North Carolina Insight
Vol. 24, No. 2 July 2014

Evaluating Mental Health Reform in North Carolina

Telepsychiatry

The Mental Health Work Force

Treating Children

North Carolina Center for Public Policy Research

N.C. Center for Public Policy Research

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Telepsychiatry in North Carolina:

Mental Health Care Comes to You

By Andrew Holton and Todd Brantley,
with Aisander Duda

Executive Summary

Telepsychiatry is part of a growing national trend called telemedicine, in which physicians can see patients from remote locations using secure video and audio-streaming technology called videoconferencing. A psychiatrist or other professional can talk to and physically view the patient through a video screen with a web camera and microphone. On the other end, the patient can view the psychiatrist through a similar audio-visual system.

This technology is a new way for mental health and substance abuse services to be delivered in rural areas of the state, easing the pressure on the state's mental health work force shortage. Dr. Sy Saeed, the chair of the Department of Psychiatric Medicine at East Carolina University (ECU), says, "There is no health without mental health. And, if you don't have professionals in the area, you have a problem."

Bringing Telepsychiatry to Northeastern North Carolina

In operation since 1992, ECU has one of the longest continuously running telemedicine centers in the world. ECU's Telemedicine Center provides telepsychiatry services at a variety of sites, ranging from state psychiatric hospitals to family doctors to pediatricians to residential schools for the deaf and blind.

Andrew Holton of Raleigh is an attorney and writer. Todd Brantley of Raleigh is a researcher and writer. Aisander Duda is on the staff at the N.C. Center for Public Policy Research.

In 2010, the Albemarle Hospital Foundation in Elizabeth City partnered with psychiatrists at Coastal Carolina Neuropsychiatric Center in Jacksonville to develop a hospital-based telepsychiatry program for northeastern North Carolina. This program was a success, expanding to serve 18 hospitals in 30 counties covering more than 1 million people.

The program has improved patient outcomes:

- *The length of stay in the emergency rooms for patients waiting to be discharged to inpatient treatment has declined from 48 hours to 22.5 hours.*
- *The percentage of patients returning for treatment within 30 days at Albemarle Hospital declined from 20 percent to 8 percent.*
- *The number of involuntary commitments to local hospitals or state psychiatric hospitals decreased by 33 percent.*
- *Readmissions to psychiatric hospitals of those with severe and persistent mental illness declined.*
- *Eighty-eight percent of patients agree or strongly agree that they were satisfied with the telepsychiatry services they received.*

Gwen Newman, a patient that uses telepsychiatry in Hyde County, says, "Driving an hour and a half to go to the doctor or to get one of my family members there is exhausting and frustrating. This telemedicine program makes a huge difference for all of us. I know we're healthier because of it." That's the promise of telepsychiatry … mental health care comes to you, even if you live in rural North Carolina.

Barriers To Acceptance and Implementation of Telepsychiatry

Nationally, the implementation of telepsychiatry has been slower than anticipated, despite the success of the technology. The ***barriers to patients*** *may include that they don't know about it, they worry about privacy, and older patients may be uncomfortable with the technology.*

The ***barriers for health care providers*** *include whether the standard of care should be different for telemedicine. Health care providers also worry about malpractice lawsuits and liability for violating privacy laws. Interstate licensure is also a concern—for instance, whether a North Carolina medical license should be required for a psychiatrist licensed and located in another state and providing care via telepsychiatry to patients here. Finally, psychiatrists have concerns about getting reimbursed for the care they provide.*

North Carolina's New Statewide Telepsychiatry Initiative

Addressing these barriers to patients and mental health providers will be key to implementing a statewide telepsychiatry system which was established by the N.C. General Assembly in July 2013 and launched in January 2014. The North Carolina Statewide Telepsychiatry Program is administered by East Carolina University's Center for Telepsychiatry and e-Behavioral Health. It will be substantially similar to the Albemarle Hospital Foundation Telepsychiatry Project. The legislature appropriated $2 million for the program for Fiscal Year 2013–14 and $2 million for 2014–15.

The N.C. Department of Health and Human Services presented a plan to the legislature to implement the statewide telepsychiatry program in August 2013. Governor Pat McCrory said, "No matter where you live in North Carolina, you will soon have better access to mental health providers with the expansion of telepsychiatry across our state. Technology will help us connect people with appropriate treatment programs so patients can avoid long waits in the emergency room. North Carolina can be a national leader with this program." Initially, the primary objective of the program is to improve access to telepsychiatry in hospital emergency rooms across the state.

In May 2014, 24 hospitals were participating in the state's telepsychiatry program. An additional 23 hospitals are scheduled to begin participating between June and September 2014. These 47 hospitals will serve 53 counties. Thirty additional hospitals are on the waiting list and are likely to join the program between November 2014 and June 2015. When these 30 hospitals participate, the program will serve 81 counties across North Carolina.

The Center's Findings and Recommendations

Based on our research, the N.C. Center for Public Policy Research finds that for many people living in rural North Carolina, access to mental health care is the biggest barrier to recovery. Telepsychiatry will increase access to treatment across the state, and it may reduce the amount of time patients have to wait in emergency rooms for treatment, reduce the likelihood that patients will have to return for treatment, reduce the number of involuntary commitments to hospitals for psychiatric care, and reduce readmissions to psychiatric hospitals for those with severe and persistent mental illness. Patient satisfaction with telepsychiatry appears to be high. Dr. Saeed says he has found no evidence that "patient satisfaction or outcomes with telepsychiatry are inferior to those seen in comparable face-to-face treatment."

Based on our findings, the N.C. Center for Public Policy Research recommends that the Governor, the N.C. General Assembly, the Office of Rural Health and Community Care in the N.C. Department of Health and Human Services (DHHS), and the N.C. Telepsychiatry Program Advisory Group consider the following actions to implement the state's new telepsychiatry program and make it a national model:

1. ***The Office of Rural Health and Community Care in the N.C. Department of Health and Human Services and East Carolina University's Center for Telepsychiatry should conduct a public campaign to raise awareness about telepsychiatry in rural and underserved communities.*** *This should include patient stories that specifically address patient concerns about their privacy, the confidentiality of their personal health information, and any discomfort older adults may feel about technology.*

2. ***The DHHS Office of Rural Health and Community Care should provide technical information directly to rural health care providers and health centers describing expected costs, funding sources, legal restrictions, and clear reimbursement rates for telepsychiatry services.***

3. ***The N.C. General Assembly should pass legislation requiring a study of telemedicine, including whether private insurers should be required to fully reimburse health care providers for telepsychiatry services.*** *House Bill 704, which passed the N.C. House in 2013 and is pending in the Senate for the 2014 legislative session, would require the Joint Legislative Oversight Committee on Health and Human Services to conduct a study of telemedicine. According to the state's plan, this bill would be "a first step for possible enactment of legislation to require full payment by third party payors for services provided via telemedicine." The Legislative Research Commission Study Committee on Health Care Provider Practice Sustainability and Training/Additional Transparency in Health Care is conducting a "comprehensive review of all existing State programs that are designed to improve access to health care provider care using telemedicine, including the name of the program, a description of the program, and details on program performance." The commission may make an interim report of recommendations to the 2014 legislature and is required to make a final report to the 2015 legislature. According to the National Conference of State Legislatures, 19 states (not including North Carolina) require private insurance plans to cover telehealth services.*

4. ***The DHHS Office of Rural Health and Community Care should provide technical and financial assistance to rural health care providers who want to incorporate telepsychiatry into their practices.*** *The Office should assess the need for a one-time subsidy to hospitals, community health departments, and rural providers to update their telecommunication capabilities. If needed, the legislature should appropriate funds to implement the subsidy. The Mental Health Subcommittee of the Joint Legislative Oversight Committee on Health and Human Services recommended in a March 2014 report that the legislature provide funding to expand the telepsychiatry program to primary care providers. In April 2014, the Joint Legislative Oversight Committee on Health and Human Services included this recommendation in its report to the N.C. General Assembly.*

5. ***The N.C. General Assembly should increase funding to the state's medical schools, nursing programs, schools of social work and psychology programs, as needed, to incorporate telemedicine and telepsychiatry as part of the curriculum.*** *The UNC Board of Governors should decide where to focus the funding, which programs will take a leadership role, and the number of campuses involved.*

6. ***The DHHS Office of Rural Health and Community Care should partner with medical schools in North Carolina to incorporate telepsychiatry into the residency programs at East Carolina University, Duke University, UNC-Chapel Hill, and Wake Forest University and partner with local Area Health Education Centers (AHECs) to connect psychiatric residents under appropriate faculty supervision with rural providers via centralized telepsychiatry services.***

7. ***As part of its implementation of North Carolina's statewide telepsychiatry program, the N.C. Department of Health and Human Services should adopt in its rules the practice guidelines for video-based online mental health services developed by the American Telemedicine Association in May 2013.*** *The Association established these practice guidelines and technical standards for telemedicine, based on clinical and empirical evidence, "to help advance the science and to assure the uniform quality of service to patients." These guidelines serve as both a reference guide for operations and an educational tool to provide appropriate care for patients. Implementing these guidelines for telepsychiatry will improve clinical outcomes and ensure informed and reasonable patient expectations.*

8. ***The N.C. Department of Health and Human Services should develop criteria and outcome measures to evaluate the successes and failures of the state's telepsychiatry program.*** *Currently, ECU's Center for Telepsychiatry is required to develop and administer an oversight process, including quality management as well as monitoring and reporting of outcomes for the state's telepsychiatry program. The Center for Telepsychiatry is already required to report quarterly and annually to the DHHS Office of Rural Health and Community Care on (a) the number of consultant sites and referring sites participating in the program, (b) the number of psychiatric assessments conducted under the program, reported by site or region, (c) the length of stay of patients receiving telepsychiatry services in the emergency rooms of hospitals participating in the program, reported by disposition, and (d) the number of involuntary commitments as a result of telepsychiatry assessments, reported by site/region and year, compared to the number of involuntary commitments prior to implementation of this program. Additionally, all clinical providers are required to participate in a peer review process.*

ECU's Center for Telepsychiatry also should be required to track and report these additional outcomes: (a) satisfaction of emergency room staff, the psychiatrist, and the patient, and (b) recidivism data on the number of patients who return to the emergency room within 30 days.

The DHHS Office of Rural Health and Community Care should implement its goals for the telepsychiatry program, including among others increasing the number of patients served with telepsychiatry, reducing the average length of stay of telepsychiatric patients in the emergency departments of local hospitals and state psychiatric hospitals, increasing the number of psychiatrists and psychiatric residents trained to use telepsychiatry, and reducing the cost of mental health care. The Office should adopt additional outcome measures that evaluate: (a) whether the patients' mental health status actually improves; (b) whether involuntary commitments from telepsychiatric patients are reduced; and (c) whether more patients are served after the state's telepsychiatry initiative is implemented than was true before; and (d) especially whether more are served in rural counties or in medically underserved areas.

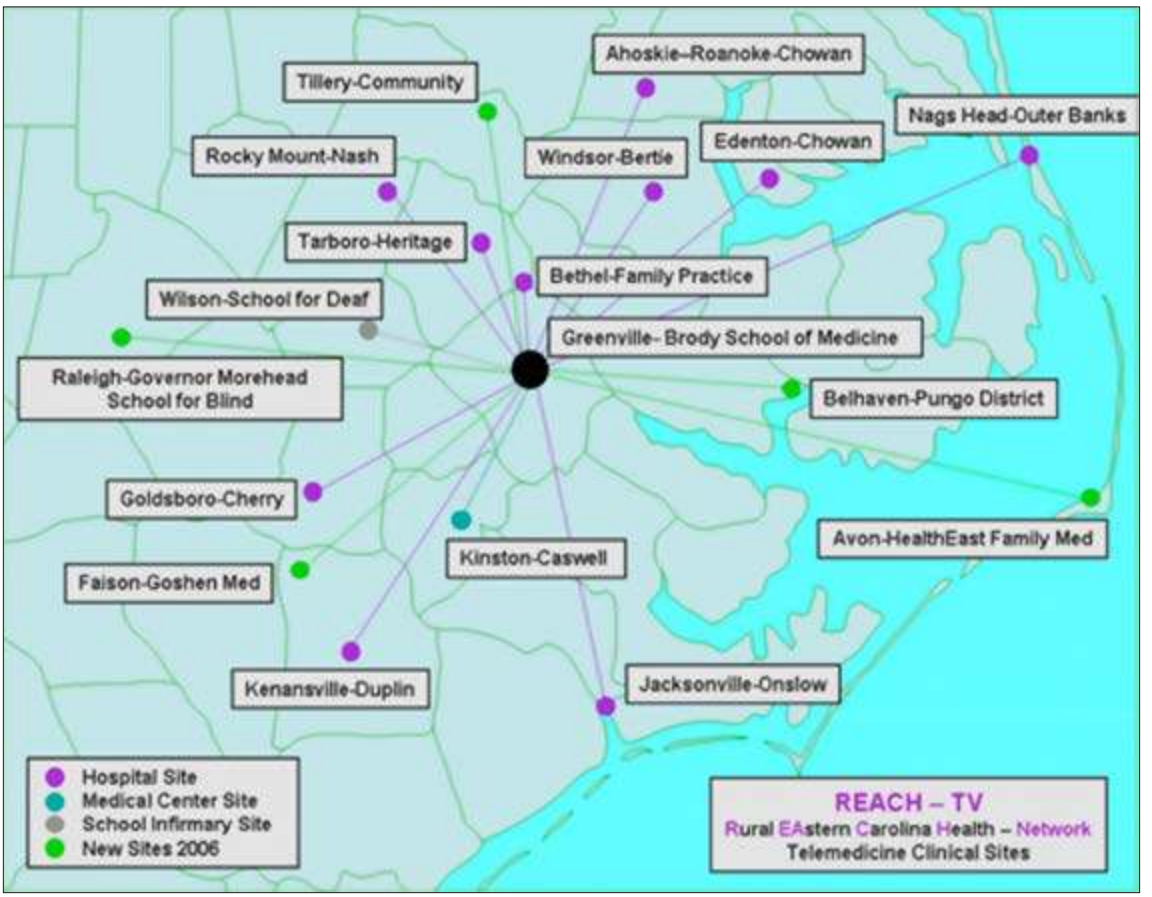
Getting mental health care to the rural areas of North Carolina has never been easy. Twenty-eight counties across the state still do not have a psychiatrist. This work force shortage is real, and it has a real impact on the lives of those needing mental health treatment in places that are far away.

In northeastern North Carolina, mental health care providers tell stories about "the 18-hour work day." A psychiatrist would wake up early in the morning to take a three-hour ferry to the Outer Banks. If the psychiatrist took the ferry back, then he would only be able to provide treatment services for one hour. So he took the long way back, resulting in an 18-hour work day to provide these important services to people in need in our rural counties.

No one questions the existence of the problem, but solutions have been hard to find. Until now. Telepsychiatry is changing the way mental health care is provided to people in need in very rural areas all across our state.

Telepsychiatry is part of a growing national trend called telemedicine, in which physicians can see patients from remote locations using secure video and audio-streaming technology called videoconferencing. A psychiatrist or other health care professional can talk to and physically view the patient through a video screen with a web camera and microphone. On the other end, the patient can view the psychiatrist through a similar audio-visual system. North Carolina is a national leader in the use of telepsychiatry, thanks to the leadership, hard work, and determination of a group of professionals committed to this solution.

Dr. Sy Saeed, the chairman of the Department of Psychiatric Medicine at the Brody School of Medicine at East Carolina University, pioneered the use of this technology. The ECU Telemedicine Center has been addressing that problem since 1992, making



East Carolina University

East Carolina University

Telepsychiatry with the Eastern North Carolina School for the Deaf

it one of the longest continuously running telemedicine centers in the world. ECU's Telemedicine Center provides telepsychiatry services at a variety of sites, ranging from state psychiatric hospitals to family doctors to pediatricians to residential schools for the deaf and blind. Saeed says, "There is no health without mental health. And, if you don't have professionals in the area, you have a problem."

Expanding the Use of Telepsychiatry in Northeastern North Carolina

For Phil Donahue, the former vice president of the Albemarle Hospital Foundation in Elizabeth City, the mental health work force shortage became all too real in February 2009. The Albemarle local mental health management entity (LME)—an organization funded by the state to oversee the referral and payment for mental health services for a 10-county region in northeastern North Carolina—became financially insolvent, leaving area hospitals and free clinics without much-needed psychiatric services. Those 10 counties served in the northeastern part of the state were Camden, Chowan, Currituck, Dare, Hyde, Martin, Pasquotank, Perquimans, Tyrrell, and Washington counties.[1]

"Because of some improprieties of the director, the LME went under, it just collapsed," says Donahue. "What happened then was that the psychiatrists they employed all left because they weren't getting paid, and they took other jobs. So we were left with no psychiatric services for the entire 10-county region."

Located in Elizabeth City in Pasquotank County, the Albemarle Hospital Foundation was created in 2003 as a part of the Albemarle Health system, and it currently oversees 12 programs in northeastern North Carolina. The Foundation's Community Care Clinic in Elizabeth City offers free primary care and prescription services to the region's indigent and uninsured population. Other clinics in Gatesville and Tyner offer

"We live in a time when the treatment of mental illness has never been more effective. Recovery is possible and within reach! Unfortunately, many of our patients don't have access to treatment. It's not uncommon for me when I'm in the clinic to hear from the patient that the reason they can't come to the clinic is because they can't afford the gas. Telepsychiatry offers the promise of bridging the distances between providers and patients."

— Dr. Sy Saeed, Chairman of the Department of Psychiatric Medicine, Brody School of Medicine, East Carolina University

services on a sliding scale based on family income. The Albemarle Health System also operates the Albemarle Hospital in Elizabeth City and a regional medical center in Kitty Hawk.

"We had an agreement with the LME that we would see all of their uninsured patients through our pharmacy programs," says Donahue. "So, we had all of these patients who all of a sudden needed refills on their prescriptions and no doctor to authorize it."

"The need for more and more care will increase. So we just have to be smart and use technology to tie the number of providers to the growing need and number of patients."

— Dr. Robin Cummings, Director, Division of Medical Assistance and Deputy Secretary for Health Services, N.C. Department of Health and Human Services

The result was an increasing number of uninsured patients arriving at the doors of the region's hospital emergency rooms. Psychiatric lengths of stay for patients presenting to local emergency rooms with mental health issues began to burden the capacities of local hospitals. According to Donahue, many patients entering emergency rooms for psychiatric services only need a psychiatric evaluation or a change in their medications. However, many emergency medical providers are not trained properly to provide those psychiatric services, so they admit the patient and hold them until they can obtain a psychiatric consultation or have them admitted to one of the state's psychiatric hospitals.

"When we're holding a patient, we have about one or two staff people who have to drop what they're doing to (1) physically watch this patient and make sure they don't hurt themselves or someone else, and (2) start that whole committal process — of writing all the papers and making all the phone calls, doing all the things you have to do to get this person committed into an institution," says Donahue. "Sometimes we can get it done in a day or two, sometimes it takes three or four days to do it. And we have had patients being held up to six days in our hospital. That wait comes at a huge cost for the hospital, the family, and most importantly, the patient."

The number of admissions to hospital emergency departments statewide continues to increase for those with a mental health, developmental disability, or substance abuse diagnosis from 132,214 in 2009 to 156,661 in 2012, an 18.5 percent increase. The N.C. Hospital Association collected data in 2012 for about 40 percent of the hospitals across the state on persons with mental health and substance abuse diagnoses, including wait times by disposition. For those admitted to a community hospital psychiatric bed, the wait time was 24.5 hours. For those admitted to a state psychiatric hospital the wait time was more than 78 hours. In the first half of 2013, the average wait time for state hospital admissions had increased to more than 85 hours.[2]

Albemarle Hospital Foundation

Albemarle Hospital in Elizabeth City

"I have met with every county manager in these 10 counties, and it's the biggest single problem they face," says Donahue. "They either have to send their sheriffs to stay with the patient in the hospital or to drive the patient to the state institution where they can get a commitment. Nine times out of 10, these patients don't need to be committed. They are evaluated there, and they are sent home. We have had cases where the patient gets back to town before the sheriff does."[3]

The Albemarle Hospital Foundation's foray into telepsychiatry has been a success. The hospital-based telepsychiatry program expanded to

Definition of Telepsychiatry

The definition of telepsychiatry is the delivery of acute mental health or substance abuse care, including diagnosis or treatment, by means of a secure, two-way real-time interactive audio and video by a health care provider in a remote location to an individual needing care at a referring site. "The term does not include the standard use of telephones, facsimile transmissions, unsecured electronic mail, or a combination of these in the course of care," according to N.C. General Statute § 143B-139.4B.

