse services. There are 313,910 children in need of services. These numbers are calculated by the Division using national estimates of prevalence—the occurrence of chronic and serious mental health, developmental disabilities, and substance abuse problems in the population—and then applying them to North Carolina's population.

To evaluate access to mental health treatment, it also is important to look at the number of people that received services through the state's *public* system of care. Overall, the state treated 52 percent of adults needing mental health services, 40 percent of adults needing services for developmental disabilties, and 12 percent of adults needing substance abuse services (see Table 1, p. 32). In fiscal year 2010–11, the state's system treated 372,995 people: 360,180 (97 percent) were served in the community, and 12,815 (3 percent) were served in state-operated facilities (see Table 2, pp. 36–37).[2]

There are concerns about how the state counts the numbers of those served in the community compared to those served in state-operated facilities. Vicki Smith of Disability Rights NC says, "The state includes in their community numbers those treated at psychiatric residential treatment facilities (PRTFs), for example. Advocates contend such facilities are more like institutions. PRTFs hardly seem like community placements since many of them are locked facilities." Also in question are adult care homes. The U.S. Department of Justice has been investigating whether adult care homes in North Carolina are sufficiently integrated into the community to meet federal law. In response, state and federal officials have agreed to an 8-year plan to move people out of adult care homes and into the community.

Reprinted with permission

"Yes, yes—angst, indefinable cravings, sleeplessness, weltschmerz, and occasional outbursts of rage. Just something that's going around."

Mark Long: From State Hospitals to Community-Based Treatment

by Aisander Duda

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

Diagnosed with paranoid schizophrenia as a young man, Mark spent most of the 1970s and 1980s in and out of psychiatric hospitals. 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, Mark left the family care home where he was living, walked down the street, and found Residential Treatment Services of Alamance in Burlington. He was placed in the Bellshire Apartments in Greensboro, a community of individuals disabled by chronic mental illness. With the help of his apartment coordinator, he began to maintain his own medications and appointments. He even worked with the Division of Motor Vehicles to obtain a driver's license.

> *"I felt like a yo-yo. I would bounce into one situation, and then I would bounce back out."*

After he learned to live independently, Mark decided to attend UNC-Greensboro in 2007, graduating with a degree in social work in May 2009. At the same time, Mark became 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. In July 2012, there were 695 certified Peer Support Specialists in North Carolina.

Mark says, "To the people I work with, I can be as important as someone with a master's degree in social work or a psychiatrist. It's my life and experiences that allow me to connect with consumers in a different way and offer the kind of help another professional can't." Mark Long finally has found the right treatment, a place to call home, and a vocation.

David Swann is the chief clinical officer for Partners Behavioral Health Management and former director of Crossroads Behavioral Healthcare, the local management entity serving Iredell, Surry, and Yadkin counties. He says the data used to show the number of people served in the community does not demonstrate the full scope of those treated. Swann explains that reports do not capture the actual number served because some services provided to consumers in the community are not reported. There are codes for each service provided, and if a code does not exist for a service then it cannot be submitted for payment and thus recorded.

At the Crossroads program, anywhere from 20 to 30 percent of the total services provided are delivered to consumers and paid for without data being submitted because no code exists for the service. Crossroads receives slightly more than $900,000 in county funds, and these dollars are used to provide critical services that are not authorized by the state or Medicaid. For example, a six-bed transitional housing program provides shelter and care to keep people in the community, and it lowers the readmission rate to hospitals. Recovery services are offered at three education centers, helping consumers learn to manage their illness while providing access to care. And, provider organizations deliver psychiatric care by using resident physicians from Wake Forest University Baptist Medical Center. Swann says, "These services are essential to the system of care within our community; however no service code exists for these services, and therefore, the services do not get reported or captured by the current state system."

Aisander Duda

State-Operated Facilities for the Treatment of MH/DD/SA

State Psychiatric Hospitals: Treating People with Mental Illness

The state operates 14 facilities serving the MH/DD/SAS population in North Carolina (see Figure 1). There are three psychiatric hospitals: Broughton Hospital in Morganton, Central Regional Hospital in Butner, and Cherry Hospital in Goldsboro.[3] Generally, with state facilities, the goal is to have one in the West, one in the Piedmont, and one in the East.

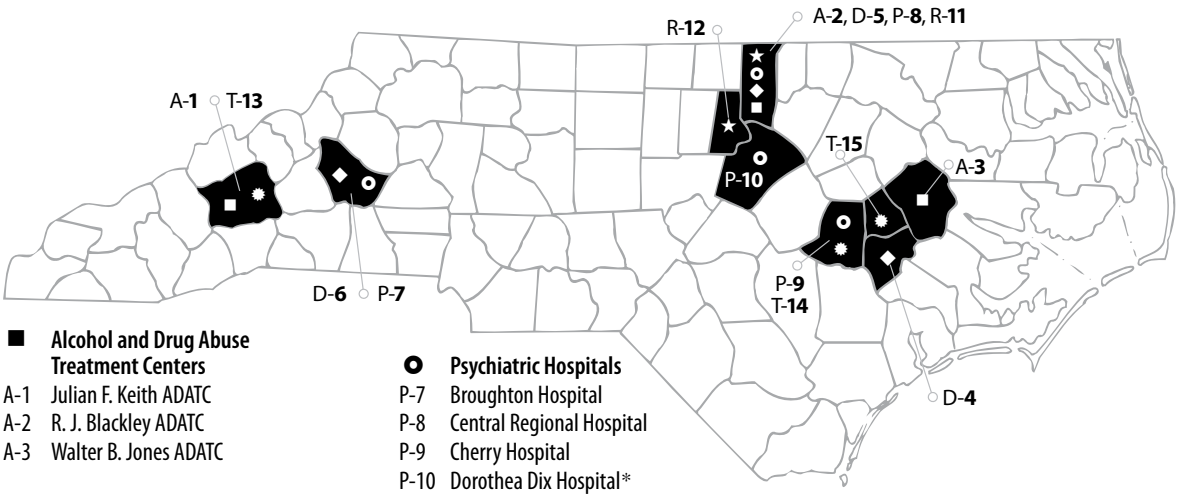
An April 1, 2012 report to the Joint Legislative Oversight Committee on Health and Human Services notes, "In most other states, acute care is provided in community hospitals, reserving the use of state psychiatric hospitals for consumers needing long-term care. North Carolina, however, has historically served more people overall in its state psychiatric hospitals than other states and with shorter average lengths of stay."[4] Of the care provided at North Carolina's state psychiatric hospitals, 21 percent

Table 1. Number of People in N.C. in Need of Mental Health, Developmental Disability, and Substance Abuse Services, by Age and Disability, 2011

Disability	Numbers of Persons in Need	Percent of People in Need Served by the System
Mental Health	**609,087**	
Adults	401,860	52%
Children	207,227	56%
Developmental Disabilities	**122,813**	
Adults	60,398	40%
Children	62,415	21%
Substance Abuse	**639,512**	
Adults	595,244	12%
Children	44,268	10%
TOTAL	**1,371,412**	

Source: N.C. Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "Semi-Annual Report to the Joint Legislative Oversight Committee on Health and Human Services," Statewide System Performance Report, SFY 2011–12, Spring Report, Raleigh, NC, April 1, 2012, Table 1.1.a, p. 6, and Table 1.1.b, p. 7. The numbers of persons in need is calculated based on N.C. Office of State Budget and Management (OSBM) State Demographics Unit, July 2011, population projection data. These numbers are calculated by the Division using national estimates of prevalence – the occurrence of chronic and serious mental health, developmental disabilities, and substance abuse problems in the population – and then applying them to North Carolina's population. The percent of people in need served by the system is calculated using Medicaid and State Service Claims Data from July 1, 2010 to June 30, 2011.

Figure 1. State of North Carolina Facilities for Treatment of MH/DD/SAS



■ **Alcohol and Drug Abuse Treatment Centers**
A-1 Julian F. Keith ADATC
A-2 R. J. Blackley ADATC
A-3 Walter B. Jones ADATC

◆ **Developmental Centers**
D-4 Caswell Developmental Center
D-5 Murdoch Developmental Center
D-6 J. Iverson Riddle Developmental Center

O Psychiatric Hospitals
P-7 Broughton Hospital
P-8 Central Regional Hospital
P-9 Cherry Hospital
P-10 Dorothea Dix Hospital*

★ **Residential Programs for Children**
R-11 Whitaker School
R-12 Wright School

✹ **Neuro-Medical Treatment Centers**
T-13 Black Mountain
T-14 Longleaf
T-15 O'Berry

**Dix Hospital has transferred most of its services to Central Regional Hospital.*

is for a stay of seven days or less, 41 percent is for stays between eight and 30 days, 35 percent is for stays between 30 and 365 days, and 3 percent is for a stay longer than one year (see Figure 2).

The state psychiatric hospitals served 16,789 people in FY 1999–2000, which increased to 18,498 in FY 2006–07, before declining to 5,754 in FY 2010–11 (see Figure 3, p. 38). Wainwright, the former Director of the Division, says the long-term drop in the number of consumers served is due to several factors, including a conscious effort early in the days of mental health reform to close 535 state hospital beds and move patients into the community, as well as the subsequent closure of adult admissions beds at Cherry and Broughton Hospitals due to certification issues with the federal government for Medicaid.[5] Of those served in FY 2010–11, Broughton Hospital treated 1,352; Central Region Hospital treated 2,119; Cherry Hospital treated 1,563 people; and Dorothea Dix Hospital in Raleigh treated 720 before it closed.[6]

Wainwright says, "People do not fit into single categories. Many people with mental illness also have substance abuse challenges, individuals with developmental disabilities sometimes also have behavioral issues, and people with all three types of disabilities have physical health care needs. The system has had to change what it *—continues on page 36*

SFY 2011–12

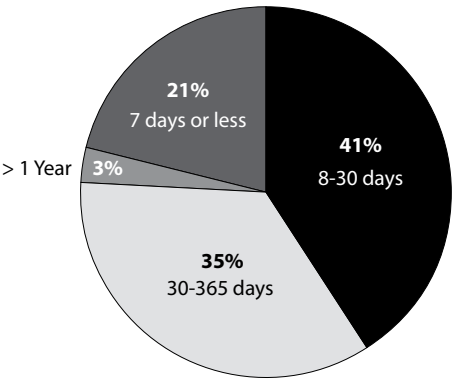


Figure 2.
Length of Stay for Consumers in State Psychiatric Hospitals

Source: N.C. Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "Semi-Annual Report to the Joint Legislative Oversight Committee on Health, and Human Services," Statewide System Performance Report, SFY 2011–12, Spring Report, Raleigh, NC, April 1, 2012, Table 3.2.a, p. 14.

Broughton Hospital in Morganton

Aisander Duda

The new Central Regional Hospital in Butner

—*continued from page 33*

does to be able to serve the whole person. There is a greater emphasis on multiple diagnoses and collaboration between primary health care providers and specialty mental health providers."

But Vicki Smith of Disability Rights NC says that the state hospitals don't do a good job of cross disability care. She says, "Cherry Hospital, for example, could not treat a dual diagnosed patient (mental retardation and mental illness) showing aggression. And, the hospitals don't regularly even screen for substance abuse issues, let alone provide treatment or programming for substance abuse."

Table 2. Number of People Served by the N.C. Mental Health System, State-Operated Facilities and Local Management Entities (LME), 2011

State-Operated Facilities	Subtotal 12,815
State Psychiatric Hospitals	**5,754** [a]
Developmental Centers	**1,355** [b]
Resident	1,312
Respite Care	43
Neuro-Medical Treatment Centers	**1,000** [c]
Alcohol & Drug Abuse Treatment Centers (ADATCs)	**4,590** [d]
Residential Programs for Children	**116** [e]
Whitaker School	54
Wright School	62

Notes:

[a] Jeannette Barham, "Annual Statistical Report, North Carolina Psychiatric Hospitals, Fiscal Year 2011," Division of MH/DD/SAS, Raleigh, NC, Jan. 2012, Table 1, p. 3.

[b] Jeannette Barham, "Annual Statistical Report, North Carolina State Developmental Centers, Fiscal Year 2011," Division of MH/DD/SAS, Raleigh, NC, Jan. 2012, Table 1, p. 3.

[c] Jeannette Barham, "Annual Statistical Report, Black Mountain Neuro-Medical Center, O'Berry Neuro-Medical Center, Longleaf Medical Center, Fiscal Year 2011," Division of MH/DD/SAS, Raleigh, NC, Jan. 2012, Table 2-A, p. 7.

[d] Jeanette Barham, "Annual Statistical Report, North Carolina Alcohol & Drug Abuse Treatment Centers, Fiscal Year 2011," Division of MH/DD/SAS, Raleigh, NC, Jan. 2012, Table 2, p. 4.

[e] Jeannette Barham, "Annual Statistical Report, Wright and Whitaker Residential Programs for Children, Fiscal Year 2011," Division of MH/SS/SAS, Raleigh, NC, Jan. 2012, Table 2-A, p. 6.

[f] Jeannette Barham, "North Carolina LMEs, Annual Statistics and Admission Report, Fiscal Year 2011," Division of MH/DD/SAS, Raleigh, NC, Jan. 2012, Table 2, p. 6.

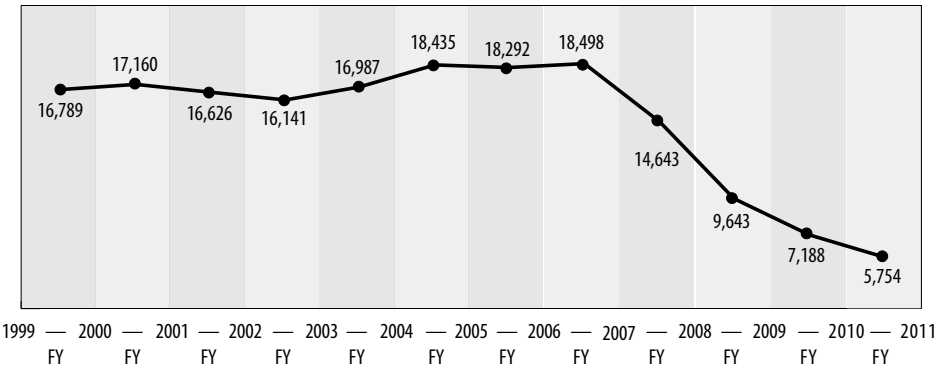
[g] In 2012, Piedmont Behavioral Healthcare (PBH) became Cardinal Innovations Healthcare Solutions.

[h] Treatment Accountability for Safer Communities. TASC provides care management services to people with substance abuse or mental illness who are involved in the justice system.

Table 2. Number of People Served by the N.C. Mental Health System, State-Operated Facilities and Local Management Entities (LME), 2011, *continued*

Community-Based Treatment: Local Management Entities	Subtotal 360,180 [f]
1. Alamance-Caswell LME	7,258
2. Beacon Center LME	5,832
3. CenterPoint LME	14,410
4. Crossroads LME	7,968
5. Cumberland LME	10,182
6. Durham LME	10,460
7. East Carolina Behavioral Healthcare LME	25,646
8. Eastpointe LME	62,780
9. Five County LME	6,455
10. Guilford LME	15,961
11. Johnston LME	5,240
12. Mecklenburg LME	25,144
13. Mental Health Partners LME	7,777
14. Onslow-Carteret LME	3,017
15. Orange-Person-Chatham LME	7,649
16. Pathways LME	15,901
17. Piedmont Behavioral Healthcare LME [g]	12,440
18. Sandhills LME	19,377
19. Smoky Mountain LME	17,211
20. Southeastern Center LME	10,299
21. Southeastern Regional LME	8,277
22. Wake LME	19,443
23. Western Highlands LME	17,837
TASC [h] Region 1	7,247
TASC Region 2	5,741
TASC Region 3	6,140
TASC Region 4	4,488
Total Served by the N.C. Mental Health System	**372,995**

Figure 3. Number of People Served in State Psychiatric Hospitals, Fiscal Year (FY) 1999–2000 through 2010–2011



Source: Jeannette Barham, "Annual Statistical Report, North Carolina Psychiatric Hospitals, Fiscal Year 2011," Division of MH/DD/SAS, Raleigh, NC, Jan. 2012, Graph 1, p. 4. The state's fiscal year runs from July 1 to June 30.

Developmental Centers:

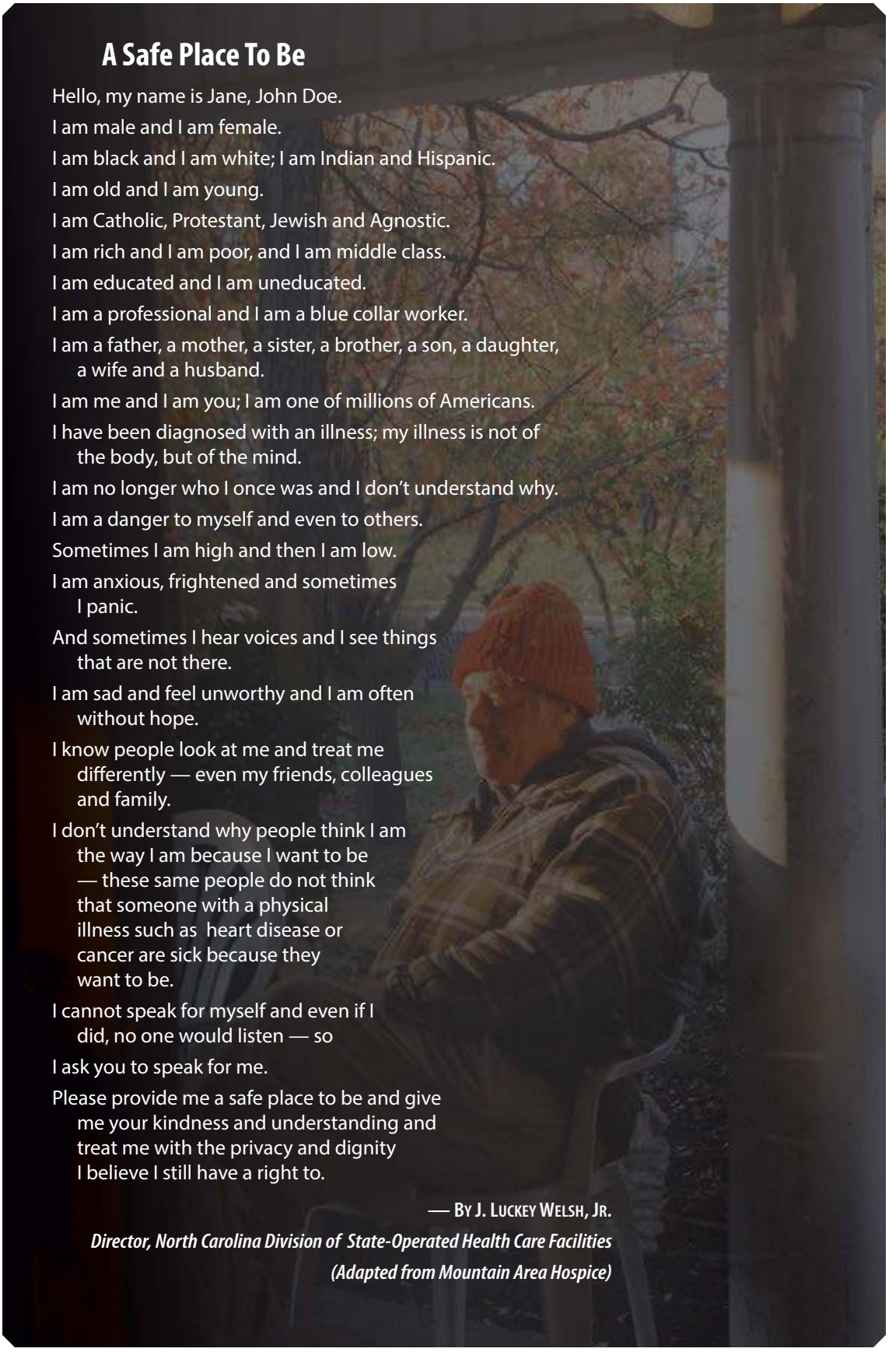
Treating People with Intellectual and Developmental Disabilities

There are three state-operated developmental centers that treat those with profound or severe mental retardation or related developmental disabilities: Caswell Developmental Center in Kinston, J. Iverson Riddle Developmental Center in Morganton, and Murdoch Developmental Center in Butner. In FY 1998–99, the three facilities served 2,409 people, with 2,136 residents and 273 people in respite care beds.[7] Over a decade later in FY 2010–11, the facilities served just 1,355 people, including 1,312 residents and 43 people in respite beds. The Caswell Center served 412 people, the Riddle Center served 337, and the Murdoch Center served 601.

—continues on page 42

At the Riddle Developmental Center in Morganton

Aisander Duda



A Safe Place To Be

Hello, my name is Jane, John Doe.

I am male and I am female.

I am black and I am white; I am Indian and Hispanic.

I am old and I am young.

I am Catholic, Protestant, Jewish and Agnostic.

I am rich and I am poor, and I am middle class.

I am educated and I am uneducated.

I am a professional and I am a blue collar worker.

I am a father, a mother, a sister, a brother, a son, a daughter, a wife and a husband.

I am me and I am you; I am one of millions of Americans.

I have been diagnosed with an illness; my illness is not of the body, but of the mind.

I am no longer who I once was and I don't understand why.

I am a danger to myself and even to others.

Sometimes I am high and then I am low.

I am anxious, frightened and sometimes I panic.

And sometimes I hear voices and I see things that are not there.

I am sad and feel unworthy and I am often without hope.

I know people look at me and treat me differently — even my friends, colleagues and family.

I don't understand why people think I am the way I am because I want to be — these same people do not think that someone with a physical illness such as heart disease or cancer are sick because they want to be.

I cannot speak for myself and even if I did, no one would listen — so

I ask you to speak for me.

Please provide me a safe place to be and give me your kindness and understanding and treat me with the privacy and dignity I believe I still have a right to.

— By J. Luckey Welsh, Jr.

Director, North Carolina Division of State-Operated Health Care Facilities

(Adapted from Mountain Area Hospice)

Karen Tam

Joshua Stuart: A Developmentally-Disabled Child in Search of Treatment

by Mebane Rash with Karen Tam

Joshua Stuart is autistic. He has an IQ of 36, and he can only speak a few words, like "Ma" and "hurt." After he violently attacked his mother and little brother at home when he was 13 years old, Joshua spent eight days at Wake County Mental Health Services, his local management entity, waiting for a bed to open up. He slept in a chair. He did not have access to a shower.

At the time, there were open beds at Central Regional Hospital. There were only 13 children there, and they have the capacity for 34. But there were not enough workers to care for Joshua. After his eight-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. Then he was moved to the Murdoch Developmental Center in Butner in the PATH program—Partners for Autism Treatment and Habilitation.

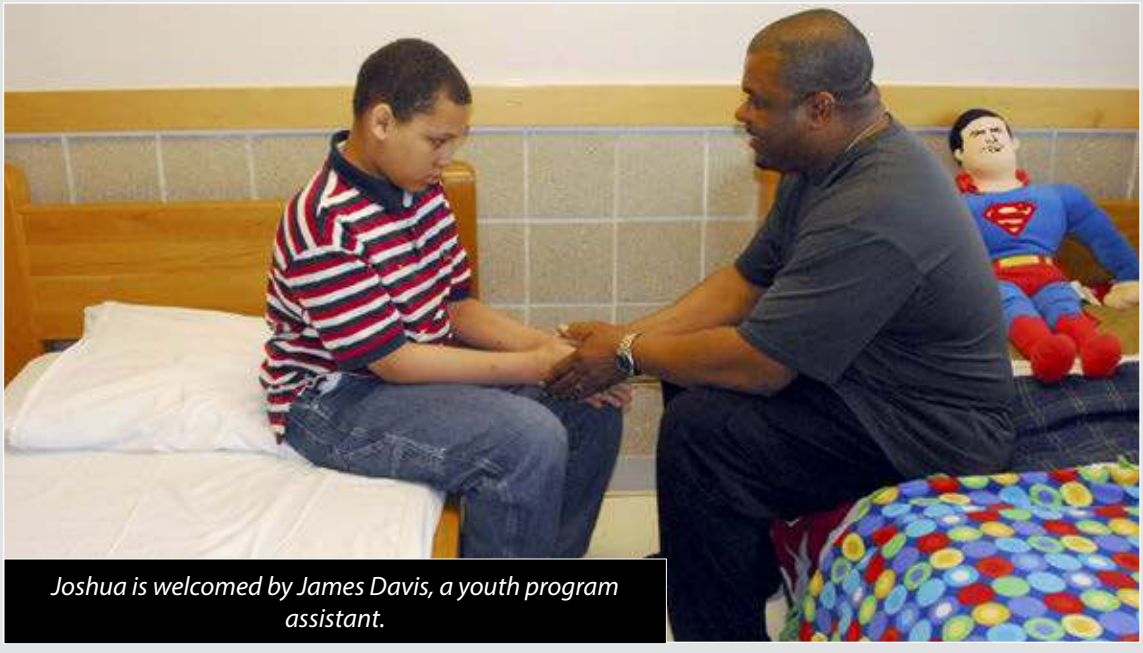
This program is designed to serve children from ages six to 16 with autism spectrum disorder and serious behavioral challenges. The goal is to reduce behavior problems and to promote positive social skills. Joshua's treatment includes person-centered teaching in the areas of self-help, education, communication, and recreation, as directed by the interdisciplinary team of professionals working with him.

Joshua spent six hours each day in 30-minute classes learning everything from new words to daily living skills. With only four children per class, each child has an individualized education and therapy plan. The staff at the Murdoch Center closely follow the progress of each child, monitoring everything from sleep schedules to diet and nutrition to changes in a child's daily completion of basic tasks (e.g., brushing teeth and getting dressed). Some of the children in the PATH program go to classes at the Butner-Stem Middle School, giving them an opportunity to learn tasks and activities in a regular school setting. Other children receive educational services at the Murdoch Center. It depends on the needs of the child. Joshua was discharged, and he now lives back in the community.

The family is greeted by the staff, including Aleck Myers, the Director of the Murdoch Developmental Center.

Joshua with his parents, arriving at Murdoch Developmental Center in Butner.

Joshua laughing with his dad, Antonio Stewart.



Joshua is welcomed by James Davis, a youth program assistant.

Joshua's parents, Salima Mabry and Antonio Stewart, are surrounded by 16 staff members in a meeting room. They ask questions about Joshua's needs, wants, likes, and dislikes.

Karen Tam

—continued from page 38

The Neuro-Medical Treatment Centers:
Treating People with Disabilities Needing Long-Term Care

There are three state-operated neuro-medical treatment centers, serving 1,000 people with disabilities needing long-term care in FY 2010–11: Black Mountain Neuro-Medical Center serving 426 people, O'Berry Neuro-Medical Center in Goldsboro serving 299, and Longleaf Neuro-Medical Treatment in Wilson serving 275.[8] The Black Mountain Center serves those with lifelong disabilities and those diagnosed with Alzheimer's disease.[9] The O'Berry Center was the first institution in N.C. for African Americans with mental retardation, and now it serves those with developmental disabilities in need of long-term care.[10] Longleaf Neuro-Medical Treatment Center serves adults with severe and persistent mental illness with long-term medical conditions requiring residential, medical, and nursing care. The Center also serves adults with a diagnosis of Alzheimer's or dementia who are unable to be treated in a traditional nursing home setting because of assaultive and combative behavior.[11]

Alcohol & Drug Abuse Treatment Centers:
Treating People Addicted to Alcohol or Drugs

North Carolina has three state-operated alcohol and drug abuse treatment centers (ADATCs) that treated 4,590 people in FY 2010–11 for alcohol or drug addictions: Julian F. Keith ADATC in Black Mountain serving 1,610 people; R.J. Blackley ADATC in Butner serving 1,296; and Walter B. Jones ADATC in Greenville serving 1,684.[12]

Aisander Duda

Figure 4. Local Management Entities (LMEs) and Their Member Counties, as of July 1, 2010

Unless otherwise indicated, the LME name is the county name(s).

Source: N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

Residential Programs for Children:
The Wright and Whitaker Schools

There are two state-operated facilities that offer residential programs for children with serious emotional and behavioral disorders: the Wright School in Durham serving 62 children (see p. 45), and the Whitaker School in Butner serving 54 children.[13] The Wright School provides residential mental health treatment for children aged 6–12.[14] The Whitaker School is a long-term treatment program for emotionally handicapped adolescents aged 13–17.[15]

Community-Based Services for the Treatment of MH/DD/SA: Local Management Entities

Local management entities (LMEs) are the agencies responsible for managing, coordinating, facilitating, and monitoring the provision of mental health, developmental disability, and substance abuse services in the area served. LME responsibilities include offering consumers access to services 24 hours a day, seven days a week, 365 days a year, as well as developing and overseeing providers, and handling consumer complaints and grievances.[16] They are the basic building blocks for the state's provision of community-based services, providing referrals to both public and private providers of care. Vicki Smith of Disability Rights NC says that although LMEs are supposed to provide screening, triage,[17] and referral 24 hours a day, seven days a week, there is nothing that actually requires the provision of treatment services around the clock.

In 2010–11, there were 23 LMEs statewide serving 360,180 people, a 46 percent increase since 2001 (see Figure 4 above and Figure 5, p. 47). Of these, 23,616 were served by TASCs (Treatment Accountability for Safer Communities), which provides care management services to people with substance abuse or mental illness who are charged with or convicted of a crime.[18] Of those persons served in the community, 257,364 were mentally ill; 20,637 had developmental disabilities; and 80,179 were treated for substance abuse.[19] Many LMEs are in flux as they merge

—continues on page 47

Aisander Dudá

The Wright School: A Place for All Kinds of Faces

by Mebane Rash

Since 1964, the Wright School has been a place in North Carolina for more than 2,000 kids with all kinds of faces. Kids who are mad and scared. Kids who are exhausted and sad. Kids aged 6–12 with severe emotional and behavioral diagnoses. The state-operated residential treatment services provided at the Wright School in Durham enable these same kids to feel silly and happy, surprised and mischievous. They come for treatment, which is called re-education. The goal is not to cure them. Instead, the school provides each child and their caregivers with enough skills so the kids can move back home and go to school in their own communities.

A typical child at the Wright School has three psychiatric diagnoses, takes three psychotropic medications, and has had two hospitalizations in the previous year. The capacity of the school is 24 children. They serve three groups of eight children: the Olympians, the Royals, and the Eagles. In 2010–11, there were 37 admissions, and 62 children were served. The staff ratio is two staff for eight children.

> *CL is 10 and from Alamance County. He had seven hospitalizations between 2005 and 2009 prior to his admission to the Wright School. He is diagnosed with post-traumatic stress disorder, oppositional defiant disorder, and expressive language disorder. He takes Thorazine, Clonidine, Depakote, and Strattera. Prior to admission, he was being educated in a state psychiatric hospital school setting.*

> *JB is 10 and from Cumberland County. She had three hospitalizations between April 2009 and January 2010. She is diagnosed with bipolar disorder, mania with psychotic features, attention deficit hyperactivity disorder (ADHD), and oppositional defiant disorder. She is treated with Thorazine, Depakote, and Strattera. Prior to admission, she was educated in an alternative public school setting.*

“A typical child at the Wright School has three psychiatric diagnoses, takes three psychotropic medications, and has had two hospitalizations in the previous year.”