Albemarle Hospital Foundation

"We have the nurse prepare the patient, tell them what to expect, tell them they are going to talk to a psychiatrist in a different location. They have the option to have a member of their family with them, if they choose to, but most of them do not. And then we close the door and let them interact with the psychiatrist. Of course, we are there if they need us for any reason."

— Phil Donahue, former vice president of the Albemarle Hospital Foundation and now with East Carolina University

serve 18 hospitals in 30 counties covering more than 1 million people.[4] Donahue is quick to note that the success of the program would not have been possible without funders like The Duke Endowment and Kate B. Reynolds Charitable Trust, health care providers like ECU's Telemedicine Center and Coastal Carolina Neuropsychiatric Center, skilled professionals like his former director of telepsychiatry Sheila Davies, who figured out how to make this idea work on the ground, and the patients who were willing to give it a try.

The program has improved patient outcomes. The length of stay (LOS) in the emergency rooms for patients waiting to be discharged to inpatient treatment has declined from 48 hours to 22.5 hours. The percentage of patients returning for treatment within 30 days at Albemarle Hospital declined from 20 percent to 8 percent. The number of involuntary commitments to local hospitals or state psychiatric hospitals decreased by 33 percent. Readmissions to psychiatric hospitals of those with severe and persistent mental illness also declined.[5] Eighty-eight percent of patients agree or strongly agree that they were satisfied with the telepsychiatry services they received. See Table 1 for additional information on outcomes at different telepsychiatry programs in North Carolina.

South Carolina's Experience with Telepsychiatry

In looking for solutions to the lack of psychiatric services in the Albemarle region, Phil Donahue visited South Carolina to study their telepsychiatry system, which has been in operation since 2007 when it was first funded by The Duke Endowment in Charlotte. It had proven to be a valuable service for communities that do not have the psychiatric professionals necessary to meet their mental health consumers' needs.

The use of telepsychiatry in South Carolina not only has increased access to care for rural communities, but it also has contained costs by decreasing the number of people admitted to state institutions from hospital emergency rooms. In three years, from 2010–13, the number of patients treated using telepsychiatry increased from

Table 1. Outcomes in 2012: The Duke Endowment Telepsychiatry Project, including Albemarle Hospital, FirstHealth of the Carolinas, and Novant Health

Metric	Description	Definition	Albemarle Hospital	First Health	Novant	TOTAL
Number of ED Psychiatric Patients	The number of psychiatric patients admitted to the ED		2,839	789	2,376	6,004
Number of ED Telepsychiatry Patients	The number of psychiatric patients who receive at least one telepsychiatry assessment		1,203	3	198	1,404
Number of Psychiatric Assessments	The number of psychiatric assessments conducted		1,465	20	198	1,683
Length of Stay	Number of hours ED telepsychiatry patients spend in the emergency department	Length of Stay = length of time from when the patient is admitted to the ED to the time the patient is discharged	11	7	3	21
Involuntary Commitment	Total number of IVCs in the ED	Total number of ED patients who have an IVC — this includes those who come in with an IVC and those who become IVC'd after being assessed	479	3	74	556
Involuntary Commitment Overturned	Number of IVCs overturned	Total number of IVCs that are overturned in the ED saving law enforcement man hours, travel time, and fuel	149	2	49	200
Emergency Department Recidivism	Patients who return to the ED within 30 days	Total number of patients that return to the ED within 30 days of a psychiatric visit.	18	0	59	77
Disposition	The arrangement or outcome ending the patient's ED visit	For each patient, the hospital will select one of the following dispositions:				
		Transferred for Inpatient Psychiatric or Substance Abuse Treatment	528	1	61	590
		Admitted to Hospital	29	0	7	36
		Home/Outpatient Follow-Up	381	22	129	532
		Patient Left Hospital Against Medical Advice	13	0	0	13

Notes: ED = Emergency Department IVC = Involuntary Commitment
Source: Sheila Davies, Program Implementation, East Carolina University

South Carolina's Eight Goals for Its Telepsychiatry Network

1. Increase the number of patients receiving comprehensive assessment utilizing telemedicine technology.
2. Ensure focused documentation is generated for each telemedicine consultation.
3. Maximize the number of patients seen through a seamless joint consultation process.
4. Secure better quantitative information on the diagnosis of mental health, substance abuse, and co-occurring disorders.
5. Reduce the average length of stay in the emergency department.
6. Increase the number of professional staff in local hospitals receiving training via the Department of Mental Health training presentations.
7. Increase the number of psychiatrists and psychiatric residents trained to use the telemedicine system and provide opportunity for a larger pool of psychiatrists for consultation.
8. Reduce the cost of mental health care by decreasing the utilization of sheriff deputies, probate judges, and designated examiners.

Source: On the Internet at *http://www.state.sc.us/dmh/telepsychiatry*, accessed August 21, 2013.

8.7 to 12.3 per day. The length of stay in emergency departments waiting for treatment has decreased from 48–72 hours to less than six hours in July 2013.[6]

After visiting South Carolina, the Albemarle Hospital Foundation initially provided the necessary technology to allow patients at two free clinics to have access to Dr. Sy Saeed and a group of psychiatric professionals at East Carolina University in Greenville, more than 100 miles from Elizabeth City. Unable to afford high-end telepsychiatry technology, which Phil Donahue estimated to cost $35,000–40,000 per unit, he used some older equipment from the local mental health management entity and the local hospital. "We made it work," Donahue says. "Patients seemed to be ok with it, even though the screens were rather small, and it was not ideal for telepsychiatry." Once a week, patients at the free clinics could see a psychiatric professional for medication management, evaluations, and basic mental health check-ups. "Our hope in doing this," says Donahue, "is that we avoid having these same people in our emergency departments later on." The telepsychiatry program at the clinics is not operational anymore, but it was the building block for the Foundation's hospital-based telepsychiatry program, which in turn was the building block for North Carolina's new statewide telepsychiatry program.

I'd like to help you doctor
Yes I really really would
But the din in my head
It's too much and it's no good
I'm standing in a windy tunnel
Shouting through the roar
And I'd like to give the information
You're asking for.

—Suzanne Vega, *Blood Makes Noise*

Using Telepsychiatry To Increase Access to Mental Health Services in Rural Areas

Electronic information and telecommunication technologies provide new ways to deliver medical care and can ease the pressure on North Carolina's mental health work force shortage. In a handful of North Carolina settings, telepsychiatry allows rural health care providers to connect to mental health experts in other parts

Rose Hoban

Sheila Davies demonstrates how the telepsychiatry unit functions.

of the state. Interactive technologies like videoconferencing, the Internet, store-and-forward technology,[7] and streaming media make it possible for mental health providers to be "in two places at once."[8] The American Psychiatric Association says telepsychiatry is "one of the most effective ways to increase access to psychiatric care for individuals living in underserved areas."[9] And, as part of its mission to assure quality health care for underserved, vulnerable, and special needs populations, the U.S. Department of Health and Human Services promotes the use of telehealth technologies for health care delivery.[10]

In 2013, the Sheps Center for Health Services Research at UNC-Chapel Hill released data for 2011 on the number of physician specialists by county. Twenty-eight counties in North Carolina do not have a psychiatrist (compared to 30 the year before in 2010), and an additional 18 counties have only one psychiatrist. Seventy counties do not have a child psychiatrist, and an additional 14 only have one. Only six counties have a geriatric psychiatrist. Only five counties have addiction psychiatrists, and

How Telepsychiatry Works

"A nurse rolls a portable cart outfitted with a monitor, camera, and microphone into the patient's bay or room, establishes a secure link to the psychiatric provider site and introduces the patient to an intake specialist on the other end who's already reviewed the patient's information. This psychologist or social worker explores the patient's situation and gathers more information from family members. A psychiatrist then interviews the patient and makes a recommendation to the referring hospital physician, who is ultimately responsible for care decisions."

Source: Doug Boyd, "Serving Statewide: Brody Telepsychiatry Network To Expand Across N.C.," Aug. 16, 2013, on the Internet at *http://www.ecu.edu/cs-admin/news/telepsychiatry.cfm*.

only 13 counties have physicians specializing in addiction and chemical dependency. See Table 2.

Using federal data, in August 2013, 58 counties in North Carolina were designated as Health Professional Shortage Areas because they do not have enough mental health providers.[11] Telepsychiatry is part of the solution for providing mental health and substance abuse care to North Carolinians in rural areas.

Telepsychiatry networks typically have a "regional medical center or state psychiatric hospital" as a hub, with community organizations and providers connected like spokes. Consultations and evaluations are sent from the hub to the various spokes through telecommunication mechanisms, such as videoconferencing. At the central hub site is the mental health specialist. At the spoke site with the patient, is a "community mental health staff member who provides case management, information, and support." Many spoke sites have a nurse physically present in the room during the consultation to observe the patient and assist with ordering medications and other medical services.[12]

Research on Telepsychiatry

Telepsychiatry improves collaboration between practitioners and can improve patient satisfaction.[13] The American Psychiatric Association has reported nationally that patients are generally satisfied with the experience.[14] Dr. Sy Saeed of ECU says he has found no evidence that "patient satisfaction or outcomes with telepsychiatry are inferior to those seen in comparable face-to-face treatment."[15]

A survey of children and their parents using telepsychiatry services in rural Kentucky found similar patient satisfaction. All the respondents in Kentucky felt

—continues on page 19

Table 2. Annual Profile of Health Professionals in North Carolina, Physician Specialties, 2011

Type of Physician Specialty	Counties with 0	Counties with 1	Counties with 2 or more	Total # of Professionals Statewide
Addiction Psychiatry	95	3	2	9
Addiction/Chemical Dependency	87	9	4	22
Psychiatry	28	18	54	971
Child Psychiatry	70	14	16	146
Geriatric Psychiatry	94	4	2	9

Note: The 28 counties in North Carolina that do not have a psychiatrist are Alleghany, Anson, Ashe, Bertie, Bladen, Camden, Dare, Edgecombe, Franklin, Gates, Graham, Hoke, Hyde, Jackson, Jones, Macon, Madison, McDowell, Mitchell, Montgomery, Northampton, Pamlico, Scotland, Swain, Transylvania, Tyrrell, Warren, and Yancey.

Source: The Cecil G. Sheps Center for Health Services Research at UNC-Chapel Hill. See the Excel spreadsheet for physician specialties. On the Internet at *http://www.shepscenter.unc.edu/hp/prof2011.htm.*

Telepsychiatry and Telemedicine: Access, Quality of Care, and Affordability Are Key Considerations

by Dr. Don W. Bradley, Chief Medical Officer and Senior Vice President of Healthcare for Blue Cross and Blue Shield of North Carolina

Blue Cross and Blue Shield of North Carolina (BCBSNC) supports the use of telemedicine when used appropriately and therefore supports a study of telemedicine. However, BCBSNC opposes regulations that would require reimbursement for telemedicine because most insurers include, or are working to include, coverage for telemedicine and a mandate could have unintended consequences, including increased out-of-pocket costs or premiums for our members.

Among the many issues we face in the health care industry, increasing access to high quality, affordable care remains a challenge in both the public and private sectors. Telemedicine, if employed appropriately, can be a useful tool. In making the case for this technology, several key components must be considered: access, quality of care/outcomes, patient experience, and affordability (including patient out-of-pocket costs and the pressure of health care costs on premiums). These measures will have different meanings to different stakeholders and will impact the public and private sectors differently. Consequently, telemedicine policies should be developed collaboratively and comprehensively among all stakeholders — both in the public and private sectors.

BCBSNC has reimbursed telemedicine claims since 1997. In North Carolina, our current claims experience shows that the majority of telemedicine services that we pay for are claims for mental health care. As a result of the Affordable Care Act, BCBSNC anticipates a growth in demand for mental health services and supports a comprehensive approach to developing telemedicine in mental health care, not just telepsychiatry.

BCBSNC opposes mandates requiring reimbursement that could lead to increased out-of-pocket costs or premiums for our members and thus opposes a reimbursement mandate for telemedicine — especially one that protects fee-for-service payments. Reimbursement decisions between private parties should be left to the private marketplace.

Reimbursement mandates are not necessary in the private market to achieve the broader goals of telemedicine. Collaborative efforts between private payers and providers are taking place across the state. These efforts not only address provider compensation, but also focus on access, quality outcomes, and affordable health care for consumers. A reimbursement mandate focusing on dated models of payment could hamper this innovation.

Profit margins for providers can be preserved, or even improved, without reimbursement mandates. For example, if patients leave the emergency room sooner or are discharged more quickly because of access to telepsychiatry, then facilities will save money by providing this type of care. Furthermore, telemedicine technology reduces overhead because of the reduced need for "bricks and mortar," nurses, patient gowns, etc. — all of which would support a cost-savings that should be passed on to the patient.

Blue Cross and Blue Shield of North Carolina provides insurance to 3.7 million customers across the state.

Furthermore, it is unnecessary for "a structure for reimbursement of collateral changes, such as technicians and line time," particularly if the equipment is subsidized by an outside source, like a foundation or the state. More specifically, mental health telemedicine programs do not require sophisticated cameras (as is required when using telemedicine to provide dermatology services, for example) or peripherals (auxiliary devices allowing a computer to perform additional functions). On a secure network, providers can use a standard, built-in webcam on their device or computer. The need for expensive equipment may not be justified for this type of program

When Telemedicine Is Covered by Blue Cross and Blue Shield of North Carolina

Evaluation and management and consultation services using Telemedicine or Telehealth technologies may be considered medically necessary under the following conditions:

The patients must be present at the time of consultation.

The medical examination of the patient must be under the control of the consulting practitioner.

All services provided must be medically appropriate and necessary.

The distant site of the services shall be of a sufficient distance from the originating site to provide services to patients who do not have readily available access to such specialty services.

The consultation must take place via an interactive audio and video telecommunications system. Interactive telecommunications systems must be multi-media communication that, at a minimum, include audio and video equipment permitting real-time consultation among the patient, consulting practitioner, and referring practitioner (as appropriate).

A permanent record of online communications relevant to the ongoing medical care of the patient should be maintained as part of the patient's medical record.

Source: Blue Cross and Blue Shield of North Carolina, Telemedicine Corporate Medical Policy, Last Review April 2013, p. 2.

given the nature of videoconferencing capabilities in personal devices.

BCBSNC supports a study of telemedicine to assess the cost-effectiveness of its use and its impact on access, patient experience and acceptance, and care outcomes. Key factors to consider in the study should include:

- The impact of telemedicine in different settings on access, outcomes, and affordable health care for consumers;
- Existing barriers to telemedicine, including requirements of an in-person examination before prescribing;
- Training, credentialing, and privileging both at the originating site and the consulting site;
- Adequate clinical evaluation to justify the evaluation and management code providers will file and full clinical documentation for each encounter filed;
- Expectations around providing only medically necessary care;
- Consumer protections from fraudulent claims and systematic double-dipping;
- Ensuring patient privacy and confidentiality;
- Patient consent;
- The role of telemedicine in supporting alternative delivery methods;
- The role of telemedicine in supporting a move from fee-for-service reimbursement to fee-for-value reimbursement; and
- The potential for increased utilization, particularly in a fee-for-service reimbursement model.

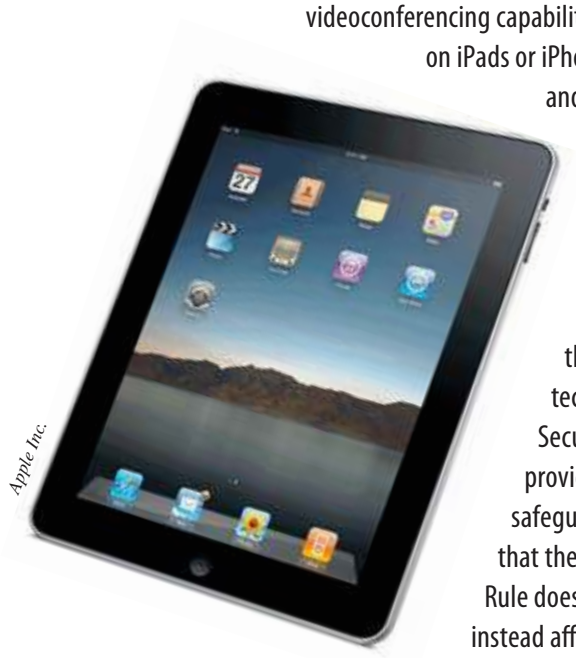
Online care can increase access to high quality, convenient, and affordable care in North Carolina, but only if rules and processes are aligned with modern care models. There are numerous regulatory and legal barriers to a full spectrum of on-line care. BCBSNC looks forward to working with all stakeholders to develop collaboratively a regulatory and legal environment that encourages a model that improves access, care/outcomes, patient experience, and affordability for consumers.

Is FaceTime HIPAA Compliant?

There is confusion about which devices comply with state and federal regulations to protect patient privacy. The only thing that is clear is that technology is changing quickly.

Dr. Sy Saeed at ECU says at this point Skype, Apple's FaceTime, and other smart phone applications do not support the provision of telepsychiatry services because they do not comply with the federal law known as HIPAA (the Health Insurance Portability and Accountability Act) and other privacy laws. While many of these devices use encryption and other technologies to secure the information, his understanding is that none of them currently meet the thresholds for HIPAA. He says some Medicaid policies specifically exclude Skype, FaceTime, and other similar applications. For example, North Carolina's Medicaid policy indicates "video cell phone" conversations as not covered. However, Saeed concludes, "I think much of this will change with time."

On the other hand, Blue Cross Blue Shield of North Carolina says, "The need for expensive equipment may not be justified for this type of program given the nature of videoconferencing capabilities in personal devices." Apple suggests FaceTime on iPads or iPhones could be HIPAA compliant if WPA2 Enterprise and 128-bit encryption is used over a Wi-Fi connection.



Apple Inc.

Freddie Zufelt, an attorney practicing healthcare and privacy law in Raleigh, says, "Asking whether a particular device or technology is 'HIPAA-compliant' is the wrong starting point for the analysis. The more accurate inquiry is whether the health care provider is using the device or technology in a HIPAA-compliant manner. The HIPAA Security Rule requires physicians and other health care providers to implement reasonable and appropriate safeguards to protect the electronic health information that they create, receive, maintain, or transmit. The Security Rule does not dictate the use of any specific technologies, but instead affords providers flexibility in deciding what measures are 'reasonable and appropriate' based on the provider's infrastructure and the likelihood and severity of potential risks to electronic health information. As a result, physicians that wish to use iPads or other mobile devices in their practices may do so in a HIPAA-compliant manner, provided that they evaluate the potential security risks associated with the device and implement reasonable and appropriate safeguards (such as encryption) to protect against those risks."

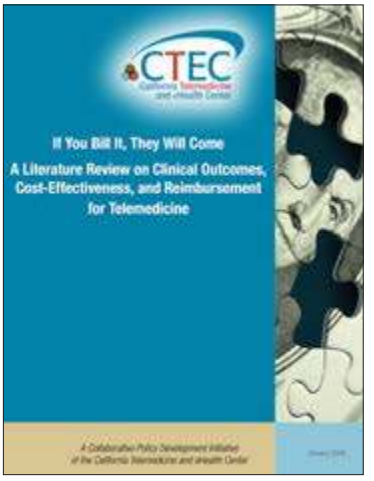
—Mebane Rash

Doug Boehm

that telepsychiatry allowed greater access to care and "almost all" did not prefer an in-person consultation to a telepsychiatry visit. Interestingly, some of the children participating in the service found it easier to be open with a provider in a telepsychiatry consultation than in a traditional in-person consultation.[16]

A review by the California Telemedicine and eHealth Center of multiple studies found high patient satisfaction with telepsychiatry. In addition to patient satisfaction, research on telepsychiatry noted an increase in access to care and specialty consultations. Good clinical outcomes also are indicated using telepsychiatry, but more research is needed. While telemedicine has been expensive for providers to set up at the start, it often results in cost savings for patients and their employers, specifically by decreasing travel time and time off work and increasing worker productivity.[17]

A 2004 study showed that telepsychiatry can be an effective means of treating adults with depression, particularly in small medical practices. The study found that when telepsychiatry is used in a collaborative care approach in rural settings, patients were more likely to take their medications. This reduced the severity of depression and increased their "mental health status, health-related quality of life, and satisfaction."[18]



Barriers To Acceptance and Implementation of Telepsychiatry

While telepsychiatry has shown great promise, policymakers in North Carolina need to be aware of barriers to patients and practitioners that prevent widespread acceptance and implementation of telepsychiatry. The California Center's review identified the following barriers:

Should a North Carolina Medical License Be Required To Provide Telepsychiatry Services?

by Mebane Rash

Telepsychiatry connects patients that need help with providers that are located somewhere else. Right now, that somewhere else is typically a psychiatrist at East Carolina University. But it is not hard to imagine that someday the psychiatrist might be located out of state or even in another country. Former Rep. Jim Fulghum (R-Wake) said, "The non-North Carolina medical professional credentialing problem needs immediate clarification for all forms of telemedicine delivery."