SC is 10 and from Durham County. He had five hospitalizations between September 2009 and March 2010. He is diagnosed with cyclothymia, ADHD, and oppositional defiant disorder. He takes Lithium, Depakote, Benztropine, Chlorpromazine, and Propranolol. He had three changes in his public school setting in the 2009–10 academic year.

The budget for the Wright School is $2.6 million annually. It is entirely funded with state dollars because it does not qualify for Medicaid. The cost per bed is $443.49—cheaper by the day and by the course of treatment than other residential options. The state leases the property for $1 each year from a private foundation.

The school's director, Deborah Simmers, has been there since 1984. On her watch, turnover among the psychiatrists has not been a problem, with only four in 28 years. In fact, most of the staff has worked at the Wright School a long, long time. Of the more than 40 employees, 70 percent have worked there five or more years. Two have been there for more than 30 years.

From 2006 to 2010, surveys' of parents' satisfaction with services averaged 90 percent or higher annually. There were no investigations into the care the Wright School provided in 2010.

"The treatment at the Wright School is so much more normalizing and less traumatic than other kinds of out-of-home care, like a hospital or a psychiatric residential treatment facility," says Simmers.

A study of the treatment provided by the school published in *Behavioral Disorders* in 2006 found that "children with very serious problems and from families facing multiple challenges… made substantial improvement and maintained much of this improvement for at least 6 months postdischarge."[1]

Glossary

These definitions are from the U.S. National Library of Medicine's A.D.A.M Medical Encyclopedia, available online at *http://www.ncbi.nlm.nih.gov/pubmedhealth/.*

- *Oppositional defiant disorder* is a pattern of disobedient, hostile, and defiant behavior toward authority figures.
- *Post-traumatic stress disorder* (PTSD) is a type of anxiety disorder. It can occur after you've seen or experienced a traumatic event that involved the threat of injury or death.
- Children with an *expressive language disorder* have problems using language to express what they are thinking or need.
- *Bipolar disorder* is a condition in which people go back and forth between periods of a very good or irritable mood and depression. The "mood swings" between mania and depression can be very quick.
- *Mania with psychotic features* is an abnormally elated mental state combined with a loss of touch with reality.
- *Attention deficit hyperactivity disorder* (ADHD) is one of the most common childhood disorders and can continue through adolescence and adulthood. Symptoms include difficulty staying focused and paying attention, difficulty controlling behavior, and hyperactivity (over-activity).
- *Cyclothymic disorder* is a mild form of bipolar disorder in which a person has mood swings over a period of years that go from mild depression to euphoria and excitement.

Endnote

[1] Elaine Fields, *et al.*, "Treatment and Posttreatment Effects of Residential Treatment Using a Re-education Model," *Behavioral Disorders*, Vol. 31, No. 3, Council for Children with Behavioral Disorders, May 2006, pp. 312–22.

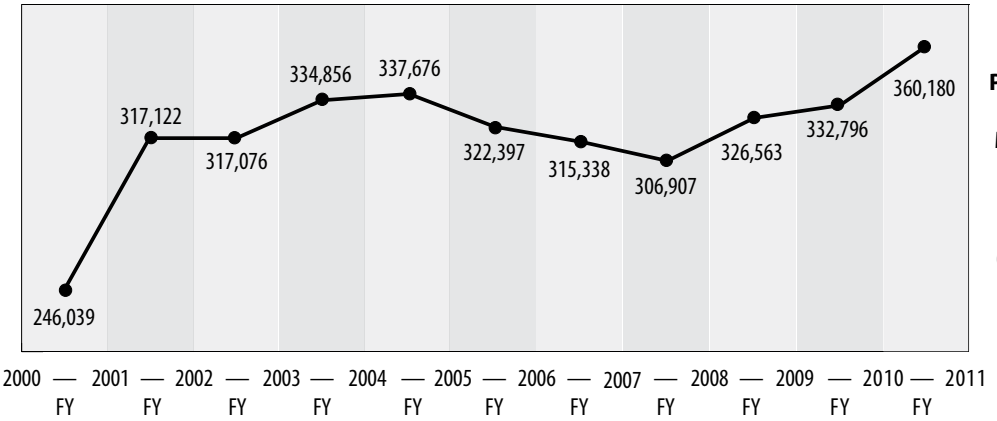


Figure 5. Number of People Served in Local Management Entities (LMEs), Fiscal Year (FY) 2000–01 through 2010–11

Source: Jeannette Barham, "North Carolina LMEs, Annual Statistics and Admission Report, Fiscal Year 2011," Division of MH/DD/SAS, Raleigh, NC, Jan. 2012, Graph 1, p. 4. The state's fiscal year runs from July 1 to June 30.

—*continued from page 43*

into the 11 managed care organizations (MCOs) that are expected to exist after the state's implementation of a federal waiver of Medicaid regulations governing mental health services.

The system served more than 114,000 more people in the community in 2011 than in 2001 (see Figure 5). Wainwright says, "This shift toward community services follows national trends and also creates a more consumer-friendly type of care. People can stay at home in their communities and receive most of the services they need. The state facilities now play a very different role than they have in the past. They are no longer the first place people get treatment. Instead, they now are used for those people with special challenges and for difficult-to-serve populations."

But advocates do not agree. Says Vicki Smith of Disability Rights NC, "State facilities can be used for people with special challenges and for difficult-to-serve populations, but the lack of an appropriate continuum of care in the community results in many institutionalizations for individuals more appropriately served in the community—if appropriate services were available. In fact, due to the lack of appropriate community-based treatment, many people with acute needs are stuck in limbo—between poor ongoing support and inadequate or in some areas non-existent crisis services. The result is long waits in hospital emergency departments. Crisis services are not available in adequate numbers throughout the state to maximize the potential to keep people out of the state facilities. There is no safety net for community services, particularly for adults with mental illness."

Conclusion: Three Important Changes in the System over the Past 30 Years

As Leza Wainwright looks back on her career in mental health in North Carolina, she sees three important changes: the consumer movement, the changes in local service delivery and management, and the evolving role of the state facilities. She says "Nothing about us, without us" is the rallying cry for consumers, and she believes that the consumer movement changed the provision of mental health services in this state. "Recovery is now the expected outcome for people with mental health and substance abuse issues. For people with developmental disabilities, the goals are self-determination and learning self-advocacy skills. Treatment plans have been replaced by Person Centered Plans, and when done correctly, the focus is on the services and supports that are important *for* the

"In Lincoln County, near a public road… is a log cabin strongly built and about 10 feet square, and about seven or eight feet high; no windows to admit light… no chimney indicates that a fire can be kindled within, and the small low door is securely locked and barred… You need not ask to what uses it is appropriated. The shrill cries of an incarcerated maniac will arrest you on the way… Examine the interior of this prison [and] you will see a ferocious , filthy, unshorn half-clad creature, wallowing in foul, noisome straw. The horrors of this place can hardly be imagined; the state of the maniac is revolting in the extreme…."

—Dorothea Dix

person *and* those that are important *to* the person. Consumers' goals and dreams guide the plan."

Wainwright says that 30 years ago, practically all community mental health and substance abuse services in North Carolina were delivered by area mental health programs. Consumer access and choice were limited by the number of clinicians working for the area program. She says, "The state's reform plan, which changed the area programs from service providers to managers of the system at the local level, created a good environment for the growth of private providers. Now there are literally thousands of providers. This has given people needing services a greater choice of provider agencies and has made access to services easier. It also has increased concerns about the quality of the services being delivered since the system is challenged to monitor such a large provider community effectively. And, it has made the system more complicated for some people since there are so many providers and since so many of them deliver only a few services."

The third change Wainwright notes is the role of the state facilities. In 1991, a large number of the people served by the mental health, developmental disability, and substance abuse services system still were being served in state institutions. "That has

Aisander Duda

changed dramatically over the past 30 years," says Wainwright. "In 2009, the number of people with developmental disabilities served in the state developmental centers had decreased since 1991 by more than 53 percent. The number of people with mental illness and substance use disorders served in state psychiatric hospitals decreased by more than 10 percent over the same period."

The mental health system in North Carolina is anything but static. The changes in the system can be seen in the numbers of those served and where they are served, but also in the experiences—good and bad—of the consumers.

Endnotes

[1] N.C. Office of State Budget and Management (OSBM), Annual North Carolina Population Growth, July 2011. The state population was 9,735,890.

[2] Others pay for treatment themselves and are served through private providers.

[3] Dorothea Dix Hospital in Raleigh has stopped accepting new patients. Three units at Dix Hospital will be kept open: the Forensics Minimum Security Unit, Child Outpatient Services, and Clinical Research Outpatient Services. Most of the services have been transferred to Central Regional Hospital in Butner.

[4] N.C. Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "Semi-Annual Report to the Joint Legislative Oversight Committee on Health and Human Services," Statewide System Performance Report, SFY 2011–12, Spring Report, Raleigh, NC, April 1, 2012, Table 3.2.a, p. 14.

[5] In 1999, the U.S. 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. This decision led to mental health reform in all 50 states and in North Carolina to legislation called the Mental Health System Reform Act in the 2001 session of the General Assembly. See *Olmstead v. L.C.,* 527 U.S. 581, 119 S. Ct. 2176, 144 L.E.2d 540 (1999). See also N.C. Session Law 2001–437 (House Bill 381).

[6] Jeannette Barham, "Annual Statistical Report, North Carolina Psychiatric Hospitals, Fiscal Year 2011," Division of MH/DD/SAS, Raleigh, NC, Jan. 2012, Table 1, p. 3, and Table 2-A, p. 11.

[7] Jeannette Barham, "Annual Statistical Report, North Carolina State Developmental Centers, Fiscal Year 2011," Division of MH/DD/SAS, Raleigh, NC, Jan. 2012, Table 1, p. 3, and Table 2-A, p. 8.

[8] Jeannette Barham, "Annual Statistical Report, Black Mountain Neuro-Medical Center, O'Berry Neuro-Medical Center, Longleaf Medical Center, Fiscal Year 2011," Division of MH/DD/SAS, Raleigh, NC, Jan. 2012, Table 2A, p. 7.

[9] On the Internet at *http://www.bmcnc.org/body_bmc_home.htm,* accessed on Feb. 6, 2010.

[10] On the Internet at *http://www.ncdhhs.gov/mhddsas/oberry.htm,* accessed on Feb. 6, 2010.

[11] On the Internet at *http://www.longleafneuromedical.ncdhhs.gov/,* accessed on Feb. 6, 2010.

[12] Jeanette Barham, "Annual Statistical Report, North Carolina Alcohol & Drug Abuse Treatment Centers, Fiscal Year 2011," Division of MH/DD/SAS, Raleigh, NC, Jan. 2012, Table 3A, p. 7.

[13] Jeannette Barham, "Annual Statistical Report, Wright and Whitaker Residential Programs for Children, Fiscal Year 2011," Division of MH/SS/SAS, Raleigh, NC, Jan. 2012, Table 2-A, p. 6.

[14] On the Internet at *http://www.wrightschool.org/,* accessed on Feb. 6, 2010.

[15] On the Internet at *http://www.ncdhhs.gov/mhddsas/whitaker.htm,* accessed on Feb. 6, 2010. The Whitaker School has been converted by the state into a psychiatric residential treatment facility (PRTF) so that services provided there qualify for Medicaid. See the Joint Conference Committee Report on the Continuation, Expansion, and Capital Budgets, Senate Bill 897, June 28, 2010, p. G-2. Vicki Smith, Executive Director of Disability Rights NC, says the Whitaker School "doesn't have the staff to serve at that capacity (30 children)." She also notes that there is typically a waiting list of 30 to 60 kids at any given time. "There is no capacity to serve the neediest children," she says.

[16] N.C. Gen. Stat. § 122C-115.4.

[17] Triage is the process of determining which patients need to be treated first, based on their condition.

[18] According to the Treatment Accountability for Safer Communities website, "In North Carolina, TASC operates as a component of a community mental health/substance abuse service provider maintaining close relationships with their local criminal justice system, which refers eligible clients to TASC. Eligible clients are those who demonstrate a need for addiction treatment and/or mental health services and have been charged with or convicted of crimes eligible for intermediate or community punishments. Referrals come from the criminal courts, as well as community corrections." On the Internet at *http://www.dhhs.state.nc.us/mhddsas/tasc/files/TASCfactsheet07.pdf*, accessed Aug. 10, 2010.

[19] Jeannette Barham, "North Carolina LMEs, Annual Statistics and Admission Report, Fiscal Year 2011," Division of MH/DD/SAS, Raleigh, NC, Jan. 2012, Table 2, p. 6.

Karen Tam

The Public in Public Policy

Stories from North Carolinians with Mental Health Challenges

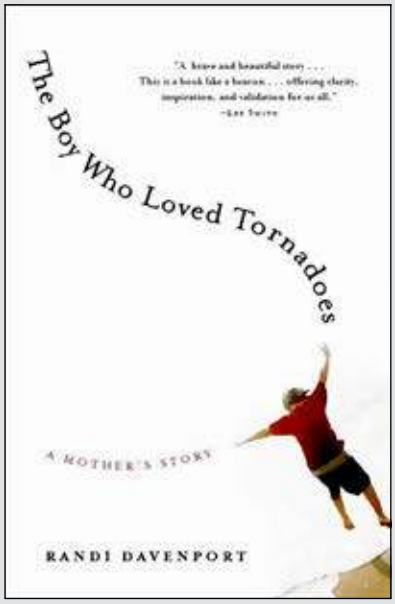
Editor's Note: One of the goals of the Center's Strategic Plan for 2012–16 is to "increase the use of stories of people affected by our research." It is important to see the faces and hear the stories of the public in public policy and to understand that real lives are impacted, for better or for worse, by changes in policy.

No Place To Go

by Randi Davenport

I noticed her as soon as I arrived at the podium. She sat in the back with her purse on her lap and a tense expression on her face. As I read from my book about my son's mental illness, she leaned forward. When I finished, her hand shot up. She was counting on me to save her family. But I knew that neither I, nor the latest in health care reform, would provide the help she needed for a loved one facing chronic mental illness.

They come to my readings in droves, these women with lost children, siblings sleeping on the streets, parents vanished into worlds beyond reach. One woman stood up and said, "Tell me what to do." She had a wrenching tale of not being able to find services for her son. Others send email messages. "I knew the minute I read your book," one wrote, "that you were the person with whom I must speak." Another said, "I will do anything." They describe their loved ones: "My daughter who is 23," "My son who is 14," "My sister abandoned by our parents." They share stories of unspeakable loss and pain. I hear them clearly. They need answers. They need to save someone. And they believe that I can help.



I can't. I know no better than they do how to wring services from a state that has made cuts or from an insurer that refuses to pay. But I have deep sympathy. I used to be just like them, calling everyone I could think of, saying, "Please. Please." I could be just like them again, at any moment, with one stroke of the pen.

My son, now 22, suffers from a disorder that includes features of both autism and a psychiatric illness. Just exactly what is wrong with him has eluded experts from Duke to UNC to Yale. When he was hospitalized with a baffling psychosis, I found myself on a self-guided tour of our mental health system just as some of the worst budget cuts were getting underway. I heard of states that stopped funding group homes, sending the sick into the streets; of parents forced to quit work and go on welfare to care for a child no provider would take; of residents of private group homes living on powdered milk because it cost too much to buy milk in a carton. I did *not* hear of providers willing to take patients whose clinical picture disrupted the business model. The most disabled were left with no place to go.

Randi Davenport is the author of The Boy Who Loved Tornadoes*, a book about her son's mental illness.*

"I'm Back, Baby!"

by Laura Anne Middlesteadt

I was 41 when I experienced my first mental illness — a wicked battle with Generalized Anxiety Disorder. I had led a pretty charmed life until my thirties, but then a series of hardships — my mother's accidental death, infertility, layoffs, and finally a disastrous cross-country move — tipped me over into relentless anxiety. My family and I ended up turning around and moving back across the country to the East Coast because of my mental state, which I attributed to our new location. Of course, by then I needed medical treatment, but I didn't understand that at the time. I waited until I had gotten a job and my insurance had kicked in before seeing a doctor. Once I did, a standard dose of a common antidepressant turned me around in a month — but the damage was done, both to our family's finances and to my marriage.

Although I remained healthy, my husband ended up moving out a year-and-a-half later. I stayed on my medicine and got through what initially seemed like the end of the world. I did so well, in fact, that a little over a year later, I decided I didn't need an anti-depressant anymore and stopped taking it. Four months afterwards, my divorce was finalized, I had to put my dog to sleep, and my doctor ordered an MRI to look for brain tumors — all in the same week! In hindsight, it appears obvious what would happen, but I didn't see it coming at the time. In a matter of days, anxiety had me in its unbearable grip once again.

Treatment was not so straightforward this time. Although I restarted my medication, I felt worse initially and made the irrational decision to stop taking it. My doctor then ordered a different medication, which was disastrous for my digestive system. I began to lose weight rapidly. At this point, I was referred to a psychiatrist for the first time. I had to drive out of town to find one who was accepting new patients. A period of constant flux followed — additions, subtractions, and dose changes in my meds, while I got sicker and sicker and saw my hope for recovery dwindle to nothing.

I had two suicide attempts in two weeks: an overdose and a violent attempt to kill myself. I ended up in a large hospital in a nearby city for more than seven weeks. I spent three weeks in intensive care and three weeks in the psychiatric ward. When I was released by a judge in January of 2008, I stood 5' 7" and weighed 93 pounds. I had had two major surgeries and was covered with scars. My short-term memory was impaired. I was unable to work, drive, care for my son, or live on my own.

I had a million obstacles to overcome at this point, but I had one key advantage: I was no longer anxious. My old standby medicine, at the old standby dose, had kicked in sometime while I was in the midst of my feverish morphine dreams.

I have to credit my recovery to medication, because without it, I never could have been well enough to benefit from recovery's other key components: a great counselor, a wonderful family, the responsibilities of my job, my son, running my household, and my own determination to get my life back and "make it up" to everyone. I wrote encouragement to myself in my journal: lists of goals, things to do to make myself feel better, helpful mantras, and a list of everyone who supported me. As I began to gain the weight back, I took many well-documented baby steps back toward my normal life. Privately, I celebrated each one: buying jeans that fit, getting my teeth cleaned, and baking a cake.

In June of that year, four months after my release, I bought my first house since my divorce. After that, my recovery really took off. The day of the closing, I finally wrote the words I'd been waiting to write in my journal: "I'm BACK, baby!"

Too Fearful To Sleep

by Gloria Harrison

Like lots of Geminis, I embody the duality of nature. I love to laugh and play and am also full of despair and sadness. I like to read and frustrate myself with politics. I have a dog, Lefty, who is the light of my life. His politics consist of a belief in benevolent dictatorships, as long as he is the dictator. In order to get away from him for at least eight hours a day, I work at the NAMI (National Alliance on Mental Illness) North Carolina state office and answer the Helpline. I have taken calls from around the state for 20 years.

My diagnosis is depression with episodes of psychosis. I have also had insomnia for my entire life. I had several bouts of severe depression as a child, including two suicide attempts before the age of 16.

One of my worst days came at the age of 36 when lack of sleep and despair had me locked in the bathroom at 4:00 a.m. I was holding a butcher knife in case demons or burglars or whatever tried to get me. I thought there was no difference in that episode from hiding in the bathroom of the orphanage all night as a child, too fearful to sleep. That thought prompted me to completely give up on life.

I was always told that I was difficult to love because I was so isolated and took myself too seriously. However, after starting on medication, I actually came out of my depression enough to realize that it wasn't all my terrible "nature." It was a treatable illness.

I have been on antidepressants for 25 years, and so far, my liver is still talking to me. I attended group support meetings for 15 years and still participate in other kinds of support, including using the Internet. I have been happily married for 10 years. Of course, we have been married for 37 years.

Acceptance, Family, and Friends = Recovery

by Deb Johnson

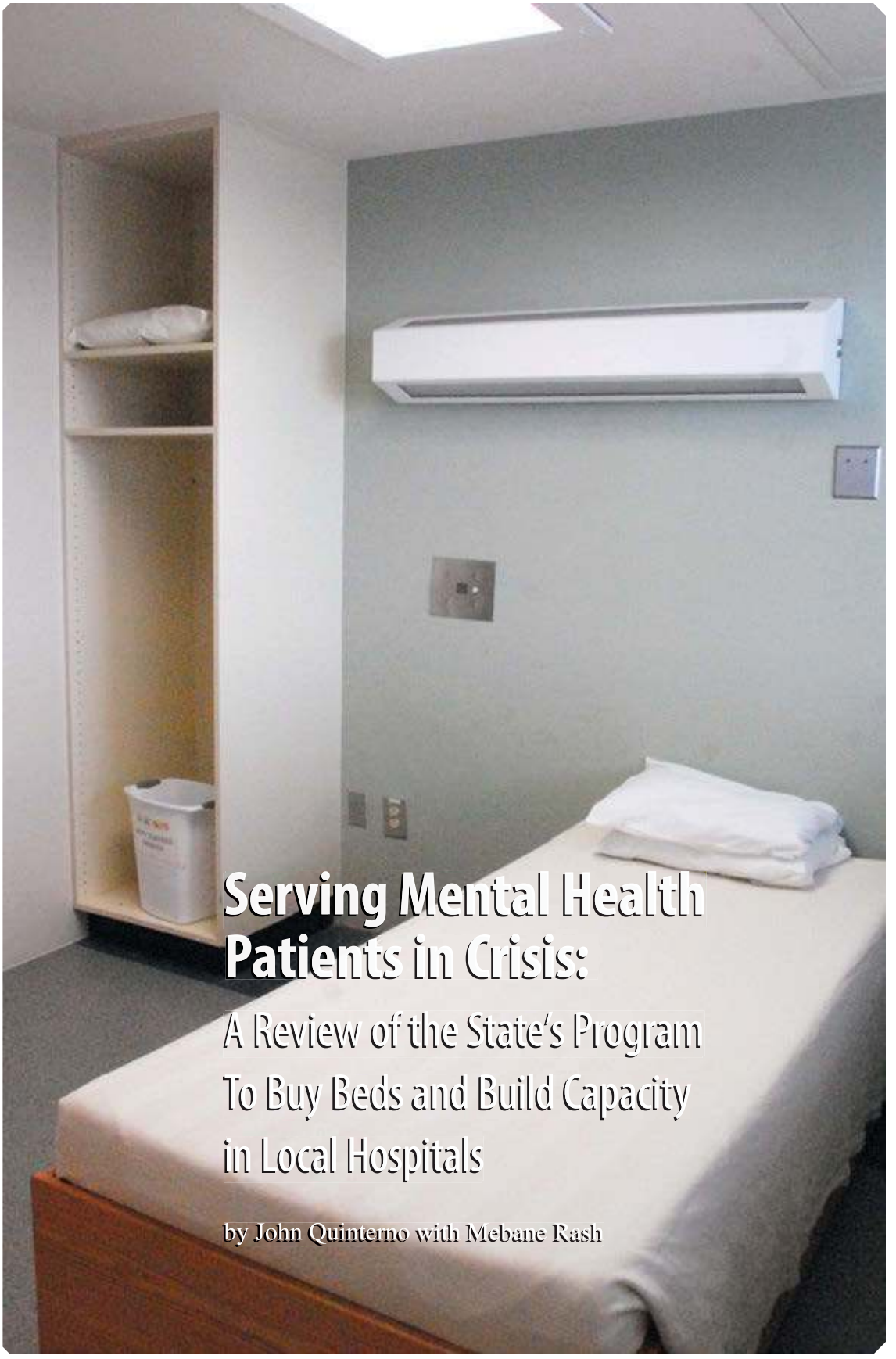
My diagnosis of bipolar disorder II came after six long months of physical pain, an exhaustive mania, and a sudden crushing depression. I was lucky enough to have a friend who was around me frequently enough to suggest that I see a psychiatrist. She had bipolar disorder and recognized the symptoms. My diagnosis was not a surprise, and—though it may sound trite—it was a relief to have an illness instead of just "crazy Debbie behavior."

Though I accepted my illness easily, I can't say my recovery was smooth sailing. Medications introduced into my system took weeks to begin to take effect, and my depression deepened as I waited. The first six months of treatment were complicated by a diagnosis of diabetes, a miscarriage, and a burst gall bladder—all testing my ability to stay the course of therapy, psychiatry, and medications.

My husband was my saving grace. His unwavering love and understanding had him curled up in dark corners with me as I contemplated suicide. He waited with me silently until I was ready to move again. My friends asked questions and educated themselves to help understand what I was going through, and they provided tough love when they noticed changes before I did.

Yet for all the love and assistance I have readily available, I have not been able to escape relapse completely. Learning to understand my triggers and creating an action plan to avoid them has been immensely helpful. I've found mini-episodes to be situational and typically beyond my control. Thus, I have an action plan in place that includes outside support.

And then there is relapse. I had no action plan for complete relapse as it has only happened once in the 12 years since this wild dance began. In March of 2009, a work-related issue sent me into the dark places that no one likes to talk about. It lasted for almost a year. Like any episode, a relapse brings about new information, new avenues of help, and new perspectives. Medication, doctors, and the love of family and friends helped me rise out of the darkness once again. I am stronger now—comfortably dancing between the broken places in my world of acceptance and recovery.



Serving Mental Health Patients in Crisis:

A Review of the State's Program To Buy Beds and Build Capacity in Local Hospitals

by John Quinterno with Mebane Rash

Karen Tam

Executive Summary

In 2008–09, the legislature first funded "three-way contracts" among the N.C. Department of Health and Human Services (DHHS), local mental health management entities (LMEs), and local hospitals. The goal of these contracts is to increase bed capacity within the community by paying hospitals for short-term care of mental health patients in crisis. The contracts allow adults needing inpatient psychiatric services to be treated for up to seven days and patients needing medical detoxification services for substance abuse to be treated for up to four days. With approval from the LME, patients may be treated in the local hospital for as long as necessary to stabilize them or transfer them to a state facility. Most of those served are a danger to themselves or others, or they are unable to care for themselves as a result of their mental health crisis. Others have relapsed in their substance abuse treatment. Without these contracts, individuals experiencing short-term crises often turn instead to a state psychiatric hospital for care—care that may be far from home, detached from the support of family and local health care providers, and costs more than local options. This detracts from a state facility's ability to serve patients needing long-term mental health care.

The Design of the State's Initiative

In theory, the project is designed to yield the following benefits:

- *Patients* will obtain mental health treatment in their own communities that is well-integrated into larger continuums of care.
- *Hospitals* will receive payments for serving patients needing mental health care who are otherwise uninsured.
- *Local areas* will strengthen their continuums of care for mental health, especially their services for patients in crisis.
- *The state* will reduce short-term admissions to state psychiatric hospitals, freeing up beds for individuals that require treatment longer than seven days.

The three-way contracts were developed as a way of moving North Carolina closer to the comprehensive local service system envisioned by the 2001 mental health reform legislation. The program's purpose is to increase capacity for treating mental health patients in crisis at local hospitals and to close service gaps.

Trends in the Number of Beds Available for Mental Health Care

While increasing the number of beds for those in crisis that can be treated in seven days or less is essential to the larger task of statewide mental health reform, few communities in North Carolina have enough beds. Due to financial and practical constraints, the total number of psychiatric inpatient beds in North Carolina declined from 1,958 beds in 2000 to 1,744 beds in 2010—a decline of 214 beds. Compounding this trend is the reduction in state psychiatric hospital bed capacity. Over an almost 20-year span between 1992 and 2011, the state psychiatric hospitals lost 1,879 beds, and between 2000 and 2011, they went from serving 16,789 people to serving just 5,754 people. This kind of care has been expensive for community hospitals to provide because insurance companies did not always cover mental health care, and if they did, the payment rates were often less than the cost to the hospital of providing inpatient care.

Without enough beds available, those in crisis began turning to their local hospital emergency rooms for help. In 2010, more than 135,000 people across the state were seen in a hospital emergency room for a mental health crisis. Community hospitals have responded to the need for more patient beds, and between 2009 and 2011, the number of patients served in community hospitals increased by 22.8 percent, rising from 15,442 to 18,966. At the same time, the number of patients served through three-way contracts nearly quadrupled, rising from 1,531 to 5,650—almost as many as those now served by the state's psychiatric hospitals. This means the state hospitals can focus on patients with more complex needs requiring longer care. Even so, the demand for these beds still often exceeds supply.

Meanwhile, local mental health management entities (called LMEs, these are the local agencies responsible for managing the provision of mental health services in the area served), worry that the need for more inpatient beds is constraining their ability to provide the comprehensive mental health services expected of them, especially care for patients in crisis. Many also are coping with state and local funding reductions, mounting service demands, and caseloads of individuals who are difficult to serve. Many LMEs also are in flux as they merge into the 11 managed care organizations (MCOs) that are expected to exist after the state's implementation of a federal waiver of Medicaid regulations governing mental health services. The waiver and the merger of the LMEs should not affect the three-way contracts because the shift to MCOs is primarily a change

in organizational structure and purpose that will not change the need for the contracts or the need for short-term beds.

The Center's Findings in Its Research on the Three-Way Contracts: A Qualified Success

During its first year of operation in fiscal year 2008–09, the legislature provided $8.1 million to purchase beds serving mental health patients on a short-term basis at local hospitals. This paid for 13 contracts involving the purchase of 77 beds. In 2009, the N.C. General Assembly increased funding by $12 million, bringing total funding for fiscal year 2009–10 to $20.1 million. This led to the signing of seven additional contracts for another 26 beds for fiscal year 2009–10, bringing the total to 103 beds. In 2010, the legislature increased the funding by $9 million, bringing total funding for fiscal year 2010–11 to $29.1 million. In 2010–11, the number of contracts (20) remained the same, but 10 beds were added, bringing the total to 113 beds. For fiscal year 2011–12, the appropriation remained the same at $29.1 million, with 21 contracts for 122 beds. In 2012, the legislature appropriated an additional $9 million, bringing the total appropriation to $38.1 million and providing funding for up to 186 beds.

The contracts receive generally positive reviews from the state mental health agency, local mental health management entities, hospitals, and patient advocates. Based on a review of progress to date, the N.C. Center for Public Policy Research finds that the three-way contracts have been a *qualified* success. Although this review did not attempt to establish a causal relationship, the Center finds:

- The number of patients served under three-way bed contracts is almost as many served each year by the three state psychiatric hospitals combined.
- Readmission rates for people served under the three-way contracts are lower than for those served in state hospitals.
- Short-term admissions to state hospitals (seven days or less) have dropped from 51 percent of total admissions in 2008–09 to 21 percent in 2011–12.
- The average length of stay in emergency departments for those who were transferred to a community hospital (only some of which were operating under three-way contracts) was more than

12 hours shorter than the average length of stay for those that were transferred to a state psychiatric hospital.