The very nature of telemedicine and telepsychiatry means the delivery of care is not confined within a state's borders. For a psychiatrist licensed and located in another state to provide telepsychiatry services here in North Carolina, currently that psychiatrist must also have a license to practice medicine in this state as well. A license is required in both states. This debate occurs at the crossroads of globalization and protectionism.

When we asked a group of stakeholders whether it was time for the N.C. General Assembly to create a legislative study commission to explore whether to ease licensure requirements to allow out-of-state health care providers an exemption to practice telepsychiatry within North Carolina the answer was "no" and really closer to "hell no!"

The comments and concerns included:

"It would weaken the state's ability to regulate physician practice, behavior, and qualifications."

"There are no prohibitions that keep them from applying for an N.C. license."

"This would undermine our goal of connecting N.C. psychiatrists with N.C. patients as a way to develop community capacity and build a service delivery system within the state."

"Clinical decision-making for a patient requires some real knowledge of the environment, services, and local care systems available to the patient."

"Clear understanding of the statutes and local rules, especially our two-exam commitment process, play an important part in clinical decision making."

"North Carolina will not be able to keep and attract needed psychiatric physicians if we are not working hard to build the work force in the state."

"There are too many companies using a business model to sign on as many psychiatrists as they can, help them procure medical licenses in

"In hospitals, there is also an issue related to granting medical staff membership and privileges. The Medicare Conditions of Participation and the Joint Commission Standards for Accreditation both require that each physician be evaluated through a prescribed process before receiving privileges to care for patients and periodically thereafter. Granting privileges solely on the basis of licensure, even if in-state, is specifically forbidden. There must be procedures in place for checking performance history, education, experience, track record, malpractice settlements, etc. In my experience, this process is very important to maintaining quality."

— Bob Morrison, Retired President/CEO, Randolph Hospital, and Board Member, N.C. Center for Public Policy Research

"The down side of teleservices is the loss of face-to-face interaction. It can be difficult to build trust. This can compound disposition problems when there is a disagreement. Overall, though, I would say that the utilization of telepsychiatry has been an asset. Initial disposition plans are established quickly. Patient medications can be actively managed. The telepsychiatry notes are available for all providers to review. My hope for the future of telepsychiatry is that it can be expanded to local clinics, not just emergency departments. The service should be expanded to agencies such as mobile crisis units to assist with stabilization as a crisis is occurring with the patient in the community."

— Dr. Jody Osborne, Director of the Emergency Department at Randolph Hospital

a dozen states, and then sell telemedicine contracts across the country."

"Any change to state medical licensing should apply to all physicians, regardless of specialty. Psychiatrists should not be singled out."

"How will the state medical board oversee quality of care for physicians without the state licensing board doing it?"

In October 2013, the *New England Journal of Medicine* reported that the ratio of debt at graduation from medical school to starting income is highest for family medicine and then psychiatry followed by emergency medicine, obstetrics and gynecology, general surgery, anesthesiology, radiology, cardiology and orthopedics. Robin Huffman, the executive director of the N.C. Psychiatric Association, says, "The widespread introduction of telemedicine will further distort the career choices made by primary care physicians and may undermine the goal of developing community capacity and building a service delivery system within the state."

According to an article written by Dr. Sy Saeed of the Brody School of Medicine at ECU, for more than 20 years, experts have suggested the following recommendations to address this problem of needing dual licensure: (1) a national licensing system, (2) assigning the responsibility of care to the referring physician, with the consulting physician's opinion treated as a recommendation, and/or (3) deeming the patient to have been "electronically transmitted" to the consultant's state — which conjures up an image of the Star Trek captain's command, "Beam Me Up, Scotty."

While the Center understands the concerns expressed about out-of-state providers, the comments assume that there is enough interest from licensed physicians in this state to meet the demand for telemedicine. If that is not true, this question warrants a public and transparent conversation with all stakeholders included at the table.

Sources:

David Asch *et al.,* "Are We in a Medical Education Bubble Market?," *New England Journal of Medicine,* October 2013, Figure 1, p. 2. On the Internet at *http://www.nejm.org/doi/pdf/10.1056/NEJMp1310778*, accessed November 5, 2013.

Sy Saeed *et al.,* "Telepsychiatry: Overcoming barriers to implementation," *Current Psychiatry,* Vol. 11, No. 12, December 2012, p. 30.

Barriers to Patients

Patients don't know about it. Patients usually learn about new services and procedures through physician referrals. Research has shown that "patients are likely to use telemedicine if their healthcare providers recommend it." However, telemedicine is used mostly by specialists currently, so many patients are not aware of the service.[19]

Patients worry about privacy. The telemedicine literature review notes that "patient uncertainty about privacy protections [is] another frequently highlighted barrier to diffusion of telemedicine."[20]

Benefits of Telepsychiatry

1. Travel time is reduced or eliminated.
2. Telehealth equipment costs have plummeted.
3. Patients in distress can be seen more quickly, reducing relapse events.
4. Consultations with off-site specialists can be quickly carried out.
5. Off-site and part-time behavioral health specialists can be members of the clinic team via telehealth.
6. Staff can meet and collaborate more easily, especially when connecting staff located at various sites.

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, "Increasing Access to Behavioral Health Care Through Technology," Meeting Summary, March 30, 2012, Rockville, MD, published February 2013, p. 3.

Older patients may be uncomfortable with technology. Some elderly patients tend to be more socially isolated as they age. Therefore, the personal, face-to-face interaction of a traditional office visit has extra meaning. Additionally, elderly patients are typically not as comfortable with "computer-assisted technologies."[21]

Barriers for Health Care Providers

What is the standard of care? Are there risks of malpractice lawsuits and liability for violating privacy laws? An important concern for providers is having an accepted standard of care for telemedicine services and protection from malpractice liability. The question is whether delivering health care services through tele-technologies should require new standards. In Canada, for example, there is consensus that new standards are not required.[22] In North Carolina, telepsychiatry providers and psychiatrist will be required to carry liability insurance. Minimum coverage for providers will be $1 million to $3 million, and minimum coverage for consultant and referring sites will be $3 million to $5 million. "The liability will reside as it usually does within the medical practice or individual provider."[23] Additionally, the "nature of IT technologies used in transmitting personal medical records creates heightened concern …" regarding complying with privacy laws.[24]

"I love [telepsychiatry] because it's real health care reform, and it changes the way health care is delivered. This is an innovative way to provide care."

— Rep. Susan Martin (R-Wilson), as quoted in *The News & Observer*

What are the costs? Incorporating telemedicine into a medical practice can require a significant up-front investment of capital and resources.[25] According to the website of the American Academy of Child and Adolescent Psychiatry, "A wide range of video systems are used for telepsychiatry practice. They vary in cost of the system, the cost of use and in the degree of resolution of the video image. More expensive systems use personal computers, video cameras at both ends of the connection, computer based video monitors and ISDN cable wiring between sites."[26] The Fiscal Research Division of the N.C. General Assembly estimates $9,000 for consultant desktop units and $19,000 for mobile telemedicine carts.[27] However, as security and privacy concerns are addressed

through advances in technology, the use of iPads, for instance, in telemedicine may lower the costs of this type of service.

Will the psychiatrists get paid? Typically, psychiatrists are reimbursed based upon "patient encounters," which is defined as the patient and provider being in the same room when care is given.[28] With telepsychiatry services, the patient and provider are not in the same room and may even be hundreds of miles apart. In the best case scenario, getting reimbursement for a telepsychiatry consultation may require some additional paperwork, and it will cover an assessment for a diagnosis, medication management, and psychotherapy.[29] In the worst case, it means that providers may not get paid. The American Psychiatric Association suggests "reimbursement for telepsychiatry should follow customary charges for delivering appropriate current procedural terminology code(s)," and "a structure for reimbursement of collateral charges, such as technician and line time…."[30] According to the National Conference of State Legislatures, 19 states require private insurance plans to cover telehealth services. Blue Cross Blue Shield of North Carolina opposes *mandatory* reimbursement policies for telemedicine.

"There will never be a virtual substitute for the human touch or voice in promoting healing. Thus, an even greater role exists for physician extenders who know their business."

— Former Rep. Jim Fulghum (R-Wake), Physician

However, restrictions on telemedicine reimbursements are easing. Some states, including North Carolina, have led the way in including telemedicine and telepsychiatry as billable Medicaid services.[31] "Medicare started reimbursing providers for telemedicine in 1999,"[32] and Medicaid now pays for telepsychiatry in 40 states.[33] "We've opened it up a lot, so traditional services can be provided by telepsychiatry and billed under Medicaid," says Dr. Michael Lancaster, former chief of clinical policy for the state Division of Mental Health, Developmental Disabilities and Substance Abuse Services. "That has yet to really move into the private sector. We really would like to see third party payors be more supportive of telepsychiatry."

Office of the Governor

Aldona Wos, Secretary of the N.C. Department of Health and Human Services (standing), and Governor Pat McCrory at ECU in August 2013

Office of the Governor

"No matter where you live in North Carolina, you will soon have better access to mental health providers with the expansion of telepsychiatry across our state. Technology will help us connect people with appropriate treatment programs so patients can avoid long waits in the emergency room. North Carolina can be a national leader with this program."

— Governor Pat McCrory

North Carolina's New Statewide Telepsychiatry Initiative

Awareness of these barriers to patients and mental health providers will help the state implement a statewide telepsychiatry system worthy of national recognition. In July 2013, the N.C. General Assembly established a statewide telepsychiatry program in North Carolina.[34] The North Carolina Statewide Telepsychiatry Program (NC-STeP) is administered by East Carolina University's Center for Telepsychiatry and e-Behavioral Health (CTeB). It will be substantially similar to the Albemarle Hospital Foundation Telepsychiatry Project. The legislature appropriated $2 million for the program for Fiscal Year 2013–14 and $2 million for 2014–15.

In August 2013, the N.C. Department of Health and Human Services presented a plan to the legislature to implement a statewide telepsychiatry program. Initially, the primary objective of the program is to improve access to telepsychiatry in hospital emergency rooms across the state.[35] Many stakeholders participated in a year-long process to develop the plan. See Table 3 for members of the N.C. Telepsychiatry Program Advisory Group.[36]

NC-STeP NORTH CAROLINA STATEWIDE TELEPSYCHIATRY PROGRAM

The state's new statewide telepsychiatry initiative launched on January 1, 2014.[37] By May 2014, 24 hospitals were participating in the state's telepsychiatry program. An additional 23 hospitals are scheduled to begin participating between June and September 2014. These 47 hospitals will serve 53 counties. Thirty additional hospitals are on the waiting list and are likely to join the program between November 2014 and June 2015. When these 30 hospitals participate, the program will serve 81 counties across North Carolina.[38]

Under the direction of Dr. Sy Saeed, and with the assistance of Phil Donahue and Sheila Davies who are both now on contract with ECU to facilitate the implementation

"The goal should not be about increasing the number of patients seen by telemedicine. Patients should receive the appropriate medical care quickly — be it in person or using a television screen."

— Robin B. Huffman, Executive Director, N.C. Psychiatric Association

N.C. Psychiatric Association

Table 3. North Carolina Telepsychiatry Program Advisory Group

Name	Title	Organization
Bryan Arkwright	Director, Center for Telehealth	Mission Health System
Victor Armstrong, MSW	Behavioral Medicine Program Manager	Alamance Regional Medical Center
Henry Boyd	Health Information Technology Coordinator	N.C. Office of Rural Health and Community Care
Chris Collins	Director	N.C. Office of Rural Health and Community Care
Robin Cummings, MD	Director of the Division of Medical Assistance and Deputy Secretary for Health Services	N.C. Department of Health and Human Services
Sheila Davies	Program Implementation	Brody School of Medicine at East Carolina University
Phil Donahue	Program Implementation	Brody School of Medicine at East Carolina University
Roy Gilbert	Health Information Technology Manager	N.C. Office of Rural Health and Community Care
Jay Kennedy	Rural Hospital Program Manager	N.C. Office of Rural Health and Community Care
Mike Lancaster, MD	Medical Director, Behavior Health Program	North Carolina Community Care, Inc.
Lynn Lanier	Chief Financial Officer	Vidant Community Hospitals
Nena Lekwauwa, MD	Medical Director and Chief of Clinical Policy	N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
Donald Rosenstein, MD	Professor, Departments of Psychiatry and Medicine	University of North Carolina Medical Center
Sy Saeed, MD	Professor and Chairman, Department of Psychiatric Medicine	Brody School of Medicine at East Carolina University
Steve Scoggins	President, CareNet	Wake Forest Baptist Health
Wayne Sparks, MD	Assistant Medical Director, Psychiatric Emergency Services	Carolinas Medical Center
Marvin Swartz, MD	Director, Behavioral Health	Duke University Medical Center
Mike Vicario	Vice President of Regulatory Affairs	N.C. Hospital Association
Leza Wainwright	Chief Financial Officer	East Carolina Behavioral Health

Source: Roy Gilbert, N.C. Office of Rural Health and Community Care

Man with Many Struggles Gets Help and His Family Back

By Carol Villareal, RHA Behavioral Health Services

RHA Behavioral Health Services is a Critical Access Behavioral Health Agency, or CABHA, that provides mental health and substance abuse services to people in rural and frontier counties.

"Mr. T" is a 63-year-old man diagnosed with generalized anxiety disorder and alcoholism in remission. He has chronic osteoarthritis, back pain, hearing loss, gout, hypertension, and hyperlipidemia. He presented to the Ocracoke Health Clinic for a routine checkup and told the medical staff he was depressed. They referred Mr. T to RHA Behavioral Health Services for psychiatric evaluation and therapy.

He was known as the "scary guy" on the island. No one wanted to go near him. "I was plum crazy," says Mr. T. "I'd forget to take my medicine and didn't sleep much. I stayed away from people, had no friends, and was always angry. I worried about everything and got angry when the Ocracoke tourists walked in the middle of the street. I felt guilty that I didn't get along with my ex-wives, kids, and relatives. I messed things up with too much drinking. I just wanted some help to get better."

Over a six-month period, Mr. T actively participated in the telepsychiatry service and was involved with medication management. He has been active in counseling, had his medication changed, and has implemented a routine so he is less forgetful and more focused. He is much happier and has rekindled his relationship with his family. He also began positive communications with his ex-wives and, at times, they also support him by sitting in the waiting room at the clinic when he comes in for services.

He is now involved with his family and grandchildren and welcomed with delight in the community and at the health clinic. Although he has experienced some hiccups in his treatment, Mr. T has gotten back on track with the support of his family, the clinic, and the medical and mental health teams. He has risen up to be part of his community, as well as part of his most precious treasure—his family.

Ocracoke Health Clinic

Mebane Rash

of the statewide telepsychiatry network,[39] ECU's Center for Telepsychiatry is required to develop and administer an oversight process. The process will include quality management as well as the monitoring and reporting of outcomes for the state's telepsychiatry program. Currently, the Center for Telepsychiatry is required to report quarterly and annually to the DHHS Office of Rural Health and Community Care on (a) the number of consultant sites and referring sites participating in the program, (b) the number of psychiatric assessments conducted under the program, reported by site or region, (c) the length of stay of patients receiving telepsychiatry services in the emergency rooms of hospitals participating in the program, reported by disposition, and (d) the number of involuntary commitments (IVCs) as a result of telepsychiatry assessments, reported by site/region and year, compared to the number of IVCs prior to implementation of this program. Additionally, all clinical providers are required to participate in a peer review process.

"It is not about technology. It is about relationship."

— Dr. Sy Saeed, Chairman of the Department of Psychiatric Medicine, Brody School of Medicine, East Carolina University

East Carolina University

. . .

Gwen Newman, a patient that uses telepsychiatry in Hyde County, says, "Driving an hour and a half to go to the doctor or to get one of my family members there is exhausting and frustrating. This telemedicine program makes a huge difference for all of us. I know we're healthier because of it."[43] That's the promise of telepsychiatry…mental health care comes to you, even if you live in rural North Carolina.

The Use of Telepsychiatry in Prisons

In 2008, a group of doctors at ECU's Department of Psychiatric Medicine at the Brody School of Medicine conducted a 50-year literature review of the use and effectiveness of telepsychiatry in correctional settings. They concluded "telepsychiatry seems to be an appropriate option to provide services to patients in correctional facilities in order to improve access to psychiatric services." There are two important distinctions to note in the provision of telepsychiatry in correctional settings: the lack of privacy for inmates given the security concerns and need to have staff present during the sessions, and the importance of clearly communicating the limits of the physician/patient relationship. The doctors made recommendations for the long-term development of telepsychiatry in correctional settings, including:

Fostering pilot projects in telepsychiatry, particularly utilizing evidence-based approaches;

Considering telephone services where teleconferencing cannot be implemented;

Looking to other states' telepsychiatry programs to develop guidelines and best practices; and

Identifying the technology infrastructure needs, and then creating and implementing a plan to meet these needs, leveraging federal dollars where available.

Source: Drs. Diana Antonacci, Richard M. Bloch, Sy Saeed, *et al.,* "Empirical Evidence on the Use and Effectiveness of Telepsychiatry via Videoconferencing: Implications for Forensic and Correctional Psychiatry," *Behavioral Sciences and the Law,* Vol. 26, Issue 3, May/June 2008, pp. 265–69.

The Center's Findings and Recommendations

Based on our research, the N.C. Center for Public Policy Research finds that for many people living in rural North Carolina, access to mental health care is the biggest barrier to recovery. Telepsychiatry will increase access to treatment across the state, and it may reduce the amount of time patients have to wait in emergency rooms for treatment, reduce the likelihood that patients will have to return for treatment, reduce the number of involuntary commitments to hospitals for psychiatric care, and reduce readmissions to psychiatric hospitals for those with severe and persistent mental illness. Patient satisfaction with telepsychiatry appears to be high. Dr. Sy Saeed says he has found no evidence that "patient satisfaction or outcomes with telepsychiatry are inferior to those seen in comparable face-to-face treatment.

Based on our findings, the N.C. Center for Public Policy Research recommends that the Governor, the N.C. General Assembly, the Office of Rural Health and Community Care in the N.C. Department of Health and Human Services (DHHS), and the N.C. Telepsychiatry Program Advisory Group consider the following actions to implement the state's new telepsychiatry program and make it a national model:

1. **The Office of Rural Health and Community Care in the N.C. Department of Health and Human Services and East Carolina University's Center for Telepsychiatry should conduct a public campaign to raise awareness about telepsychiatry in rural and underserved communities.** This should include patient stories that specifically address patient concerns about their privacy, the confidentiality of their personal health information, and any discomfort older adults may feel about technology.
2. **The DHHS Office of Rural Health and Community Care should provide technical information directly to rural health care providers and health centers describing expected costs, funding sources, legal restrictions, and clear reimbursement rates for telepsychiatry services.**
3. **The N.C. General Assembly should pass legislation requiring a study of telemedicine, including whether private insurers should be required to fully reimburse health care providers for telepsychiatry services.** House Bill 704, which passed the N.C. House in 2013 and is pending in the Senate for the 2014 legislative session, would require the Joint Legislative Oversight Committee on Health and Human Services to conduct a study of telemedicine. According to the state's plan, this bill would be "a first step for possible enactment of legislation to require full payment by third party payors for services provided via telemedicine."[40] The Legislative Research Commission Study Committee on Health Care Provider Practice Sustainability and Training/Additional Transparency in Health Care is conducting a "comprehensive review of all existing State programs that are designed to improve access to health care provider care using telemedicine, including the name of the program, a description of the program, and details on program performance."[41] The commission may make an interim report of recommendations to the 2014 legislature and is required to make a final report to the 2015 legislature. According to the National Conference of State Legislatures, 19 states (not including North Carolina) require private insurance plans to cover telehealth services.
4. **The DHHS Office of Rural Health and Community Care should provide technical and financial assistance to rural health care providers who want to incorporate telepsychiatry into their practices.** The Office should assess the need for a one-time subsidy to hospitals, community health departments, and rural providers to update their telecommunication capabilities. If needed, the legislature should appropriate funds to implement the subsidy. The Mental Health Subcommittee of the Joint Legislative Oversight Committee on Health and Human Services recommended in a March 2014 report that the legislature provide funding to expand the telepsychiatry program to primary care providers. In April 2014, the Joint Legislative Oversight Committee on Health and Human Services included this recommendation in its report to the N.C. General Assembly.