- The average length of stay for patients served through the three-way contracts at all hospitals is less than seven days—as intended.

The program's success is qualified by certain unresolved issues that may undermine the long-term effectiveness of this strategy. These concerns involve the project's structure, financing, long-term mental health reform goals, patient treatment, and the adequacy of the available work force.

The Center's Insights

Our research highlights six insights that need to be considered as this program is maintained and expanded:

Insight #1: ***Even with the 122 beds added by the three-way contracts, the number of beds available to mental health patients in crisis that can be treated in seven days or less falls short of the need in North Carolina. The state needs a methodology that provides a consistent way to determine the required ratio of beds to population that would adequately serve diverse areas of the state.***

Some experts contend that a state needs 50 psychiatric beds per 100,000 residents, but other studies support the need for between 22–31 beds per 100,000 residents. Counting the 1,744 beds in licensed psychiatric facilities and the 864 beds in the state psychiatric hospitals, North Carolina currently has a total of 2,608 psychiatric inpatient beds—26.8 beds per 100,000 residents. In an article in the *North Carolina Medical Journal*, Marvin Swartz with the Duke University School of Medicine and Joseph Morrissey with the Sheps Center for Health Sciences Research at UNC-Chapel Hill note, "The larger problem underlying the growing shortage of psychiatric beds in North Carolina is the absence of a rational bed-need methodology for determining the required ratio of beds to population that would adequately serve diverse areas of the state."

Regardless, under the State Medical Facilities Plan, seven local mental health management entities will need at least 73 more beds providing adult inpatient psychiatric care by 2014. Furthermore, the hospitals continue to want to add beds at this rate. In the fall of 2011, six hospitals wanted to add new three-way contracts totaling 26 beds and nine hospitals with existing contracts wanted to add a total of 36 beds. In sum, the hospitals

requested an additional 62 beds. Waiting times in emergency departments across the state also underscore the need for more beds.

Insight #2: ***When selecting where to establish new contracts or to expand existing contracts, equitable distribution among the three broad geographic regions of the state is one factor required by the legislature, but other factors also are important.***

When selecting where to establish new contracts or to expand existing contracts, several factors should be considered in addition to equitably placing them among the Eastern, Western, and Central regions of the state. Three-way contracts work best for hospitals with capacities they want to preserve or expand. Local mental health management entities that currently do not have contracts and are in areas where the state predicts a need for additional adult beds should have priority. Kent Woodson, program manager of the three-way contracts for the N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, emphasizes the importance of awarding contracts based on data that indicates where the beds are most likely to be used. And, although the primary goal of the contracts should be to provide beds for those in crisis, having those beds located closer to home is a real benefit to patients.

Insight #3: ***Priority transfers for those served under three-way contracts to the state psychiatric hospitals are often difficult to arrange.***

One of the most serious problems with the three-way contracts is the difficulty in arranging transfers of patients from the local hospitals to the state psychiatric hospitals. Patients who require more intense care are supposed to receive priority admission to the state psychiatric hospitals under the standard provisions of the three-way contracts. Many hospitals are not interested in treating these patients with short-term care without the assurance that if long-term care is needed, the state facilities will provide it.

Nevertheless, local stakeholders report that priority transfers are difficult to arrange. The lack of priority transfers may be due to unclear processes at state psychiatric hospitals or to delays in admission caused by staffing reductions. Or, it could be a by-product of the reduction in the number of staffed beds at the state psychiatric hospitals. The staff at the Division of Mental Health say some of the confusion results from local hospitals thinking that all of their patients qualify for priority transfers,

not just those served in the three-way beds. The Division staff also say that priority transfers have to be balanced with high-needs patients in the emergency departments. Whatever the cause, transfers to state psychiatric hospitals are a serious issue for the local hospitals and must be addressed.

Insight #4: ***At least every five years, the N.C. Department of Health and Human Services and the Joint Legislative Oversight Committee on Health and Human Services should re-examine whether the flat rate paid per day (currently set at $750) is adequate.***

The limitations of the flat rate include that it only covers inpatient services, it does not cover emergency department charges, it does not vary by severity of condition and treatment, it does not account for administrative costs, and it does not cover training for staff. However, those limitations *may be* outweighed by the benefits of having a flat rate. Furthermore, the hospitals continue to want to add beds at this rate. That said, the state needs to re-examine the rate at least every five years, especially given the implementation of national health care reform.

Insight #5: ***The state should continue to ensure that, over time, the three-way contracts serve the state's long-term goals in mental health reform.***

The three-way contract was developed as a way of moving North Carolina closer to the comprehensive local service system envisioned by the 2001 mental health reform legislation. While the program's purpose is to build capacity for mental health services in local hospitals and close service gaps, it also may run counter to some of the larger long-term goals driving mental health reform and exacerbate system problems. For example, the state's involvement in the three-way contracts seemingly detracts from the role the local mental health management entities were supposed to play in developing and coordinating local service systems.

Insight #6: ***Stakeholders have concerns about staffing requirements for substance abuse services and the inadequacy of local follow-up treatment for patients with substance abuse problems.***

While the three-way contracts allow for the provision of inpatient detoxification and substance abuse treatment, the substance abuse is often connected to a mental health problem. This is important because many stakeholders are concerned about the growing number of people with "dual diagnoses"—for example, a mental health diagnosis and substance abuse.

At only five of the participating hospitals does the provision of substance abuse services account for more than 20 percent of the billing under the three-way contracts. According to stakeholders, some hospitals are reluctant to provide substance abuse services, as required under the contracts. If the primary reason for treatment is substance abuse detox, then hospitals worry their treatment of those needing substance abuse services will preclude their treatment of those needing crisis psychiatric care.

Furthermore, the hospitals have raised concerns about whether their provision of substance abuse services under the three-way contracts meets staffing requirements under the state's rules for health and human services. For example, Division of Mental Health regulations require a full-time counselor for every 10 clients, at least one registered nurse, one direct care staff for every 20 clients, and a physician at the facility or on call 24 hours a day. The Medical Care Commission has additional rules for licensure of hospitals.

And while it is difficult to obtain follow-up mental health services, it is even harder to find follow-up services for substance abuse. Four reasons for this are identified in a 2008 report by the General Assembly's Program Evaluation Division: (1) a shortage of intensive outpatient substance abuse services statewide, (2) consumers not covered by Medicaid, (3) fewer hospital liaisons for consumers hospitalized with substance abuse problems, and (4) consumers who do not comply with treatment plans even when follow-up is attempted. Beth Melcher, chief deputy secretary of the N.C. Department of Health and Human Services, responds, "The problem is not availability of services, but lack of payers/reimbursement for services."

The Center's Recommendations

Based on its research on the three-way contracts, the N.C. Center for Public Policy Research makes four recommendations:

Recommendation #1: ***The Center recommends that the Secretary of the N.C. Department of Health and Human Services develop a strategy to ensure timely payments under these contracts.***

The timeliness of payments is a major concern for hospitals that, if left unresolved, could lead some local hospitals to terminate their contracts. While the state's problems with cash flows because of the Great Recession were the primary reason for delays in payments in the early days of this program, billing lags and slow payments continue to persist. The

standard state contract limits payment, as follows: "Division [of Mental Health] payment for approved inpatient services or approved bed capacity purchases shall be limited to the current fiscal year *availability of Division funds* in the psychiatric inpatient hospital fund reserve."

Another significant issue in the payment process is that the contract has been amended over time. The initial contract required the Division to pay the local mental health management entity (LME) within 60 days of receipt. This clause has been excluded from more recent contracts. And now, the *contract* states the LMEs must pay the hospital within 10 working days of receipt of funds from the state while *legislation* passed by the General Assembly says the LMEs must pay the hospital within 30 working days of receipt of funds from the state. Any additional billing issues that result from the state's decision to expand the federal Medicaid waiver statewide also need to be addressed expeditiously.

Recommendation #2: ***The Center recommends that the N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services publicize that they have a designated staff person serving as a liaison for the three-way contracts, as well as a state working group for the three-way contracts that addresses clinical concerns.***

It is important to local hospitals to have the state involved in these contracts. It signifies to them a longer-term state commitment, standardization across the contracts, and accountability for timely payments. Stakeholders reported that relationships with local mental health management entities were stronger than with the state, and they wanted better communication channels with the state, especially with regard to budget and payment issues. Currently, the state is viewed by many stakeholders as a distant partner, often only involved when there is a problem. Stakeholders suggested having a designated contract liaison within the Division to address these concerns.

In fact, the Division has a program manager intended to serve in this capacity. Ken Marsh was the program manager in 2008–09, Bill Bullington was the program manager from 2009–12, and Kent Woodson now is serving in this capacity. The state needs to do a better job letting hospitals know how to get in touch with the program manager.

The state also has a working group on the three-way contracts to look at the clinical aspects of this program—for example, why hospitals sometimes deny admissions. Dr. Susan Saik and Dr. Ureh Nnenna Lekwauwa

lead the working group. All hospitals with contracts are invited to the meetings of the working group. Stakeholders note that very little information is available about the working group. Stakeholders would like regularly scheduled meetings, advance notice and input on the agendas, and they would like all parties to the contracts to be invited. Another stakeholder suggested that a best practice team member from the Division should be included in the working group.

Recommendation #3: ***The Center recommends that the N.C. Department of Health and Human Services require state psychiatric hospitals to open their existing training programs (currently provided only to their own state direct care employees) to the local community hospitals participating in the three-way contracts.***

It is impractical for most community hospitals to operate their own psychiatric training programs. It also would be more expensive for training to be provided at 21 different local hospitals participating in the contracts. Meanwhile, state hospitals require their direct care employees to prepare detailed annual development plans for their staff and provide staff members with the training required by those plans. With local hospital staff trained to state standards, however, community hospitals would be better equipped to handle patients with mental illness and perhaps serve even more patients locally. And, this might speed up the state's ability to increase the overall mental health work force, an issue for the future in North Carolina. Such training programs might also induce more hospitals to participate in the three-way contracts.

Who would bear the cost of this training would need to be determined, but options include the state hospitals, the local mental health management entities, the local hospitals, or an arrangement where the cost is shared by these entities. Ultimately, the legislature is going to have to provide money for training if it wants the three-way contracts to succeed.

Recommendation #4: ***The Center recommends that the N.C. Department of Health and Human Services develop outcome measures for this program.***

Given the increased investment of state dollars in this program, the three-way contracts are now established enough that program and patient outcomes should be identified, tracked, and reported annually. For instance, stakeholders suggested to the Center the following program measures:

- short-term admissions to state psychiatric hospitals,
- the number of persons in crisis seen in local hospital emergency departments, and
- the average waiting time in the emergency departments for mental health patients transferring to hospitals with three-way bed contracts and state psychiatric hospitals.

Stakeholders also suggested the following patient outcomes:

- number of persons served;
- number of bed days purchased;
- average length of stay;
- re-admission rates after 30 days, 180 days, and one year;
- percent of those served from home LMEs;
- percent of those served from outside the hospital's region;
- total admissions; and
- most importantly, comparing patient outcomes under the three-way contracts with the outcomes of patients served by other community hospitals providing this type of treatment, as well as comparing patient outcomes under the three-way contracts with outcomes of patients served in state psychiatric hospitals.

Some of this data is already captured by current reporting, but all data pertaining to the three-way contracts needs to be reported annually so that the public and policymakers can more easily evaluate how well this program is working. For some of the outcomes suggested by stakeholders, cooperation from the N.C. Hospital Association also may be required.

* * *

North Carolina's ongoing reform of its mental health system is driven by a vision of providing comprehensive services locally. Realizing this, however, requires communities to have local hospital beds dedicated to short-term inpatient psychiatric care—beds that are missing in many communities across the state. The state's recent three-way contract project is a promising attempt to fill this gap, but the concerns described here need to be addressed.

Karen Tam

North Carolina's ongoing reform of its mental health system is guided by a vision of providing comprehensive services in local communities, reserving the state's larger psychiatric hospitals for patients needing long-term care. Achieving this, however, requires communities to have local hospitals with psychiatric units capable of providing short-term inpatient care—care for people who are temporarily unstable, pose a risk to themselves or others, and are unable to care for themselves as a result of their mental health crisis. Others have relapsed in their substance abuse treatment. Absent such psychiatric units, gaps exist in local continuums of care, and individuals experiencing short-term crises often turn instead to a state psychiatric hospital for care—care that often is far from home, detached from the support of family and local health care providers, costs more than local options, and detracts from a state facility's ability to serve patients needing long-term mental health care.

Increasing the number of beds available statewide for those in crisis that can be treated in seven days or less is essential to the larger task of mental health reform, but few communities in North Carolina have enough beds. Due to financial and practical constraints, the total number of psychiatric inpatient beds declined from 1,958 beds in 2000 to 1,744 beds in 2010—a decline of 214 beds (see Figure 1, p. 66). Compounding this trend is the reduction in state psychiatric hospital capacity. Over an almost 20-year span between 1992 and 2011, the four state psychiatric hospitals lost 1,879 beds,[1] and between 2000 and 2011, they went from serving 16,789 people to serving just 5,754 people.[2] This kind of care has been expensive for community hospitals to provide because insurance companies did not always cover it, and if they did, the payment rates were often less than the cost to the hospital of providing the care.

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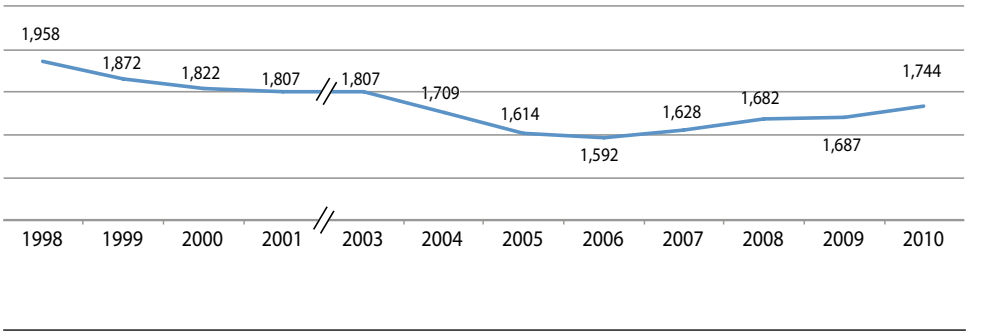
Figure 1. Psychiatric Inpatient Beds in North Carolina, *Excluding* State Facilities, 1998-2010



Sources:

1998 See State Medical Facilities Plan 2001, pp. 219, 224.

1999 See State Medical Facilities Plan 2002, pp. 281, 286.

2000 See State Medical Facilities Plan 2003, pp. 295, 300.

2001 See State Medical Facilities Plan 2004, pp. 303, 308.

2002 None of the State Medical Facilities Plans include 2002 data.

2003 See State Medical Facilities Plan 2005, pp. 289, 294.

2004 See State Medical Facilities Plan 2006, pp. 298, 302.

2005 See State Medical Facilities Plan 2007, pp. 284, 288.

2006 See State Medical Facilities Plan 2008, pp. 302, 306.

2007 See State Medical Facilities Plan 2009, pp. 333, 338.

Note: 2009 Report Discrepancy in total between p. 333 and p. 355 "Bed Supply." The base year is listed as 2006 instead of 2007 on p. 333.

2008 See State Medical Facilities Plan 2010, pp. 349, 355.

2009 See State Medical Facilities Plan 2011, pp. 398, 404.

2010 See State Medical Facilities Plan 2012, pp. 384, 388.

The 2007–12 State Medical Facilities Plans are on the Internet at *http://www.ncdhhs.gov/dhsr/ncsmfp/index.html*, accessed on April 17, 2012.

Those in crisis began turning to their local hospital emergency rooms for help. In 2010, more than 135,000 people across the state were seen in hospital emergency rooms for a mental health crisis.[3] Community hospitals have responded to the need for more beds to serve more patients, and between 2009 and 2011, the number of patients served in community hospitals increased by 22.8 percent, rising from 15,442 to 18,966.[4] At the same time, the number of patients served through three-way contracts nearly quadrupled, rising from 1,531 to 5,650—almost as many as those served by the state's psychiatric hospitals now that they can focus on patients with more complex needs requiring longer care (see Table 1, p. 68).[5] Even so, the demand for these beds still often exceeds supply.

If comprehensive mental health services are to be provided locally, the supply of short-term psychiatric beds available in community hospitals must be maintained and expanded. To that end, the General Assembly provided $8.1 million in fiscal

year 2008–09 to fund "three-way contracts" among the N.C. Department of Health and Human Services, local mental health management entities (LMEs),[6] and local hospitals. The program aims to build inpatient bed capacity within the community by paying hospitals for short-term care provided to indigent mental health patients in crisis. Some of those served are suicidal or a danger to others. Others have relapsed in their substance abuse treatment. In theory, the program will yield the following benefits:

- *Patients* will obtain mental health treatment that is well-integrated into larger continuums of care in their own communities.
- *Hospitals* will receive payments for serving patients needing mental health care who are otherwise uninsured.
- *Local areas* will strengthen their continuums of care for mental health, especially their services for patients in crisis.
- *The state* will reduce short-term admissions to state psychiatric hospitals to free up beds for individuals that require treatment longer than seven days.

> *"My friend … care for your psyche … know thyself, for once we know ourselves, we may learn how to care for ourselves."*
>
> — Socrates

During its first year of operation in fiscal year 2008–09, the legislature provided $8.1 million to purchase beds to serve mental health patients on a short-term basis in local hospitals. This paid for 13 contracts involving the purchase of 77 beds. In 2009, the N.C. General Assembly increased funding by $12 million, bringing total funding for fiscal year 2009–10 to $20.1 million. This led to the signing of seven additional contracts for another 26 beds for fiscal year 2009–10, bringing the total to 103 beds. In 2010, the legislature increased the funding by $9 million, bringing total funding for fiscal year 2010–11 to $29.1 million. In 2010–11, the number of contracts (20) remained the same, but 10 beds were added, bringing the total to 113 beds. For fiscal year 2011–12, the appropriation remained the same at $29.1 million, with 21 contracts for 122 beds. In 2012, the legislature appropriated an additional $9 million, bringing the total appropriation to $38.1 million and providing funding for up to 186 beds (see Table 2, p. 72).[7]

Based on a review of progress to date, the N.C. Center for Public Policy Research concludes that the three-way contracts have been a *qualified* success. All of the stakeholders interviewed for this article support the program's goals, but hospital officials voiced financial concerns, especially about the timeliness of the state's payments to local hospitals. Stakeholders also expressed concern about the flow of communications, partner responsibilities, provider capabilities, and the program's place within the larger landscape of mental health reform. Such concerns must be addressed if the program is to be scalable to cover the whole state and sustainable over time.

Research Background and Methodology

This analysis is part of the N.C. Center for Public Policy Research's ongoing research evaluating the state's mental health reform efforts. In 2009, the Center published a history of North Carolina's mental health reforms since Dorothea Dix's work in the 1800s, detailing the reforms in place since 2001.[8] That study identified various problems with recent reform efforts, one of which was the lack of beds available in local communities to mental health patients in crisis needing short-term care. This article examines state policies and practices regarding the purchase and provision of inpatient psychiatric care at local hospitals. It focuses on the three-way contract program as it currently is the state's main strategy in this

Table 1. A Comparison of the Number of Persons Served and Expenditures, Based on When the Service Is Provided by the Hospital vs. When the Service Is Paid for by the State, 2009–11

	Date of Service			Date of Payment		
State Fiscal Year	# Persons Served	# of Bed Days Provided	Expenditures	# Persons Served	# of Bed Days Purchased	Expenditures
2009	1,531	8,616	$ 6,462,000	1,218	6,880	$ 5,160,000
2010	4,498	24,927	18,693,931	4,336	24,895	18,671,250
2011	5,650	30,148	22,611,000	5,657	32,366	24,273,181

Source: Kent Woodson, N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

area, and it is tied to two priorities identified by the N.C. Department of Health and Human Services (DHHS): the "continued development of comprehensive crisis services" and the provision of care through alternatives to hospitalization in state facilities.[9] The goal is to develop a statewide comprehensive crisis continuum, and these contracts providing psychiatric hospitalization are part of that continuum.

Owing to the program's relative youth (a little over four years), neither comprehensive outcome data nor long-term evaluations are available yet. This research represents the first effort to trace the program's development, report initial outcomes, and identify key statewide issues.[10] The research methodology involved reviewing all available documents—primarily government reports—supplemented by interviews with 15 stakeholders and circulation of the draft article to more than 50 outside reviewers. The stakeholders included state mental health officials, local mental health management entities, local hospitals, mental health advocacy groups, psychiatrists, nurses, legislators, and legislative staff. After the draft was circulated, the Center conducted additional research, and then the report was circulated again to 19 reviewers.

Assessing North Carolina's Needs for Additional Inpatient Beds in Local Hospitals

The Division of Mental Health, Development Disabilities, and Substance Abuse Services in the N.C. Department of Health and Human Services is responsible for serving persons with mental health, developmental disabilities, and substance abuse problems who are ages three and older (ages 12 and older for substance abuse).[11] Because the three-way contract program is designed primarily to serve adults with mental health illnesses, this research focuses on that population.[12]

According to the Division, 1.37 million people need mental health, developmental disability, and/or substance abuse (MH/DD/SA) services in North Carolina—14 percent of the state population.[13] Not all of these individuals will seek treatment or use the public mental health system, but overall, the state serves about 52 percent of adults needing mental health services and 12 percent of adults needing substance abuse services.[14] Furthermore, many of the adults who turn to the *public* system are low-income and uninsured. One study found that 80 percent of adult North Carolinians seeking mental health treatment did not qualify for Medicaid in 2006.[15]

Services received by such individuals likely are either state-funded or uncompensated care (i.e., charity care provided by private health care providers).

In any given year, only a subset of the adult population receiving mental health treatment through the public system will require short-term inpatient care. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services says in a report to the legislature, "North Carolina has used its state psychiatric hospitals to provide both acute (30 days or less) and long-term care. In most other states, acute care is provided in community hospitals, reserving the use of state psychiatric hospitals for consumers needing long-term care. North Carolina, however, has historically served more people overall in its state psychiatric hospitals than other states and with shorter average lengths of stays."[16]

But, relying upon state psychiatric hospitals to provide short-term care is inconsistent with the overriding aim of the state's ongoing reform efforts: the local provision of comprehensive care. It also is inconsistent with the *Olmstead* decision, handed down in 1999 by the U.S. Supreme Court, which requires states to place people with mental disabilities in the least restrictive setting possible and in community settings rather than in institutions.[17] Specific shortcomings of providing short-term care in state institutions include the following:

- Short-term state care often *costs more than comparable local care.*
- Short-term state care often *decreases the number of beds available at state hospitals to offer long-term care.*
- Short-term state care often *requires patients to be served away from their communities.*
- Short-term state care often *is poorly integrated with local systems of care.*
- Short-term state care often *requires sheriffs or other law enforcement officers to transport patients to state hospitals.*
- The availability of short-term state care often *deters local areas from building true continuums of care because this type of care is costly for local hospitals to provide.*

All stakeholders interviewed for this evaluation agreed that many conditions requiring short-term inpatient care can be handled effectively at the local level *if* enough beds exist, *if* trained personnel are available, and *if* follow-up services are accessible. As Victoria Whitt, the CEO of the Sandhills Center for Mental Health, Developmental Disabilities, and Substance Abuse Services in West End says, "In my experience, local hospitals can handle and stabilize most people, provided the funding is there and the support services are there to handle people after discharge."

In the same vein, Dr. Marvin Swartz of the Duke University School of Medicine says that local care "is more of a normalizing experience and one that carries less stigma." He adds that local care also reduces patient interactions with the criminal justice system because law enforcement personnel typically transport people to state hospitals. In 2009, a survey of all of North Carolina's 100 county sheriffs found that there were 32,339 transports of mentally ill residents provided by deputies to serve commitment papers, transport the person to the nearest medical facility for medical clearance, and transport the individual to the nearest hospital with available psychiatric beds. A total of 228,353 hours of deputy time were involved.[18] The Raleigh *News & Observer* reported the story of Dave Descourouez, a deputy in Wake County, "'Oh, I've been to Ahoskie, and Rocky Mount, and Hickory, and Jacksonville,' said Descourouez, who estimates he's taken 150 trips since joining the department six years ago. On these trips, he's not investigating crimes or transporting criminals. He and his colleagues are carrying psychiatric patients from Wake County to mental

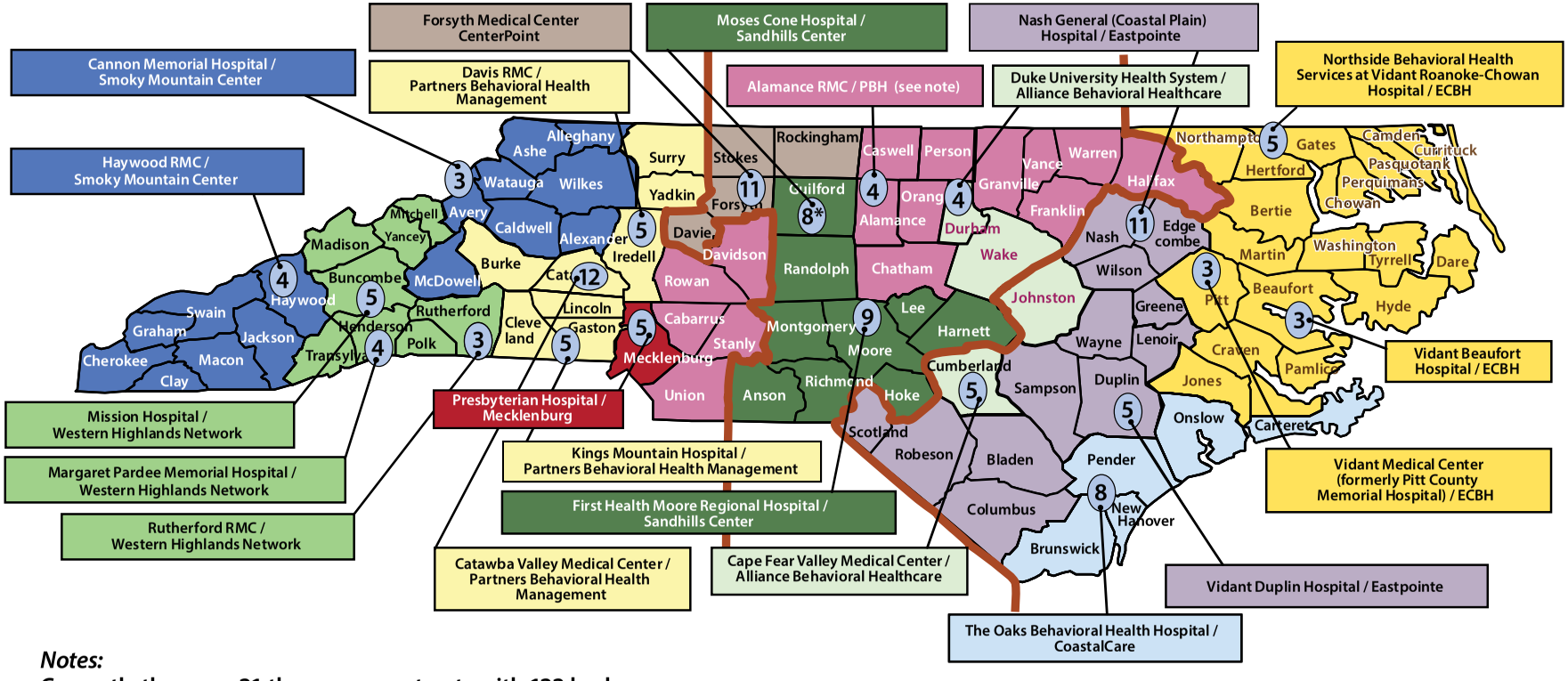
ASHBY WARD

"This is the kitchen
if you want anything . . ."
The husband
and wife
stood
looking.
I
watched her face
crack
to
pieces.

*—**HeartPrints***
by Joan Wilder Warlick

Editor's Note:
Joan Wilder Warlick was an award-winning North Carolina poet. She was treated for depression on Ashby Ward at Dorothea Dix Hospital. Her poems are reprinted in this article with her surviving daughter's permssion.

Figure 2. Three-Way Contract Community Hospital Beds as of March 9, 2012 and Proposed Local Management Entity—Managed Care Organizations (LME – MCOs) To Exist in January 2013



Notes:
Currently there are 21 three-way contracts with 122 beds:
46 in the West, 36 in the Piedmont, and 40 in the East.

= Number of beds under three-way contract

* = Moses Cone Hospital will only have 4 beds after 2011-12

In 2012, Piedmont Behavioral Healthcare (PBH) became Cardinal Innovations Healthcare Solutions.

Source: Kent Woodson, N.C. Division of MH/DD/SAS, adapted by NCCPPR, November 2012

health facilities with open beds. And the cost—in man-hours, and ultimately, dollars, of that duty for Wake and other sheriff's departments across the state is staggering."[19]

Unfortunately, many communities in North Carolina lack adequate numbers of short-term psychiatric beds. In 2006, prior to the conception of the three-way contract program, psychiatric beds in North Carolina hit a low of 1,592 beds statewide, a 23 percent drop since 1998 (see Figure 1, p. 66). The relative lack of beds meant that many local mental health management entities had no choice but to send people requiring short-term care to state hospitals—a choice which makes it harder to provide adequate follow-up services because of the distance from the hospitals to communities across the state. The three state psychiatric hospitals in North Carolina are: Broughton Hospital in Morganton, Central Regional Hospital in Butner, and Cherry Hospital in Goldsboro.

Local psychiatric beds are limited because a variety of practical and financial factors have led community hospitals to downsize or shutter their psychiatric services. According to Duke's Dr. Marvin Swartz, "Historically in North Carolina, we've lost over 500 local psychiatric beds due to private insurers' choices." Insurance companies set utilization and reimbursement rates. These limits on the number of days someone can be treated and how much providers are paid can create a disincentive to provide this service. And, many individuals requiring psychiatric care have either public insurance such as Medicaid or no health insurance, which leads to hospitals having to provide uncompensated care. In 2010, North Carolina hospitals provided at least $829 million in charity care (see Table 3, p. 78).[20] Many hospitals consequently reduced psychiatric services in response to these financial realities.

This is not to say that hospitals are insensitive to patients with psychiatric needs. Many view psychiatric care as part of their missions and partner with their local mental health management entities. Says Greg Billings, the administrator of psychiatric/secure care at Catawba Valley Medical Center in Hickory, *—continues on page 76*

Administrator of psychiatric care Greg Billings in the hallway of the adult unit on the 7th floor of Catawba Valley Medical Center.

Karen Tam

Table 2. Inpatient Beds in Local Hospitals Under Three-Way Contracts,

			13 Contracts		
			SFY 2008–09 Contracts		
	Local Management Entity (LME)	Hospital	# of Beds	Contract Amount	Contract Expenditures
1.	Alamance-Caswell (now with Piedmont Behavioral Healthcare)	Alamance Regional Medical Center	8	$ 534,000	$ 262,500
2.	Beacon Center	Nash General (Coastal Plain) Hospital	8	903,750	903,750
3.	CenterPoint	Forsyth Medical Center	8	749,000	354,000
4.	Crossroads	Davis Regional Medical Center			
5.	Cumberland	Cape Fear Valley Medical Center			
6.	Durham	Duke University Health System	2	305,000	303,750
7.	East Carolina Behavioral Healthcare	Vidant Beaufort Hospital	6	763,200	225,000
	East Carolina Behavioral Healthcare	Northside Behavioral Health Services at Vidant Roanoke–Chowan Hospital			
	East Carolina Behavioral Healthcare	Vidant Medical Center (formerly known as Pitt County Memorial Hospital)			
8.	Eastpointe	Brynn Marr Hospital	5	675,000	201,000
	Eastpointe	Vidant Duplin Hospital			
	Eastpointe	Wayne Memorial			
9.	Five County (now with Piedmont Behavioral Healthcare)				
10.	Guilford	Moses Cone Hospital			
11.	Johnston	Johnston Medical Center–Smithfield	0 [d]	250,000	184,411
12.	Mecklenburg	Presbyterian Hospital			
13.	Mental Health Partners	Catawba Valley Medical Center	8	1,700,000	1,686,090
	Mental Health Partners	Frye Regional Medical Center	5	675,000	300,000
14.	Onslow-Carteret				
15.	Orange-Person-Chatham				
16.	Pathways	Kings Mountain Hospital	5	478,000	166,500
17.	Piedmont Behavioral Healthcare				
18.	Sandhills	FirstHealth Moore Regional Hospital	6	500,000	469,500

by Local Mental Health Management Entities, State Fiscal Year (SFY) 2008–12

	20 Contracts			20 Contracts		21 Contracts			SFY 2012–2013 Contracts
	SFY 2009–10 Contracts			SFY 2010–11 Contracts		SFY 2011–12 Contracts			
	# of Beds	Contract Amount	Contract Expenditures	# of Beds	Contract Amount	# of Beds	Contract Amount	Expected Utilization % to Earn Contracts	Contract Amount
	8	$ 1,642,500	$ 1,304,250	4	$ 821,250	4	$ 1,095,000	100%	
	8	3,011,250	2,328,500	11	2,941,500	11	2,658,438	75%	
	8	2,292,500	2,039,175	11	2,941,500	11	2,569,875	75%	
	5	164,160	153,836	5	1,026,562	5	1,026,562	75%	
	5	596,250	218,500	5	1,026,563	5	1,368,750	100%	
	2	760,625	687,750	4	1,048,500	4	1,048,500	96%	
	6	1,231,875	1,072,547	3	615,938	3	821,250	100%	
	5	683,435	683,435	5	1,368,750	5	1,368,750	100%	
				3	460,688	3	615,938	75%	
			245,250 [a]						
	5	600,000	514,500	5	1,095,000	5	1,368,750	100%	
		[b]							
	4	407,250	407,250	4	821,250	8 [c]	1,274,250	100%	
						5	342,000 [e]	100%	
	12	2,763,750	2,804,250 [f]	12	3,285,000	12	3,285,000	100%	
	5	1,026,563	1,069,500 [g]	5	1,026,563	5	1,368,750	100%	
	6	2,737,500	1,483,000	9	2,394,000	9	2,394,000	97%	

Table 2. Inpatient Beds in Local Hospitals Under Three-Way Contracts,

			13 Contracts		
			SFY 2008–09 Contracts		
	Local Management Entity (LME)	Hospital	# of Beds	Contract Amount	Contract Expenditures
19.	Smoky Mountain	Cannon Memorial Hospital	7	$ 828,863	$ 400,000
	Smoky Mountain	Haywood Regional Medical Center	4	540,600	341,750
20.	Southeastern Center	The Oaks Behavioral Health Hospital	5	478,000	0 [h]
21.	Southeastern Regional				
22.	Wake				
23.	Western Highlands	Margaret Pardee Memorial Hospital			
	Western Highlands	St. Luke's Hospital			
	Western Highlands	Mission Hospital			
	Western Highlands	Rutherford Regional Medical Center			
	TOTALS		**77**	**$ 9,380,413**	**$ 5,798,251**
		Continuation Funding			
		Expansion Funding		8,121,644	
		Total Appropriation		$ 8,121,644	

Notes: In Fall 2011, there were 6 new hospitals interested in contracts totaling 26 beds and 9 existing hospitals with contracts wanting increases totaling 36 beds. The total overall known beds requested was 62.

Utilizations refers to the percentage of time beds must be occupied for hospitals to receive the full amount of the contract.

SFY: The state fiscal year runs from July 1 to June 30.

In 2012, Piedmont Behavioral Healthcare (PBH) became Cardinal Innovations Healthcare Solutions.

Source: N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

by Local Mental Health Management Entities, SFY 2008–12, *continued*

	20 Contracts			20 Contracts		21 Contracts			SFY 2012–2013 Contracts
	SFY 2009–10 Contracts			SFY 2010–11 Contracts		SFY 2011–12 Contracts			
	# of Beds	Contract Amount	Contract Expenditures	# of Beds	Contract Amount	# of Beds	Contract Amount	Expected Utilization % to Earn Contracts	Contract Amount
	3	$ 1,642,500	$ 1,010,750	3	$ 821,250	3	$ 821,250	100%	
	4	1,300,000	1,161,250	4	1,095,000	4	1,095,000	100%	
	5	1,642,500	1,674,233 [h]	8	2,120,250	8	2,190,000	100%	
	4	440,250	440,250	4	821,250	4	821,250	75%	
	1	136,125 [i]	5,250						
	5	680,625	495,750	5	1,026,563	5	1,026,563	75%	
	2	408,375	322,500	3	615,938	3	615,938	75%	
	103	**$ 24,168,033**	**$ 20,121,726**	**113**	**$ 27,373,315**	**122**	**$ 29,175,814**		
		8,121,644			20,121,644		29,121,644		29,121,644
		12,000,000			9,000,000		0		9,000,000
		$ 20,121,644			$ 29,121,644		$ 29,121,644		$ 38,121,644

[a] Contract expired on June 30, 2010. Contract expenditures in SFY 2010 include dollars paid for services provided in SFY 2009. $52,500 was recouped by the State in SFY 2010 settlement.

[b] Contract for 5 beds for $513,282 in SFY 2010 was never signed.

[c] Contract was increased to 8 beds just for SFY 2012.

[d] Contract canceled after money was provided for start up.

[e] Operational on May 15, 2012.

[f] Contract expenditures in SFY10 include dollars paid for services provided in SFY 2009.

[g] Contract expenditures in SFY10 include dollars paid for services provided in SFY 2009.

[h] Start of contract delayed. Contract expenditures for SFY 2010 include dollars for some services provided in SFY 2009.

[i] Contract expired on June 30, 2010. Western Highlands requested that the contract be allowed to expire due to low utilization and the bed was transferred to Rutherford Hospital.

These LMEs have not contracted for beds.

—*continued from page 71*

"We want the public system to succeed, and our future is interdependent with the public system." Yet from the hospitals' perspective, the economics of psychiatric care is a serious concern.

A lack of psychiatric beds makes it harder for local mental health management entities (LMEs) to provide comprehensive services, especially care for mental health patients in crisis. Under the mental health reform legislation of 2001, LMEs were gradually to assume responsibility for managing services in their areas and must ensure the availability of core services by contracting with private, public, and nonprofit providers.[21] Furthermore, LMEs must incorporate crisis services into their continuums of care.[22] Essential to that task is the availability of beds in local hospitals for people who are temporarily unstable and pose a risk to themselves or others. Absent local inpatient beds, local mental health systems will have a service gap.

Structure and Use of Three-Way Contracts for Local Hospital Beds

The three-way contract program currently is the state's main strategy to maintain and expand the supply of short-term inpatient psychiatric beds. It does so in a way that, at least on paper, reflects the institutional concerns of the N.C. Department of Health and Human Services (DHHS), local mental health management entities (LMEs), and community hospitals—the three partners in the

The Challenges of Serving People Far from Home

by Mebane Rash with Renee Elder

The three-way contracts are cross area service programs (CASPs) where hospitals treat individuals from outside their LME's service area if asked to do so. The benefit is that beds across the state are made available to those in need despite where they live. The disadvantage is that patients may be served far from home and away from their support network.

Patients often do not know which government program is paying for their bed, so it was difficult to find people to interview who were stable enough to consent to an interview and also knew their bed had been funded through a three-way contract. We did find one 25-year-old male with schizophrenia and bipolar disorder. Although he and his father live in Wake County, the son has been hospitalized twice at Vidant Duplin Hospital in a bed funded under the three-way contracts. The hospital is in Kenansville, which is 80 miles from Raleigh. This hospital uses its three-way contract to serve patients from other LMEs more than any other hospital participating in the program. More than 60 percent of those served by Duplin Hospital are from another LME (see also Table 7, p. 90).

The father said that both times his son was having a psychotic episode, the beds at Duplin Hospital were the ones available. The son said the experience was isolating and caused issues with his medications because the doctors didn't really communicate with his psychiatrist in Raleigh. The dad said the distance made visiting problematic for him and for the social worker in charge of his son's case. Both expressed the need for community support services outside the hospital setting to follow up with medication and paperwork.

The son is now in a group home in Raleigh. His father says the group home has done a good job of providing the support that his son needs to take his medication regularly and establish routines in eating and sleeping. These are the first steps toward getting a job and financial independence.

Karen Tam

Kimberly Yates works with patients admitted to a three-way contract bed.

contracts—in addition to addressing the shortcomings of past efforts. The desired result is better care for patients.

The Interests and Concerns of the Three Parties in the Contracts

All parties to the three-way contracts recognize the advantages of local care and wish to increase the number of beds available statewide for those in crisis. According to Leza Wainwright, the former director of the state's Division of Mental Health, the program begins "to reverse the trend that has been true in North Carolina and across the country of community hospitals going out of the inpatient psychiatric business." Other experts, like Duke's Dr. Swartz agree with that goal, but caution that "North Carolina is getting into this late in the game." The challenge is turning that desire into a form that satisfies stakeholder interests. Or, as Michael Watson, the director of the Division of Medical Assistance which manages the Medicaid program in North Carolina, puts it, "How do we get community capacity increased, and what are the concerns?"

"The three-way contracts use money as a carrot to bring the stakeholders together."

The three-way contracts use money as a carrot to bring the stakeholders together. From the hospitals' perspective, this is a population that, if treated, will lead to uncompensated care, so the ability to receive payment for those patients is an incentive for expanding capacity. From a local perspective, says Victoria Whitt of the Sandhills Center in West End, this approach "likely gets at people with the greatest needs." And, from the state's perspective, this is the population most likely to wind up at a state hospital.

Individual hospitals and the North Carolina Hospital Association participate in the program to receive payments for services that otherwise would be discontinued or provided without compensation. For instance, without three-way contract funds, Cannon Memorial Hospital in Linville would be —*continues on page 82*

Table 3. Estimated Costs of Treating Charity Care and Bad Debt Patients by North Carolina Hospitals, 2010

	Hospital	City	Estimated Treatment Costs		Total
			Charity Care Patients	Bad Debt Patients	
1.	Alamance Regional Medical Center	Burlington	$ 7,029,744	$ 9,041,202	$ 16,070,946
2.	Albemarle Hospital	Elizabeth City	1,919,294	5,814,595	7,733,889
3.	Alleghany Memorial Hospital	Sparta	286,543	662,528	949,071
4.	Angel Medical Center	Franklin	502,050	2,683,087	3,185,137
5.	Betsy Johnson Regional Hospital	Dunn	4,777,408	7,022,368	11,799,776
6.	Bladen Healthcare, LLC	Elizabethtown	343,214	3,527,209	3,870,423
7.	Blowing Rock Hospital	Blowing Rock	190,764	206,437	397,201
8.	Blue Ridge Regional Hospital	Spruce Pine	448,506	2,326,324	2,774,830
9.	Brunswick Novant Medical Center	Bolivia	6,062,374	1,719,859	7,782,233
10.	Caldwell Memorial Hospital	Lenoir	1,522,757	4,121,278	5,644,035
11.	Cannon Memorial Hospital	Linville	548,218	1,365,245	1,913,463
12.	Cape Fear Valley Medical Center	Fayetteville	21,784,000	23,153,000	44,937,000
13.	CarolinaEast Medical Center	New Bern	3,850,051	10,091,232	13,941,283
14.	Carolinas Medical Center	Charlotte	150,186,025	75,341,871	225,527,896
15.	Carteret County General Hospital	Morehead City	2,385,901	5,456,145	7,842,046
16.	Catawba Valley Medical Center	Hickory	3,689,748	9,475,170	13,164,918
17.	Chatham Hospital	Siler City	133,667	3,685,594	3,819,261
18.	Cleveland Regional Medical Center	Shelby	7,502,817	12,078,921	19,581,738
19.	Columbus Regional Healthcare System	Whiteville	1,574,096	2,984,302	4,558,398
20.	Care Partners Health Services	Asheville	245,543	215,511	461,054
21.	Cone Health	Greensboro	51,428,017	26,613,580	78,041,597
22.	Davie Hospital	Mocksville	101,583	1,264,041	1,365,624
23.	Duke Raleigh Hospital	Raleigh	9,185,199	3,184,301	12,369,500
24.	Duke University Hospital	Durham	37,124,435	67,570,074	104,694,509
25.	Durham Regional Hospital	Durham	17,822,703	2,049,924	19,872,627

Table 3. Estimated Costs of Treating Charity Care and Bad Debt Patients by North Carolina Hospitals, 2010, *continued*

	Hospital	City	Estimated Treatment Costs		Total
			Charity Care Patients	Bad Debt Patients	
26.	FirstHealth Montgomery Memorial Hospital	Troy	$ 565,386	$ 1,084,825	$ 1,650,211
27.	FirstHealth Moore Regional Hospital	Pinehurst	8,498,148	7,950,830	16,448,978
28.	FirstHealth Richmond Memorial Hospital	Rockingham	1,665,538	2,031,499	3,697,037
29.	Forsyth Medical Center	Winston-Salem	35,417,166	16,932,665	52,349,831
30.	Franklin Regional Medical Center	Louisburg	4,388,005	1,625,617	6,013,622
31.	Gaston Memorial Hospital	Gastonia	13,481,041	13,775,512	27,256,553
32.	Grace Hospital	Morganton	4,874,829	12,294,120	17,168,949
33.	Granville Health System	Oxford	787,166	3,463,656	4,250,822
34.	Halifax Regional Medical Center	Roanoke Rapids	432,252	6,134,512	6,566,764
35.	Harris Regional Hospital	Sylva	1,207,711	4,575,746	5,783,457
36.	Haywood Regional Medical Center	Clyde	2,646,001	4,195,344	6,841,345
37.	High Point Regional Health System	High Point	7,059,950	14,313,180	21,373,130
38.	Highlands-Cashiers Hospital	Highlands	217,981	1,014,607	1,232,588
39.	Hugh Chatham Memorial Hospital	Elkin	1,369,496	5,445,432	6,814,928
40.	Iredell Memorial Hospital	Statesville	6,763,698	6,721,403	13,485,101
41.	J. Arthur Dosher Memorial Hospital	Southport	306,998	2,399,839	2,706,837
42.	Johnston Medical Center	Smithfield	3,044,935	10,007,595	13,052,530
43.	Kings Mountain Hospital	Kings Mountain	7,502,817	12,078,921	19,581,738
44.	Lenoir Memorial Hospital	Kinston	1,234,106	9,381,894	10,616,000
45.	Lexington Memorial Hospital	Lexington	1,259,160	4,689,876	5,949,036
46.	Margaret Pardee Memorial Hospital	Hendersonville	1,317,220	7,727,137	9,044,357
47.	Maria Parham Hospital	Henderson	440,452	6,023,429	6,463,881
48.	Medical Park Hospital	Winston-Salem	1,400,264	1,243,024	2,643,288
49.	Mission Hospital	Asheville	15,395,935	23,893,441	39,289,376
50.	Morehead Memorial Hospital	Eden	1,386,772	5,706,449	7,093,221

Table 3. Estimated Costs of Treating Charity Care and Bad Debt Patients by North Carolina Hospitals, 2010, *continued*

	Hospital	City	Estimated Treatment Costs		Total
			Charity Care Patients	Bad Debt Patients	
51.	Murphy Medical Center	Murphy	$ 2,357,315	$ 2,327,674	4,684,989
52.	Nash Health Care System	Rocky Mount	3,600,201	12,553,137	16,153,338
53.	New Hanover Regional Medical Center	Wilmington	14,627,816	29,606,304	44,234,120
54.	North Carolina Baptist Hospital	Winston-Salem	46,834,476	13,522,343	60,356,819
55.	Northern Hospital of Surry County	Mount Airy	1,978,851	4,629,692	6,608,543
56.	Onslow Memorial Hospital	Jacksonville	1,966,461	11,503,033	13,469,494
57.	Park Ridge Health	Hendersonville	3,482,959	2,366,102	5,849,061
58.	Pender Memorial Hospital	Burgaw	241,291	2,186,423	2,427,714
59.	Person Memorial Hospital	Roxboro	670,570	2,742,294	3,412,864
60.	Presbyterian Hospital	Charlotte	26,876,532	14,950,138	41,826,670
61.	Presbyterian Hospital Huntersville	Huntersville	5,412,786	3,250,386	8,663,172
62.	Presbyterian Hospital Matthews	Matthews	7,492,171	4,414,364	11,906,535
63.	Randolph Hospital	Asheboro	1,741,904	7,463,234	9,205,138
64.	Rex Healthcare	Raleigh	26,157,374	8,195,089	34,352,463
65.	Rowan Regional Medical Center	Salisbury	10,403,840	4,078,442	14,482,282
66.	Rutherford Regional Medical Center	Rutherfordton	2,732,870	5,105,138	7,838,008
67.	Sampson Regional Medical Center	Clinton	243,095	5,349,687	5,592,782
68.	Scotland Health Care System	Laurinburg	3,243,965	5,383,261	8,627,226
69.	Southeastern Regional Medical Center	Lumberton	3,865,831	14,525,619	18,391,450
70.	St. Luke's Hospital	Columbus	526,195	1,161,125	1,687,320
71.	Stanly Regional Medical Center	Albemarle	3,412,822	4,194,535	7,607,357
72.	Swain County Hospital	Bryson City	90,531	1,165,564	1,256,095
73.	McDowell Hospital	Marion	441,493	2,861,928	3,303,421
74.	The Outer Banks Hospital	Nags Head	1,510,444	3,009,459	4,519,903
75.	Thomasville Medical Center	Thomasville	7,149,299	1,878,158	9,027,457

Table 3. Estimated Costs of Treating Charity Care and Bad Debt Patients by North Carolina Hospitals, 2010, *continued*

	Hospital	City	Estimated Treatment Costs		Total
			Charity Care Patients	Bad Debt Patients	
76.	Transylvania Regional Hospital	Brevard	$ 1,860,109	$ 2,529,668	$ 4,389,777
77.	UNC Hospitals	Chapel Hill	65,321,115	4,623,924	69,945,039
78.	Valdese General Hospital	Valdese	4,874,829	12,294,120	17,168,949
79.	Vidant Bertie Hospital	Windsor	725,963	888,331	1,614,294
80.	Vidant Chowan Hospital	Edenton	1,624,020	1,972,392	3,596,412
81.	Vidant Duplin Hospital	Kenansville	245,321	4,318,338	4,563,659
82.	Vidant Edgecombe Hospital	Tarboro	2,665,749	3,553,663	6,219,412
83.	Vidant Medical Center	Greenville	33,568,824	24,592,262	58,161,086
84.	Vidant Pungo Hospital	Belhaven	672,701	1,121,168	1,793,869
85.	Vidant Roanoke-Chowan Hospital	Ahoskie	2,200,324	4,106,396	6,306,720
86.	WakeMed Health and Hospitals	Raleigh	67,311,767	10,576,902	77,888,669
87.	Watauga Medical Center	Boone	2,468,283	4,233,964	6,702,247
88.	Wayne Memorial Hospital	Goldsboro	7,535,266	9,825,823	17,361,089
89.	Wilkes Regional Medical Center	North Wilkesboro	2,013,382	3,992,430	6,005,812
90.	Wilson Medical Center	Wilson	6,057,965	4,569,973	10,627,938
	TOTALS		**$ 829,514,394**	**$ 727,986,834**	**$ 1,557,501,228**

Source: Data obtained from the N.C. Hospital Association, North Carolina Hospital Community Benefits Report, 2010. On the Internet at *http://www.ncha.org/public/* and then click on Community Benefits Reports. Items A and S in the reports were used to create this table. Data accessed on April 17, 2012. This data is self-reported by the hospitals and has not been validated. Data not available for all hospitals. Some of the names of the hospitals have been updated.

—*continued from page 77*

unable to maintain the 10-bed inpatient psychiatric unit that it opened late in 2008, says Stephanie Greer, the director of behavioral health for the Appalachian Regional Healthcare System.[23]

But hospitals remain concerned about the economic viability of psychiatric care, and even with the contracts, they often are not able to cover their cost of care. At the same time, past experience in pilot programs have left some hospitals wary of the state's long-term commitment to initiatives. For instance, Greg Billings of Catawba Valley Medical Center notes how past partnerships involving the state and LMEs have been troubled by slow payment and abrupt termination.[24] This has eroded the hospitals' confidence in the reliability of state systems and funding.

For **local mental health management entities**, the availability of local inpatient beds through the contracts has increased their ability to provide the comprehensive mental health services expected of them by the state, especially crisis care. State dollars for this purpose are helpful since many LMEs are coping with state and local funding reductions, mounting service demands, and caseloads that are becoming harder to serve. For instance, in 2009–10, the Division of Mental Health's budget was cut from $820 million to $664 million—a 19 percent reduction in funds. About 20 percent of the dollars have been restored, so in 2012–13, the Division's budget increased to $696 million.[25] Over the same time period from 2009 to 2012, LMEs have increased the number of persons served by more than 30,000, a 10 percent increase from 326,563 to 360,180.[26]

DON'T DO THIS ON MY SHIFT

Just shut up!
Don't scream!
Don't on my shift.

I am having a nervous breakdown
It's with me every minute
No one will listen.

—HEARTPRINTS
BY JOAN WILDER WARLICK

Compounding the challenges facing LMEs is the fact that many of them are in flux as they merge into the 11 managed care organizations (MCOs) that are expected to exist after the state's implementation of a federal waiver of Medicaid regulations governing mental health services (see Table 4, p. 86). According to the Division, the waiver and the attendant merger of the LMEs should not affect the three-way contracts because the shift to MCOs is primarily a change in organizational structure and purpose that will not change the need for either the contracts or the need for short-term beds. The bottom line is that contract dollars free up LME-MCO funds for other uses.

As for **the state**, it wants to facilitate the transition to a locally-based mental health system. This contributes to the larger state goal of mental health reform and reducing short-term state psychiatric hospital admissions in compliance with the U.S. Supreme Court decision in *Olmstead,* requiring treatment to be provided in the least restrictive setting possible.[27] Although the care provided through the program is state-funded, it typically is cheaper than providing care in state psychiatric hospitals—where care is primarily funded by the state.[28]

The three-way contracts differ from other methods of purchasing psychiatric beds (see sidebar on p. 83) in that they involve the state, LMEs, and local hospitals. Seen one way, the program runs counter to the policy goals of local control, in that the state agency is involved in otherwise local relationships. Yet stakeholders said that the hospitals wanted direct state involvement based on the belief that direct state involvement would signal a deeper commitment, create standardization, and lead to prompt payment. Says Michael Vicario, vice president of regulatory affairs for the North Carolina Hospital Association, "There is a lot of commitment that, I think, goes into establishing a psychiatric service and when you commit to expand it as well. So, I think when local hospitals do that, they deserve some assurance from the state that the program will be continued."[29]

Target Population

The contracts allow adults needing inpatient psychiatric services to be treated for up to seven days and patients needing medical detoxification services for substance abuse to be treated for up to four days. Patients must be referred and authorized by an LME and meet the following criteria: (1) they require inpatient care; (2) they

must be indigent and uninsured; (3) they have been involuntarily committed (though some voluntary commitments are possible); (4) they are otherwise admissible to a state hospital; and (5) they need short-term stabilization. With approval, patients may be treated for as long as needed to stabilize them or transfer them to a state facility.

Patients requiring care typically are facing a destabilizing crisis that makes them a risk to themselves or others. Underlying diagnoses include severe psychotic disorders, schizophrenia, and post-traumatic stress. Crises often are triggered by a medication problem or severe stress. Some patients also may have substance abuse issues requiring treatment.

Responsibilities of the Parties

Although structured as a three-way partnership, much of the day-to-day work revolves around the relationships between local hospitals and their local mental health management entities. LMEs are responsible for managing the contracts on a daily basis and serve as the program's financial pipeline. LMEs work with the participating hospitals to authorize admissions and reauthorizations, if applicable, and also are responsible for coordinating the patient's care and discharge plans. LMEs are responsible, too, for managing admissions requested by other LMEs and making a

Buying Psychiatric Beds in North Carolina

by John Quinterno

Stakeholders in the mental health system are cognizant of the need to maintain and expand local hospital capacity. Over the years, the state and the local mental health management entities (LMEs) have entered into various partnerships with local hospitals. One way to foster capacity is to purchase psychiatric beds in local hospitals, and there have been four ways in which beds could be purchased:

- LMEs may use local funds to purchase beds. Seven LMEs have purchased beds with local funds to date: CenterPoint, Cumberland, Guilford, Mecklenburg, Mental Health Partners, Orange-Person-Chatham, and Wake. In 2010–11, these LMEs spent a combined $22 million to purchase 28,395 actual bed days.
- LMEs may use part of their generic allocation of state funding to purchase beds. In 2010–11, 16 LMEs spent $18 million to purchase 32,304 actual bed days serving 4,513 persons.
- LMEs may use hospitalization utilization project funds to purchase beds. N.C. Session Law 2007-323 provided funds for four LMEs (CenterPoint, Mecklenburg, Smoky Mountain, and Western Highlands) to purchase beds and develop strategies to serve people locally rather than send them to state hospitals.
- Partnerships among hospitals, LMEs, and the state may use three-way contract funds to purchase beds, as discussed in this article.

The services received by a patient do not vary based on funding sources, at least in theory.

Source: See North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Uniform System for Beds or Bed Days Purchased: with Local Funds, from Existing State Appropriations, under the Hospital Utilization Pilot, and from Funds Appropriated under Session Law 2011-145, Section 10.8.(b), Raleigh, NC, April 1, 2009 and May 25, 2012.

Karen Tam

Forsyth Medical Center has eleven beds in the three-way contract program.

"reasonable effort" to coordinate discharge care with the home LME. And, the LMEs receive and approve billings from the hospitals, forward bills to the state, receive payments, and then make payments to the hospitals.[30]

Participating hospitals must add or expand inpatient psychiatric capacity and use program funds to supplement, not supplant, other public funding (federal, state, and local) received for psychiatric services. Hospitals agree to accept referrals (both involuntary and voluntary) coordinated by the LME, reach an admissions decision within two hours of the initial referral or request, and agree not to transfer anyone to a state hospital without the LME's permission. Hospitals must have qualified staffs, work with the LME around discharge planning, and, if needed, provide discharged patients with a seven-day supply of psychotropic medicines—drugs that affect the mind, emotions, or behavior. Hospitals also must satisfy reporting and billing requirements.[31]

The state, meanwhile, is responsible for coordinating the overall program, paying authorized claims, and sanctioning parties for noncompliance. Additionally, the state agrees to grant priority admission at state hospitals to three-way contract patients who prove to have more complex treatment needs. The area LME and regional state hospital must approve transfers.[32]

Payment Rates and Funding

Participating hospitals receive a flat rate of $750 per day. This rate is designed to include a payment for hospital services, a payment for physician services, and a payment for discharge medications. The rate does not vary by condition or treatment type. Payment is made only for inpatient psychiatric services and does not cover other services like emergency room charges and administrative costs. The total amount of funding that a hospital may receive over a 12-month period also is capped.[33]

According to a 2012 report to the legislature by the Division, "[t]he current rate at state psychiatric hospitals ranges from $886 to $1,147 per day."[34] Michael Watson of the Division of Medical Assistance says the Medicaid payment rate is around $480–550 per day, but that does not include physician charges or discharge medication. When making these types of comparisons, Watson cautions that the three-way contracts are targeting a different group of patients needing a different mix of services than these other populations.

Funding for the three-way contracts comes from appropriations by the legislature from the state's General Fund. During state fiscal year 2008–09, the legislature provided $8.1 million in recurring funding. For state fiscal year 2009–10, the legislature added $12 million in recurring funds for a total of $20.1 million. For state fiscal years 2010–11 and 2011–12, the legislature added $9 million in recurring funds bringing the total annual appropriation to $29.1 million.[35] In 2012, the legislature added another $9 million in recurring funds, bringing the total annual appropriation to $38.1 million.[36]

Issues and Concerns

Although just in its fourth year of operation, the three-way contract program has succeeded in expanding the number of beds available statewide for those in crisis at local hospitals and diverting admissions from state hospitals to the local hospitals. The contracts receive generally positive reviews from the state agency, LMEs, hospitals, and patient advocates. Nevertheless, this success is qualified by certain unresolved issues that may compromise long-term effectiveness. These concerns involve the program's structure, financing, the state's long-term mental health reform goals, patient treatment, and the adequacy of the work force.

Increasing Capacity To Serve Patients with Mental Health Needs

By the end of fiscal year 2008–09, contracts had been signed with 13 hospitals for the purchase of 77 beds. These contracts were renewed for fiscal year 2009–10, and another seven contracts for the purchase of 26 additional beds were signed, bringing the total to 103 beds. In fiscal year 2010–11, the number of contracts (20) remained the same, but 10 beds were added, bringing the total to 113 beds. For fiscal year 2011–12, there are 21 contracts for 122 beds (see Table 2, p. 72). This means that the three-way contracts have succeeded in adding 122 short-term psychiatric beds to the state's supply.

The three-way contracts allowed hospitals to serve 1,531 persons in fiscal year 2008–09, providing 8,616 actual bed days. The additional capacity in fiscal year 2010–11 allowed for 5,650 persons to be served through the provision of 30,148 bed days (see Table 1, p. 68). There were 5,975 total admissions. The average length of stay for patients served through the three-way contracts at all hospitals is less than seven days.[37]

Yet even with these 122 beds, the supply falls short of the need. Some experts contend that a state needs 50 psychiatric beds per 100,000 residents.[38] For North Carolina to have 50 psychiatric beds per 100,000 residents, the state would need 4,868 beds statewide, or 2,087 more beds.[39] However, Beth Melcher, chief deputy secretary of the N.C. Department of Health and Human Services, notes that other studies support the need for between 22–31 beds per 100,000 residents. Adding the 1,744 beds in licensed psychiatric facilities (see Figure 1, p. 66) and the 864 beds in the state psychiatric hospitals (see Table 5, p. 87), North Carolina currently has a total of 2,608 psychiatric inpatient beds—26.8 beds per 100,000 residents.