5. **The N.C. General Assembly should increase funding to the state's medical schools, nursing programs, schools of social work and psychology programs, as needed, to incorporate telemedicine and telepsychiatry as part of the their curriculum.** The UNC Board of Governors should decide where to focus the funding, which programs will take a leadership role, and the number of campuses involved.
6. **The DHHS Office of Rural Health and Community Care should partner with medical schools in North Carolina to incorporate telepsychiatry into the residency programs at East Carolina University, Duke University, UNC-Chapel Hill, and Wake Forest University and partner with local Area Health Education Centers (AHECs) to connect psychiatric residents under appropriate faculty supervision with rural providers via centralized telepsychiatry services.**
7. **As part of its implementation of North Carolina's statewide telepsychiatry program, the N.C. Department of Health and Human Services should adopt in its rules the practice guidelines for video-based online mental health services developed by the American Telemedicine Association in May 2013.**[42] The Association established these practice guidelines and technical standards for telemedicine, based on clinical and empirical evidence, "to help advance the science and to assure the uniform quality of service to patients." These guidelines serve as both a reference guide for operations and an educational tool to provide appropriate care for patients. Implementing these guidelines for telepsychiatry will improve clinical outcomes and ensure informed and reasonable patient expectations.
8. **The N.C. Department of Health and Human Services should develop criteria and outcome measures to evaluate the successes and failures of the state's telepsychiatry program.** Currently, ECU's Center for Telepsychiatry is required to develop and administer an oversight process, including quality management as well as monitoring and reporting of outcomes for the state's telepsychiatry program. The Center for Telepsychiatry is already required to report quarterly and annually to the DHHS Office of Rural Health and Community Care on (a) the number of consultant sites and referring sites participating in the program, (b) the number of psychiatric assessments conducted under the program, reported by site or region, (c) the length of stay of patients receiving telepsychiatry services in the emergency rooms of hospitals participating in the program, reported by disposition, and (d) the number of involuntary commitments as a result of telepsychiatry assessments, reported by site/region and year, compared to the number of involuntary commitments prior to implementation of this program. Additionally, all clinical providers are required to participate in a peer review process.

   ECU's Center for Telepsychiatry also should be required to track and report these additional outcomes: (a) satisfaction of emergency room staff, the psychiatrist, and the patient, and (b) recidivism data on the number of patients who return to the emergency room within 30 days.

   The DHHS Office of Rural Health and Community Care should implement its goals for the telepsychiatry program, including among others increasing the number of patients served with telepsychiatry, reducing the average length of stay of telepsychiatric patients in the emergency departments of local hospitals and state psychiatric hospitals, increasing the number of psychiatrists and psychiatric residents trained to use telepsychiatry, and reducing the cost of mental health care. The Office should adopt additional outcome measures that evaluate: (a) whether the patients' mental health status actually improves; (b) whether involuntary commitments from telepsychiatric patients are reduced; and (c) whether more patients are served after the state's telepsychiatry initiative is implemented than was true before; and (d) especially whether more are served in rural counties or in medically underserved areas.

Endnotes

[1] These counties currently are served by East Carolina Behavioral Health, a managed care organization that oversees the provision of mental health services, serving 19 counties.

[2] N.C. Department of Health and Human Services, "Mental Health Crisis Management Report, March 2013-May 2013: Status Report," Raleigh, NC, October 1, 2013, p. 7. On the Internet at *http://www.ncleg.net/documentsites/committees/JLOCHHS/Handouts%20and%20Minutes%20by%20Interim/2013–14%20Interim%20HHS%20Handouts/October%208,%202013/Reports/LME%20Crisis%20Report-10-01-2013.pdf*, accessed October 20, 2013. Wait times reported in this report are more than those reported in the one-month study conducted in November 2010. This report found that during fiscal year 2009–10, 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 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. 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," Raleigh, NC, March 1, 2011, pp. 3–5.

[3] A pilot program in western North Carolina uses sitters instead of law enforcement for high acuity patients. The cost in fiscal year 2011 was $503,494 rising to $642,498 in FY 2012 and $671,168 projected for FY 2013. Mission Health Hospital, "North Carolina's Mental Healthcare Crisis and the Resulting Challenges Facing Mission Hospital," July 2013, p. 10.

[4] See also N.C. Department of Health and Human Services, "Statewide Telepsychiatry Program Plan," Raleigh, NC, August 15, 2013, pp. 9, 11. On the Internet at *http://governor.nc.gov/sites/default/files/TelepsychiatryProgramPlan.pdf*, accessed on August 21, 2013.

[5] *Ibid*., pp. 10–11. For more information on program outcomes, see Sheila Davies, Telepsychiatry Program Director, Albemarle Hospital Foundation, "A Hospital Driven Telepsychiatry Initiative to Improve Patient Care and Reduce Costs," *North Carolina Medical Journal,* Vol. 73, No. 3, May/June 2012, p. 228.

[6] On the Internet at *http://www.state.sc.us/dmh/telepsychiatry/*, accessed on September 19, 2013.

[7] Store-and-forward technology involves clinical information (for example, data, image, sound, or video) that is created, stored, then forwarded to another provider for clinical evaluation using email, for example. On the Internet at *http://www.telehealth.va.gov/sft/*, accessed September 20, 2013.

[8] Henry Smith and Roland A. Allison, Telemental Health: Delivering Mental Health Care at a Distance: A Summary Report, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, Washington, DC, 1998, p. 29.

[9] On the Internet at *http://www.psychiatry.org/practice/professional-interests/underserved-communities/telepsychiatry*, accessed on August 23, 2013.

[10] On the Internet at *http://www.hrsa.gov/ruralhealth/about/telehealth/*, accessed on August 23, 2013.

[11] On the Internet at *http://hpsafind.hrsa.gov/HPSASearch.aspx*, data as of August 22, 2013. See also N.C. Department of Health and Human Services, "Fact Sheet: Using Technology to Take on NC's Toughest Mental Health Challenges." On the Internet at *http://governor.nc.gov/sites/default/files/Telepsych%20Fact%20Sheet.pdf*, accessed on August 21, 2013.

[12] Smith and Allison, note 8 above, p. 22.

[13] On the Internet at *http://www.psychiatry.org/practice/professional-interests/underserved-communities/telepsychiatry*, accessed on August 23, 2013.

[14] *Ibid*.

[15] Sy Saeed, MD, *et al.*, "Telepsychiatry: Overcoming barriers to implementation," *Current Psychiatry*, Vol. 11, No. 12, December 2012, p. 29.

[16] Lee Ann Blackmon, H. Otto Kaak, and John Ranseen, Consumer Satisfaction With Telemedicine Child Psychiatry Consultation in Rural Kentucky, *Psychiatric Services,* Arlington, VA, November 1997, Vol. 48, No. 11, pp. 1464–66.

[17] William D. Leach, "If You Bill It, They Will Come: A literature review on clinical outcomes, cost-effectiveness, and reimbursement for telemedicine," California Telemedicine and eHealth Center, Sacramento, CA, January 2009, pp. 3–6.

[18] John C. Fortney, Jeffrey M. Pyne, Mark J. Edlund, David K. Williams, Dean E. Robinson, Dinesh Mittal, and Kathy L. Henderson, "A Randomized Trial of Telemedicine-based Collaborative Care for Depression," *Journal of General Internal Medicine,* Washington, DC, 2007, p. 1090.

[19] Leach, note 17 above, p. 8.

[20] *Ibid*.

[21] *Ibid*.

[22] *Ibid*., p. 9.

[23] Statewide Telepsychiatry Program Plan, note 4 above, p. 14.

[24] Leach, note 17 above, p. 9.

[25] *Ibid*.

[26] John Sargent, MD, and Meredith Sargent, Ph.D., on the Internet at *http://www.aacap.org/aacap/Medical_Students_and_Residents/Mentorship_Matters/DevelopMentor/Telepsychiatry.aspx*, accessed on September 19, 2013.

[27] Legislative Fiscal Note for House Bill 580 (First Edition), May 24, 2013, p. 2.

[28] David Brantley *et al.*, Innovation, Investment and Demand in Telehealth, U.S. Department of Commerce Office of Technology Policy, February 2004, p. 73.

[29] Sy Saeed, MD, *et al.*, note 15 above.

[30] *Ibid*., p. 30, citing a resource document on telepsychiatry via videoconferencing of the American Psychiatric Association that is not available online anymore.

[31] Brantley *et al.*, note 28 above, p. 74.

[32] Saeed *et al.*, note 15 above, p. 29.

[33] On the Internet at *http://www.securetelehealth.com/medicaid-reimbursement.html*, accessed on August 21, 2013.

[34] N.C. Session Law 2013–360, Senate Bill 402 §12A.2B(a), p. 149.

[35] Statewide Telepsychiatry Program Plan, note 4 above, p. 7.

[36] *Ibid*., p. 23. The N.C. Telepsychiatry Work Group led to the creation of the North Carolina Telepsychiatry Program Advisory Group. See Table 3.

[37] *Ibid*., p. 11.

[38] Emails from Sheila Davies, former telepsychiatry project director of the Albemarle Hospital Foundation, on Oct. 29, 2013 and May 28, 2014.

[39] Email from Phil Donahue, former vice president of the Albemarle Hospital Foundation, on Oct. 30, 2013.

[40] Statewide Telepsychiatry Program Plan, note 4 above, p. 15.

[41] Letter from Sen. Phil Berger, President Pro Tempore of the N.C. Senate, and Rep. Thom Tillis, Speaker of the N.C. House of Representatives, to Sen. Tom Apodaca and Rep. Tim Moore, Co-Chairs of the 2013–14 Legislative Research Commission, on October 29, 2013.

[42] On the Internet at *http://www.americantelemed.org/practice/standards/ata-standards-guidelines/practice-guidelines-for-video-based-online-mental-health-services*, accessed on August 23, 2013.

[43] Annual Report, Albemarle Hospital Foundation, 2012, p. 4. On the Internet at *http://www.albemarlehealth.org/wp-content/uploads/2013/04/AHFoundationAnnual201212.pdf*, accessed on August 23, 2013.

Dorothea Dix Hospital

Aisander Duda

North Carolina Considers Building Fourth State Psychiatric Hospital

By Mebane Rash

In its January 2013 report to the N.C. General Assembly, the Joint Legislative Oversight Committee on Health and Human Services included the following recommendation for the state to explore the costs and feasibility of building a new state psychiatric facility:

RECOMMENDATION 1:
Explore Costs and Feasibility of New Psychiatric Facility:

The Joint Legislative Oversight Committee on Health and Human Services encourages the General Assembly to direct the Department of Health and Human Services to (i) determine the cost of increasing the number of beds in State psychiatric hospitals, (ii) explore the possibility of creating a south central mental health region to include at least Anson, Cabarrus, Davidson, Mecklenburg, Montgomery, Moore, Randolph, Richmond, Rowan, Scotland, Stanly, and Union counties, and (iii) investigate the possibility of placing a new psychiatric facility in this region of the State. The Department shall provide a written report to the Joint Legislative Oversight Committee on Health and Human Services no later than April 1, 2013.[1]

On April 1, 2013, the N.C. Department of Health and Human Services (DHHS) submitted its report on the costs and feasibility of building a new state psychiatric facility to the Mental Health Subcommittee of the Joint Legislative Oversight Committee on Health and Human Services.[2]

Filed on April 17, 2013, House Bill 981 would appropriate the funds for a new state psychiatric hospital in the south central region of the state. It was referred to the Appropriations Committee in the N.C. House.[3]

Based on our research on mental health reform, the Center recommends that the state develop a methodology that provides a consistent way to determine the required ratio of psychiatric beds to population that would adequately serve diverse areas of the state.[4]

As the state considers whether to build a fourth state psychiatric hospital, the Center recommends that the state first determine (a) how many short-term and long-term beds are needed in North Carolina, (b) what kinds of beds are needed, (c) where those beds should be located, and (d) what type of facility would best serve the needs of mental health patients. Other options should also be considered.

How Many Beds Are Needed?

Dr. Marvin Swartz at Duke and Dr. Joseph Morrissey at the Sheps Center for Health Services Research at UNC-Chapel Hill, wrote in the *North Carolina Medical Journal*, "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. 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."[5]

Some experts contend that states need 50 psychiatric beds per 100,000 people.[6] DHHS says that number is too high, and the staff suggests a range of 22–31 per 100,000.[7] In 2014, North Carolina has 28.4 beds per 100,000 (2,770 total psychiatric beds, including adult and child beds, and including state and community beds).[8]

What Kind of Beds?

Once the state knows how many psychiatric beds are needed, the next question is what kind of beds?

If the need is for additional *short-term crisis treatment beds*, then the state should consider expanding the three-way bed contracts first. These are beds that the state purchases at local hospitals to treat mental health patients in short-term crisis.[9]

If *longer-term public beds* are needed, then it is prudent, as the DHHS report suggests, to maximize capacity at the existing state psychiatric hospitals first.[10] In February 2014, the three state psychiatric hospitals were funded for 892 beds, and it is expected that by 2015 capacity could expand to 1,137 beds if funded.[11]

Where To Locate the Beds?

The next question is where to locate the beds. As instructed by the Joint Legislative Oversight Commission, the DHHS report only considers the south central region of North Carolina. Is that the best location given the resources in that region, including a new planned 66-bed unit in Davidson? As the DHHS report notes, admissions for the south central region historically have been lower per

capita than the rest of the state.[12] Mecklenburg County also has the only psychiatric emergency room in the southeastern United States.

The 2014 State Medical Facilities Plan notes a need for additional adult psychiatric hospital beds by 2016 in the Coastal Care Managed Care Organization (serving Brunswick, Carteret, New Hanover, Onslow, and Pender counties), Cumberland County, the Smoky Mountain Managed Care Organization (serving Cherokee, Clay, Graham, Haywood, Jackson, Macon, and Swain counties), and Wake County.[13] Mecklenburg County is projected to have a surplus of beds.

What Type of Facility Would Best Serve Mental Health Patients?

The final question is what type of facility would best serve the needs of mental health patients in North Carolina?

The Center's evaluation of the state's efforts in mental health reform includes research on what kind of mental health facilities North Carolina will need in the future. We are researching approaches in other states — traditional state psychiatric facilities and state psychiatric facilities with community-based components, as well as smaller, regional state facilities. Our researchers visited Michigan, which has opted for a hub-and-spoke design of state facilities — one central state institution with smaller, regional facilities located throughout the state providing a continuum of care. North Carolina might consider building regional crisis facilities supported by the existing state psychiatric hospitals across the state.

Massachusetts has a new state psychiatric hospital that incorporates a building plan emphasizing the phases of recovery. However, this state-of-the-art facility cost $302 million, much more than the $132 million DHHS estimates it would cost to build a new state psychiatric hospital here in North Carolina.[14]

It is important to remember that mental health reform in North Carolina and throughout the United State is premised on the U.S. Supreme Court decision in *Olmstead*, which requires states to treat people with mental disabilities in the *least restrictive setting possible* and in *community settings,* rather than in state institutions.

Massachusetts Department of Mental Health

Worcester Recovery Center and Hospital in Massachusetts opened in August 2012. The design of this 320-bed facility reflects the stages of recovery, encouraging the return to community living as patients progress from their unit or "house," to "neighborhoods" of shared space, to the "downtown" with a bank and gym and other aspects of community living.

Endnotes

[1] Joint Legislative Oversight Committee on Health and Human Services, "Report to the 2013 General Assembly," Raleigh, NC, January 2013, p. 19. On the Internet at *http://www.ncleg.net/documentsites/committees/JLOCHHS/Final%20Reports%20to%20the%20NCGA%20from%20Oversight%20Committee/2013%20Joint%20Legislative%20Oversight%20Committee%20on%20HHS%20Report.pdf,* accessed Feb. 19, 2014.

[2] N.C. Department of Health and Human Services, "Report on Exploring the Costs and Feasibility of New Psychiatric Facility," Raleigh, NC, April 1, 2013. On the Internet at *http://www.ncleg.net/documentsites/committees/JLOCHHS/Final%20Reports%20to%20the%20NCGA%20from%20Oversight%20Committee/2013%20Joint%20Legislative%20Oversight%20Committee%20on%20HHS%20Report.pdf,* accessed on Feb. 19, 2014.

[3] Bill status on the Internet at *http://www.ncleg.net/gascripts/BillLookUp/BillLookUp.pl?Session=2013&BillID=H981*

[4] 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," *North Carolina Insight*, Vol. 23, No. 4/Vol. 24, No. 1, N.C. Center for Public Policy Research, Raleigh, NC, December 2012, p. 85.

[5] 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.

[6] Quinterno, note 4 above, p. 85.

[7] *Ibid*.

[8] Dave Richard, "NC Psychiatric Bed Need v. Capacity," PowerPoint to the Joint Legislative Oversight Committee on Health and Human Services Subcommittee on Mental Health, Raleigh, NC, February 24, 2014, Slide 3.

[9] Quinterno, note 4 above, p. 85.

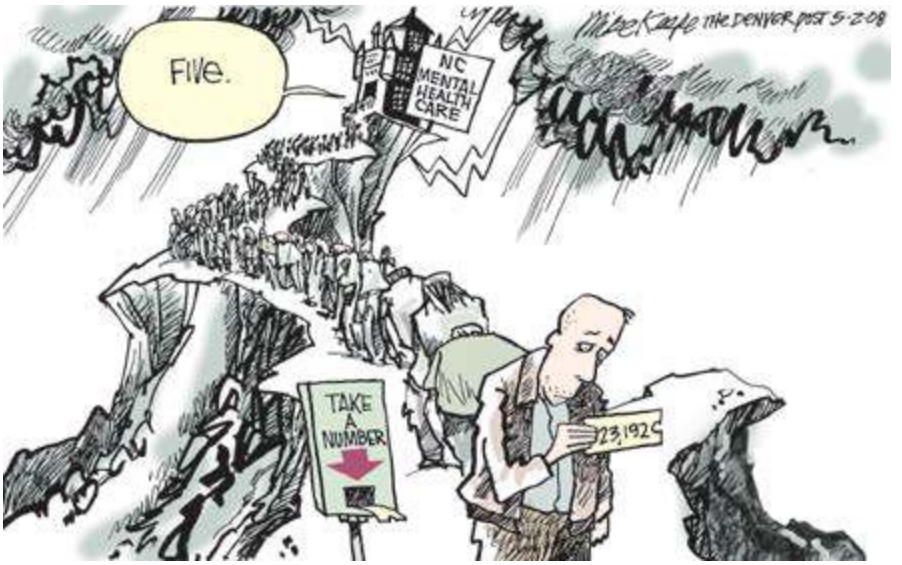
[10] DHHS Report, note 2 above, p. 15.

[11] Richard, note 8 above, Slide 13.

[12] DHHS Report, note 2 above, p. 8.

[13] N.C. Division of Health Service Regulation, "2014 State Medical Facilities Plan," Chapter 15, Table 14, Part 2, Raleigh, NC, January 2014. On the Internet at *http://www.ncdhhs.gov/dhsr/ncsmfp/,* accessed on Feb. 19, 2014.

[14] On the Internet at *http://www.mass.gov/anf/property-mgmt-and-construction/design-and-construction-of-public-bldgs/current-and-completed-projects/human-services-projects/dmh-new-worcester-recovery-center-and-hospital.html,* accessed on Feb. 19, 2014.



An Analysis of the Mental Health Work Force in North Carolina

The Work Force in the N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and in State Facilities

By John Quinterno

Imagine trying to build a company without basic work force information. The state employs more than 10,000 people in its mental health system, and yet until now, basic data about the work force has been unavailable.

In 2008, the Workforce Development Initiative released its report on the mental health work force situation in North Carolina.[1] The report notes that information about the current work force was not available, and therefore the initiative was unable to compare the work force needs against the then-available staff and their skills. The report says: "Ideally, the following information would be available for staff of service providers, of LMEs [local mental health management entities], and the state-operated facilities and central office of the Division: the number of positions by title, number of vacancies, wage range, turnover rate, education/training and experience, and demographics of managerial, administrative, clinical, and direct support staff."