Insight #1: ***Even with the 122 beds added by the three-way contracts, the number of beds available to mental health patients in crisis that can be treated in seven days or less falls short of the need in North Carolina. The state needs a methodology that provides a consistent way to determine the required ratio of beds to population that would adequately serve diverse areas of the state.***

In an article in the *North Carolina Medical Journal*, Marvin Swartz of the Duke University School of Medicine and Joseph Morrissey of the Sheps Center for Health Sciences Research at UNC-Chapel Hill note:

> The larger problem underlying the growing shortage of psychiatric beds in North Carolina is the absence of a rational bed-need methodology

Table 4. Projected Local Management Entities — Managed Care Organizations (LME-MCOs) in North Carolina

	LME-MCO	#	Counties	# of Persons Served	Effective Date
	Western Region				
1.	Piedmont Behavioral Healthcare (PBH)	15	Alamance, Cabarrus, Caswell, Chatham, Davidson, Franklin, Granville, Halifax, Orange, Person, Rowan, Stanly, Union, Vance, Warren	1,390,537	April 2012
2.	Western Highlands Network	8	Buncombe, Henderson, Madison, Mitchell, Polk, Rutherford, Transylvania, Yancey	511,122	January 2012
3.	Partners Behavioral Health Management	8	Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Surry, Yadkin	906,746	July 2012
4.	Smoky Mountain Center	15	Alexander, Alleghany, Ashe, Avery, Caldwell, Cherokee, Clay, Graham, Haywood, Jackson, Macon, McDowell, Swain, Watauga, Wilkes	525,754	July 2012
5.	Mecklenburg	1	Mecklenburg	909,493	January 2013
	Central Region				
6.	Sandhills Center	9	Anson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond	1,039,175	October 2012
7.	Alliance Behavioral Healthcare	4	Cumberland, Durham, Johnston, Wake	1,670,677	January 2013
8.	CenterPoint Human Services	4	Davie, Forsyth, Rockingham, Stokes	542,942	January 2013
	Eastern Region				
9.	East Carolina Behavioral Health	19	Beaufort, Bertie, Camden, Chowan, Craven, Currituck, Dare, Gates, Hertford, Hyde, Jones, Martin, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Washington	593,300	April 2012
10.	CoastalCare	5	Brunswick, Carteret, New Hanover, Onslow, Pender	608,215	July 2012
11.	Eastpointe	12	Bladen, Columbus, Duplin, Edgecombe, Greene, Lenoir, Nash, Robeson, Sampson, Scotland, Wayne, Wilson	802,055	January 2013
	TOTALS	**100**		**9,500,016**	

Note: In 2012, Piedmont Behavioral Healthcare (PBH) became Cardinal Innovations Healthcare Solutions.

Source: N.C. Department of Health and Human Services, "Why are Local Management Entities Merging?" On the Internet at *http://www.ncdhhs.gov/mhddsas/communicationbulletins/commbulletin123/lmesmerging-factsheet.pdf*, accessed on July 10, 2012.

> for determining the required ratio of beds to population that would adequately serve diverse areas of the state. Current beds allocations are based largely on historical trends rather than on careful assessments of population needs and the varying availability of state, private, and general hospital psychiatric beds and crisis services that can help to meet needs for intensive care with fewer beds per capita.[40]

But according to the state's own plan, seven LMEs will need at least 73 more beds providing adult inpatient psychiatric care by 2014 (see Table 6, p. 88). Furthermore, demand from the hospitals for additional beds at this rate continues. In fall 2011, six hospitals wanted to add new three-way contracts totaling 26 beds and nine hospitals with existing contracts wanted to add a total of 36 beds. In sum, the hospitals requested an additional 62 beds.

And, wait times in emergency departments across the state also underscore the need for more beds. For instance, during fiscal year 2010, 135,536 people were treated in hospital emergency departments across the state for a mental health crisis. More than 20 percent were transferred to a community psychiatric hospital bed—only some of which were operating under three-way contracts. Only 239, or 2.7 percent, were sent to a state psychiatric hospital. The average length of stay in emergency departments for those that were transferred to a community hospital was 14 hours and 7 minutes. The average length of stay for those that were transferred to a state psychiatric hospital was 26 hours and 38 minutes—more than 12 hours longer.[41]

When selecting where to establish new contracts or to expand existing contracts, several factors should be considered. Because the state's goal is to divert patients from admission to a state psychiatric hospital, the state wants to add capacity to areas

Table 5. Number of Beds at State Psychiatric Hospitals in North Carolina

State Psychiatric Hospital	Number of Beds 2011–12	Beds Added by 2012 Legislature	Total Number of Beds 2013
Broughton Hospital, Morganton	278	19	297
Cherry Hospital, Goldsboro	190	124	314
Central Regional Hospital (including Dorothea Dix Hospital), Butner	396	0	396
Total	**864**	**143**	**1,007**

Source: Division of State Operated Healthcare Facilities

Table 6. Comparison of Adult Inpatient Psychiatric Beds, Excluding State Hospitals, with the State's Projection of Beds Needed in 2014 and Allocation of 3-Way Contract Beds by Local Mental Health Management Entities

	LME	Total # of Adult Beds	Projected Surplus or Deficit of Adult Beds in 2014	# of Beds Under 3-Way Contracts in SFY 2011–12
1.	Alamance-Caswell (PBH)	36	13	4
2.	Beacon Center	67	29	11
3.	CenterPoint	154	86	11
4.	Crossroads	28	–2	5
5.	Cumberland	28	8	5
6.	Durham	42	16	4
7.	East Carolina Behavioral Healthcare	125	34	11
8.	Eastpointe	86	51	5
9.	Five County (PBH)	33	–3	0
10.	Guilford	74	7	8
11.	Johnston	20	0	0
12.	Mecklenburg	165	–6	5
13.	Mental Health Partners	144	98	12
14.	Onslow-Carteret	22	–5	0
15.	Orange-Person-Chatham	58	29	0
16.	Pathways	50	–3	5
17.	Piedmont Behavioral Healthcare	87	14	0
18.	Sandhills	72	13	9
19.	Smoky Mountain	32	–23	7
20.	Southeastern Center	62	23	8
21.	Southeastern Regional	33	3	0
22.	Wake	68	–37	0
23.	Western Highlands	131	35	12
	Total	**1,617**		**122**

Note: In 2012, Piedmont Behavioral Healthcare (PBH) became Cardinal Innovations Healthcare Solutions.

Source: The N.C. Division of Health Service Regulation, State Medical Facilities Plan 2012. On the Internet at *http://www.ncdhhs.gov/dhsr/ncsmfp/index.html,* accessed on April 17, 2012.

that have mental health needs, but institutional and practical concerns also come into play.

A budget provision in 2011 required that "[t]he Department shall work to ensure that these contracts are awarded equitably around all regions of the State."[42] Currently, there are signed three-way contracts in 16 of the state's LMEs. Beds purchased through the three-way contract program are allocated across the state's three major geographic regions—46 beds in the Western Region, 36 beds in the Central Region, and 40 beds in the Eastern Region (see Figure 2, p. 70).

But there are other important considerations. First, if a hospital doesn't offer mental health services, the three-way contract is a much harder sell because the hospital needs to create the unit from scratch, and the three-way contract does not provide an incentive to do so. In some cases, start-up costs have been provided: for instance, $100,000 in start-up costs was provided for the contract with Davis Regional Medical Center in Statesville and the Crossroads LME. Three-way contracts work best for hospitals with capacities they want to preserve or expand.

Insight #2: ***When selecting where to establish new contracts or to expand existing contracts, equitable distribution among the three broad geographic regions of the state is one factor required by the legislature, but other factors also are important.***

Second, determining where the beds are needed most can be difficult. LMEs that currently do not have contracts and are in areas where the state predicts a need for additional adult beds should have priority. According to the State Medical Facilities Plan, seven LMEs will need at least 73 more beds providing adult inpatient psychiatric care by 2014: Crossroads needs two beds, Five County under management of Piedmont Behavioral Healthcare needs three beds, Mecklenburg needs six beds, Onslow-Carteret needs five beds, Pathways needs 3 beds, Smoky Mountain needs 23 beds, and Wake needs 37 beds (see Table 6).[43]

Third, Kent Woodson, program manager for the three-way contracts for the Division, emphasizes the importance of awarding contracts based on data that

Greg Billings, administrator of psychiatric care, prepares a seclusion room with only a mat.

Karen Tam

Table 7. Cross Area Service Plan Analysis for Three-Way Contracts: Percent of Contract Beds Used by Hospitals Inside Their Local Mental Health Management Entity's Service Area

	Hospital	% of Contract Beds Used by Hospital for Their LME
1.	Vidant Duplin Hospital	39%
2.	Vidant Beaufort Hospital	47%
3.	Catawba Valley Medical Center	47%
4.	Cannon Memorial Hospital	50%
5.	Duke University Health System	52%
6.	Northside Behavioral Health Services at Vidant-Chowan Hospital	58%
7.	Kings Mountain Hospital	71%
8.	Nash General (Coastal Plain) Hospital	76%
9.	Davis Regional Medical Center	77%
10.	Moses Cone Hospital	83%
11.	Alamance Regional Medical Center	89%
12.	Vidant Medical Center (formerly known as Pitt County Memorial Hospital)	89%
13.	Haywood Regional Medical Center	93%
14.	Forsyth Medical Center	94%
15.	Cape Fear Valley Medical Center	95%
16.	FirstHealth Moore Regional Hospital	95%
17.	Margaret Pardee Memorial Hospital	96%
18.	The Oaks Behavioral Health Hospital	97%
19.	Rutherford Regional Medical Center	97%
20.	Mission Hospital	98%

Source: Kent Woodson, N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

indicates where the beds are most likely to be used. The state should continue to evaluate the number of short-term admissions at state psychiatric hospitals coming from each LME, wait times in emergency departments, and cross area service plan data when it considers where to award or expand contracts. For instance, although the primary goal of the contracts should be to provide beds for those in crisis, having those beds closer to home is a real benefit to the program's structure and a benefit to patients. For four participating hospitals, at least 50 percent of their beds are for people who are not from their home LME (see Table 7).

The Division's research suggests that participating hospitals have neither increased the lengths of patients stays to draw down extra money, nor have they swapped one kind of publicly-funded bed for another (e.g., switching from Medicaid patients to charity care patients), according to Leza Wainwright, the former director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.[44] And as Victoria Whitt of the Sandhills Center in West End notes, this dynamic has freed up funds which LMEs can redirect to other services. Additionally, Michael Vicario of the N.C. Hospital Association says that other hospitals are interested in joining the program.

Concerns About Transfers to State Psychiatric Hospitals

One of the most serious problems with the three-way contracts is the difficulty in arranging transfers of patients from the local hospitals to the state psychiatric hospitals.[45] Patients who require more intense care are supposed to receive priority admission to the state psychiatric hospitals under the provisions of the three-way contracts. Many hospitals are not interested in treating these patients with short-term care without the assurance that if long-term care is needed, the state facilities will provide it. Nevertheless, local stakeholders report that priority transfers are difficult to arrange. One hospital administrator says,

> In our experience, patients served by three-way contracts do not receive priority. Fortunately, our LME has continued to reauthorize the longer stays. It seems that referrals are triaged as presented and those being held in emergency departments generally take priority. Given the volume, it is hard to fault those on the front lines making these decisions. Once a patient is admitted to an inpatient unit, they automatically drop down the wait list. In our experience, typically there are approximately 25 males on the Broughton [one of the state's psychiatric hospitals] list at any given time. As proven again yesterday, a patient has to actually cause harm and/or damage before they are expedited to a state bed. We had an extremely aggressive patient for a week before he was accepted to Broughton, one of the state's psychiatric hospitals. It took several staff assaults and significant unit damage before the transfer took place. And, although we accept patients from across the state, it is virtually impossible to get a bed in either the central or eastern region if a patient requires that disposition after being admitted to our unit. We have continued to harden our environment and increase the level of training for our staff, but there are limits to what any community hospital can manage.

Insight #3:
Priority transfers for those served under three-way contracts to the state psychiatric hospitals are often difficult to arrange.

The lack of priority transfers may be due to unclear processes at state psychiatric hospitals or to delays in admission caused by staffing reductions. Or, it could be a by-product of the reduction in the number of staffed beds at the state psychiatric hospitals. The staff at the Division of Mental Health says some of the confusion results from local hospitals thinking that all of their patients qualify for priority transfers, not just those served in the three-way beds. The Division staff also say priority transfers have to be balanced with high-needs patients in the emergency departments.

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Susan Saik, the medical director for the Division of State Operated Healthcare Facilities, says, "There is a structured process in place for transfers. Delays are never due to staffing problems in the admitting office. There are a fixed number of inpatient beds, which is associated with the number of staff that the state has authorized and funded to operate those beds." Whatever the cause, transfers to state psychiatric hospitals are a serious issue for the local hospitals and must be addressed.

Cristy Williams[46] is a nurse at Catawba Valley Medical Center in Hickory, and she is the patient care coordinator in the psychiatric unit. She is in charge of the three-way contracts at her hospital. Williams says that in her experience referring patients who require more intensive or longer-term care to state hospitals can be difficult due to bed shortages. "My biggest challenge is getting patients to state facilities when longer-term residential treatment is required. If I have a patient who is violent, I can call and that helps with priority, but still, if they don't have a bed, they don't have a bed." (See Williams' sidebar on "The Admissions Process Begins the Discharge Process," p. 93).

Insight #4: ***At least every five years, the N.C. Department of Health and Human Services and the Joint Legislative Oversight Committee on Health and Human Services should re-examine whether the flat rate paid per day (currently set at $750) is adequate.***

Financial Concerns

Financial concerns were the single most important issue raised by those interviewed. The concern was especially prominent among hospital stakeholders. Three specific issues were raised: (1) the adequacy of the $750 per day rate paid by the state to the local hospitals, (2) the timeliness of the payments, and (3) the fairness of the payments.

The Admissions Process Begins the Discharge Process: Three-Way Contracts at Catawba Valley Medical Center in Hickory

An Interview with Cristy Williams, BSN, RN-BC, Patient Care Coordinator by Mebane Rash

Cristy Williams is the patient care coordinator in the psychiatric unit of the Catawba Valley Medical Center in Hickory. Her work involves a mix of direct care and middle management responsibilities. "I oversee the more complex patients in our unit, which now includes the three-way contract beds," she says. Three-way contracts among the N.C. Department of Health and Human Services, local mental health management entities (LMEs), and local hospitals build capacity by paying hospitals for short-term inpatient care. Williams makes sure that a patient is eligible for services under the three-way contract, that patients receive the appropriate discharge medications, and that the appropriate connections to post-discharge services are made. "I make sure that patients come full circle back into the community."

Much of Williams' work involves the three-way contract because Catawba Valley's 30-bed unit is one of the largest involved in the project with 12 beds, and it has a high level of utilization. Within her hospital, she described her role as being "the center that makes the project come together."

Williams says there are many advantages to providing care locally, including short-term crisis care. Catawba Valley admits patients both from their local area and patients from other LMEs. In fact, they have had patients from as far away as Eastern North Carolina.

Williams also notes that providing short-term care at a community hospital can lead to better follow-up services and coordination of care. For instance, Catawba Valley has a strong working relationship with the LME. It is harder, however, to serve patients from different local areas. She says, "It is much more difficult because we don't have the same working relationships."

Regardless of a patient's home region, Williams says there is an advantage to providing care through community hospitals. That is because the community hospitals specialize in providing short-term acute care and don't mix short-term and long-term care patients, as happens in the state psychiatric hospitals.

She says that "the admissions process begins the discharge process." By that, she means that she and her colleagues are thinking about the services a patient will need once he/she is stabilized and discharged. She adds, "We have a plan in place by the time each patient is stabilized." To that end, she and her colleagues look at the patient's symptoms and the severity of those symptoms and also consider the patient's history. While in the hospital, patients receive a combination of services appropriate to their situations (e.g., medication, psychiatric treatment, detoxification/substance abuse treatment, case management, or social services).

In terms of the logistics of serving more patients, Williams says, "We're evolving as we need to and as the contract does in order to provide optimal care." But she adds, "If we were going to serve more patients, we would need more staff."

"We are providing acute care to patients who otherwise would go to state psychiatric hospitals," says Williams, adding that reductions in the number of long-term beds in state hospitals will result in more people with complex needs living in communities, thereby increasing the importance of community services.

Williams says the kind of care provided to patients doesn't vary based on the payment source. "It doesn't matter where they came from or who the payer source is. We're providing the patients with the same services. The only difference is who I send the paperwork to." She adds, "I love it. I love my patients."

PILL TOWN

Some count time until
It's time to
Ease time to
Stop

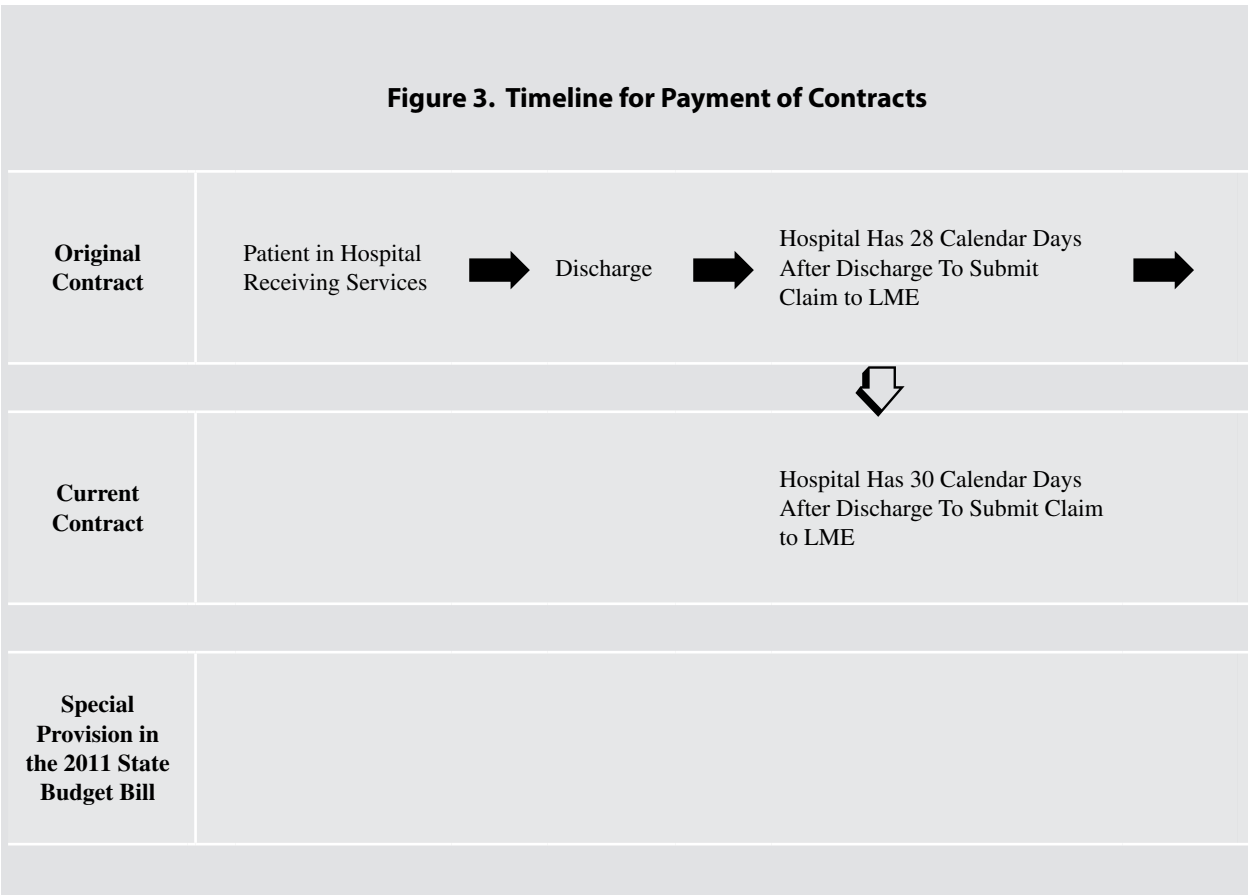
—HEARTPRINTS
BY JOAN WILDER WARLICK

All hospital respondents expressed concerns about the rate of $750 per day. All indicated that it was comparable to Medicaid payment rates, though Medicaid does not require hospitals to provide discharge medication. However, the rate does not fully capture costs, and neither do Medicaid payments, they say. Specific limitations include the following:

- The rate only covers inpatient services, not emergency room charges.
- The rate does not apply to potentially less-expensive services like beds used for observation instead of treatment.
- The rate does not vary by severity of condition and treatment, whereas Medicaid rates do vary.
- The rate does not account for the significant administrative costs incurred by the program.
- The rate may need to be re-evaluated given the implementation of health care reform nationally.

Glenn Simpson, administrator of health services at Pitt County Memorial Hospital, and Jo Haubenreiser, vice president of Novant Health in Winston-Salem, both made presentations at the legislature in 2011 about their hospitals' three-way bed contracts. They noted that patients served under three-way bed contracts often have multiple diagnoses, often making it more difficult to treat them. Haubenreiser said that these medically-complex patients make the $750 inadequate, and the hospitals can't begin to cover their costs with the flat rate.

Figure 3. Timeline for Payment of Contracts



On the other hand, those limitations might be outweighed by the benefits of having a flat rate. For instance, trying to vary the rates by the severity of the condition could require new rates and new service codes, prior authorization, and payment through the state's Integrated Payment and Reporting System (IPRS), which tracks, pays, and reports on all claims submitted by providers for mental health services. Furthermore, the hospitals continue to want to add beds at this rate. Hospitals requested at least 62 more three-way contract beds in the fall of 2011, according to the Division. A state three-way bed working group looks at clinical aspects of the program, and the group has discussed the concept of tiered-rates.

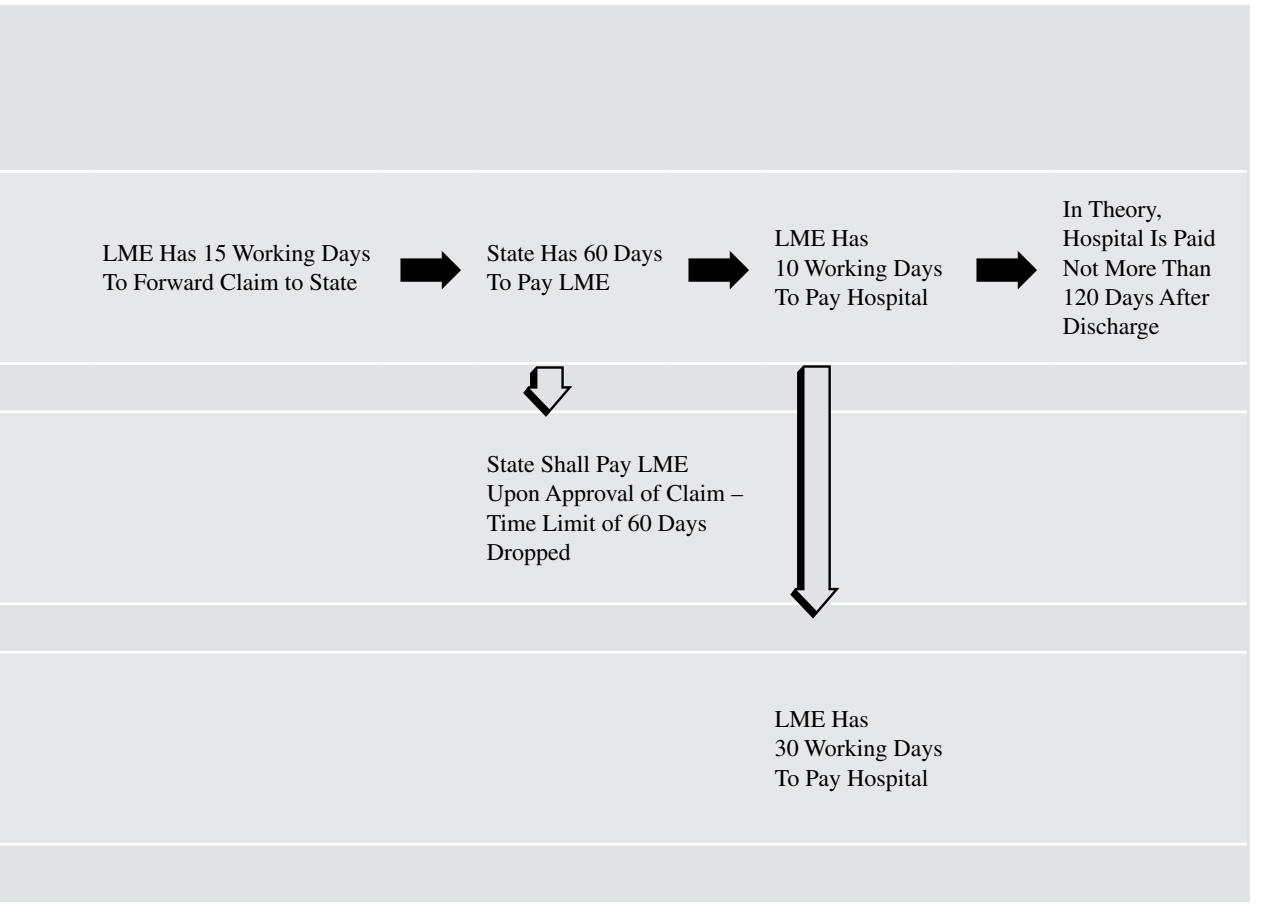
While sharing similar concerns about reimbursement rates, hospital respondents varied in their assessment of the financial usefulness of the contracts. Says Dr. Marvin Swartz of Duke University School of Medicine about the three-way contracts, "It covers some of the cost, but there is no real financial incentive to participate." Other hospitals like Catawba Valley in Hickory, Cannon Memorial in Linville, and FirstHealth in Pinehurst had a more positive experience, though all say it takes a great deal of oversight and management (e.g., controlling prescription costs) to make the numbers work. In some ways, the financial attractiveness may depend upon a hospital's service area and cost structure competitiveness. Nevertheless, all three indicated that the contracts have helped to expand their psychiatric wings and that the beds are well-used and generating revenue. Catawba Valley actually added more beds to its contract.

Perhaps even more important than the rate level is concern about timeliness of payments. Based on the timelines specified in the *original* contract documents, hospitals should have received payment no more than 120 days after patient discharge.

RX

Paraldehyde makes your stomach quit feeling like it's gonna fly out through your throat

*—**HeartPrints***
BY JOAN WILDER WARLICK



The Benefits of Serving Patients Closer to Home

by Mebane Rash with Greg Billings

A 34-year-old patient was admitted to Catawba Valley Medical Center in Hickory after a 12-hour wait in an emergency department in Western North Carolina—much quicker than the last time he was in crisis. The patient said the care he received at the medical center was better than when he had been sent to Broughton Hospital in Morganton, one of the state's psychiatric hospitals. Because the waiting lists are so long to get into state psychiatric hospitals, he had previously waited three days in the emergency department before he could be admitted to Broughton. He was so anxious because of the extended wait that he hit staff, was restrained, and given several shots of drugs to calm him down. Being able to get into Catawba Valley Medical Center more quickly alleviated a lot of his stress and decreased the amount of time he needed to get back on track. The patient's family expressed gratitude for the opportunity to come and speak to the treatment team, an option that had been impossible when he was served at the state hospital. The patient and his family had a higher degree of comfort being served in a community hospital closer to home. He was able to identify with other patients, and his family did not have any concerns about his safety while he was away.

Hospitals had 28 calendar days to submit bills; LMEs had 15 working days to forward clean claims to the state; the state had 60 calendar days to pay; and LMEs had 10 working days to make payment. Holidays or billing problems could extend the timeline (see Figure 3, p. 94).

In the early days of the three-way contracts, the availability of cash to pay the contracts was a primary reason for delays in payments. In many ways, this was a by-product of the national economic recession and the resulting state budget crisis. The state faced a $4.6 billion budget shortfall (about 22 percent of the state's 2008–09 budget) as the legislature prepared its 2009–10 budget. The budget was not passed until August 2009, a month after the new fiscal year 2009–10 started on July 1, 2009. The state also slowed all payments—such as tax refunds and these payments to local hospitals for mental health services—as a way to manage its very tight cash flow. State officials were aware of the problem of timeliness of payments to local hospitals. Michael Watson directly acknowledged the problem, and the Division and the DHHS Secretary's office worked to make these payments a priority. For instance, on January 1, 2010, the payment process was changed to address this issue, with three-way contract payments being taken out of the state's Integrated Payment and Reporting System (IPRS) and payments being given priority.

Billing lags and slow billings to IPRS continued into 2011. The slow billings were usually a delay in the hospitals giving billing information to the LMEs—perhaps as the hospitals tried to make sure there was no third party insurance or Medicaid coverage which could pay. In response, in February 2011, the Division started asking for weekly bed census information from each local hospital to more accurately project potential utilization of expenditures, according to Kent Woodson, a budget officer in the Division, who now manages the three-way contract program. This continues to be a valuable tool, but delays in payment persist.

For example, one contract went six months without being paid for care provided after July 1, 2011. Most of what was due was received on December 23, 2011. But one month later, more than $500,000 was pending payment again on this contract.

Several problems remain with the timeliness of contract payments. The contract limits payment: "Division payment for approved inpatient services or approved bed capacity purchases shall be limited to the current fiscal year *availability of Division funds* in the psychiatric inpatient hospital fund reserve." According to the Division, current payments schedules are developed at the end of each month and dollars are distributed to LMEs based on cash availability.

Another significant issue in the payment process is that the standard three-way contract has been amended over time. The initial contract required the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to pay the LME within 60 days of receipt. This clause has been dropped (see Figure 3, p. 94).

And, now there is a difference between when the contract states the LMEs must pay the hospital (within 10 working days of receipt of funds from the state) and when the General Assembly says the LMEs must pay the hospital (within 30 working days of receipt of funds from the state) (see Figure 3, p. 95).[47] According to a budget provision enacted in 2011, the funds appropriated for these contracts are to be held in a statewide reserve at the Division. LMEs are to submit claims for payment to the Division within 15 working days of receipt of a clean claim, and the LME is to pay the hospital within 30 working days of receipt of payment from the Division. The Department now has the authority to contract with another LME to manage the beds or it may pay the hospital directly, but it has not had to do so yet.[48] Although the state's cash flow issues are real, the timeliness issue is a major concern for hospitals that, if left unresolved, could lead some to terminate their three-way contracts with the state.