The Center's analysis of the mental health work force in North Carolina is part of our five-year study of mental health reform in North Carolina.[2] This analysis of the work force of the N.C. Division of Mental Health, Developmental Disabilities, and

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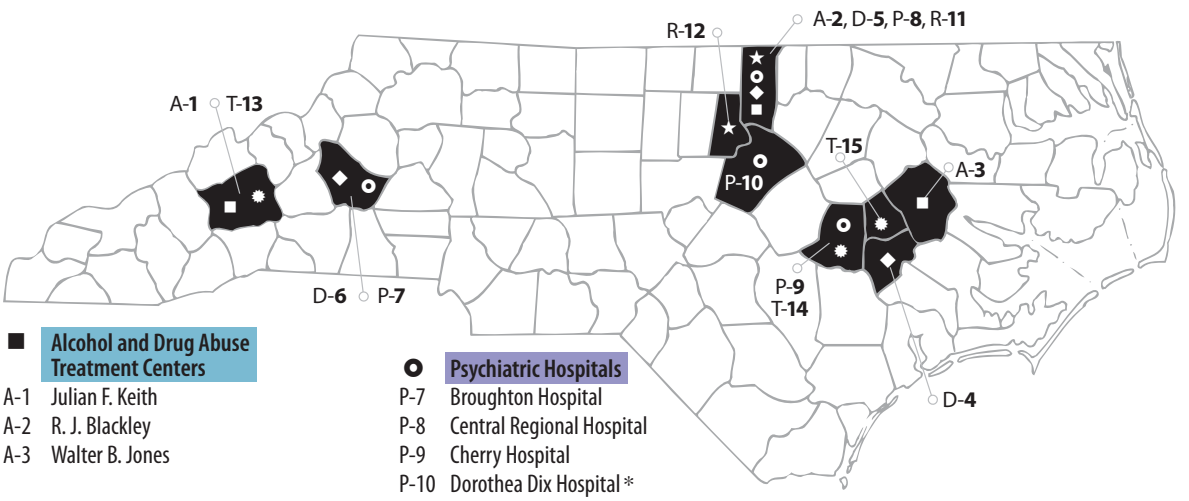
Figure 1:
State of North Carolina Facilities for Treatment of MH/DD/SAS



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

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

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

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 its services to Central Regional Hospital.*

Substance Abuse Services (MH/DD/SAS) and also of the state facilities providing mental health, developmental disability, and substance abuse services. Even after mental health reform, the state has continued to operate inpatient facilities statewide, including three state psychiatric hospitals, three alcohol and drug abuse treatment centers (ADATC), three developmental centers for people with intellectual and developmental disabilities, two residential programs for children, and three neuro-medical treatment centers (NMTC).

Technical Notes

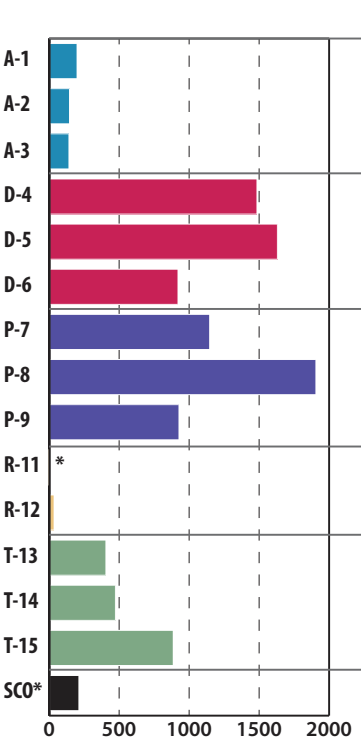
The raw data for this analysis comes from a database prepared by the N.C. Division of MH/DD/SAS based on administrative records. The database merged data from two internal human resource systems.

Database preparation began in summer 2012. The files were submitted to South by North Strategies, Ltd. (SBN) at the end of August 2012. SBN coded and analyzed the data in September 2012. Data review and revision by the Division, SBN, and the Center occurred from December 2012 to February 2013.

In principle, the database provides a count of every employee working in the state facilities and central office and functions like an administrative census. Of course, the quality of the data in the database depends on the quality of the underlying databases. As with any census, the data are for one moment in time. In short, they are a snapshot of the N.C. Division of MH/DD/SAS and Division of State Operated Healthcare Facilities (DSOHF) human resource landscape in summer 2012.[3]

System Overview

As of summer 2012, the N.C. Division of MH/DD/SAS employed 10,564 persons in 13 of the state-operated facilities and in the state central office (SCO). Table 1 presents a count by facility.



Type	Facilities	Number Employed
A-1	Keith ADATC	203
A-2	Blackley ADATC	149
A-3	Jones ADATC	145
D-4	Caswell Developmental Center	1,488
D-5	Murdoch Developmental Center	1,634
D-6	Riddle Developmental Center	924
P-7	Broughton Hospital	1,150
P-8	Central Regional Hospital	1,909
P-9	Cherry Hospital	931
R-11	Whitaker School *	–
R-12	Wright School	39
T-13	Black Mountain NMTC	409
T-14	Longleaf NMTC	477
T-15	O'Berry NMTC	890
SCO	DMH/DD/SAS & DSOHF *	216

Table 1: Distribution of Work Force

Notes:
ADATC=Alcohol and Drug Abuse Treatment Center
NMTC=Neuro-Medical Treatment Center
DMH/DD/SAS= Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
DSOHF=Division of State Operated Healthcare Facilities
SCO=State Central Office
* See footnote 3

Source:
Work Force Database, North Carolina DMH/DD/SAS and DSOHF, Summer 2012

When viewed in terms of broad facility types, 38.3 percent of the work force is in the developmental centers, 37.8 percent in the state psychiatric hospitals, 16.8 percent in neuro-medical treatment centers, 4.7 percent in alcohol and drug abuse treatment centers, 2 percent in the state office, and 0.4 percent in residential facilities for children (see Figure 2).

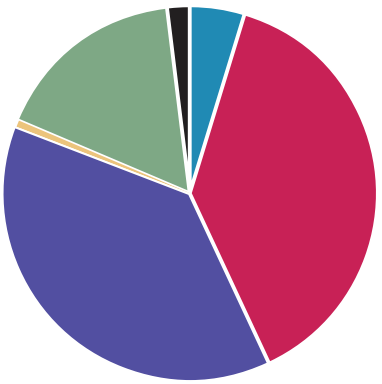


Figure 2: Distribution of Work Force

- 4.7% Alcohol and Drug Abuse Treatment Centers (ADATC)
- 38.3% Developmental Centers
- 37.8% Psychiatric Hospitals
- 0.4% Residential Facilities for Children
- 16.8% Neuro-Medical Treatment Centers (NMTC)
- 2.0% State Central Office

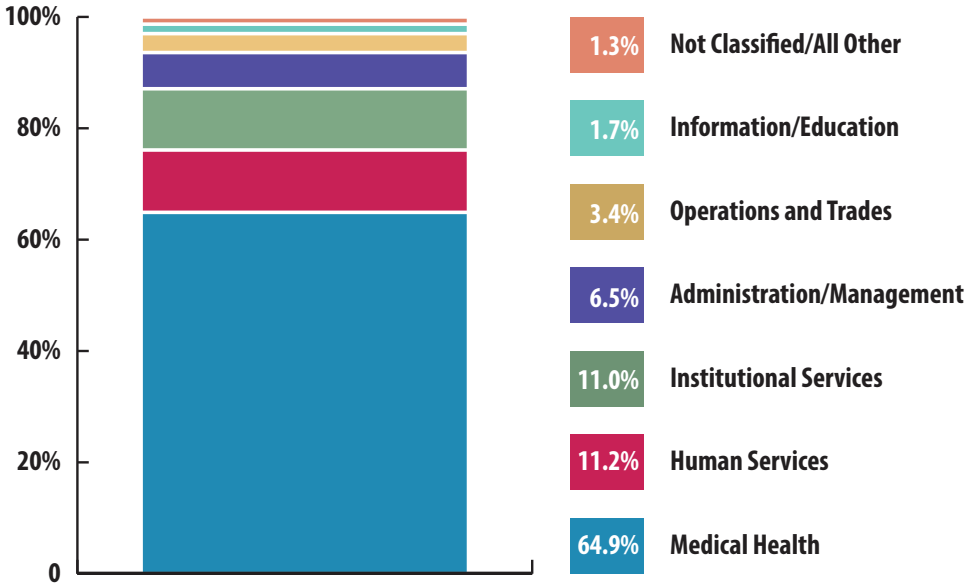
Job Functions

Of the 10,348 persons directly employed in state-operated facilities (excluding state central office employees), 10,018 (96.8 percent) held **full-time** posts, and 330 persons (3.2 percent) held **part-time** posts.

Of the 10,348 persons directly employed in state-operated facilities (excluding state central office employees), 9,553 (92.3 percent) were **non-supervisory** employees, 772 (7.5 percent) were **supervisory employees**, and the remaining 23 positions (0.2 percent) were **unclassified**.

The work force in the state-operated facilities (excluding central administration) divides into eight broad **job families**. The largest family is medical health, which contains 64.9 percent of the work force (see Figure 3).

Figure 3:
Distribution of State-Operated Facilities Work Force, by Job Family



Source: Work Force Database, North Carolina DMH/DD/SAS and DSOHF, Summer 2012

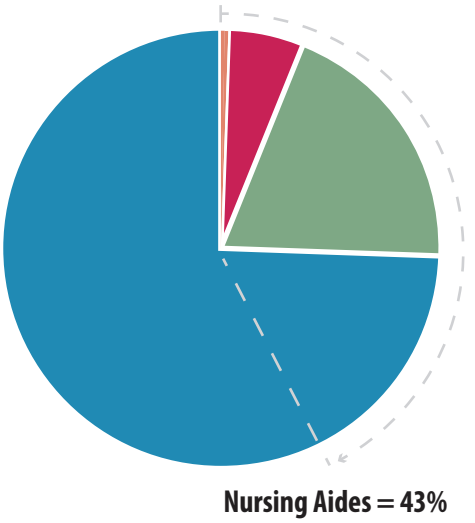


Figure 4:
Distribution of State-Operated Facilities Work Force, by Nursing Job Branch

- 0.3% Medical Health Services Managers
- 5.6% Nurse Practitioners
- 19.4% Registered Nurses
- 74.7% Nursing, Psychiatric, & Home Health Aides

The Division of MH/DD/SAS divides the broad **job families** in the state-operated facilities into 25 **job branches**. The single largest job branch is the nursing job branch (57.8 percent).

The nursing job branch encompasses 10 job titles: five job titles pertain to nursing aides, three to registered nurses, one to nurse practitioners, and one to nurse managers.

Overall, nursing aides account for 43 percent of all employees (see Figure 4).

. . . a lighter look at mental health . . .

"He's a mental-health critic."

Work Force Demographics: Age

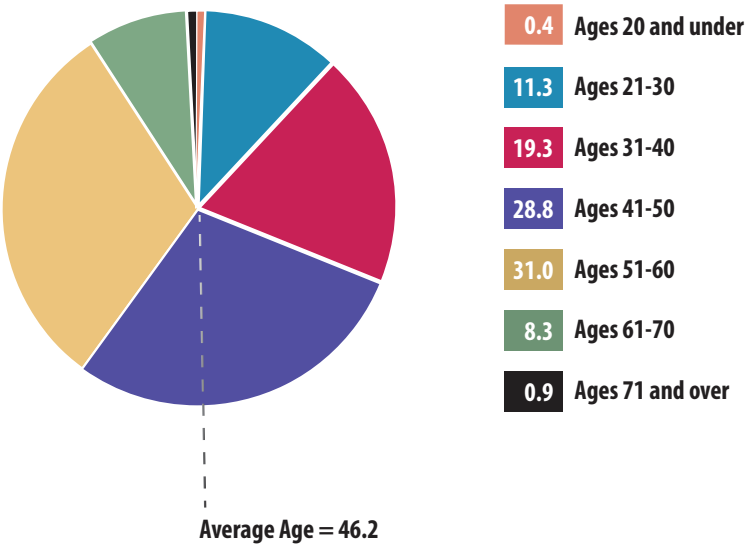
The **median age** of the entire work force (state-operated facilities and central administration) is 48, with an **average age** of 46.2. The **mode** or most typical age is 48.

Thirty-one percent of the work force is between ages 51 and 60, and another 8.3 percent is between ages 61 and 70; altogether, 40.2 percent of the work force is age 51 and older.

Another 28.8 percent of the work force is between ages 41 and 50.

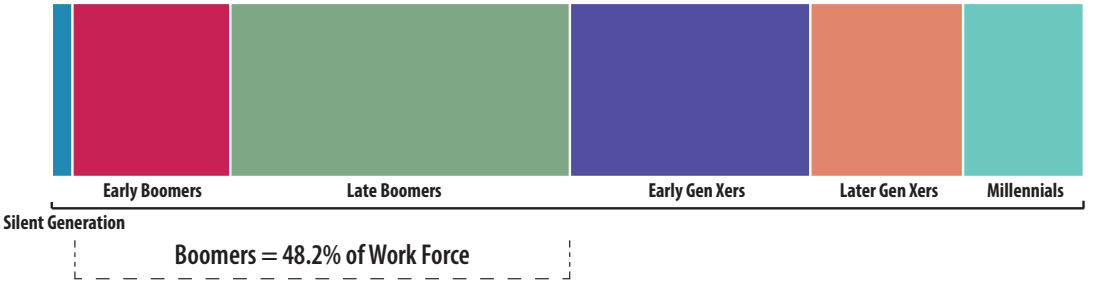
Thirty-one percent of the work force is age 40 or younger (see Figure 5).

Figure 5:
Distribution of Work Force, by Ten-Year Age Bands

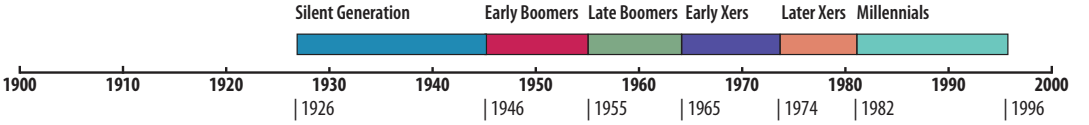


Source: Work Force Database, North Carolina DMH/DD/SAS and DSOHF, Summer 2012

Figure 6:
Distribution of Work Force, by Generational Cohort



Definition of Generational Cohort of Work Force



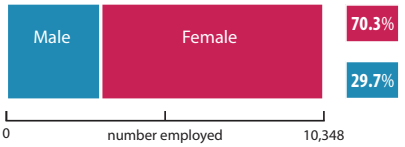
Another way of looking at the age of the work force is in terms of generational cohorts. Seen that way, Baby Boomers account for 48.2 percent of the work force (Figure 6 and Table 2).

Table 2:
Work Force by Generational Cohort

Generation	*Number*	*Percent*
Silent Generation (b. 1926–1945)	211	2.0%
Baby Boomers (b. 1946–1964)	5,095	48.2%
Early Boomers (b. 1946–1954)	1,620	15.3%
Late Boomers (b. 1955–1964)	3,475	32.9%
Generation X (b. 1965–1981)	4,025	38.1%
Early Xers (b. 1965–1973)	2,459	23.3%
Late Xers (b. 1974–1981)	1,566	14.8%
Millennial Generation (b. 1982–1996)	1,233	11.7%
Totals	10,564	100.0%

Source: Work Force Database, North Carolina DMH/DD/SAS and DSOHF, Summer 2012

Work Force Demographics: Gender and Race/Ethnicity



In terms of **gender**, females comprise 70.3 percent of the work force in state-operated facilities (excluding state central office employees), while males comprise 29.7 percent.

In terms of race, 51.1 percent of the employees in state-operated facilities (excluding state central office employees) are non-Hispanic African Americans, followed by non-Hispanic Whites (46.7 percent). Asians are responsible for 1.1 percent of the work force, and Hispanics contribute 0.7 percent (see Figure 7).

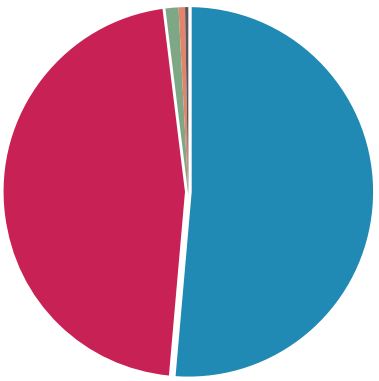


Figure 7:
Composition of State-Operated Facilities Work Force, by Race/Ethnicity

- 51.1% Black/African American (Non-Hispanic)
- 46.7% White (Non-Hispanic)
- 1.1% Asian
- 0.7% Hispanic
- 0.4% All Other

Source: Work Force Database, North Carolina DMH/DD/SAS and DSOHF, Summer 2012

Female	*Number*	*Percent*
Black, Non-Hispanic	3,735	36.1%
White, Non-Hispanic	3,397	32.8%
Asian	69	0.7%
Hispanic	40	0.4%
All Other/Unclassified	31	0.3%
Subtotals	7,272	70.3%

Male	*Number*	*Percent*
Black, Non-Hispanic	1,557	15.0%
White, Non-Hispanic	1,435	13.9%
Asian	49	0.5%
Hispanic	30	0.3%
All Other/Unclassified	5	0.0%
Subtotals	3,076	29.7%
Totals	10,348	100.0%

Table 3: Racial/Ethnic Composition of State-Operated Facilities Work Force, by Gender

When gender and race are combined, the single largest component of the work force in state-operated facilities (excluding central administration employees) consists of African-American women (36.1 percent), followed by White females (32.8 percent). White and African-American men each contribute another 13.9 and 15 percent, respetively, of the work force (see Table 3).

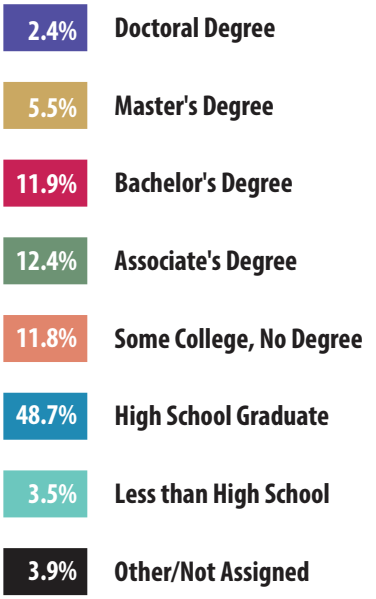
Source: Work Force Database, North Carolina DMH/DD/SAS and DSOHF, Summer 2012

Work Force Demographics: Education

Due in part to the occupational composition of the work force, more than half of the work force in state-operated facilities (excluding central administration employees), or 52.2 percent, possesses no more than a **high school diploma** (see Figure 8).

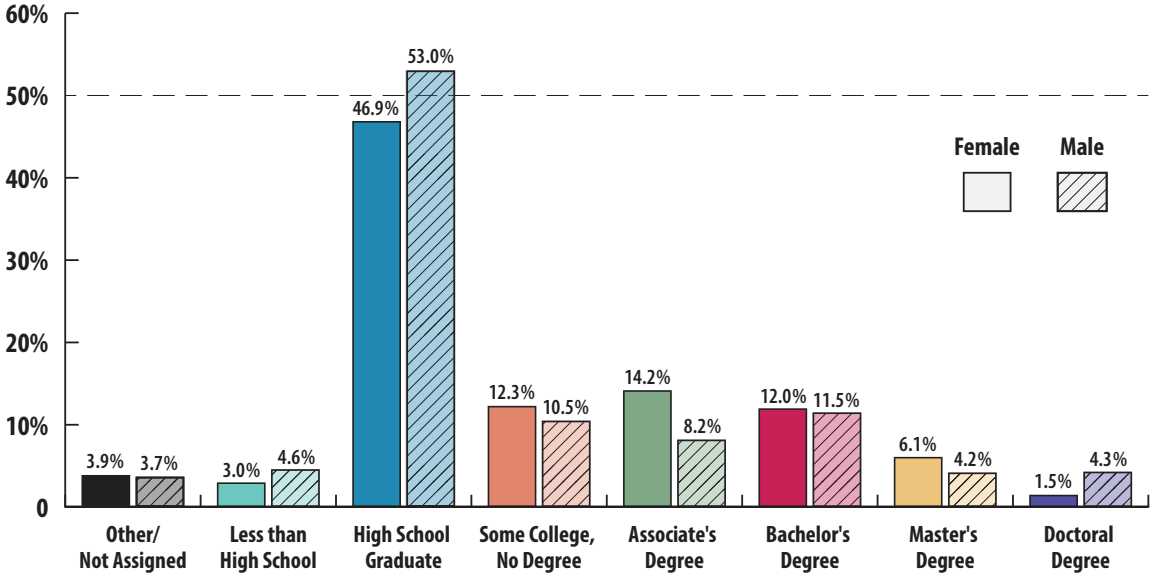
An additional 11.8 percent of the work force has some college education but no degree. Some 32.2 percent of the work force has at least an associate's degree or more.