Other billing issues may result from the state's decision to expand the federal Medicaid waiver statewide. One provider in Western North Carolina has been practicing submitting claims for three-way contracts since April 2012 in anticipation of the Smoky Mountain Center's waiver start date of July 1, 2012. The provider notes that although the process is "exceptionally frustrating at times," the Smoky Mountain LME-MCO has been responsive and most of the glitches have had fairly simple technical fixes. That said, as of mid-July 2012, approximately 60 percent of the claims are still being erroneously rejected. The problem is that the billing systems for the waiver are not compatible with some components of the billing systems for the three-way contracts and other pilot programs. Furthermore, they are often different from standard hospital-based billing practices.

Aixander Duda

The Smoky Mountain Center has been working to process claims for three-way contracts after implementing the federal Medicaid waiver.

Rep. Verla Insko (D-Orange), the sponsor of the 2001 mental health reform legislation, says, "All the provider agencies want and actively lobby for having a state-run system. It is easier and less expensive to them to work with one person than with all the LMEs.[49] It is also easier for them to influence one person in Raleigh than to influence all the LME directors at the local level. That influence might be for less oversight, more money, or a favorable policy, but it is almost never solely to benefit the consumer or protect the taxpayer. The stated interest that state involvement ensures continuity is probably right, but it is not true that it ensures prompt payment. The reason LMEs can't pay providers on time is because the State Budget Office doesn't release the money to DHHS and/or DHHS doesn't release the money to the LMEs."

Finally, some hospitals have raised concerns about the fairness of the contracts to local hospitals that have a long tradition of providing uncompensated care. Prior to the creation of the three-way contract program, some nonprofit and public hospitals had provided inpatient psychiatric care to indigent patients as part of their missions, knowing the services probably would go uncompensated; other hospitals did not provide much charity care. Under the program, some hospitals that had not provided uncompensated care previously are participating and drawing money. This has led some hospitals that long have provided free care to ask if, as Leza Wainwright former Director of the Division puts it, "no good deed goes unpunished."[50]

Concerns About Meeting the Long-Term Goals of Mental Health Reform: The Role of the State

The three-way contract was developed as a way of moving North Carolina closer to the comprehensive local service system envisioned by the 2001 mental health reform legislation. While the program's purpose is to build capacity for local mental health services in local hospitals and close service gaps, it also may run counter to some of the larger long-term goals driving mental health reform and exacerbate systemic problems.

For example, the state's involvement in the three-way contracts seemingly detracts from the role the local mental health management entities were supposed to play in developing and coordinating local service systems. Granted, the local hospitals wanted the state involved in the program due to institutional concerns, but that does not change the fact that the state arguably is involved in a local function.

As mentioned previously, the contracts were designed as a three-way partnership with state involvement driven by the hospitals' belief that state involvement would lead to long-term commitment and timely payment. On a daily basis, hospitals and local mental health management entities deal with each other in a manner similar to their dealings on other projects involving public funds. The state pays the bills but does so through the LMEs. Some partners consequently view the state as a distant partner. "The three-way title for the project is just a title in a lot of ways," says Greg Billings of Catawba Valley Medical Center in Hickory. He adds that the state only seems to become involved when there are problems.

Insight #5: ***The state should continue to ensure that, over time, the three-way contracts serve the state's long-term goals in mental health reform.***

LMEs voiced concerns that the three-way contract structure appears to be inconsistent with the concept of a local service system. LMEs see themselves as the conduit that makes the program run and have wondered if similar outcomes could be achieved more directly if funds were just appropriated directly to LMEs. Rep. Insko says, "The concept of the LME as the local manager of the entire mental health system was to include control of both the Medicaid and state dollars and eventually the state facilities money as well." Yet stakeholders said that the hospitals wanted direct state involvement based on the belief that direct state involvement would signal a deeper commitment, create standardization, and lead to prompt payment.

All stakeholders, especially local ones, attributed the program's successes to strong working relationships between local hospitals and area LMEs. Says Mary Silverman, the administrative director of FirstHealth of the Carolinas in Pinehurst, "You have to have a solid relationship with an LME to make this work." Some stakeholders reported that relationships with the state were much weaker and would be helped by more communication, especially with regard to budget and payment issues. Specifically, some hospitals have asked to have a designated program liaison within the Division of Mental Health.

In fact, the Division has a program manager intended to serve in this capacity. Ken Marsh was the program manager in 2008–09, Bill Bullington was the program manager from 2009–12, and Kent Woodson, a budget officer with the Division, now is serving in this capacity. The state needs to do a better job letting hospitals know how to get in touch with this program manager.

To re-align the need for a state contact with the larger goals of mental health reform, Dr. Nicholas Stratas, Sr., a psychiatrist in Raleigh, suggests instead of a state liaison that "a more practical recommendation is to identify someone at each state psychiatric hospital to work with the local management entities covered by each state hospital. This would begin to tie the state hospitals to the LMEs, thus allowing for better collaboration and providing consultation from the state hospital to the LMEs (something which used to happen but no longer does)."

SELF DIAGNOSIS

Once in awhile
I try to tell them something
In words fitly framed
So they will understand . . .

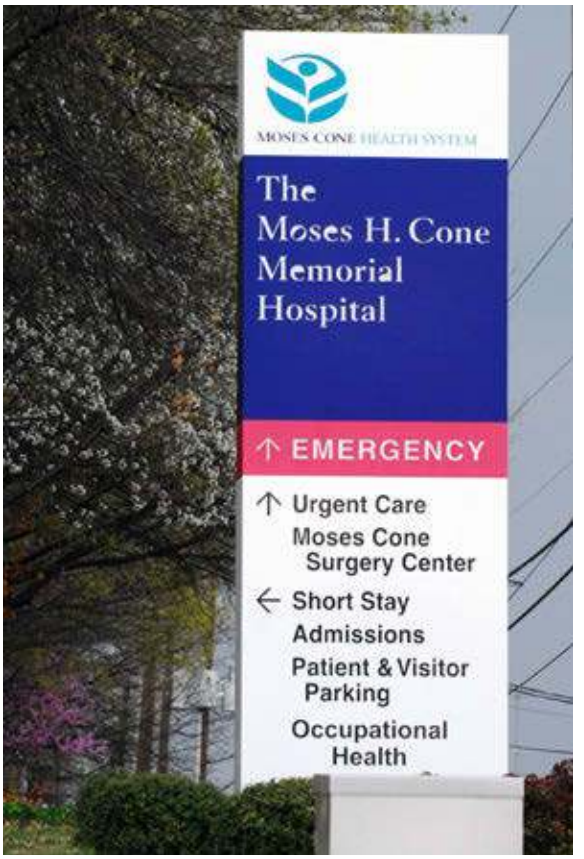
—HeartPrints
BY JOAN WILDER WARLICK

The state also has a working group for the three-way bed contracts that looks at the clinical aspects of this program—for example, examining why hospitals sometimes deny admissions. Dr. Susan Saik and Dr. Ureh Nnenna Lekwauwa, the medical directors of the Division of State Operated Healthcare Facilities and the Division of Mental Health, respectively, lead this working group.

But stakeholders note that very little information is available about the working group. According to one provider, the last meeting of the working group was held on December 8, 2011. Stakeholders would like regularly scheduled meetings, advance notice and input on the agendas, and they would like all parties to the contracts to be invited. Another stakeholder suggested that a best practice team member from the Division should be included in the working group.

Another concern involves the role of the state psychiatric hospitals. The three-way contracts reflect the idea that the state hospitals' primary mission should be the provision of long-term care for patients with more severe mental health problems such as schizophrenia—an idea supported by advocacy groups for the patients. At the same time, North Carolina long has relied upon its state hospitals to provide short-term care. Even now, 62 percent of patients stay in the hospitals for 30 days or less.[51] This has led some analysts at the legislature's Fiscal Research Division to ask if stakeholders are clear about the state hospitals' mission and when the move away from short-term care will manifest itself in data on admissions to state hospitals.

An initial analysis of outcomes for the three-way contracts indicates that short-term admissions to state hospitals (seven days or less) have dropped from 51 percent in the first quarter of fiscal year 2008–09 to 39 percent in the first quarter of fiscal year 2009–10 to 32 percent in first quarter of fiscal year 2010–11 to 21 percent in the first quarter of fiscal year 2011–12 (see Figure 4, see p. 101).[52] However, the reduction in the short-term admission rates to state hospitals is also a function of bed reductions and admission delays at the state hospitals. And, it may be that the criminal justice system is now becoming an unintentional provider of beds. As Dr. Stratas says, "In fact, there is reason to believe or at least suspect that the reduction of state hospital census is more likely due to the increase in the mentally ill entering our prisons."



Karen Tam

Moses Cone had eight beds in the program in 2011–12.

Concerns About Patient Treatment

Another area of concern involves the treatment provided to patients under the contract. Three specific issues were raised.

First, interviewees cautioned that care provided in local hospitals may not necessarily be "local" care. "Sometimes local hospitals are no more local than state ones," says Dr. Marvin Swartz of Duke University Health System. What makes inpatient care local, he says, is its integration into larger continuums of care, which is why discharge and follow-up services are so critical. This explains why good relationships between hospitals and LMEs are critical to success and why some participants have concerns about serving patients from LMEs outside their area. Out-of-area admissions complicate discharge planning and can make it harder to connect patients to follow-up services (see Table 7, p. 90).

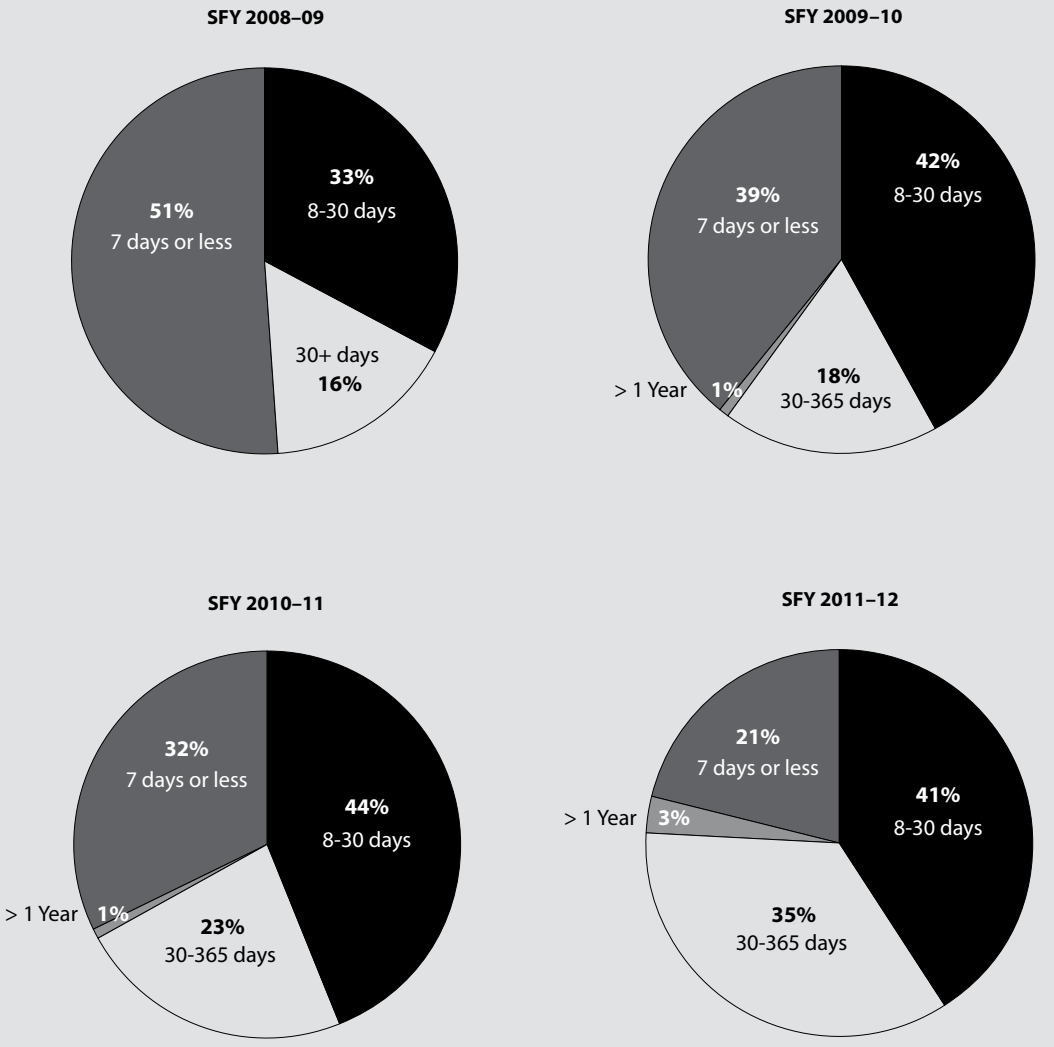
Second, the adequacy and availability of follow-up services for those discharged from local hospitals is important. A 2008 study by the General Assembly's Program Evaluation Division (a study based on data collected *prior* to the establishment of the three-way contract program) found that patients hospitalized in community hospitals were more likely to receive follow-up services than those treated in state psychiatric hospitals (69 percent vs. 50 percent). The study found, "[C]loser connections exist between community-based hospitals and local outpatient service providers, and therefore consumers discharged from these hospitals [are] more likely to receive community-based services." [53]

At the same time, patients discharged from local hospitals tended to receive low-intensity services (e.g., medication management or community support) due in large part to the difficulties in obtaining psychiatric services locally. Absent the ability to access moderate-intensity services (e.g., psychiatrist), patients run the risk of requiring re-hospitalization in the future. "Access to a psychiatrist or physician … is critical to ongoing treatment in the community because establishing an immediate relationship with a psychiatrist after discharge is key to minimizing recurrent crises and hospital readmissions," says the study.[54] Beth Melcher, chief deputy secretary of DHHS, notes that the development of walk-in psychiatric services and improved crisis support through mobile teams will help going forward.

Stephanie Greer, the director of behavioral health at Appalachian Regional Healthcare System in Watauga County and a former state psychiatric hospital administrator, agrees that follow-up after discharge is an important part of the benefits to consumers of the three-way contracts. She says, "Delivery of local support services after discharge has been done very well and is a true benefit of the three-way contract program. Local support is available in a very different way than it is at state hospitals like Broughton. There is a significant difference in quality."

Readmission rates for people served under the three-way contracts are lower than for those served in a state hospital.[55] The readmission rate *after 30 days* is 10 percent at state hospitals, but it is 6.3 percent for patients served by three-way contracts. The readmission rate *after 180 days* is 21 percent at state hospitals, but it is 11.2 percent

Figure 4. Short Term Care for Consumers in State Psychiatric Hospitals in North Carolina, State Fiscal Years 2009–12



Note: SFY = The state fiscal year runs from July 1 to June 30.

Source: N.C. Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "Semi-Annual Report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services," Statewide System Performance Reports, Spring Reports, Raleigh, NC, April 1, 2009–12, Table 3.2.a.

Table 8. Percent of Three-Way Contract Billing for Substance Abuse by Local Mental Health Management Entity, State Fiscal Year 2012

LME	Participating Hospitals	Three-Way Contract Billing for Substance Abuse
Sandhills	FirstHealth Moore Regional Hospital	42.04%
Mental Health Partners	Catawba Valley Medical Center	34.80%
Alamance-Caswell	Alamance Regional Medical Center	34.13% [a]
CenterPoint	Forsyth Medical Center	33.32%
Guilford	Moses Cone Hospital	28.49%
Pathways	Kings Mountain Hospital	26.61%
Piedmont Behavioral Healthcare [c]	Alamance Regional Medical Center	16.05% [a]
Smoky Mountain	Haywood Regional Medical Center Cannon Memorial Hospital	15.03%
Western Highlands	Margaret Pardee Memorial Hospital Mission Hospital Rutherford Regional Medical Center	14.30%
Cumberland	Cape Fear Valley Medical Center	12.80%
Beacon Center	Nash General (Coastal Plain) Hospital	6.06%
Eastpointe	Vidant Duplin General	5.15%
Crossroads	Davis Regional Medical Center	4.19%
Durham	Duke University Health System	2.55%
Southeastern Center	The Oaks Behavioral Health Hospital	0.40%
East Carolina Behavioral Healthcare	Vidant Beaufort Hospital Northside Behavioral Health Services at Vidant Roanoke-Chowan Hospital Vidant Medical Center (formerly known as Pitt County Memorial Hospital)	–0.16% [b]

Notes:

[a] Note the drop in percentage of substance abuse treatment for those treated at Alamance Regional Medical Center under management of Piedmont Behavioral Healthcare. The percentage for Alamance-Caswell is for services through October 2011.

[b] This negative percentage is because the hospital had to reimburse the state for some units that were paid in error.

[c] In 2012, Piedmont Behavioral Healthcare (PBH) became Cardinal Innovations Healthcare Solutions.

SFY = The state fiscal year runs from July 1 to June 30.

Source: Jim Jarrard, N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

for patients served by three-way contracts.[56] The readmission rate *after one year* for those patients served by three-way contracts is 17.3 percent.[57] The comparable rate for state hospitals is not available.

Finally, numerous interviewees described substance abuse services as being a missing part of the treatment equation. While the three-way contracts allow for the provision of inpatient detoxification and substance abuse treatment, the substance abuse is often connected to a mental health problem. This is important because many stakeholders are concerned about the growing number of people with "dual diagnoses."

At only five of the participating hospitals does the provision of substance abuse services account for more than 20 percent of the billings under the three-way contract: FirstHealth Moore Regional Hospital (42%), Catawba Valley Medical Center (35%), Forsyth Medical Center (33%), Moses Cone Hospital (29%), and Kings Mountain Hospital (27%) (see Table 8). When Alamance Regional Medical Center was in the Alamance-Caswell LME, 34 percent of the billings under the three-way contracts were for substance abuse services; however, since November 2011, when the LME for Alamance Regional Medical Center changed to Piedmont Behavioral Healthcare, the percentage has dropped to 16 percent. According to stakeholders, hospitals may be reluctant to provide substance abuse services because if the primary reason for treatment is substance abuse detoxification, then hospitals could fill all of their beds under the contracts 24 hours a day, seven days a week, providing just that treatment to the exclusion of serving those needing crisis psychiatric care.

Furthermore, the hospitals have raised concerns about whether their provision of substance abuse services under the three-way contracts meets staffing requirements under the state's rules for health and human services.[58] For example, Division of Mental Health regulations require a full-time counselor for every 10 clients, at least one registered nurse, one direct care staff for every 20 clients, and a physician at the facility or on call 24 hours a day. The Medical Care Commission has additional rules for licensure of hospitals.

Insight #6:
Stakeholders have concerns about staffing requirements for substance abuse services and the inadequacy of local follow-up treatment for patients with substance abuse problems.

While it is difficult to obtain follow-up mental health services, it is even harder to find follow-up services for substance abuse. The 2008 report by the General Assembly's Program Evaluation Division identifies the following four reasons:

> First, there was a lack of intensive outpatient substance abuse services in 2007, which remains the case today in spite of reform. Second, most consumers with substance abuse do not have Medicaid coverage. As a result, many go untreated after discharge. Third, whereas hospital liaisons triage care for mental health consumers in most Local Management Entities, there are fewer liaisons for consumers hospitalized with substance abuse problems. Finally, many consumers with substance abuse may be noncompliant with treatment protocols even when follow-up is attempted.[59]

Duke's Dr. Marvin Swartz adds, "Many more substance abusers are uninsured, and there are fewer local treatment options for them." But Beth Melcher with DHHS says, "The problem is not availability of services but lack of payers/reimbursement for services."

Concerns About the Adequacy of the Mental Health Work Force

All stakeholders interviewed for this review expressed concerns about both the availability of mental health workers and their training. While the availability of such caregivers varies across the state, they play a critical role in the provision of inpatient

psychiatric services and follow-up care at the local level. In North Carolina, 30 counties do not have a psychiatrist, and an additional 14 counties only have one.[60]

Although work force shortages typically are seen as a problem related to follow-up care, they also bear on the ability of local hospitals to provide short-term care. According to Stephanie Greer of Appalachian Regional Healthcare System in Watauga County, financial concerns are not the sole barrier preventing community hospitals from providing inpatient care. They also need physical and medical resources, but perhaps most importantly, they need direct care workers *trained* to handle varying levels of mental health issues. Without such workers, hospitals will be unable to serve all the patients they could and will refer patients to state psychiatric hospitals even if local beds are funded.

Cristy Williams, the nurse at Catawba Valley Medical Center, says, "It is a totally different way of thinking when dealing with psychiatric patients." She stressed the need for "safety, safety, safety," and how that involves tasks such as knowing where patients are at all times and ensuring that doors are locked.

Because it is impractical and too expensive for most community hospitals to operate their own psychiatric training programs, Stephanie Greer and other community leaders argue that the state psychiatric hospitals should open their existing training programs for their own state hospital employees to the local community hospitals participating in the three-way contract program. Says Greer, "The community hospital can't

Opening Up State Training Programs to Local Mental Health Workers

by Stephanie Greer, Director, Behavioral Health Services, Appalachian Regional Healthcare System in Watauga County

There are two fundamental components to building inpatient behavioral health capacity. The first component is the development of the physical capacity, which is what the state historically has focused on. I believe that the second component of capacity is developing the clinical skills in milieu management, de-escalation, and crisis prevention necessary to be able to treat the level of crisis that is routinely seen in the state psychiatric hospital setting. It is this lack of clinical capacity that results in lengthy waiting lists at the state hospitals while there are still vacant beds in the communities.

I worked as an administrator at Broughton Hospital, a state psychiatric hospital, for 11 years prior to accepting my current position. I have become acutely aware of the fact that in a small community setting it is extremely difficult to duplicate the level of training needed to manage truly acute psychiatric patients. Across our state, small hospitals are forced to "reinvent the wheel" by developing training programs that focus on a psychiatric patient population without the economies of scale and level of expertise available at our state psychiatric hospitals.

I support the proposal that we develop collaborative relationships between our state hospitals and local hospitals who are actively participating in the three-way contracts for training opportunities in milieu management, de-escalation, and crisis prevention. This would involve shared training opportunities in which community employees would participate in training exercises with state hospital employees in the areas mentioned above. This initiative would simply mean opening up the already scheduled and staffed training calendars to the community hospitals to fill any vacant class slots. In doing this, we would be developing more consistency in training and enhancing the provision of clinical services to the patients served under the state

recreate the training for dealing with acute psychiatric care patients that exists at the state hospitals." With staff trained to those standards, however, community hospitals would be better equipped to handle patients with mental illness and perhaps serve even more patients locally (see Greer's sidebar on "Opening Up State Training Programs to Mental Health Workers" below).

Specifically, Greer and others think that the state and the state hospitals should play an active role in work force training. For instance, state hospitals require their direct care employees to prepare detailed annual development plans for their staff and provide the staff with the training required by those plans. Why couldn't such existing programs in areas like patient *de-escalation* (workers trained in techniques that reduce a patient's agitated behaviors, like pacing, cursing, spitting, and throwing items) and *milieu management* (workers trained on how to arrange the hospital setting to promote safety as well as stabilization and recovery of their patients) be opened to employees from community hospitals participating in the three-way contracts? Says Greer, "Just open all the existing training programs at state hospitals to three-way contractors because they are state agents."

Community hospitals, particularly rural ones, might have difficulties in arranging release time for employees to attend training or covering training-related absences. But, the work force improvements and ability to better utilize local inpatient beds might make the inconveniences worthwhile.

contracts. This would develop true capacity in the communities by developing or enhancing the clinical skill sets of community employees and by developing more positive working relationships between the state and community service providers. In fact, at least two community hospitals have already contracted with state trainers to provide this instruction at the community hospital. The results of that experience have been overwhelmingly positive and directly correlate to fewer denials by local hospitals related to psychiatric acuity and/or physical aggression.

In addition, geographic location is often a limiting factor in the ability to recruit and develop expertise in dealing with acute psychiatric patients for the clinical staff. This has been an issue for Cannon Memorial Hospital in Linville, and I believe it will be an issue for other small rural hospitals if they choose to attempt to develop inpatient psychiatric services.

The benefit of the participation in the three-way contract is especially powerful in a small rural community. In fiscal year 2009, Cannon Memorial Hospital admitted almost 900 consumers in our 10-bed unit. Fifty-seven percent of those patients were served under this contract and would have been forced to receive treatment at a state hospital, or at the nearest inpatient facility which is more than 40 miles away. These patients were often experiencing their first inpatient psychiatric admission and were able to receive care close to home; close to their support systems including family members and doctors; and in an area where strong discharge planning can occur between the inpatient service provider and the outpatient service provider. And, without the presence of this contract, this small unit would not be able to maintain financial viability over the long term.

"This would develop true capacity in the communities by developing or enhancing the clinical skill sets of community employees and by developing more positive working relationships between the state and community service providers."

I believe there are ample opportunities to continue to improve the provision of behavioral health services in our state. But, this will require direct collaboration between state systems and community service providers in order to equip our communities to meet the wide range of patient and community needs.

Dr. Swartz of Duke cautions, "Calling on the state to train non-state folks is ill-advised. The state has very limited training capacity and is already well beyond its capacity for training. They are looking for help with their workers. There needs to be a serious investment in workforce training, but not by the state."

The state's 11 Area Health Education Centers (AHECs) may be another option. Bob Morrison, the retired President/CEO of Randolph Hospital, says, "There is one AHEC for each region, and they operate a wide variety of professional education programs. Typically, the faculty for the programs are practicing clinicians who work in the region. North Carolina has one of the best AHEC systems in the country, and the community hospitals and health professionals across the state are already accustomed to receiving continuing education through their AHECs."

Jim Jarrard, the acting director of the N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, says, "State hospitals, as centralized sites in the three regions, can contract with AHECs to provide training on hospital grounds. Continuing education units (CEUs) may not be attached, but effective, inexpensive training can be provided with certificates of attendance."

As these options are evaluated, Susan Saik with the Division of State Operated Healthcare Facilities notes that logistics, staffing, resources, and legal and regulatory issues will need to be considered by the state.

Who would bear the cost of this training would need to be determined, but options include the state hospitals, the local mental health management entities, the local hospitals, or an arrangement where the cost is shared by these entities. Ultimately, the legislature is going to have to provide money for training if it wants the three-way contracts to succeed. Either way, such a training program may induce more hospitals to participate in the three-way contracts or add capacity.

Expanding the Number of Local Hospitals Beds Going Forward

North Carolina's ongoing reform of its mental health system is driven by a vision of providing comprehensive services locally. Realizing this, however, requires communities to have local hospital beds dedicated to short-term inpatient psychiatric care—beds that are missing in many communities across the state. The state's recent three-way contracts are an attempt to fill this gap. Based on a review of progress to date, the contracts have been a *qualified* success.

Although this review did not attempt to establish a causal relationship, the Center finds:

Karen Tam

- The number of patients served under three-way bed contracts is almost as many served each year by the three state psychiatric hospitals combined.
- Readmission rates for people served under the three-way contracts are lower than for those served in state hospitals.
- Short-term admissions to state hospitals (seven days or less) have dropped from 51 percent in 2008–09 to 21 percent in 2011–12.
- The average length of stay in emergency departments for those that were transferred to a community hospital was more than 12 hours shorter than the average length of stay for those that were transferred to a state psychiatric hospital.
- The average length of stay for patients served through the three-way contracts at all hospitals is less than seven days as intended.

At the same time, stakeholders have concerns. These concerns involve the program's structure, financing, the state's long-term mental health goals, patient treatment, and the adequacy of the mental health work force.

Our research examines these findings and concerns and highlights six insights that need to be considered as this program is maintained and expanded.

Insight #1: ***Even with the 122 beds added by the three-way contracts, the number of beds available to mental health patients in crisis that can be treated in seven days or less falls short of the need in North Carolina. The state needs a methodology that provides a consistent way to determine the required ratio of beds to population that would adequately serve diverse areas of the state.***

Insight #2: ***When selecting where to establish new contracts or to expand existing contracts, equitable distribution among the three broad geographic regions of the state is one factor required by the legislature, but other factors also are important.***

Insight #3: ***Priority transfers for those served under three-way contracts to the state psychiatric hospitals are often difficult to arrange.***

Insight #4: ***At least every five years, the N.C. Department of Health and Human Services and the Joint Legislative Oversight Committee on Health and Human Services should re-examine whether the flat rate paid per day (currently set at $750) is adequate.***

Insight #5: ***The state should continue to ensure that, over time, the three-way contracts serve the state's long-term goals in mental health reform.***

Insight #6: ***Stakeholders have concerns about staffing requirements for substance abuse services and the inadequacy of local follow-up treatment for patients with substance abuse problems.***

The Center's Recommendations

Based on its research on the three-way contracts, the N.C. Center for Public Policy Research makes four recommendations:

Recommendation #1: ***The Center recommends that the Secretary of the N.C. Department of Health and Human Services develop a strategy to ensure the timely payment of these contracts.***

The timeliness of payments is a major concern for hospitals that, if left unresolved, could lead some local hospitals to terminate their contracts. While the state's problems with cash flows because of the Great Recession were the primary reason for delays in payments in the early days of this program, billing lags from the local management entities (LMEs) and slow payments by the state continue to persist. The standard state contract limits payment, as follows: "Division [of Mental Health] payment for approved inpatient services or approved bed capacity purchases shall be limited to the current fiscal year *availability of Division funds* in the psychiatric inpatient hospital fund reserve."

Another significant issue in the payment process is that the contract has been amended over time. The initial contract required the Division to pay the local mental health management entity (LME) within 60 days of receipt. This clause has been excluded from more recent contracts. And now, the *contract* states the LMEs must pay the hospital within 10 working days of receipt of funds from the state, while *legislation* passed by the General Assembly says the LMEs must pay the hospital within 30 working days of receipt of funds from the state. Any additional billing issues that result from the state's decision to expand the federal Medicaid waiver statewide also need to be addressed expeditiously.

Recommendation #2: ***The Center recommends that the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services publicize that they have a designated staff person serving as a liaison for the three-way contracts, as well as a state working group for the three-way contracts that addresses clinical concerns.***

It is important to local hospitals to have the state involved in these contracts. It signifies to them a longer-term state commitment, standardization across the contracts, and accountability for timely payments. Stakeholders reported that relationships with LMEs were stronger than with the state, and they wanted better communication channels with the state, especially with regard to budget and payment issues. Currently, the state is viewed by many stakeholders as a distant partner, often only involved when there is a problem. Stakeholders suggested having a designated contract liaison within the Division to address these concerns.

In fact, the Division has a program manager intended to serve in this capacity. Ken Marsh was the program manager in 2008–09, Bill Bullington was the program manager from 2009–12, and Kent Woodson now is serving in this capacity. The state needs to do a better job letting hospitals know how to get in touch with the program manager.

The state also has a working group on the three-way contracts to look at the clinical aspects of this program—for example, why hospitals sometimes deny admissions. Dr. Susan Saik and Dr. Ureh Nnenna Lekwauwa lead the working group. Stakeholders note that very little information is available about the working group. Stakeholders would like regularly scheduled meetings, advance notice and input on the agendas, and they would like all parties to the contracts to be

invited. Another stakeholder suggested that a best practice team member from the Division should be included in the working group.

Recommendation #3: ***The Center recommends that the N.C. Department of Health and Human Services require state psychiatric hospitals to open their existing training programs (currently provided only to their own state direct care employees) to the local community hospitals participating in the three-way contracts.***

It is impractical for most community hospitals to operate their own psychiatric training programs. It also would be more expensive for training to be provided at 21 different local hospitals participating in the contracts. Meanwhile, state hospitals require their direct care employees to prepare detailed annual development plans for their staff and provide staff members with the training required by those plans. With local hospital staff trained to state standards, however, community hospitals would be better equipped to handle patients with mental illness and perhaps serve even more patients locally. And, this might speed up the state's ability to increase the overall mental health work force, an issue for the future in North Carolina. Such training programs might also induce more hospitals to participate in the three-way contracts.

Who would bear the cost of this training would need to be determined, but options include the state hospitals, the local mental health management entities, the local hospitals, or an arrangement where the cost is shared by these entities. Ultimately, the legislature is going to have to provide money for training if it wants the three-way contracts to succeed.

Recommendation #4: ***The Center recommends that the N.C. Department of Health and Human Services develop outcome measures for this program.***

Given the increased investment of state dollars in this program, the three-way contracts are now established enough that program and patient outcomes should be identified, tracked, and reported annually. For instance, stakeholders suggested to the Center the following program measures:

- short-term admissions to state psychiatric hospitals,
- the number of persons in crisis seen in local hospital emergency departments, and
- the average waiting time in the emergency departments for mental health patients transferring to hospitals with three-way bed contracts and state psychiatric hospitals.

Stakeholders also suggested the following patient outcomes:

- number of persons served;
- number of bed days purchased;
- average length of stay;
- re-admission rates after 30 days, 180 days, and one year;
- percent of those served from home LMEs;
- percent of those served from outside the hospital's region;
- total admissions; and

- most importantly, comparing patient outcomes under the three-way contracts with the outcomes of patients served by other community hospitals providing this type of treatment, as well as comparing with outcomes of patients served in state psychiatric hospitals.

Some of this data is already captured by current reporting, but all data pertaining to the three-way contracts needs to be reported annually so that the public and policymakers can more easily evaluate how well this program is working. For some of the outcomes suggested by stakeholders, cooperation from the N.C. Hospital Association also may be required.

The U.S. Supreme Court decision in Olmstead requires states, including North Carolina, to treat mental health patients in the least restrictive setting possible. To its credit, the state has invested almost $125 million, purchasing bed space at community hospitals across the North Carolina to serve those in crisis since 2008. These beds keep patients out of the state psychiatric hospitals and provide care for them close to home—near family and friends and treatment providers, in communities where they belong. The state has chosen a strategy to address this critical need, implemented the strategy, and funded the strategy. Often the state's biggest problem with mental health reform has been its ability to stay the course. While the Center's research suggests some changes to the three-way contracts and evaluation of the program going forward, the state should stay the course with this strategy and continue to fund the three-way contracts. It's better for the patients, the local hospitals, and the state.

A three-way contract patient at Catawba Hospital.

Karen Tam

Endnotes

[1] Mike Vicario, "The 'Crisis' Crisis: Emergency Department Use and Community Resources in North Carolina's Behavioral Health Crisis System," *North Carolina Medical Journal*, Vol. 73, No. 3, North Carolina Institute of Medicine and The Duke Endowment, Morrisville, NC, May/June 2012, p. 216.

[2] Jeannette Barham, "Annual Statistical Report, North Carolina Psychiatric Hospitals, Fiscal Year 2009 and 2011," Division of MH/DD/SAS, Raleigh, NC, Jan. 2010 and Jan. 2012, Table 1, p. 3. The reduction in the number of persons served by state psychiatric hospitals is a function of both reduced capacity and the increasing number of state hospitals admissions that require a longer length of stay.

[3] N.C. Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "Report on the Provision of Behavioral Health Crisis Services by Hospital Emergency Departments," March 1, 2011, p. 3.

[4] N.C. Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "Semi-Annual Report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services," Statewide System Performance Report, FY 2011–12, Spring Report, Raleigh, NC, April 1, 2012, Table 1.1.a, p. 15.

[5] The populations served by the three-way contracts and the state psychiatric hospitals are now intentionally different. State hospitals treat more complex patients requiring longer lengths of stay. To a large degree, the reduced number of unique patients served in the state facilities reflects the longer lengths of stay of the more complex patients and demonstrates some success of the state initiative to serve short-term patients in the community.

[6] Local management entities (LMEs) replaced the state's old area mental health authorities as part of state mental health reform. LMEs are the agencies responsible for managing, coordinating, facilitating, and monitoring the provision of mental health, developmental disability, and substance abuse services in the area served. LME responsibilities include offering consumers access to services 24 hours a day, seven days a week, 365 days a year, as well as developing and overseeing providers, and handling consumer complaints and grievances. On the Internet at *http://www.ncdhhs.gov/mhddsas/lmedirectory.htm#lmelist*, accessed on Feb. 6, 2010. See also N.C. Gen. Stat. § 122C-115.4.

[7] This provides funding for up to 186 beds. However, "[f}unds may not be expended prior to January 1, 2013 and only after OSBM [Office of State Budget and Management] certification that the funding is not needed for the Medicaid Program."

[8] See Alison Gray, "The History of Mental Health Reform in North Carolina," *North Carolina Insight*, Special Report, N.C. Center for Public Policy Research, Raleigh, NC, March 2009. See also N.C. Session Law 2001–437 (H.B. 381).

[9] N.C. Department of Health and Human Services, *Transformation of North Carolina's System of Services for Mental Health, Development Disabilities, and Substance Abuse: The State Strategic Plan, 2007–2010*, Raleigh, NC, July 1, 2007, p. 19.

[10] For an evaluation of the three-way contract in Durham County, see The Durham Center, "A Study of the Three-Way Contract in Durham County. On the Internet at *http://www.durhamcenter.org/uploads/docs/area_board/reports/ Area_Board_Report_March_2010.pdf*, accessed May 22, 2012.

[11] N.C. Department of Health and Human Services , N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "Semi-Annual Report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services," Statewide System Performance Report, FY 2009–10, Spring Report, Raleigh, NC, April 1, 2010.

[12] The contract is limited to inpatient adult psychiatric services and inpatient medical detox services. Children with mental illnesses also may require short-term inpatient care, but low-income children are more likely than adults to have public insurance through Medicaid.

[13] N.C. Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "Semi-Annual Report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services," Statewide System Performance Report, FY 2011–12, Spring Report, Raleigh, NC, April 1, 2012, Table 1.1.a, p. 6. Based on N.C. Office of State Budget and Management (OSBM) State Demographics Unit, July 2011, population projection data. These numbers are calculated by the Division using *national estimates of prevalence*—the occurrence of chronic and serious mental health, developmental disabilities, and substance abuse problems in the population—and then applying them to North Carolina's population. To assess the percent of the state's population, see also the N.C. Office of State Budget and Management (OSBM), Annual Population Totals, July 2011, when the state's total population was estimated to be 9,735,890.

[14] *Ibid*., Table 1.1.b, p. 7.

[15] Mental Health Association–NC, "Mental Health, Developmental Disabilities, and Substance Abuse Services System Reform in North Carolina," May 2006.

[16] N.C. Department of Health and Human Services , N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "Semi-Annual Report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services," Statewide System Performance Report, FY 2011–12, Spring Report, Raleigh, NC, April 1, 2012, p. 14. However, this trend may be changing. In 2012, 21 percent of the discharges from the state's psychiatric hospitals involved stays of seven or fewer days, down from 32 percent in 2011, 39 percent in 2010, and 51 percent in 2009. N.C. Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "Semi-Annual Report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services," Statewide System Performance Reports, Spring Reports, Raleigh, NC, April 1, 2009–12, Table 3.2.a.

[17] *Olmstead v. L.C.*, 527 U.S. 581, 119 S. Ct. 2176, 144 L.E.2d 540 (1999). The Court held, "States are required to provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities."

[18] Gerald G. Akland, *Involuntary Commitments: NC Sheriff's Office Impact (Including Observations on the Outcomes for People with Mental Illness)*, 2009 Update, NAMI–Wake County, Jan. 4, 2010, pp.7–8.

[19] Ruth Sheehan, "Shuttling Patients Burdens Deputies," *The News & Observer*, Raleigh, NC, Jan. 15, 2010.

[20] In April and May of 2012, *The News & Observer* published a series of articles on hospitals in North Carolina, finding "that while North Carolina hospitals get tax breaks worth hundreds of millions, some are doing little to help the poor. Instead, many hospitals are pursuing uninsured patients with lawsuits or collections agencies that can destroy their credit." The articles are available online at *http://www.newsobserver.com/2012/04/22/2016905/north-carolinas-urban-hospitals.html*

[21] Gray, see note 8 above, pp. 62–63.

[22] North Carolina Department of Health and Human Services, note 9 above, p. 19.

[23] See also Monte Mitchell, "Psychiatric Unit Ready to Reopen at Hospital," *The Winston-Salem Journal*, Winston-Salem, NC, Sept. 28, 2008. On the Internet at *http://www2.journalnow.com/content/2008/sep/28/psychiatric-unit-ready-to-reopen-at-hospital/news-regional/,* accessed on Aug. 7, 2010.

[24] Kent Woodson, program manager of the three-way contracts for the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, says, "The abrupt termination referenced happened when the budget crisis hit. The Division of State-Operated Healthcare Facilities and state regional hospitals abruptly suspended or terminated all of their community contracts. This sent a shockwave throughout the three-way contract community. So in working with the North Carolina Hospital Association and as a backup measure for reassurance, we contracted with Brynn Marr and Frye Regional as temporary support and backup if needed during the initial stages of the three-way contract development where the state hospitals could use them for overflow. Both hospitals are free standing psychiatric hospitals and the contracts were eventually terminated because they were not deemed to be community hospitals."

[25] For budget information online, see *http://www.ncga.state.nc.us/fiscalresearch/Budget_Legislation/ budget_legislation.shtml.* Because Mecklenburg County needs to cut its budget by $95 million, it ended a relationship with a provider of outpatient mental health services for about 750 children that had existed since 1984. According to *The Charlotte Observer*, "The programs primarily serve low-income families with children who suffer from issues that include anxiety, depression and bipolar disorder." Brett Loftis, the executive director of the Council for Children's Rights, says, 'People are going to go without.'" Peter St. Onge, "County's cuts disrupt youth mental health programs," *The Charlotte Observer*, Charlotte, NC, April 2, 2010. On the Internet at *http://www.charlotteobserver.com/201%4/02/v-print/1350960/mecklenburg-cuts-mental-health.html*, accessed on Aug. 7, 2010.

[26] Jeannette Barham, "North Carolina LMEs, Annual Statistics and Admission Report, Fiscal Year 2009," Division of MH/DD/SAS, Raleigh, NC, Jan. 2010, Figure 1, p. 1, and Jeannette Barham, "North Carolina LMEs, Annual Statistics and Admission Report, Fiscal Year 2011," Division of MH/DD/SAS, Raleigh, NC, Jan. 2012, Figure 1, p. 1.

[27] *Olmstead v. L.C.,* see note 17 above.

[28] Susan Saik, the medical director for the Division of State Operated Healthcare Facilities, notes, "A large portion of individuals served in state facilities are or at some time have been Medicaid eligible." However, Medicaid does not cover inpatient care for people aged 21–65 treated at a state psychiatric hospital. 42 U.S.C. § 1396(d)(a)(1). This exception was meant to keep states from funding their state institutions with Medicaid dollars. This has created incentives for states to find other Medicaid-funded facilities where they can treat those individuals and capture federal funding. Regarding the different costs of care at state hospitals as compared to community hospitals, Saik says, "There is a more intensive level of care being provided to patients with more complex needs in the state facilities. Community hospitals and state hospitals have different populations, and that factors into the cost of providing care."

[29] Inpatient psychiatric services, in either general acute care hospitals or specialized inpatient psychiatric care hospitals, are regulated by the state's Certificate of Need law. A general hospital seeking to add beds on its own would need to go through the Certificate of Need process if it intended to create a new inpatient unit or if it wanted to reallocate existing beds to new psychiatric ones. See N.C. General Statutes § 131E-176(13), § 131E-176(16)c, § 131E-176(5), and § 131E-176(9c). According to the website of the N.C. Department of Health and Human Services, "The North Carolina Certificate of Need (CON) law prohibits health care providers from acquiring, replacing, or adding to their facilities and equipment, except in specified circumstances, without the prior approval of the Department of Health and Human Services…. The fundamental premise of the CON law is that increasing health care costs may be controlled by governmental restrictions on the unnecessary duplication of medical facilities." Beds at *state* hospitals are not subject to Certificate of Need laws. The statutory provisions also do not apply to beds being converted to mental health use pursuant to a contract with the state Department of Health and Human Services or a local management entity. N.C. General Statute § 131E-184 (c) states, "The Department shall exempt from certificate of need review any conversion of existing acute care beds to psychiatric beds provided: (1) The hospital proposing the conversion has executed a contract with the Department's Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and/or one or more of the Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities to provide psychiatric beds to patients referred by the contracting agency or agencies; and (2) The total number of beds to be converted shall not be more than twice the number of beds for which the contract pursuant to subdivision (1) of this subsection shall provide." See also Chapter 15 of the 2010 State Medical Facilities Plan. On the Internet at *http://www.dhhs.state.nc.us/dhsr/ncsmfp/2010/2010smfp.pdf*, accessed on Aug. 7, 2010.

[30] These are the duties outlined in the standard contract provided by North Carolina Department of Health and Human Services, Dec. 2009, pp. 5–6.

[31] *Ibid*., p. 6.

[32] *Ibid*., pp. 5 and 17.

[33] *Ibid*., p. 1. The cap is set at different amounts for different contracts.

[34] North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Uniform System for Beds or Bed Days Purchased: with Local Funds, from Existing State Appropriations, under the Hospital Utilization Pilot, and from Funds Appropriated under Session Law 2011–145, Section 10.8.(b), Raleigh, NC, May 25, 2012.

[35] N.C. Session Law 2008–107, N.C. Session Law 2009–451, N.C. Session Law 2010–31, and N.C. Session Law 2011–145. In fiscal years 2009–10 and 2010–11, contracts were not signed until partway through the fiscal year, and spending during those partial years did not exceed budgeted amounts. On an annualized basis, however, the state overcommitted the funds, and there was approximately a $3.5 million ongoing obligation that needed to be closed. The Division of Mental Health knew it was over-committing funds and did so with the consent of the Secretary of the Department of Health and Human Services and the Governor's office.

Michael Watson of Division of Medical Assistance says the additional $9 million appropriated by the legislature in 2010 allowed the Department to address the issue of over-committed funds in several ways. "One was to annualize the cost of existing contracts, and in doing that, what we did was look at the actual utilization of those contracts. The good news is that we spent all the money, and for those contracts that used all of their money, we annualized them at 100 percent. For those that stayed around the 75 percent utilization that we initially budgeted for, we kept them there. For those that we phased in, we annualized those. So, we solved the problem of over-committing funds. Then, the money that was left over then went into either new contracts or expanding existing ones."

[36] For budget information online, see *http://www.ncga.state.nc.us/fiscalresearch/Budget_Legislation/ budget_legislation.shtml.*

[37] Kent Woodson, N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

[38] E. Fuller Torrey, M.D., *et al.,* "The Shortage of Public Hospital Beds for Mentally Ill Persons: A Report of the Treatment Advocacy, The Treatment Advocacy Center," Arlington, VA, p. 8. On the Internet at *http://www.treatmentadvocacycenter.org/storage/tac/documents/the_shortage_of_publichospital_beds.pdf,* accessed on Aug. 7, 2010. To estimate the minimum number of psychiatric beds needed for children and adults with serious psychiatric disorders, including forensic patients, "we solicited opinions from 15 experts on psychiatric care in the United States. They included individuals who have run private and state psychiatric hospitals, county mental health programs, and experts on serious psychiatric disorders. We asked them to assume the existence of good outpatient programs and the availability of outpatient commitment and told them that they would not be publicly identified…. The replies received were surprisingly consistent. Almost all 15 experts estimated a need for 50 (range 40 to 60) public psychiatric beds per 100,000 population for hospitalization for individuals with serious psychiatric disorders. Since it assumes the availability of good outpatient programs and outpatient commitment, this is a minimum number." The Treatment Advocacy Center is a national nonprofit organization dedicated to eliminating barriers to the timely and effective treatment of severe mental illnesses.

[39] This calculation is based on a financial report provided by the N.C. Division of Mental Health, Development Disabilities, and Substance Abuse Services on Dec. 10, 2009, and data contained Torrey, note 38 above, Table 1: Degree of Deinstitutionalization: Public Psychiatric Beds Per Population, 1955 and 2004–2005. On the Internet at *http://www.treatmentadvocacycenter.org/documents/Table1—PublicPsychBedsperpop1955and 2004–2005_5_.pdf,* accessed on Aug. 8, 2010. North Carolina's population in July 2011 was 9,735,890. The population of 9,735,890 divided by 100,000 persons equals 97.4 multiplied by 50 beds equals 4,868 beds needed in North Carolina using this methodology.

[40] Marvin Swartz and Joseph Morrissey, "Public Behavioral Health Care Reform in North Carolina: Will We Get It Right This Time Around?," *North Carolina Medical Journal*, Vol. 73, No. 3, North Carolina Institute of Medicine and The Duke Endowment, Morrisville, NC, May/June 2012, p. 181.

[41] Report on Emergency Departments, note 3 above, pp. 3–5. The transfer times to community hospitals apply to all transfers to community hospitals, not just those operating with three-way contracts.

[42] N.C. Session Law 2011–145, § 10.8.(b). See Ran Coble, "Special Provisions in Budget Bills: A Pandora's Box for North Carolina Citizens," N.C. Center for Public Policy Research, Raleigh, NC, June 1986.

[43] In May 2012, UNC announced it will build a $30 million, 28-bed psychiatric facility in Wake County. Mandy Locke and John Frank, "WakeMed and Rex Hospital reach settlement, ending public feud," *The News & Observer*, Raleigh, NC, May 23, 2012, p. 1A.

[44] Furthermore, the standard three-way contract restricts the use of funds for "the purchase of 'new or expanded capacity' of local inpatient psychiatric beds or bed days." There also is no financial incentive for hospitals to swap patients from Medicaid to the three-way contract stream. Medicaid is a better deal for the hospitals and for patients, provided they are eligible. Finally, overall bed capacity has increased.

[45] See also Gerald and Ann Akland, "State Psychiatric Hospital Admission Delays in North Carolina," National Alliance on Mental Illness—Wake County, January–June 2010 (released Aug. 6, 2010) and July–September 2010 (released Jan. 17, 2011).

[46] Cristy Williams is a board certified registered nurse with a Bachelor of Science in Nursing.

[47] N.C. Session Law 2011–145, § 10.8.(b).

[48] *Ibid*.

[49] The number of LMEs is in flux as they merge to form LME-MCOs as required by the federal waiver of Medicaid regulations to provide mental health care in North Carolina. For instance, Alamance-Caswell and Five County are now with Piedmont Behavioral Healthcare.

[50] See note 20 above and Table 3 on pp. 78–81.

[51] N.C. Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "Semi-Annual Report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services," Statewide System Performance Report, SFY 2011–12, Spring Report, Raleigh, NC, April 1, 2012, Table 3.2.a, p. 14.

[52] N.C. Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "Semi-Annual Report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services," Statewide System Performance Report, FY 2008–09, Spring Report, Raleigh, NC, April 1, 2009, Table 3.2.a, p. 19; Statewide System Performance Report, FY 2009–10, Spring Report, Raleigh, NC, April 1, 2010, Table 3.2.a, p. 16; Statewide System Performance Report, FY 2010–11, Spring Report, Raleigh, NC, April 1, 2011, Table 3.2.a, p. 15; Statewide System Performance Report, FY 2011–12, Spring Report, Raleigh, NC, April 1, 2012, Table 3.2.a, p. 14.

[53] Program Evaluation Division, *Caring for Previously Hospitalized Consumers: Progress and Challenges in Mental Health System Reform*, Raleigh, NC, Dec. 10, 2008, p. 11.

[54] *Ibid*., pp. 14–15.

[55] Susan Saik with the Division of State Operated Healthcare Facilities cautions, "The etiology of readmissions to the state facilities is multi-factorial because different populations are being served."

[56] Michael Watson, "DHHS Report on Local Inpatient Community Hospital Contracts (3 Way Contracts) Update, Presented to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, April 14, 2010, Slide 14.

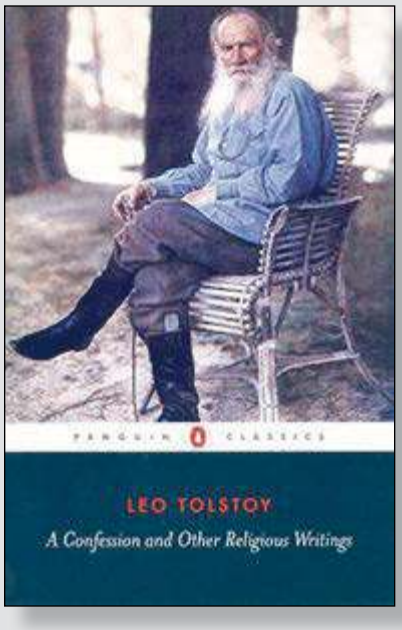
[57] Data provided by Kent Woodson, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

[58] See 10A N.C. Administrative Code 27G .6002 and 10A N.C. Administrative Code 13B .5203.

[59] Program Evaluation Division, note 53 above, p. 11.

[60] North Carolina Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, Chapel Hill, NC, with data derived from the North Carolina Medical Board and North Carolina Medical Society, Aug. 19, 2011. On the Internet at *http://www.shepscenter.unc.edu/hp/prof 2010.htm*, accessed on April 20, 2012. With the implementation of Critical Access Behavioral Health Agencies (CABHAs) statewide, it is likely that psychiatrists will become more available in rural regions. CABHAs are large providers of mental health and substance abuse services, and the state requires certain staffing, including having a medical director if more than 750 consumers are served

One Man's Journey Out of Depression Through Tolstoy's *A Confession*



by William S. Bost, III

As Leo Tolstoy approached age 50, he was depressed, suicidal, and disappointed with his life, even though he was arguably Russia's most famous and admired citizen. He already has published *War and Peace* (1865–68) and *Anna Karenina* (1874–76), but he rejected literary success, saying the latter novel was "an abomination that no longer exists for me."[1] His work, *A Confession*, is an essay on his definition of the problem within himself and his search for a solution. *A Confession* (1879–82) is important in the discussion of mental health for three reasons. First, for those without a mental health or depression problem or for those who are concerned about a person with such a problem, *A Confession* provides a spot-on description of the feelings experienced by many depressed people. For those with a mental health problem, Tolstoy's book lets us know that we are not alone. In addition, Tolstoy puts in eloquent words the thoughts that are rattling around our heads. And, third, after discussing in-depth his efforts to overcome depression and "soul-sickness," Tolstoy provides his solution to those who are affected.

William S. Bost, III, practices law in Raleigh. Since his journey through A Confession, *he no longer strives for perfection, and he is no longer depressed.*

Editor's Note: Count Leo Nikolayevich Tolstoy was born in Russia in 1928. He married Sonya Andreyevna Behrs when he was 34 and she was 18, and they had 13 children. He ran his vast estate on the Volga Steppes south of Moscow, improved the condition of the Russian peasants, and wrote the books of realist fiction for which he became so famous—*War and Peace, Anna Karenina,* and *The Death of Ivan Ilyich.* Tolstoy was an early believer in the moral force of nonviolent protest and "championed the oppressed by persuasively undermining the entire social, religious and political structure on which the lives of the well-to-do rested; his influence was enormous, both at home and abroad," according to Jane Kentish in the commentary of her translation of *A Confession* (see pp. 8–9). Along the way, he encountered a lot of opposition. The government began to censor his writings, and in 1901 after his active support for persecuted religious sects, he was excommunicated from the Russian Orthodox Church. It is said that from then on, there were two powers in Russia—Czar Nicholas II and Leo Tolstoy. He died in 1910 at a small railway station on his way to a monastery. This journey is the subject of the 2010 film, "The Last Station."

Tolstoy's Description of Depression

Tolstoy wrote *A Confession* at the age of 51. He was among the wealthiest, the most famous, and most beloved men in Russia. And he was miserable. He describes his condition as follows:

> My life came to a standstill. I could breathe, eat, drink and sleep and I could not help breathing, eating, drinking and sleeping; but there was no life in me because I had no desires whose gratification I would have deemed it reasonable to fulfil. If I wanted something I knew in advance that whether or not I satisfied my desire nothing would come of it.
>
> If a magician had come and offered to grant my wishes I would not have known what to say. If in my intoxicated moments I still had the habit of desire, rather than real desire, in my sober moments I knew that it was a delusion and that I wanted nothing. I did not even wish to know the truth because I had guessed what it was. The truth was that life is meaningless.
>
> It was as if I had carried on living and walking until I reached a precipice from which I could see clearly that there was nothing ahead of me other than destruction. But it was impossible to stop, and impossible to turn back or close my eyes in order not to see that there was nothing ahead other than deception of life and of happiness, and the reality of suffering and death: of complete annihilation.
>
> Life had grown hateful to me, and some insuperable force was leading me to seek deliverance from it by whatever means. I could not say that I wanted to kill myself. The force beckoning me away from life was a more powerful, complete and overall desire. It was a force similar to my striving after life, only it was going in the other direction. I fought as hard as I could against life. The thought of suicide now came to me as naturally as thoughts of improving my life had previously come to me. This idea was so attractive to me that I had to use cunning against myself in order to avoid carrying it out too hastily. I did not want to rush, simply because I wanted to make every effort to unravel the matter. I told myself that if I could not unravel the matter now, I still had time to do so. And it was at this time that I, a fortunate man, removed a rope from my room where I undressed every night alone, lest I hang myself from the beam between the cupboards; and I gave up taking a rifle with me on hunting trips so as not to be tempted to end my life in such an all too easy fashion. I myself did not know what I wanted. I was afraid of life and strove against it, yet I still hoped for something from it.
>
> All this was happening to me at a time when I was surrounded on all sides by what is considered complete happiness: I was not yet fifty, I had a kind, loving and beloved wife, lovely children, and a large estate that was growing and expanding with no effort on my part. I was respected by relatives and friends far more than ever before. I was praised by strangers and could consider myself a celebrity without deceiving myself. Moreover I was not unhealthy in mind or body, but on the contrary enjoyed a strength of mind and body such as I had rarely witnessed in my contemporaries. Physically I could keep up with the peasants tilling the fields; mentally I could work for eight or ten hours at a stretch without suffering any ill effects from the effort. And in these circumstances I found myself at the point where I could no longer go on living and, since I feared death, I had to deceive myself in order to refrain from suicide.[2]

What Was the Source of Tolstoy's Depression?

Tolstoy was perplexed by his unhappiness and emptiness. He reflected on his path through his life. In that reflection, he found that he had focused on those things that his peers focused upon. He had been guided by a quest for perfection and a sense of competition. As Tolstoy says,

> Now, looking back at that time, I can clearly see that the only real faith I had, apart from the animal instincts motivating my life, was a belief in perfection. But what this perfection consisted of, and what its aim was, were unclear to me. I tried to perfect myself intellectually and studied everything I came upon in life. I tried to perfect my will, setting myself rules I tried to follow. I perfected myself physically, practising all kinds of exercises in order to develop my strength and dexterity, and I cultivated endurance and patience by undergoing all kinds of hardship. All this I regarded as perfection. The beginning of it all was, of course, moral perfection, but this was soon replaced by a belief in general perfection, that is a desire to be better not in my own eyes or before God but in the eyes of other people. And very soon this determination to be better than others became a wish to be more powerful than others: more famous, more important, wealthier.[3]

This path through life brought him to a point at which he could not find a way forward. As he said,

> My question, the one that brought me to the point of suicide when I was fifty years old, was a most simple one that lies in the soul of every person, from a silly child to a wise old man. It is the question without which life is impossible, as I had learnt from experience. It is this: what will come of what I do today or tomorrow? What will come of my entire life?
>
> Expressed another way the question can be put like this: why do I live? Why do I wish for anything, or do anything? Or expressed another way: is there any meaning in my life that will not be annihilated by the inevitability of death which awaits me?[4]

How Does This Apply Now to Us?

Many people reach a point in their life in which they no longer feel passion for living. Like Tolstoy, even if they are at the top of the social and educational ladder, they feel empty, exhausted, and with a complete lack of desire and purpose. The emptiness and pain manifests itself in poor work habits and even poorer relationships with family and others. Ineffective coping mechanisms lead to aberrant behavior, substance abuse, clinical depression, and, more often than we like to admit, suicide. And how could we describe more perfectly than Tolstoy the competitive drive for personal perfection that propels many of us to success and accomplishment.

What Did Tolstoy Do About It?

"But perhaps I have overlooked something, or failed to understand something?," Tolstoy asks. "It cannot be that this state of despair [referring to Tolstoy's condition] is common to all men!"[5]

And so he set out to find the answer. He observed those around him closely to determine whether and how they dealt with the problem. He also did some research, asking experts in the physical sciences, philosophy, and religion about their opinions.

What Did Tolstoy Observe Regarding How Others Deal with the Problem?

Tolstoy identified four different approaches among his peers to the problem, that is, in a few words, the inability to find meaning in life. The first approach was ignorance which "consists of failing to recognize, or understand, that life is evil and absurd,"[6] that life is meaningless. Tolstoy believed that people of this sort simply have not thought and do not think about their purpose or the meaning of life. Tolstoy concluded there was little to learn from these people; as Tolstoy says, "we can never cease knowing what we know."[7]

The second approach is epicureanism. It consists, while being aware of meaninglessness, in making use of the advantages one has to enjoy the immediate and material pleasures of life. As in Tolstoy's time,

> This second method of escape sustains the majority of people of our circle. The conditions in which they find themselves dictate that they have a greater share of the good things in life than the bad; their moral torpor allows them to forget that all the privileges of their position are accidental and that not everyone can have a thousand wives and palaces as Solomon did; that for every man with a thousand wives there are a thousand men without wives, and that for every palace there are a thousand men who built it by the sweat of their brow, and that the same chance that has made you Solomon today might make you Solomon's slave tomorrow. The inertia of these people's imagination enables them to forget why it was Buddha was granted no peace: the inevitability of illness, old age and death, which can, if not today then tomorrow, destroy all these pleasures.[8]

These people did not inspire Tolstoy as he could not artificially dull his imagination to eliminate the concept of meaninglessness.