Figure 8: Composition of State-Operated Facilities Work Force, by Educational Level



Source: Work Force Database, North Carolina DMH/DD/SAS and DSOHF, Summer 2012

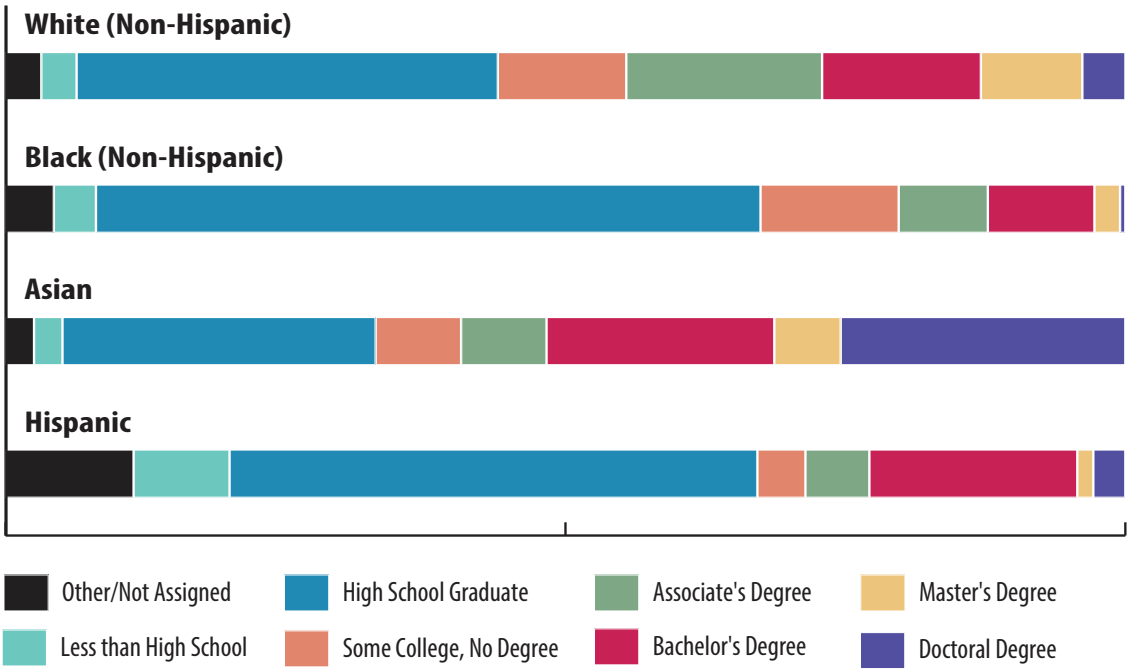
Figure 9:
Educational Composition of State-Operated Facilities Work Force, by Gender



In terms of **gender**, higher proportions of the male work force in state-operated facilities (excluding central administration employees) have a high school degree (53 percent of males versus 46.9 percent of females). Also more males have doctoral degrees (4.3 percent versus 1.5 percent) than females in the work force (see Figure 9).

Source: Work Force Database, North Carolina DMH/DD/SAS and DSOHF, Summer 2012

Figure 10:
Educational Composition of State-Operated Facilities Work Force, by Race/Ethnicity



In terms of **race/ethnicity**, White non-Hispanic workers in state-operated facilities (excluding central administration employees) are more apt to have at least some college compared to Black, non-Hispanic workers (56.1 percent versus 32.6 percent).

Though very small in numbers, the Asian work force is at the higher end of the education spectrum; 51.6 percent have at least a bachelor's degree, and a quarter hold doctorates (see Figure 10 and Table 4).

Though very small in numbers of workers, the proportion of the Hispanic work force with at least an associate's degree exceeds the African-American share (28.6 percent versus 20.3 percent).

Detailed Analysis for the Nursing Job Branch

The nursing job branch is the single largest category of employees. This branch employs 57.8 percent of the work force in state-operated facilities (excluding central administration employees).

The nursing job branch contains 5,982 employees divided into four broad occupational categories: nursing, psychiatric, and home health aides (4,469); registered nurses (1,641); nurse practitioners (335); and medical health services managers (17).

Source: Work Force Database, North Carolina DMH/DD/SAS and DSOHF, Summer 2012

Table 4:
Educational Composition of State-Operated Facilities Work Force, by Race/Ethnicity

	White (Non-Hispanic)	Black (Non-Hispanic)	Asian	Hispanic
Other/Not Assigned	3.2%	4.3%	2.5%	11.4%
Less than High School	3.1%	3.8%	2.5%	8.6%
High School Graduate	37.6%	59.4%	28.0%	47.1%
Some College, No Degree	11.5%	12.3%	7.6%	4.3%
Associate's Degree	17.5%	8.0%	7.6%	5.7%
Bachelor's Degree	14.2%	9.5%	20.3%	18.6%
Master's Degree	9.1%	2.3%	5.9%	1.4%
Doctoral Degree	3.8%	0.5%	25.4%	2.9%

There is a racial pattern to employment within the nursing job branch employed in state-operated facilities (excluding central administration employees). African-American workers tend to cluster in the health care support occupations; in fact, African-American workers account for 69 percent of all aides. White workers account for much larger shares of the nurse practitioners (54.3 percent) and registered nurses (68.4 percent) categories.

Nursing, psychiatric, and home health aide positions tend to require little formal education and pay relatively low wages. According to the U.S. Department of Labor, the median hourly wage for aides in North Carolina in 2011 was $10.64.

Postsecondary education is required for those in nursing positions (either licensed practical nurses or registered nurses).

Altogether, 74.8 percent of the aides in the system have no more than a high school diploma, while another 10.9 percent have some education beyond high school but less than an associate's degree.

Margie struck Geneva with her baby doll
Barb knocked off the medcart comin'
down the hall
...
Who will save me
From myself
In the night?
...
A clean room with a window and some
Prozac in warm milk
And sneak us in some whiskey 'cause it's
prob'ly not allowed
Only God can save us now

— Karen Bergquist, Over the Rhine, *Only God Can Save Us Now*

Source: Work Force Database, North Carolina DMH/DD/SAS and DSOHF, Summer 2012

28 North Carolina Counties Do Not Have a Psychiatrist

The Sheps Center for Health Services Research at UNC-Chapel Hill released data on the number of physician specialists by county. Twenty-eight counties do not have a psychiatrist, and an additional 18 only have one psychiatrist. Seventy counties do not have a child psychiatrist, and an additional 14 only have one. Only six counties have a geriatric psychiatrist. Only five counties have addiction psychiatrists, and only 13 counties have physicians specializing in addiction and chemical dependency.

The 28 counties that do not have a psychiatrist include Alleghany, Anson, Ashe, Bertie, Bladen, Camden, Dare, Edgecombe, Franklin, Gates, Graham, Hoke, Hyde, Jackson, Jones, Macon, Madison, McDowell, Mitchell, Montgomery, Northampton, Pamlico, Scotland, Swain, Transylvania, Tyrrell, Warren, and Yancey.

Source: See the Excel spreadsheet for physician specialties at *http://www.shepscenter.unc.edu/hp/prof2011.htm*

Need for Additional Information

The N.C. Division of MH/DD/SAS was unable to provide data on job tenure and wages. This information is still unavailable and is needed to better understand trends in turnover.

Conclusion and Recommendation

Perhaps the Center's most important finding is that the state's mental health work force is aging, as Baby Boomers (1946-1964) account for 48 percent of the work force. This means that almost half of the state's mental health workers are nearing retirement.

To address this concern and the need for additional information, the N.C. Center for Public Policy Research recommends that the N.C. General Assembly require the N.C. Department of Health and Human Services to provide an update to the Joint Legislative Oversight Committee on Health and Human Services on the implementation of the 2008 Workforce Development Initiative.

Endnotes

[1] The N.C. Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services and the N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, The Workforce Development Initiative, April 15, 2008, p. 22. On the Internet at *http://www.ncdhhs.gov/mhdd-sas/statspublications/reports/workforcedevelopment-4-15-08-initiative.pdf,* accessed on Jan. 3, 2013.

[2] The Center released a special report entitled *The History of Mental Health Reform in North Carolina* in March 2009, an assessment of the state's mental health reform strategy in March 2011, and an issue of its journal, *North Carolina Insight* on the state of mental health reform in North Carolina in December 2012. These reports are available on the Center's website at *http://www.nccppr.org*.

[3] The state did not break out data for the work force at the Whitaker Psychiatric Residential Treatment Facility in Butner, which is a long-term treatment program for emotionally handicapped adolescents aged 13–17. The work force data for the Whitaker PRTF was reported as part of the state central office, since the central office staff provides most of the administrative support for the facility.

Stories from North Carolinians with Mental Health Challenges

Editor's Note: One of the goals of the Center's Strategic Plan for 2012–2016 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.

In April 2014, Senator Fletcher Hartsell (R-Cabarrus) implored the mental health community at a legislative breakfast, "Tell us your story. Become real to us."

The Cost of System Failure: Losing Josh

by Julie Jarrell Bailey

> *"Mental health system failure is personal and it's painful. It has different names for different people. In my case, system failure is also known as Joshua, Jacob, and Isaac Bailey."*

The state estimates that there are 230,776 children in need of mental health services across North Carolina. Another 45,321 need substance abuse treatment. A fraction of those get the care they need—50 percent of the kids needing mental health treatment and 9 percent of those needing substance abuse treatment are served.

For me and for many people in North Carolina, the failure of the mental health system isn't just about numbers, budget cuts, a lack of services, or political will. Mental health system failure is personal and it's painful. It has different names for different people.

Meet the Bailey Family

In my case, system failure is also known as Joshua, Jacob, and Isaac Bailey. When my husband, Steve, and I adopted these three brothers from the state foster care system in 1996, Josh was eight, Jacob was seven, and Isaac was four. We decided to adopt from foster care because being a parent meant more to us than parenting an infant. We believed then as we do now that every kid deserves a loving, caring home, regardless of their age.

The Department of Social Services (DSS) classified all three of our boys as "special needs" because each had a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD). This meant they were eligible until age 18 for Medicaid, the state-run federal program providing health insurance for the poor, long-term care for the elderly, and services for persons with disabilities. But ADHD was just the tip of the iceberg for our boys, and it took us about five years to build a more complete story about their histories and problems. Among other things, we learned that we were Josh's ninth home, Jacob's tenth, and Isaac's fifth, including back and forth attempts at reunification and living with biological family members.

Photos courtesy of Julie Jarrell Bailey

The DSS profile photo of the boys in 1995 as provided by the foster system.

Accessing Treatment and Education for the Boys

By the time Josh arrived in our home, he was what we described as "fighting mad." He managed to keep his anger hidden from Steve and me for about two or three days before lashing out at Jacob over a whiffle ball game in the front yard. He chased his brother with the plastic baseball bat, hitting him and calling him names, saying he hated him and hated all of us. He ran away, and it took more than two hours of following and talking to him with non-punitive words to entice him back home.

We placed the boys in a private school. Josh and Jacob were in a combined classroom that covered grades one and two. We had frequent calls about the two of them being disruptive in the classroom and calling each other names. It didn't seem as though they liked each other very much, but we were determined to help them learn to be a family again.

It took us from April until June of 1996 to find a therapist and medication manager who would accept the boys' Medicaid insurance as payment. After our psychiatrist moved to private practice and then passed away, we had to begin the search for a new Medicaid provider all over again. In the interim, we secured a therapist and psychiatrist who accepted our private Blue Cross Blue Shield insurance with co-payments each week, which quickly became very expensive for three children in treatment. By 1999, we had moved all treatment services to the Orange-Person-Chatham Area Mental Health Program.

All three boys struggled with school. When we moved from Chatham County to Orange County to be closer to treatment, we enrolled Josh and Jacob in public school while I home-schooled Isaac for kindergarten. In fourth grade, Josh was tested at UNC-CH and we found he had a severe learning disability. We requested that the school implement an Individualized Education Program (IEP) plan for him based on the testing scores from both the school and UNC. While his math scores were acceptable, his reading scores were that of a first grade student. During one meeting, the school principal asked, "Mrs. Bailey, why is it that you think your son can't read?" I said, "I don't think Josh can read because when all of his little friends were learning their ABCs, Josh was learning how to dial 911. That's why I don't think Josh can read, sir." By the time we left the meeting, Josh had an IEP.

Out-of-Home Treatment for the Boys

Each boy has needed more help than we could provide at home. Despite therapy and medications, the boys had severe behaviors that included expressing extreme rage, self-harming behaviors, physical aggression at everyone in the family, running away, destruction of property, school issues and more. The diagnoses for each of them expanded from ADHD to include Bipolar Disorder, Post Traumatic Stress Disorder, Reactive Attachment Disorder, Oppositional Defiant Disorder, Generalized Anxiety Disorder, learning disabilities, and additionally Rage Disorder for Josh and Isaac while Jacob's diagnosis included borderline features.

Our Child and Family Team felt the Wright School in Durham would provide the best treatment for the older boys because of the school's behavior modification and remediation model. The Wright School is a state-operated residential treatment facility for children with severe emotional and behavioral disorders. Josh was 12 years old, the cutoff age limit for Wright School student, and there was a waiting list. After about three months of waiting, Josh was accepted into the program a few months before his 13th birthday. A month after Josh entered the Wright School, Jacob's application was accepted. Out of 24 beds in the entire facility, we felt very grateful to have two of them.

Josh thrived at the Wright School. He won awards, his grades improved, he finally felt confident in himself, and he returned home seven months later as a new person. He became more thoughtful, compliant, and engaging. He still had struggles and challenges, but the changes were significant and the

parent education provided us tools to help sustain him at home.

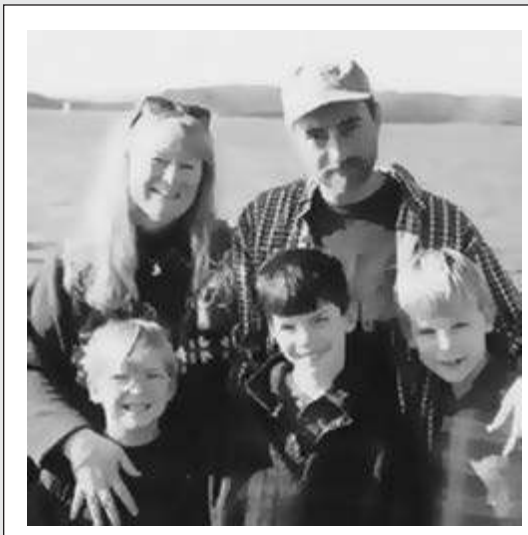
Jacob did not return home from the Wright School. After about seven weeks in the Wright School program, he tried to commit suicide by hanging himself on the playground after finding a short piece of rope. His brief stay there was just the beginning of numerous residential placements and hospitalizations over the years, including Eliada Home in Asheville, Youth Focus in Greensboro, Gateway in Durham, and multiple placements at the adolescent treatment program located at Butner.

In his later teen years, we were fortunate Jacob was accepted into the Whitaker School, which I compare to a high school version of the Wright School. His treatment and supports there were helpful. He was discharged the day before his 18th birthday and quickly had some setbacks. He eventually ended up living in a Family Care Home. It wasn't an appropriate match, but there were no beds anywhere in the state designated for a transitioning young adult with mental illness.

Once an adolescent with mental illness turns age 18, the resources and options are greatly reduced. Unfortunately, Jacob's poor coping skills, anxiety, and impulsiveness caused him to be moved to four different Family Care Homes in less than a year because they were not equipped to manage his mental illness and emotional/behavioral outbursts. None of the Family Care Homes provided any therapeutic supports. That wasn't within their service definition.

His move into a group home for adults with mental illness in Durham made move number five, but it didn't last long. One day, he just left. Supervision was poor, and it was easy for him to walk off. His treatment provider at the time said they weren't going to respond to his phone calls for help because he needed to live on the streets for a night or two to teach him a lesson. We argued that Jacob would not learn the lesson they described, but instead he would learn he could actually survive on the streets, and it would make it more difficult to get him to agree to return to a group home. They refused to provide him assistance when he called, even though he told his case manager that he was scared and asked for someone to come pick him up. He promised to return peaceably to the group home, but they left him on the streets of Durham. They wanted him to learn their lesson.

Jacob's one or two nights on the streets turned into seven months of homelessness and growing dysfunction compromised by drug and alcohol use. That was in 2008. Since that time, Jacob has experienced additional hospitalizations and group home placements. In 2011, his last lengthy hospitalization, Jacob's treatment team changed his medication to include the drug Clozaril. This medication has provided Jacob with a high level of stabilization. As a result, he's lived in the same group home for nearly three years. He has just completed a vocational training program, which has given him skills in carpentry, and he's hopeful of becoming gainfully employed. He is invested in his own recovery plan and is happy with his life's direction. So are we.



Bailey family at Smith Mountain Lake in 1998.

Isaac never attended the Wright School, although in hindsight, he should have. Instead, we worked at providing his treatment at home, utilizing Multi-Systemic Therapy and Outpatient Therapy. Finally, in 2007–08, as puberty and adolescence conflicted with his mental health issues, Isaac went to Eliada Home in Asheville for out-of-home treatment. His coping and self-management skills improved there, but we had to engage Intensive In-Home Therapy when he deteriorated in the fall of 2008.

The Realities of the Transition to Adulthood

For many young adults, turning 18 is a relatively easy, exciting transition. They plan for college, trade school, military service, or jobs in the community. They fantasize about what being a legal adult means. For some, it means they no longer have to ask their parents if they can go out for a night on the town. Some move out and live on their own for the first time.

> *For young adults with a mental health issue, and especially for their parents, turning 18 is scary. These kids are not equipped to cope with the stress and pressure of being adults.*

For young adults with a mental health issue, and especially for their parents, turning 18 is scary. These kids are not equipped to cope with the stress and pressure of being adults. This has been the case with all of my children, and I hear the same reports and concerns from other parents in similar situations. Our kids tend to take common developmentally expected behaviors in young adults to the ultra-extreme. What was considered to be at-risk behavior when they were children becomes high-risk behavior as young adults, often dangerous and with serious consequences.

Many parents tell me that their transitioning adult children choose to stop taking their psychiatric medications and disengage from therapy. My kids did this in their bid for independence. Once a child turns 18, parents are no longer consulted by treatment providers in therapeutic decisions. Despite having a mental illness, the law states that an 18-year-old is a legal adult and can make their own choices. The law applies to the abled as well as the disabled, unless a parent secures legal guardianship. Steve and I learned this the hard way.

Josh's Story

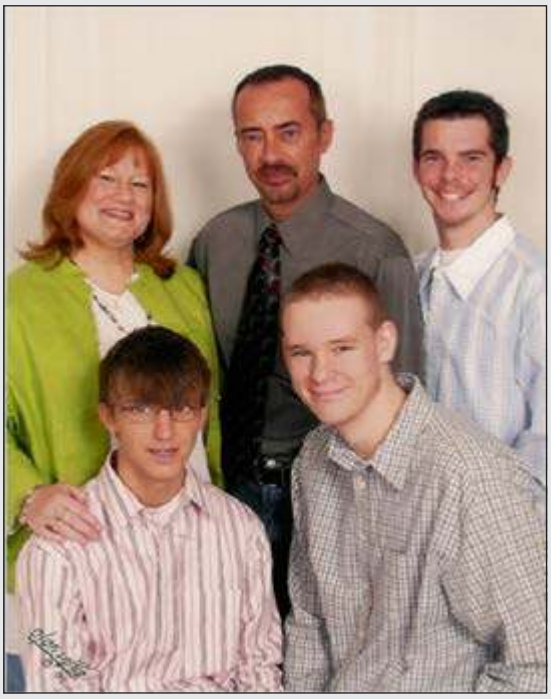
Josh was always too busy quieting the demons in his head to allow support services to be very effective. His anger escalated, and at home he was physically aggressive against all of us, even pushing Jacob down the stairs and attacking Steve and me while we were driving the car. He was about 10 years old when we hospitalized him the first time. Yet, he managed to hold things together better in public settings. He worked desperately to keep a smile on his face and fit in. Being accepted by everyone he knew always seemed to be more important to Josh than learning how to conjugate verbs.

For Josh, talk therapy was never very productive. He was a secretive child and didn't like talking about his past. When the boys joined our family, they each came with a Life Book created by their social worker. Josh's Life Book contained a photograph of him with Jacob that I always loved. They were very young, maybe four and five years old. The photo shows them playing in the kitchen cabinets, and they are laughing really hard. It's a precious photo.

One day after therapy, I was alone with Josh when he asked, "You know that photo you always like of me and Jacob as babies playing in the kitchen and laughing real hard?" I said, "Yes, I love that photo." Josh said, "Well, I need you to know that we weren't laughing in that picture. We were crying. That was the day the social workers came to take us away. We were hiding in the kitchen cabinets, but they found us and took that picture before taking us away from our home."

By the time Josh got to high school, his academics were in sad shape. In 11th grade, we moved him from public school to a charter school with a curriculum that better supported students moving into a trade rather than those who were university bound. Steve and I had come to accept that Josh was not university material, and that was okay with us. We just wanted each of our kids to be happy and to find a way to support themselves after high school. His

The Bailey family in 2006. The three boys faced the transition to adulthood within four years of each other. Josh, upper right, was the oldest child.



school conducted aptitude testing, and it supported career paths that already interested Josh, including culinary arts, the retail industry, and fire/rescue work. They helped Josh get a part-time job at a local grocery story working as a bagger and cashier. It was great experience for Josh, and he continued bagging groceries past his 2006 high school graduation. But his growing experimentation in alcohol and drug use triggered cycles of mania and depression that worsened with each episode.

He had turned age 18 in 2006, and his legal adult status meant that Steve and I were no longer allowed inside his therapist's quarters. We weren't consulted about his medications either, despite having a lengthy history to provide of what had and had not worked over the years. We were totally discounted as members of Josh's treatment team. Also on his 18th birthday, Josh lost the Medicaid insurance that he had had since foster care. He was on our private Blue Cross Blue Shield plan as long as he stayed in community college, which continued to provide his medications and therapy on a co-pay basis until he dropped out of school at age 19.