The third approach that Tolstoy observed was one of "strength and energy:" suicide. Tolstoy believed that those who truly understood the meaninglessness "act accordingly and instantly bring an end to this stupid joke, using any available means: a noose round the neck, water, a stab in the heart, a train on a railway line."[9] Tolstoy thought that this was the worthiest means of escaping his misery, but he could not do it.

The fourth way to address the meaninglessness Tolstoy felt is that of weakness consisting "of clinging to a life that is evil and futile, knowing in advance that nothing can come of it."[10] Tolstoy found himself in that category.

Tolstoy's four categories apply equally today to wealthy and well-educated Americans. There are those who do not think of, or have not yet thought of, the issue; those who engage in the pleasurable activities of life in spite of their knowledge of the problem; those who end their lives; and those, like me, who wait. For something.

What Did the Physical Sciences Have To Offer?

Tolstoy, like many educated people, began his search with the premise that the answer must lie in science. He divided science into two categories: physical science and philosophy. Neither offered a satisfactory answer to his question.

With respect to physical sciences, he found that they did a superb job of describing the process by which we live and by which events occur in the known universe. In other words, physical sciences were occupied with the answers to the questions of "How?," "What?," or "When?" Tolstoy's problem, however, was a question of "Why?" Physical science simply did not bother with this issue.

As Tolstoy puts it —

> If we turn to those branches of knowledge that attempt to provide solutions to the questions of life, to physiology, psychology, biology and sociology, we encounter a startling poverty of thought, extreme lack of clarity and a completely unjustified pretension to resolve questions beyond their scope, together with continual contradiction between one thinker and another (or even with their own selves). If we turn to the branches of knowledge that are not concerned with resolving life's questions, but which answer their own specialized, scientific questions, we may be enraptured by the power of the human intellect, but we know in advance that they will provide no answers to the questions of life. These branches ignore the question. They say, 'As for what you are and why you live, we have no answers and do not involve ourselves with it. On the other hand, if you need to know about the laws governing light, or about chemical combinations, or about the laws governing the development of organisms; or if you need to know about the laws governing physical bodies and their forms, and the relationship between their size and quantity; or if you need to know about the laws governing your own mind, then we have clear, precise and irrefutable answers to all this.'[11]

How About the Abstract, Philosophical Sciences?

Philosophy, art, and other abstract sciences also offered no answers to Tolstoy. These sciences acknowledged the problem and acknowledged the existence of an essence of life. But, philosophy, in all of its forms, could not answer the question of our purpose generally or our purpose individually.

As Tolstoy says,

> [Philosophy] clearly poses the question: who am I? And: what is the universe? Why do I exist and why does the universe exist? And since it has existed this science has always given the same answer. Whether the philosopher calls the essence of life that is within me and within everything an idea, or a substance, a spirit or a will, he is saying the same thing: that I exist and that *I* am this essence. But how and why he does not know, and if he is a precise thinker he does not answer. I ask, 'Why does this essence exist? What comes of the fact that it is and will be?' And philosophy not only fails to answer but can only ask the same thing itself. And if it is a true philosophy, its whole task lies precisely in posing this question clearly. And if it holds firmly to its purpose then it can have no other answer to the question of what I am and what the universe is than: 'All and nothing.' And to the question of why the universe exists and why I exist, then: 'I do not know.'[12]

Tolstoy infers in *A Confession* that his despair deepened when he finally accepted that science and philosophy offered him no answers to the most important question of his existence. He, like many of us, proceeded through life with the idea that the answers to the questions that puzzle or affect us will be made available to us. We learn science and math and English in school, we learn to make a living, and we learn to raise a family. Many of us have access to the knowledge that we need and want when we need and want it. Often science advances at exactly the pace we need to satisfy our growing individual and collective curiosity.

This sense of confidence that knowledge will be made available remains when we first begin to ask "Why?" As the question becomes more important, and the answer becomes more elusive and maybe even unknowable, despair and anxiety set in.

What About Religion?

Tolstoy was most disappointed by the answers that organized religion provided to his predicament and a significant portion of *A Confession* discusses its shortcomings. But faith is a different story…[13]

What Was Tolstoy's Solution?

Two of Tolstoy's findings affected me greatly. The first was that Tolstoy was struck by the fact that "the poor, simple, uneducated folk," "the labouring people," "knew the meaning of life and death, endured suffering and hardship," and yet found "tremendous happiness in life."[14] For them, uncertainty, discomfort, and boring toil are parts of life that those who find contentment accept without question.

> In contrast to what I saw happening in my own circle, where the whole of life is spent in idleness, amusement and dissatisfaction with life, I saw that these people who laboured hard throughout their entire lives were less dissatisfied with life than the rich. In contrast to the people of our class who resist and curse the privations and sufferings of their lot, these people accept sickness and grief without question or protest, and with a calm and firm conviction that this is how it must be, that it cannot be otherwise and that it is all for the good. Contrary to us, who the more intelligent we are the less we understand the meaning of life and see some kind of malicious joke in the fact that we suffer and die, these people live, suffer and approach death peacefully and, more often than not, joyfully. In contrast to the fact that a peaceful death, a death without horror and despair, is a most rare exception in our circle, a tormented, rebellious and unhappy death is a most rare exception amongst these people. And there are millions and millions of these people who are deprived of all those things, which for the Solomons and I are the only blessings in life, and who nevertheless find tremendous happiness in life. I looked more widely around me. I looked at the lives of the multitudes who have lived in the past and who live today. And of those who understood the meaning of life I saw not two, or three, or ten, but hundreds, thousands and millions. And all of them, endlessly varied in their customs, minds, educations and positions, and in complete contrast to my ignorance, knew the meaning of life and death, endured suffering and hardship, lived and died and saw this not as vanity but good.
>
> And I came to love these people. The further I penetrated into the lives of those living and dead about whom I had read and heard, the more I loved them and the easier it became for me to live. I lived like this for about two years and a great change took place within me, for which I had been preparing for a long time and the roots of which had always been in me. What happened was that the life of our class, the rich and learned, became not only distasteful to me, but lost all meaning. All our activities, our discussions, our science and our art struck me as sheer indulgence. I realized that there was no meaning to be found here. It was the activities of the labouring people, those who produce life, that presented itself to me as the only true way. I realized that the meaning provided by this life was truth and I accepted it.[15]

A significant part of our dissatisfaction with life is that "we don't like what we do," "work is hard," "my boss doesn't appreciate me," "work is not emotionally fulfilling," "coworkers are difficult to deal with," "I don't make enough money," "the deadlines

are unreasonable," or any number of a list of common complaints, some true and some trivial. In order to find contentment, we must accept that these unpleasant things, whatever they may be, and struggle through them as a part of life—our life, the one that we are living now. When we accept our hardships as integral to our being, instead of complaining of them like a temporary ache that will go away, then we can live with more peace.

And the second of Tolstoy's concepts is that once we accept hardship as a part of life, our purpose here is to help others with their toils. By "toils" Tolstoy did not mean intellectual questions about theoretical matters of interest or issues related to the allocation of wealth or where we are going to build the next monument to ourselves or others. "Toils" to him meant matters that directly affect the comfort and well-being of all people:

> Indeed, a bird is made in such a way that it can fly, gather food and build a nest, and when I see a bird doing these things I rejoice. Goats, hares and wolves are made in order to eat, multiply and feed their families, and when they do this I feel quite sure that they are happy and that their lives are meaningful. What should a man do? He too must work for his existence, just as the animals do, *but with the difference that he will perish if he does it alone, for he must work for an existence, not just for himself, but for everyone.* And when he does this I feel quite sure that he is happy and that his life has meaning. And what had I been doing for all those thirty years of conscious life? Far from working for an existence for everyone, I had not even done so for myself. I had lived as a parasite and when I asked myself why I lived, I received the answer: for nothing. If the meaning of human existence lies in working to procure it I had spent thirty years attempting, not to procure it, but to destroy it for myself and for others. How then could I get any answer other than that my life is evil and meaningless? Indeed it was evil and meaningless.
>
> The life of the world runs according to someone's will; our lives and the lives of everything in existence are in someone else's hands. In order to have any chance of comprehending this will we must first fulfil it by doing what is asked of us. If I do not do what is asked of me I will never understand what it is that is asked of me, and still less what is asked of us all, of the whole world.[16]

As a lawyer, as my career advanced, my office become more opulent, my clients became more wealthy, and my cases became bigger and more document-intensive. Along the way, I lost contact with humanity, the great number of people who live out their days in some form of contentment without the ability or the desire to do "important" things. When I lost my contact with them, I lost my opportunity to know what was wanted of me, and I lost my sense of self. My way back to peace, and out of depression and despair, was to reconnect with humanity and to do my part "toiling" together with others. Tolstoy also lived the rest of his life helping others.

Endnotes

[1] Leo Tolstoy, *A Confession and Other Religious Writings,* Translated with an Introduction by Jane Kentish, Penguin Books, London, England, 1987, p. 7.
[2] Chapter 4, pp. 30–31.
[3] Chapter 1, p. 21.
[4] Chapter 5, pp. 34–35.
[5] Chapter 5, p. 34.
[6] Chapter 7, p. 45.
[7] *Ibid.*
[8] Chapter 7, pp. 45–46.
[9] Chapter 7, p. 46.
[10] *Ibid.*
[11] Chapter 5, p. 36.
[12] Chapter 5, p. 38
[13] See Chapters 1, 9, the first part of 10, and 12–15.
[14] Chapter 10, pp. 58–59.
[15] Chapter 10, p. 59.
[16] Chapter 11, p. 61 (emphasis added).

Retirements and Republicans' Redistricting Bring High Legislative Turnover for 2013

by Ran Coble

"If you have lower than a ten percent turnover, there is a problem. And if you have higher than, say 20 percent, there is a problem."
— Former U.S. President Richard M. Nixon, 1969–74

Even before the November elections in 2012, 34 percent of the state's legislators who began the 2011–12 session will not return to their seats in 2013. Of the 170 legislators in the 2011–12 N.C. General Assembly, 57 members—including 29 Republicans and 28 Democrats—will not return next year. In addition, four more legislators will not return to the same chamber, as four House members won election to the Senate.

In the 2011–12 legislature, there were 46 freshman legislators (27 percent). Sixty-one more legislators are not returning at all or to the same chamber in 2013. In the 2013–14 General Assembly, 102 legislators (60 percent) will not have been there just three years ago. A combined 652 years of institutional memory and policy expertise will be lost with this much turnover. On the other hand, there will be room for lots of new ideas.

Potential for Record-Setting Turnover

The modern records for highest legislative turnover were set in 1973 and 1975, when 65 and 70 new legislators, respectively, came to the General Assembly. After the general elections on November 6, 2012, North Carolina's legislative turnover in 2013 approached but did not surpass the record turnover of the mid-1970s.

In 1973, the Republican Party became a force in North Carolina with the victories of Republican U.S. Senator Jesse Helms and Republican Governor Jim Holshouser. By 1975, the record-setting turnover swung the opposite direction as many Democrats were elected to the N.C. General Assembly as part of the nationwide backlash against the Watergate[1] scandal involving President Richard Nixon and Republican Party campaign officials.

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New Political Landscape

In addition to this influx of newcomers, Republicans took majority control of both the state House and Senate in North Carolina in 2011 for the first time since 1897. In the 2011 Senate, Republicans held 31 of the 50 seats, compared to 20 in the prior session. In the 2011 House, Republicans held 68[2] of the 120 seats, compared to 52 in the prior session. In 2013, the Republicans increased their majority to 32–18 in the Senate and 77–43 in the House.

It is unusual for freshmen to be appointed as committee chairmen, but nine Republican freshmen in the Senate were chosen as Co-Chairs of standing committees in 2011.[3] By contrast, in 2009 no freshman chaired any standing committees in either chamber of the General Assembly.

Sen. Charlie Dannelly (D-Mecklenburg): Retiring after more than nine terms

Sen. Linda Garrou (D-Forsyth): Retiring after seven terms

The Reasons for Legislators' Departures

There are four reasons for this year's legislative turnover—retirements, runs for higher office, accepting other jobs, and, most of all, redistricting. Departing legislators have different reasons for leaving, but all returning legislators will have a lot of new faces to meet in the 2013 session.

Examples of **retiring** legislators are Senator Charlie Dannelly (D-Mecklenburg), 87, who is retiring after more than nine terms to care for his ailing wife, and nine-term Representative Larry Womble (D-Forsyth), 70, who is retiring after a serious auto accident. Other departures resulted from the deaths of Sen. James Forrester (R-Gaston), Sen. Don East (R-Surry), Rep. Larry Brown (R-Forsyth), and Rep. William Wainwright (D-Craven). In addition, four of the five Democratic Representatives who joined Republicans to override Democratic Gov. Beverly Perdue's veto of the Republicans' budget will not be back. Representatives Dewey Hill (D-Columbus), Bill Owens (D-Pasquotank), and Timothy Spear (D-Washington) are retiring, and Rep. Jim Crawford, Jr. (D-Granville) lost in the May 2012 Democratic primary.

Several legislators left the General Assembly to **run for higher office**. These include Rep. Bill Faison (D-Orange), who ran for Governor but lost in the primary; Sen. Eric Mansfield (D-Cumberland), Rep. Dale Folwell (R-Forsyth), and Rep. Grey Mills (R-Iredell), who all ran for Lieutenant Governor but lost in their party primary; and Sen. David Rouzer (R-Johnston), Rep. Ric Killian (R-Mecklenburg), Rep. Fred Steen (R-Rowan), and Rep. Patsy Keever (D-Buncumbe), who all ran for Congressional seats. Rouzer and Keever won their party primary in May but lost in November, while Killian and Steen lost in May primaries. Representatives Glen Bradley (R-Franklin), Bill Cook (R-Beaufort), Earline Parmon (D-Forsyth), Shirley Randleman (R-Wilkes), and Norman Sanderson (R-Pamlico) all ran for the state Senate instead of running for re-election to their House seats. All but Bradley won in November.

Sen. Don East (R-Surry): Passed away October 2012

Sen. William Wainwright (D-Craven): Passed away July 2012

Rep. Dale Folwell (R-Forsyth): Ran for Lt. Governor but lost in the primary

Rep. Martha Alexander (D-Mecklenburg): Lost election after 10 terms

Rep. G.L. Pridgen (R-Robeson): Lost election after one term

New job opportunities also pulled members away from the legislature. Sen. Debbie Clary (R-Cleveland), Sen. Richard Stevens (R-Wake), Rep. Jeff Barnhardt (R-Cabarrus), and Rep. Harold Brubaker (R-Randolph) left the legislature for careers in lobbying, and Rep. David Guice (R-Transylvania) accepted a position as Director of the N.C. Division of Community Corrections in the Department of Public Safety.

Sen. Debbie Clary (R-Cleveland): Resigned to go into lobbying

Redistricting of the state's 170 legislative districts—50 Senate and 120 House districts—had the biggest impact on legislative turnover. The legislative maps drawn by Republicans put at least 10 Senators into districts with other incumbents, usually with a Republican advantage. The maps put 28 House incumbents into districts with other incumbents. Putting two incumbents in one district is called "double bunking." Some legislators, such as Rep. Grier Martin (D-Wake), were double-bunked with other veteran legislators and chose not to run. Other legislators, such as Democratic Representative Jim Crawford, Jr. (D-Granville) and Republican Representatives Darrell McCormick (R-Yadkin) and Efton Sager (R-Wayne) were double-bunked and lost in the May 8th primary elections in their own party. In addition, Representatives Stephen LaRoque (R-Lenoir) and Trudi Walend (R-Transylvania) lost in the May Republican primary elections.

The new legislative maps shift political clout to urban areas and to Republicans. John Rustin, director of the N.C. Free Enterprise Foundation, says that the new Senate redistricting maps created:

13 strong Republican districts,
14 that lean Republican,
16 strong Democratic districts,
2 that lean Democratic, and
5 swing districts.

With 50 members in the N.C. Senate, 26 seats are needed for a majority. In the House, the new redistricting maps create:

48 strong Republican districts,
18 that lean Republican,
34 strong Democratic districts,
10 that lean Democratic, and
10 swing districts.

With 120 legislators in the N.C. House, 61 seats are needed for a majority.

Rep. Darrell McCormick (R-Yadkin): Double-bunked in redistricting and lost in Republican primary

The redistricting maps were challenged in two lawsuits that have now been combined into one case, *Dickson v. Rucho*.[4] The plaintiffs include the N.C. NAACP, the League of Women Voters, and Democracy North Carolina. The defendants include the State of North Carolina, the State Board of Elections, Speaker of the House Thom Tillis (R-Mecklenburg), President Pro Tempore of the Senate Philip Berger (R-Rockingham), and Sen. Bob Rucho (R-Mecklenburg), the Chair of the Senate's Redistricting Committee. Within that overall challenge to the redistricting maps, a question about evidence has been raised concerning whether documents prepared for Republican legislators by outside lawyers are confidential under attorney-client privilege or should be disclosed to the public. This interim issue has been appealed to the N.C. Supreme Court,[5] and that Court held a hearing on July 10, 2012. A three-judge panel of Superior Court judges has yet to hear the overall case challenging the redistricting plan. The 2012 elections were held using the districts drawn in 2011 by the Republican legislative majority.

Rep. Joe Hackney (D-Orange): Retired after being double-bunked in redistricting

Some of the Most Effective Legislators Won't Be Back

Some of the most effective legislators in the 2011–12 session also won't be back in 2013. The Center released new rankings of all legislators' effectiveness in April 2012 based on surveys of all legislators, lobbyists based in North Carolina, and capital news media. Sen. Richard Stevens (R-Wake), ranked the 3rd most effective in the Senate, is retiring to go into lobbying after serving five terms. Rep. Harold Brubaker

(R-Randolph), ranked 2nd most effective in the House, resigned in July also in order to go into lobbying in 2013. A six-month "cooling off" period is required by state law before a legislator can go into lobbying. Rep. Jim Crawford, Jr. (D-Granville), ranked 7th most effective, lost his primary election. Rep. Dale Folwell (R-Forsyth), who ranked 8th in effectiveness, left the House to run unsuccessfully for Lieutenant Governor. Finally, former Speaker of the House Rep. Joe Hackney (D-Orange), ranked as the 13th most effective Representative, retired after being double-bunked in redistricting with Rep. Verla Insko (D-Orange). Hackney served 16 terms in the House.

The Pros and Cons of Turnover

Keith Jackson, a professor of political science at the University of Canterbury in New Zealand, warned that low turnover can lead to the ever-dangerous three As—"arrogance, apathy, and atrophy."[6] In legislatures where turnover is low, legislators often are seen as being out of touch.

On the other hand, Professors Yanna Krupnikov, Rebecca Morton, and Charles Shipan say high turnover rates lead to inexperienced legislatures, "which can hurt their ability to deal on an equal footing with governors,"[7] and lead to poor policymaking.[8]

For the public in North Carolina, many of the legislators and committee chairs are new. For many of the legislators, the legislative process and state-level issues are new. With a Republican, Pat McCrory, in the Governor's office for the first time since 1985–93 (Jim Martin), a Republican majority in both houses of the legislature, and a Republican majority on the 7-member state Supreme Court in 2013, North Carolina is entering a new political era—even if legislative turnover didn't set a record.

Endnotes

[1] "A burglary at a Washington office complex called the Watergate in June 1972 grew into a wide-ranging political scandal that culminated in the resignation of President Richard Nixon two years later. 'Watergate' is shorthand for this tumultuous time in America and its enduring impact." *The Washington Post* Website, online at *http://www.washingtonpost.com/watergate*, accessed on Aug. 29, 2012.

[2] Rep. Bert Jones was elected as an unaffiliated candidate in 2010, but then joined the Republican caucus in 2011, bringing their voting majority to 68. He later officially switched parties to become a Republican.

[3] The nine freshman Senators who chaired committees were: Warren Daniel (R-Burke) as Co-Chair of the Judiciary II Committee; Jim Davis (R-Macon) as Co-Chair of both the Appropriations Committee on General Government and Information Technology and the Committee on State and Local Government; Thom Goolsby (R-New Hanover) as Co-Chair of the Appropriations Committee on Justice and Public Safety; Kathy Harrington (R-Gaston) as Co-Chair of the Appropriations Committee on the Department of Transportation; Ralph Hise (R-Mitchell) as Co-Chair of the Pensions and Retirement and Aging Committee; Wesley Meredith as Co-Chair of the Insurance Committee; Buck Newton (R-Wilson) as Co-Chair of the Judiciary II Committee; Bill Rabon (R-Brunswick) as Co-Chair of the Transportation Committee; and Dan Soucek (R-Watauga) as Co-Chair of the Education/Higher Education Committee.

[4] *N.C. State Conference of Branches of the NAACP v. Rucho*, No. 11-CVS-16940 (N.C. Superior Ct. Wake Co.) was consolidated into *Dickson et al., v. Rucho et al*., No. 11-CVS-16896 (N.C. Superior Ct. Wake Co.).

[5] *Dickson et al., v. Rucho et al*., 201PA12 (N.C. Supreme Ct.).

[6] Keith Jackson, "Stability and Renewal: Incumbency and Parliamentary Composition," in Albert Somit *et al*., eds., *The Victorious Incumbent: A Threat to Democracy?,* Ashgate Publishing, Dartmouth, MA, 1994, p. 270.

[7] Yanna Krupnikov *et al.*, "Voter Uncertainty, Political Institutions, and Legislative Turnover," Working Paper, Oct. 20, 2008, p. 2.

[8] *Ibid*.

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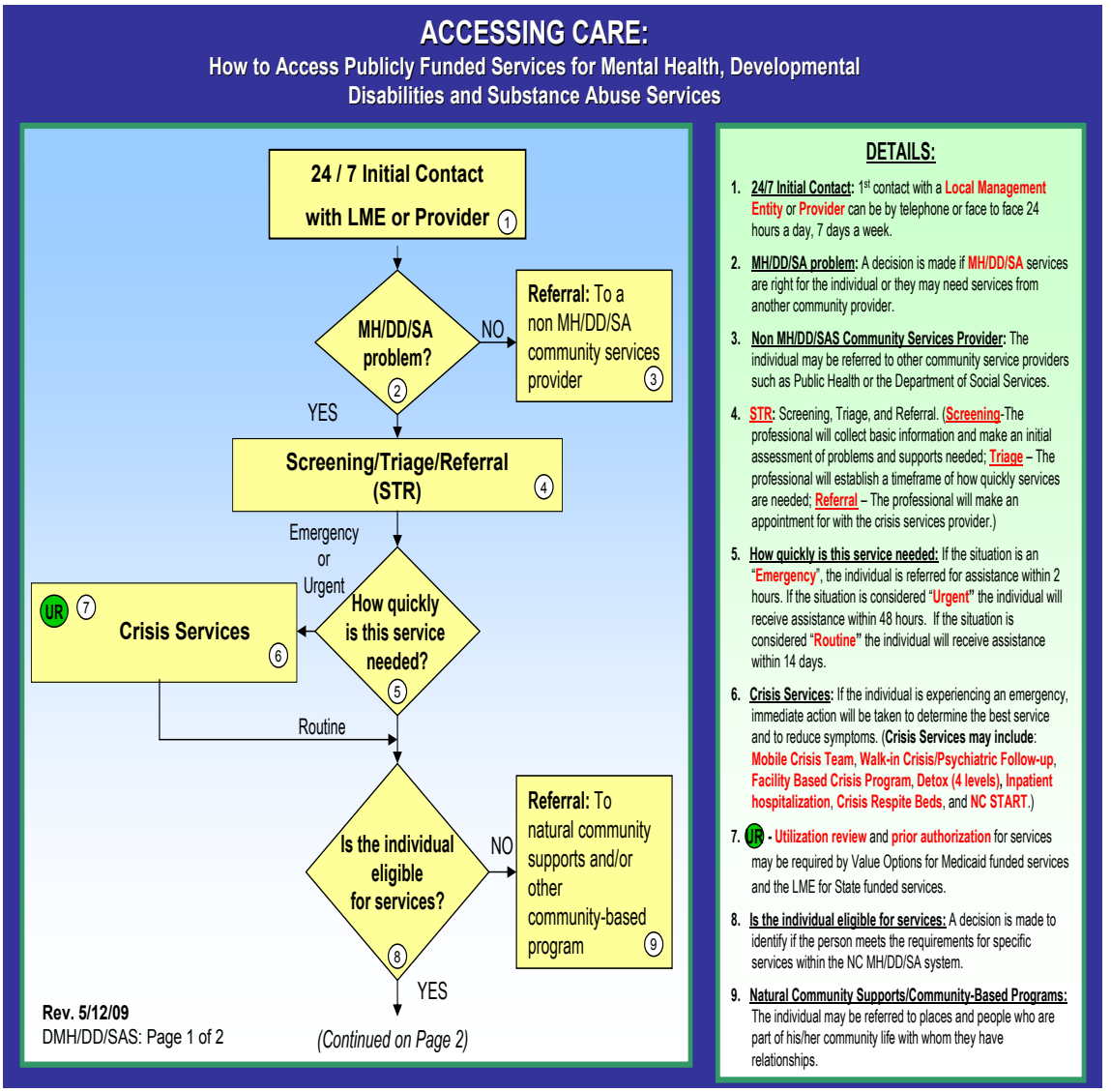
Memorable Memo

LMEs, CABHAs, and Other Acronyms To Challenge Your Mental Health

LME stands for Local Management Entity. CABHAs are Critical Access Behavior Health Agencies. Unless you are an insider in the world of mental health services, these acronyms are hard to understand. Once you get past the acronym, the only clue that they relate to mental health services is the use of behavioral health. Plenty of North Carolinians don't know what behavioral health is either.

Take a look at the chart provided by the state to consumers of mental health, developmental disabilities, and substance abuse services. There are 16 different steps and 16 different acronyms. LME, MH/DD/SAS, STR, NC START, IIH, MST, ACTT, CST, SAIOP, SACOT, TCM, CS, CAP-MR/DD, NC-TOPPS, UR, 24/7. All of these acronyms need to be reviewed—perhaps by the Joint Select Legislative Study Committee on the Use of Acronyms in Mental Health Services Provided by the State, or JSLSCUAMHSPS for short.

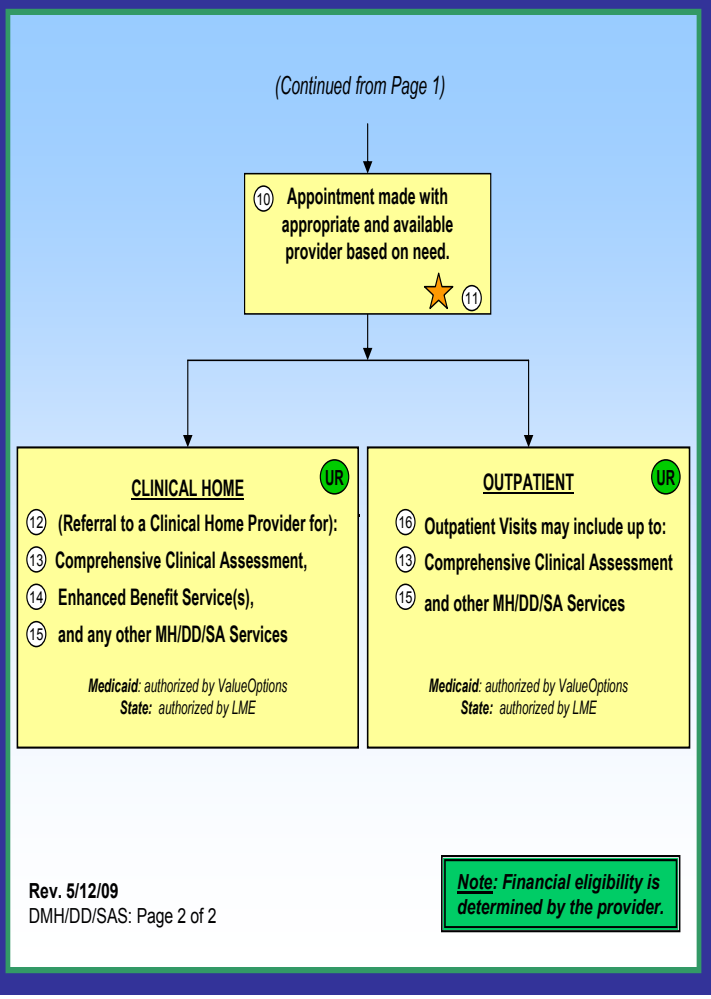


The people who use this system of care are often in crisis. Many are mentally ill. Others have developmental disabilities. The state has a duty, at a minimum, to use plain English, and provide a guide to the mental health system that can be understood and accessed easily by the consumers it is intended to serve.

In 1978, newly elected Governor Jim Hunt penned what became known as the Rock Ridge Memo, which *Insight* reprinted in 1982. This memorandum was directed to those in his administration who believed "the best way to impress the Governor is to fill pages and pages with obscure, multi-syllabic words." Instead, the Governor requested simple, direct language. Coming from the small rural community of Rock Ridge in Wilson County, Hunt's test for a good memo was "Would the average person in Rock Ridge understand it?"

Our test is "Would the average person needing mental health, developmental disability, or substance abuse services understand it?" The answer in this case is no.

ACCESSING CARE: A Flow Chart for New Medicaid and New State Funded Consumers, *continued*



DETAILS:

10. **Appointment made with the appropriate provider based on need:** The professional makes an appointment with a provider for specific services based on the individual's needs.
11. ★ - The individual may choose an appropriate and available provider.
12. **Clinical Home Provider:** If the individual is in need of multiple or complex services, a provider is responsible for coordination of all of his/her services. A **Qualified Professional** schedules a Comprehensive Clinical Assessment and assists the person in developing their **Person Centered Plan** & **Crisis Plan**, in completing various authorization forms and the **NC –TOPPS**. They also act as a **First Responder** in the event of a crisis.
13. **Comprehensive Clinical Assessment:** - A licensed professional conducts an assessment which is used to gather the clinical and diagnostic information necessary to develop the person centered plan. Assessment tools include, but are not limited to: Diagnostic Assessment, Evaluation/Intake, and State Substance Abuse Assessment.
14. **Enhanced Benefit Services:** Any of the following services may be included on the individual's Person Centered Plan:
    - **Intensive In-Home (IIH)**
    - **Multisystemic Therapy (MST)**
    - **Assertive Community Treatment Team (ACTT)**
    - **Community Support Team (CST)**
    - **SA Intensive Outpatient Program (SAIOP)**
    - **SA Comprehensive Outpatient Treatment (SACOT)**
    - **Targeted Case Management (TCM)**
    - **Community Support-Children/Adolescents (CS)**
    - **Community Support-Adults (CS)**
15. **Other MH/DD/SA Services:** There are other Mental Health, Developmental Disabilities and Substance Abuse Services that may be offered, including **CAP-MR/DD Waiver services**.
16. **Outpatient Visits:** If your needs can be met by outpatient services, you can receive services without prior authorization by **ValueOptions** or the LME. Authorization for services is required after 8 visits for adults, and 26 visits for children.

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