Steve applied for assistance with paying for Josh's medications with one of the drug companies, which was helpful. He asked the treatment provider to accept Josh on a sliding scale fee, which they did. We even drove him to his appointments to make sure he showed up because by this time, he had moved deeper into the drug culture and often missed appointments. He was spending many nights away from home to party with friends, which kept Steve and me awake all night worrying. He was in a hypomanic state for a lengthy period of time, and we were helpless to prevent him from spiraling.

He finally ran away from home. He lied to the parents of his friend, telling them we had kicked him out so the parents would take pity on him and let him stay. He called every few days to let us know he was okay and told us the name of his friend but wouldn't say where his friend lived or give us the name of the kid's parents. After about three weeks, Josh cycled into depression and was ready to come home. We got him back into therapy, on medication, and into Alcoholics Anonymous (AA), which he attended seven days a week. He started to resume some normalcy in his life and went back to work to learn skills as a butcher.

About two months later, he hit another manic cycle and ran off for a few days to party. When he cycled through the mania again, he was ready to go back to work and refocus. He couldn't understand why his employer wasn't as forgiving. We made a plan for him to enter Caramore Community. In the beginning, he was successful. He didn't mind the work and got along with his house mates. He attended AA meetings again. Then, like clockwork, two months later he had another manic episode and didn't return to the facility for a few days. When he contacted us after these episodes, he was always remorseful, and there were always consequences. This time Caramore said that Josh no longer met the criteria to remain in their program, and they discharged him in early April 2008.

The difference in this situation and previous episodes was that Josh refused to come home. He was 20 years old now. He had experienced brief periods of independence and liked setting his own schedule while disliking our house rules. What 20-year-old doesn't? He told us he was going to stay with a friend in Burlington. When the friend moved back to town, Josh came with him. They were in frequent party mode. We did see and speak with him frequently. He got a temporary job with UNC food services that didn't last long. He did some construction work. He mowed lawns. Mostly, however, he came by to see us at our jobs, which was easy because Steve and I worked in the same building. He wasn't able to maintain consistent employment and needed money for food and cigarettes.

One day in late June 2008, Josh met with us to ask for help in getting into a rehab treatment facility. He said he realized that his life was going nowhere, and he had reached rock bottom. He wanted to turn his life around with our help. We were ecstatic. He came home for a family gathering over the Fourth of July to see his grandparents, aunts, and cousins from Florida and local family too. He talked to Steve and me about wanting a new start. We invited Josh to come back home, and he said he might do that after his grandparents returned to Florida. My mother had stayed with us for three months for cancer treatment at UNC, and Josh was concerned about crowding us. Over the course of the next few weeks, we saw Josh every day as we worked towards helping him reach his goals.

When he visited us on July 21, 2008, his physical appearance was concerning. He looked very dirty, and some of his clothing was torn as though someone had tried to yank off his shirt. We asked him about it, and he said, "Nah, I've just been mowing lawns for money, so I'm dirty." We made plans for a family cookout each of the next two weekends, and he was going to call us to pick him up on Saturday. That call never came. When he missed the second

weekend, which was my birthday, we knew something was wrong.

On August 5th, Steve and Isaac went to the Chapel Hill Police Department to file a missing person's report. The officer told Steve that Josh was a legal adult, and if he didn't want to call his parents, he didn't have to. Steve explained that Josh had Bipolar Disorder and was not on his medications. We were used to seeing him every day, and it had been two weeks, so we were very concerned. The officer said it didn't make a difference that Josh had mental illness. But he did say he would take the flyer we made and announce it during shift announcements.

August 13th was the date we had set to fly my mother back to Florida because we had a wedding to attend on August 16th. A close friend here called while we were in Florida and said she spoke to a friend at the Orange County Sheriff's Department who told her we should come visit him when we got home from our trip. He was willing to help us launch a missing person's report. We caught an early flight home and Steve spoke with Investigator Tim Horne on August 19th.

One of the first things we learned was the officer who spoke to Steve at the Chapel Hill Police Department was misinformed. The department could have taken Steve's missing person report on Josh. Tim opened an investigation to determine why Josh was missing and where he might have gone. He enlisted the assistance of Special Detective Phillip Stevens with the State Bureau of Investigation. A Silver Alert was issued to the media. We were contacted by the National Center for Missing and Exploited Children and paired with a couple whose daughter had been missing for 10 years. I broke down in tears wondering how we might emotionally survive if we had no answer for 10 or more years.

Our experiences and lives became surreal. On Friday, September 12, 2008, we saw a news clip about a friend of Josh's named Matt Johnson, and it reported that he had been kidnapped. Steve had given investigators Matt's name. The news report gave us hope that Josh had been with Matt, and they had been kidnapped together.

By morning, we were feeling defeated and stupid for thinking Matt might know anything. Steve and

Josh on fishing trip to the Keys for 20th birthday in 2008.

Isaac decided to take a drive up to Smith Mountain Lake, Virginia. He used the excuse of "work" but he really wanted to go see if there were any signs that Josh had been staying on our boat.

About 30 minutes after Steve left, Tim Horne called, asking for Steve and said he had several more questions. I told him that Steve had taken off for the lake, but I could reach him by phone. Tim said I should call Steve, which I did. Steve said he would turn around and head home. I was supposed to leave for a pottery class, so I called to let them know I would be late. Then I went out to sweep my porch. As soon as I started sweeping, I saw Tim walking up the sidewalk, and we started greeting one another. Then out of the corner of my eye, I saw someone else. I looked up and saw my pastor, Ray Warren. The last thing I remember is the sound of my voice screaming, "No, no, no, no, no…"

While my memories are sketchy, I am told that we were given the names of six young men who were involved in murdering Josh, including Matt Johnson. It took nearly five years after Josh's murder for the first person to come to trial. Our District Attorney, Jim Woodall, felt that it was important to first try Brian Minton since he was the alleged ringleader in Josh's kidnapping, torture, and murder. A jury agreed with him and sentenced Brian to life in prison plus 30 years. Four other defendants have accepted plea bargains and will serve anywhere from 25 to 38 years in prison for their role in Josh's murder. The fifth defendant was sentenced in Spring 2014 to life in prison without parole for the kidnapping and murder.

Both of Brian's parents pled guilty to obstruction of justice this past December 2013. Mishele Minton had driven her son to Lowe's Home Improvement to purchase muriatic acid to pour on Josh's body so it would not be found. Superior Court Judge George Abernathy said, "I just can't conceive of what kind of person would want to assist someone in just desecrating a body with acid. I can't conceive of somebody that is so evil they would assist in buying acid so that a mother and dad would never find out what happened to their child."

Steve and I are emotionally drained and physically exhausted from the legal process. Our roller coaster ride through the legal system only taught us that there is no such thing as swift justice nor is there anything resembling closure.

The life of Joshua McCabe Bailey meant a great deal to us. Steve and I fought and advocated for him every step of his life. The frustrating thoughts are that it shouldn't have to be so complicated for kids, young adults, or anyone living with a mental health issue. I wish Josh could have felt more comfortable with who he was and could have embraced his mental health issues. It definitely would have helped him further with his recovery process.

"Our roller coaster ride through the legal system only taught us that there is no such thing as swift justice nor is there anything resembling closure."

The system failed Josh before he was born by failing his birth mother. My descent into hell is defined by "what ifs" ...

- What if their birth mother had received the help she needed as a child?
- What if the Department of Social Services had conducted mental health assessments of the boys?
- What if when Steve and I adopted the boys, we had been introduced to our area mental health agency and educated about the mental health system of care?
- What if the justice system had kept Brian Minton behind bars for previous arrests and charges instead of releasing him?

The reality is that none of these "what ifs" will bring our son back to us. We prefer to help other parents raising kids with mental health conditions in the here-and-now so they don't have to experience a nightmare similar to ours.

Julie Jarrell Bailey has worked for 10 of the past 14 years as both a staff member and volunteer with the Family Advocacy Network (FAN), a program at Mental Health America of the Triangle (MHAT). Julie served as Interim Executive Director for MHAT for 15 months in 2010–2012. Prior to her work in the field of mental health, she worked as a journalist and public relations professional. Julie is the author of the book "The Adoption Reunion Survival Guide: Preparing Yourself for the Search, Reunion and Beyond." Along with her husband, Steve, Julie is co-founder of Josh's Hope Foundation, Inc., a nonprofit organization in Hillsborough, NC, working to bridge gaps in services for transitioning young adults with mental illness.

New Hope Carolinas in Rock Hill, SC

Outsourcing Our Children: **The Failure To Treat Mental Illness In-State**

By Matthew Herr

Imagine taking your child to the hospital for intensive brain surgery and doctors telling you that his post-operative care would have to take place in another state. Or imagine your child being turned away from an emergency room that could heal her, but won't because she is "too sick" and therefore not profitable to treat. What if your child could no longer receive her cancer treatment because she turned eighteen? This is the reality faced by many families in North Carolina who have children with mental illness. In July 2013, 208 children in North Carolina were sent out-of-state for mental health treatment at a psychiatric residential treatment facility.[1]

Over the past decade, North Carolina largely privatized its mental health system.[2] One particular type of private provider — psychiatric residential treatment facilities (PRTFs) — delivers inpatient mental health services for children.[3] The state operates one PRTF, and 40 others are operated by private providers.[4] The first PRTF opened in North Carolina in 2006 (see sidebar on Eliada Homes). These facilities provide treatment in a physically secure, locked environment (see textbox on levels of care).

The lone state-run PRTF, called the Whitaker School and located in Butner, is an 18-bed, long-term treatment program for teens between the ages of 13 and 17 who are experiencing severe and persistent mental health issues. Children can stay up

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to a year in this alternative education and treatment program.[5] In 2013, 36 children received treatment at the Whitaker School.[6] In July 2013, 365 children were treated at PRTFs across North Carolina.[7]

Although the state's PRTF policies indicate these facilities are supposed to be serving youth through age 21,[8] the North Carolina Administrative Code only allows PRTFs to serve children up to age 18, at which point they are considered "adults" by the state.[9] The Early and Periodic Screening, Diagnosis & Treatment (EPSDT) provision of Medicaid[10] sets the child-adult delineation at age 21.[11] EPSDT requires state Medicaid agencies to cover services, products, or procedures for Medicaid beneficiaries under 21 if the service is medically necessary and addresses a defect, physical or mental illness, or a health problem identified through an examination.[12] EPSDT covers treatment at a PRTF.

"This incongruity between state and federal regulations creates a "doughnut hole" in care for Medicaid-eligible, 18- to 21-year-olds who need intensive mental health services in North Carolina."

However, because PRTFs operate under North Carolina's regulatory definition of children and adolescents, not Medicaid's, these facilities are allowed to serve only children and adolescents until they turn 18. This incongruity between state and federal regulations creates a "doughnut hole" in care for Medicaid-eligible, 18- to 21-year-olds who need intensive mental health services in North Carolina.

Unfortunately, the service gaps do not end there. For children under the age of 18, North Carolina licenses facilities to address either mental illness or developmental disabilities, but not both.[13] As a result, complex, hard-to-serve children — for example, children with both mental illnesses and developmental disabilities — often find themselves without any appropriate EPSDT providers in-state as well.[14] These children are like octagon-shaped pegs trying to fit into a system made up of squares and circles.

In practice, this leaves North Carolina's 18- to 21-year-olds and complex, hard-to-serve children who have severe mental illness with three options. First, they can try to seek in-state inpatient treatment in state psychiatric hospitals, which may be inappropriately restrictive.[15] Second, they can go without essential services until they are sick enough to warrant psychiatric hospitalization — where, once stabilized and discharged, they are back to square one. Or, third, as is regularly the case, they are forced to obtain treatment outside of the state. Sometimes they are sent as far away as Florida or Missouri, which isolates them from their families, excludes them from their communities, and frequently results in the state of North Carolina having little or no

Levels of Care

North Carolina has a graduated service structure for the inpatient treatment of children consisting of five levels, each more restrictive than the last:

Level I provides low to moderate structure and supervision provided in a family setting.

Level II provides moderate to high structure and supervision provided in a family setting, such as a therapeutic foster care, or group home.

Level III provides a highly structured and supervised environment.

Level IV provides a physically secure, locked environment.

Finally, **psychiatric hospitalization** is "designed to provide treatment for individuals who have acute psychiatric problems . . . and is the most intensive and restrictive type of facility for individuals."

Source: N.C. Department of Health and Human Services, State Plan Under Title XIX of the Social Security Act Medical Assistance Program, Attachment 3.1-A.1, 15A.19–20, May 1980. On the Internet at *http://www.ncdhhs.gov/dma/plan/sp.pdf*, accessed on January 25, 2014. See also 10A N.C. Administrative Code 27G.6001.

meaningful oversight over their care. In July 2013, 36 percent of the North Carolina children needing treatment in a PRTF were sent out of state.[16]

For example, Zachary Hamner of Raleigh is a teen that is diagnosed with bipolar disorder and an IQ in the mid-60s, so he has mental illness and a developmental disability. In 2012, he was treated at a PRTF called New Hope Carolinas[17] in Rock Hill, SC, a 3½ hour drive for his parents. When asked why he ended up at New Hope, Zachary says, "I did something bad. I'd rather not go back into the past. I like to think of the future, like when I'll get married and have kids and get jobs."

Eric Harbour at the N.C. Department of Health and Human Services notes that more than 90 percent of the children who were served in PRTFs out-of-state in July 2013 were served in South Carolina. He says, "These youth, in addition to those placed in Virginia and Tennessee, may be in PRTFs that are closer to their home communities than PRTFs in other regions in North Carolina." A statewide initiative called "Bring Them Home" is identifying and working on strategies to reduce the number of youth placed in PRTFs out-of-state.

Before a youth in North Carolina is allowed to seek out-of-state placement, that youth has to apply to, and be rejected from, every PRTF in the state — even from facilities where he or she does not satisfy the age or gender requirements.[18] This process can take weeks or even months. For a family whose child is in crisis, this can be frustrating.

Once youth are placed out-of-state, the state relies on local mental health agencies called Local Management Entity-Managed Care Organization (LME-MCOs)[19] to continue overseeing their care. Unfortunately, this doesn't happen consistently, which is not surprising given that the state does not have an enforcement mechanism to ensure LME-MCOs' compliance with this duty. As a result, North Carolina's children are falling through the cracks once they get shipped out-of-state for treatment.[20]

Madame, I have a confusion,
will you take it away?
Madame, I have a sickness,
will you take it away?
…
Take! For God's sake take!
Mend everything!

—Anne Sexton

These service gaps violate the federal Americans with Disabilities Act and Medicaid's EPSDT provisions. They violate the state's own policies on out-of-state enrollment for residential services, which provide that "in-state placement for the support and continuity of family involvement is the first priority, with [out-of-state] placements as the last option."[21] Sending children who need mental health services to other states should be a measure of last resort, not the state's de facto treatment plan.

This issue provides the state with an opportunity to make good on some of the promises for mental health reform that it made more than a decade ago. North Carolina needs to provide these youth with evidence-based, community-based services. Not only do such services produce better outcomes, they are less expensive than institutionalized treatment.

In July 2013, the United States Department of Health and Human Services released an extensive, multi-state study on the effectiveness of implementing community-based mental health services for youth who met the requirements of being treated in a PRTF.[22] The report finds,

> For all nine states over the first three Demonstration years for which cost data was available to be collected, there was an average savings of 68 percent [from implementing community-based mental health services for children]. In other words, [these] services cost only 32 percent of comparable services provided in PRTFs. The Demonstration proved cost effective and consistently maintained or improved functional status on average for all enrolled children and youth.[23]

These states offered an array of community services to meet the needs of these youth who otherwise would have been treated in PRTFs. The core benefit package included traditional services, such as individual therapy, family therapy, and

Early, Periodic Screening, Diagnosis and Treatment: Is EPSDT the Best-Kept Secret in Medicaid for Kids Under 21?

By Mebane Rash

The Center often receives calls from parents whose children have been denied services, and they want to know if there is anything they can do. One option is to submit a "request for non-covered services."

According to the website of the N.C. Department of Health and Human Services, "Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is the federal law that says Medicaid must provide all medically necessary health care services to Medicaid-eligible children. Even if a service is not covered under the N.C. Medicaid State Plan, it can be covered for recipients under 21 years of age if the service is listed at 1905(a) of the Social Security Act and if all EPSDT criteria are met."

What services are covered? "Services must be ordered by the child's physician or another licensed clinician. The service must be medically necessary to correct or ameliorate a defect, physical, or mental illness or a condition that is identified through a screening examination. The service must be listed in section 1905(a) of the Social Security Act. The service cannot be experimental/investigational, unsafe or considered ineffective."

Beginning on April 1, 2014, NC Tracks will process all prior approval requests for EPSDT services for beneficiaries under 21 years of age. NC Tracks is the state's new Medicaid Management Information System where consumers can get information about benefits, and providers can submit claims. Computer Sciences Corporation (CSC) is the new fiscal agent for the N.C. Department of Health and Human Services. Here is the link to the new prior approval form: *https://www.nctracks.nc.gov/content/public/dms/public/pdf/prior-approval/Non-Covered-State-Medicaid-Plan-Services-Request-Form-for-Recipients-under-21-Years-Old/Non-Covered%20State%20Medicaid%20Plan%20Services%20Request%20Form%20for%20Recipients%20under%2021%20Years%20Old.pdf*

For more information, see the EPSDT Policy Instructions Update, May 29, 2010, on the Internet at *http://www.ncdhhs.gov/dma/epsdt/epsdtpolicyinstructions.pdf,* accessed on January 26, 2014.

In our research, the Center has learned that parents are often frustrated when confronted with the distinction between rehabilitative and habilitative services as it applies to EPSDT services for their children.

An attorney at Disability Rights NC explains,

> EPSDT only covers medical or "rehabilitative" services (for example, physical therapy, personal care services, doctor visits, etc.), and it explicitly excludes "habilitative" services. For example, developmental therapy, intensive in-home supports), many of which are only available through home and community-based service (HCBS) waivers.
>
> Some services may be open to interpretation. For example, there have been court decisions going both ways on Applied Behavior Analysis therapy for the treatment of autism. It has been characterized as "habilitative" by some courts and "rehabilitative" by others. But if what is needed is something like developmental therapy or independent skills training, many of which are only available through waivers, then EPSDT does not help. However, parents/guardians can request EPSDT services when they receive denials if they have a statement of medical necessity from a treating physician.

EPSDT may be a helpful tool in the toolbox for parents with children needing a service to correct or cure a health issue.

medication management. But the study showed that including a number of other home and community-based services significantly enhanced the positive outcomes. These services included but were not limited to intensive care coordination (often called "wraparound services"), family and youth peer support, intensive in-home services, respite care, mobile crisis response, and stabilization. The funding was flexible and could be used in a variety of ways to meet the needs of the child.[24]

The federal study found that with these home and community-based services kids' attendance in school improved, their school performance was better, they had stronger interpersonal relationships, more positive connections with family members, more self-confidence, more stable living situations, and fewer symptoms of mental illness. They tried to commit suicide less often, their caregivers missed work less, and there were fewer contacts with law enforcement.[25]

When it comes to providing mental health services to 18- to 21-year-olds and complex, hard-to-serve children, outsourcing our children to other states is no longer acceptable. Instead, the state should implement home and community-based services like those in the federal study. This would ensure that every taxpayer dollar that goes to providing North Carolina's youth with intensive mental health services would go to treatments that have been shown to work. It would begin to alleviate the burden on police departments, social service departments, and other service entities that invariably are strained when the state's mental health system fails. And rather than funnel taxpayer money to out-of-state agencies, filling these service gaps would employ

Recommendations

1. On May 7, 2013, the federal Centers for Medicare and Medicaid Services (CMS) and Substance Abuse and Mental Health Services Administration (SAMHSA) issued an informational bulletin on services for children, youth, and young adults with significant mental health conditions inviting states to seek assistance. Certain mental health services allow "children with complex mental health needs—many of whom have traditionally been served in restrictive settings like residential treatment centers, group homes and psychiatric hospitals—to live in community settings and participate fully in family and community life." Federal research has shown that these services are clinically and cost effective. The bulletin says, "Developing these services will help states comply with their obligations under the Americans with Disabilities Act (ADA) and to Medicaid's Early Periodic Screening, Diagnostic and Treatment (EPSDT) requirements, specifically with respect to mental health and substance use disorder services." **The N.C. Center for Public Policy Research recommends that the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services in the N.C. Department of Health and Human Services consult with CMS and SAMHSA to deliver home and community based services for children with significant mental health conditions in North Carolina.**

2. **The N.C. Center for Public Policy Research recommends that the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services in the N.C. Department of Health and Human Services address the doughnut hole in care for Medicaid-eligible, 18- to 21-year-olds, who need intensive mental health services in North Carolina.** While the state's psychiatric residential treatment facilities policies indicate these facilities are supposed to be serving youth through age 21, the N.C. Administrative Code only allows these facilities to serve children and adolescents until they turn 18. This gap in care needs to be addressed by the state.

highly-trained professionals right here in North Carolina. Most importantly, our youth would be treated with community services in the least restrictive setting possible, as required by the U.S. Supreme Court.[26] Keeping the state's promise of mental health reform to these kids is not just the right thing to do, it is the prudent thing to do.

Endnotes

[1] Email from Eric Harbour, N.C. Department of Health and Human Services, on July 3, 2014. See also Mandy Locke, "For mentally ill children in N.C., a weak network of services," *The Charlotte Observer,* Charlotte, NC, August 11, 2013, p. 13A.

[2] N.C. Session Law 2001-437 (House Bill 381). See also Alison Gray, "The History of Mental Health Reform in North Carolina," *North Carolina Insight,* N.C. Center for Public Policy Research, Raleigh, NC, 2009, pp. 76–78.

[3] Psychiatric Residential Treatment Facilities for Children Under the Age of 21, N.C. Division of Medical Assistance Enhanced Mental Health & Substance Abuse Services, Clinical Coverage Policy No.: 8D-1, August 1, 2012. On the Internet at *http://www.ncdhhs.gov/dma/mp/8D1.pdf*, accessed on January 25, 2014.

[4] Whitaker School is the only state-run psychiatric residential treatment facility in North Carolina, although the state runs a similar program for younger children called the Wright School. More information about state-operated facilities is available on the Internet at *http://www.ncdhhs.gov/dsohf/facilitycontacts.htm*, accessed on January 25, 2014. A list of the other PRTFs in North Carolina is available on the Internet at *http://www.ncdhhs.gov/dhsr/data/mhllist.pdf*, accessed on January 25, 2014 (search for PRTF in the list).

[5] On the Internet at *http://www.ncdhhs.gov/dsohf/services/whitaker.htm*, accessed on January 25, 2014.

[6] Jeannette Barham, "Annual Statistical Report, Wright and Whitaker Residential Programs for Children, Fiscal Year 2013," Division of MH/SS/SAS, Raleigh, NC, December 2013, Table 2-A, p. 6.

[7] See note 1 above.

[8] Clinical Coverage Policy No.: 8D-1, note 3 above, p. 1, stating "PRTF services are available to Medicaid recipients under 21 years of age."

[9] 10A N.C. Administrative Code 27G.0103(10) (2012). See also 10A N.C. Administrative Code 27G.0103(9) (2012) (child means a minor from birth through 12 years of age); 10A N.C. Administrative Code 27G.0103(3) (2012) (adolescent means a minor from 13 through 17 years of age); 10A N.C. Administrative Code 27G.0103(4) (2012) (adult means a person 18 years of age or older).

[10] Medicaid is the federal government's state-run health insurance program for low-income individuals. Generally, Medicaid provides health insurance for the poor, long-term care for the elderly, and services for persons with disabilities. Medicaid was established by Title XIX of the Social Security Act of 1965, 42 U.S. Code Chapter 7, Subchapter XIX, §§ 1396–1396v.

[11] 42 U.S. Code § 1396a(a)(43)A (2006).

[12] Assistance Enhanced Mental Health & Substance Abuse Services, N.C. Division of Medical Assistance, Clinical Coverage Policy No.: 8B, November 1, 2012, p. 2. On the Internet at *http://www.ncdhhs.gov/dma/mp/8B.pdf*, accessed on January 25, 2014.

[13] Disability Rights NC, "Kids Caught in a Double Bind: North Carolina's Failure to Care for Children with Dual Disabilities," Raleigh, NC, 2011. This report finds that "[t]he State separates services between Mental Health (MH) and Developmental Disabilities (DD), and the process for getting services for an individual with complex needs is confusing and difficult. Sometimes the services do not exist at all [in-state]."

[14] Generally, mental health providers cannot bill for developmental disability services, and intellectual disability providers cannot bill for mental health services. This disconnect creates a significant barrier to providers attempting to treat complex, hard-to-serve children. The expense of hiring additional staff to bridge the gap must come out of the providers' own profits. That is why it generally does not happen and why "North Carolina has only one in-state specialty provider to treat [children] with . . . dual diagnoses." Telephone interview with Becky Fields, former clinical director of F.A.C.T. Specialized Services, a Level III facility in Jacksonville, on January 23, 2013.

[15] *Olmstead v. L.C.*, 527 U.S. 581 (1999) (requiring treatment in the least restrictive setting appropriate).

[16] See note 1 above. Telephone interview with Iris Green, Senior Attorney, Kid's Team, Disability Rights NC in Raleigh on January 24, 2013.

[17] On the Internet at *http://www.newhopetreatment.com/*, accessed on January 25, 2014.

[18] N.C. Department of Health and Human Services, Compliance Verification Protocol for Client Specific, Time Limited Out-of-State Enrollment for Residential Services, April 2002, pp. 3, 13. On the Internet at *http://www.ncdhhs.gov/mhdd-sas/statspublications/Policy/policy-cf101outofst.pdf*, accessed on January 25, 2014. The protocol requires all in-state resources to be exhausted prior to requesting out-of-state placement, and states that "[i]n-state placement for the support and continuity of family involvement is the first priority, with [out-of-state] placements as the last option."

[19] LME-MCO stands for Local Management Entity-Managed Care Organization. As of Spring 2014, there were nine LME-MCOs in North Carolina.

[20] Telephone interview with Iris Green, note 16 above.

[21] Compliance Verification Protocol, note 18, p. 3. See also 10A N.C. Administrative Code 27G §§ .1303(b)(61), .1706(b), .1805(b), .1903(e) (2012). These code provisions emphasize the need for family involvement at all levels of inpatient placement. See also Susan Stefan, "Accommodating Families: Using the Americans with Disabilities Act to Keep Families Together," *St. Louis University Journal of Health, Law, and Policy,* Vol. 2, No. 1, St. Louis University School of Law, St. Louis, MO, 2008, p. 135, which notes the need to keep families intact in order to have better outcomes.

[22] Kathleen Sebelius, Secretary of Health and Human Services, "Report to the President and Congress Medicaid Home and Community-Based Alternatives to Psychiatric Residential Treatment Facilities Demonstration," Washington, DC, July 2013, p. 1. On the Internet at *http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Downloads/PRTF-Demo-Report-.pdf*, last accessed January 25, 2014.

[23] *Ibid.*, pp. 2 and 3. Nine states participated, including Alaska, Georgia, Indiana, Kansas, Maryland, Mississippi, Montana, South Carolina, and Virginia.

[24] More information about this study is available on the Internet at *http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Alternatives-to-Psychiatric-Residential-Treatment-Facilities-Demonstration-PRTF.html*, accessed on January 25, 2014. See also this federal bulletin on the Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions, on the Internet at *http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-05-07-2013.pdf*, accessed on January 25, 2014.

[25] *Ibid.*

[26] *Olmstead,* note 15 above.

Photos courtesy of Eliada Homes

The First Psychiatric Residential Treatment Facility in Western North Carolina: Eliada Homes in Asheville

By Sarah Nuñez

"*Every child needs one adult to be wildly, irrationally crazy about them and love them unconditionally.*"
– Marie Jensen, Vice President, Eliada Homes

Ask most people in Asheville about Eliada Homes, and they have heard of it. Eliada is 107 years old and attracts 20,000 people to its campus every year for the annual corn maze—a local community event that is not to be missed.

On a snowy day in February 2014, I met with four senior staff at Eliada to learn how they help children and adolescents with the most intense mental health needs move back to their own communities. As a former employee of Eliada, I was excited to be back on campus after more than a decade and curious to see what had changed over the years.

Students at Eliada have experienced mental health issues, addictions, trauma, abuse, neglect, and broken families. That's the sad story, but my visit to campus was not sad.

The story of Eliada is the story of a journey—the journey of each child treated there. Eliada's logo is a picture of a kid reaching for a star. The mission is "Helping Children Succeed." Often what they need, says Marie Jensen, Eliada's Vice President of Performance Improvement, is "one adult to be wildly, irrationally crazy about them and love them unconditionally."

The youth at Eliada are referred to intentionally as *students*, and the goal is to create a space where they can feel normal and accepted. Mark Upright, the President/CEO of Eliada, does not want to isolate his students

from the community. He says, "These kids are going to return to the community, so we can do a lot just by observing how they interact with people."

Eliada's services include the Psychiatric Residential Treatment Facility (PRTF), Foster Care, Day Treatment, Transitional Living/ Supported Vocational Education, and Child Development. Upright says, "Students spend on average five months at Eliada. We have to be intense in the programs to get the results. Twelve years ago, students would stay up to one year. So it's a lot of work to do in a short period of time. There have been tremendous changes in the system, and Eliada has remained adaptable over time."

Stories of Success

When I asked Upright what he was most proud of, he jumped up from his chair to grab pictures of students as he told me their stories. Before I could finish asking questions, he looked at me and said, "Are you ready to go and meet the kids?" Upright believes that "adversity can do two

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Editor's Note: Background on Eliada Homes

Eliada Homes, Inc., opened the first Psychiatric Residential Treatment Facility (PRTF) in Western North Carolina in 2006, beginning with one nine-bed cottage for adolescent females. But Eliada's story starts more than a century ago.

Eliada grew out of Faith Cottage, a ministry founded in 1903 by Reverend Lucius B. Compton as a home for unwed mothers. In 1906, he expanded Eliada to include an orphanage. As time went on and the needs of the community grew, so did Eliada. It didn't take long for the number of children not kept by their mothers to exceed the capacity of Faith Cottage.

Dr. Compton dreamed of finding a permanent home with land for these babies and toddlers. By 1906, he found a small cabin with a few acres of land about five miles west of Asheville. His daughter Mary Elizabeth writes, "I don't know what he paid for the house. I think he paid $1.00 an acre for the land — complete with beautiful pine and hardwood trees, and probably more weeds and blackberry bushes than he wanted." It was at this time that Dr. Compton named the home Eliada. Eliada was one of King David's sons; the Hebrew word means "one for whom God cares." More land was bought and donated, including a farm, until the campus swelled to more than 320 acres.

Mark Upright became the President/CEO in 2002. His multiple degrees in accounting, law, and human services have equipped him to guide this agency into its second hundred years of operation. Upright also oversaw the conversion of Eliada's campus to serve children and adolescents as a PRTF. Eliada is now able to treat the most vulnerable young people in the mental health system.

Eliada's PRTF program has 42 beds in five unique cottage programs, serving children and adolescents in a residential campus setting. Each program is supervised by a leadership team consisting of a licensed clinician, program manager, and a case manager. All students receive individual, group, and family therapy. PRTF students receive education by teaching specialists within the programs. Psychiatric and medical oversight is under the direction of a medical director/psychiatrist. A nursing team provides nursing oversight for the students 24 hours a day, 7 days a week.

Eliada provides crisis management on campus during evening and weekend hours to ensure that crisis situations are managed safely and effectively. PRTF students have access to therapeutic recreation services including team and individual sports, physical fitness activities, a therapeutic horse/ animal program, a mini-bike program, and outdoor experiential activities.

things — it can either victimize you or create tremendous character. If you look at leadership throughout history you will find that greatness was achieved through some kind of adversity." He sees this potential in each of Eliada's students.

Often the stories students tell show how Eliada helped them turn a corner in their lives. For example, students create marketing campaigns to sell candied applies at the annual corn maze fundraiser. A Wall of Fame with success stories of the students reminds the kids, the staff, and the community that miracles happen. He says, "It helps to destigmatize what people think about the kids at Eliada. The reality is that these kids don't have the support network that most have had, and we're trying to undo the damage and to change the way the students perceive the world."

According to Residential Director Kim Moore, "Each student is unique and needs to learn more about their own medications, illness, strengths, and problems."

Eliada uses a variety of techniques to keep students safe. Kim describes some of the de-escalation techniques, such as breathing and drinking a cup of hot tea, to help calm students. She explains how they teach students about crisis and crisis management. When I was visiting the cottages, she showed me the motivation system used to reward behavior, and the symbol that corresponds with each level. For example, the youth in Reuter Cottage strive to get to the Eagle/Executive level by the time they leave. Upright explains, "We're not just controlling behavior, but helping the students understand behavior."

Abigail has been at Eliada for six months. She says her experience at Eliada has been better than her treatment in other facilities in North Carolina. She likes the barn the most, saying "Once you get to level 2 [out of 5] you can get a paying job and earn $4.00 an hour." Abigail works in the barn and saves her money. She will be going to see her sisters and plans to buy them gifts for Valentine's

Day. I asked Abigail if she will be ready to go back to school and her community after her experience at Eliada. She says, "Yes, I've been going back on home pass and that helps a lot."

Michael and Jacob are great friends. They are both interested in attending college and plan to use the services provided by Eliada — including help with applications and applying for scholarships — to make that dream a reality. Michael says when he first got to Eliada he was nervous, scared, overwhelmed, and didn't understand all the rules. As he adjusted, he discovered a loving and caring environment. He says, "What I enjoy the most is the Positive Peer Culture that we use here. I get feedback about how I behave with my peers."

He graduates in March, and he will move to a group home. He says he will return home one day. "It's where my heart is, and it's been over six months since I have been home. I'll be ready soon, and I am getting better."

Jacob shares a story of another PRTF that he attended, which was much bigger than Eliada. He has been in five different placements, and he says that Eliada is "different because of all the opportunities of things to do inside and outside of Eliada. We have work too. It's nice to be responsible, since we're reaching adulthood, and it gets us used to how to apply for jobs and working."

Jacob has been at Eliada for three months and will move to therapeutic foster care after Eliada. He hopes to be placed closer to his hometown and eventually to return to his mother's home.

Beyond Treatment

All of the facilities at Eliada have exercise space, including a gymnasium, workout facilities, classes such as Thai chi, yoga, and a climbing wall, a community wrestling program, tennis courts, and Girl Scouts.

A therapeutic animal stewardship program includes seven horses, three pigs, 20 chickens, a llama, a goat, a donkey, and an ever increasing population of cats. Upright says, "Sometimes we have students that go to the barn to work with the horses, and they seem really calm on the outside, but we can tell by the reaction of the horse what's really going

on with the students. The horses' eyes will get wide, and they will be hesitant. So the kids work with the horses and will recognize that as they change what they feel on the inside, the horses also will become calmer."

Another program that receives rave reviews from the students is the National Youth Project Using Minibikes (NYPUM) program. According to Upright, "We are the only PRTF that puts kids on minibikes and lets them ride across campus. It's a huge motivator because students have to earn the ability to participate in the program." Jacob said earlier in the day, "Here we are really active, unlike other places where you sit around all day just waiting to get out."

At Eliada, the emphasis is not only on the student and their time at Eliada but also on what will happen after they leave. The tools they are gaining through the PRTF services will help them to monitor their medications and illness, learn to function in society, get along with others, and manage their treatment and recovery. It's not just about the present but also about their future success.

Upright says that the "success that the students have is their own. They work hard at it." Jacob agrees, and says "It is hard. It's taken me two months to get to level three. But if you really invest in this program, you can achieve greatness."

Sarah Nuñez lives and works in Asheville. She is on the Community Leadership Council of the Z. Smith Reynolds Foundation.

Jeremy M. Lange/The New York Times/Redux

Improving the Transfer of Children and Adolescents to Hospitals for Psychiatric Treatment

By John M. Diamond, M.D.

Imagine your daughter is starting high school. She has a fight with her boyfriend. She becomes despondent and begins to cut herself. Her grades decline. She is moody.

It doesn't stop. She keeps to herself. She even stops using Facebook.

One evening, you see an open bottle of her mother's Xanax. Your daughter has taken 20 of the prescription pills, and she is out cold on the floor.

You dial 911, and an ambulance takes her to the emergency room (ER).

Twelve hours later, she wakes up.

In the ER, you wait for a psychiatric evaluation for many hours. Your daughter is not stable. She doesn't want to live anymore, and she will not say that she won't try to commit suicide again.

She is involuntarily committed to a hospital, but the only open child psychiatry bed is hundreds of miles away.

The sheriff is dispatched, but it is many hours before he arrives. She is transported by the sheriff in shackles and handcuffs because she is potentially dangerous or may hurt herself or others.

She ends up far from home. Because the sheriff picks her up at 2 am, you do not get to say goodbye to her before she leaves.

John M. Diamond, M.D., works in the Division of Child and Adolescent Psychiatry at the Brody School of Medicine, East Carolina University.

Rowan County

The N.C. Center for Public Policy Research recommends that the Joint Legislative Oversight Committee on Health and Human Resources of the N.C. General Assembly study different methods of transporting children needing mental health treatment instead of relying on our sheriffs.

We conducted an informal survey of 50 states. We randomly picked two hospitals in each state and asked the emergency department, "How are kids transported to the psychiatric hospital?"

Although this method may not lead to completely valid results, they are illustrative nonetheless. Eight states use the police, sheriff, or other law enforcement for transportation. Twenty-seven states use an ambulance or other emergency medical service (EMS) transportation. Thirteen states use a combination of law enforcement or EMS. Two states outsource transportation to a private provider.

For example, Virginia uses EMS, Tennessee uses the police, South Carolina uses the sheriff, and Mississippi uses ambulances. Based on discussions with colleagues in other countries, Finland, Holland, and Norway use ambulances. Sweden uses the police.

The model used in North Carolina begs several questions. Why does hospitalization often occur 90 miles or more away? Why is the expense of a hospital needed? Safety can be found in less expensive, community-based settings where the family can be involved in treatment.

In Kentucky, for example, crisis stabilization units are used. Most regions of the state have had these units for at least 15 years. Some are for adults, but the state has 10 units for children. The units have eight to 12 beds. The length of stay varies, but recent data indicates the average length of stay is 5.85 days. Only 2.88 percent of the kids are readmitted within seven days, 8.83 percent are readmitted within 30 days, and 15.17 percent are readmitted within 90 days. Psychiatrists visit the unit two to three times a week. Therapists provide crisis intervention up to 24 hours a day.

North Carolina can do better. We need different methods to transport children needing treatment that are cost effective and that keep them closer to home. We can learn a lot from other states and nations without reinventing the wheel.

Source: John M. Diamond, "Concepts for Improving Mental Health Services for Children and Adolescents," PowerPoint to the Mental Health Subcommittee of the Joint Legislative Oversight Committee on Health and Human Services, Raleigh, NC, February 24, 2014. On the Internet at *http://www.ncleg.net/documentsites/committees/JLOCHHS/HHS%20Subcommittees%20by%20Interim/2013-14%20HHS%20Subcommittees/Mental%20Health%20Subcommittee%20Folder/2-24-14%20MH%20Subcom%20Meeting/IVd-Diamond%20Concepts%20for%20Improving.02.14.14.pdf*, accessed on July 8, 2014.

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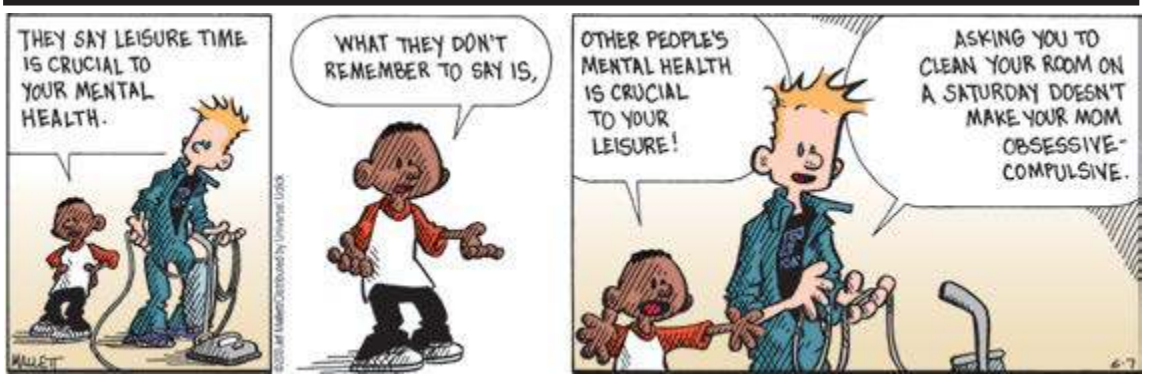

Second-Term Republicans Gain in New Effectiveness Rankings

By Paige Worsham and Ran Coble

With a supermajority in the state legislature, Republicans claimed the top 15 spots in both houses in the rankings of legislators' effectiveness by the N.C. Center for Public Policy Research. President Pro Tem of the Senate Phil Berger (R-Rockingham) and Speaker of the House Thom Tillis (R-Mecklenburg) top the rankings for the second time in a row.

Sen. Phil Berger

President Pro Tem of the Senate Phil Berger (R-Rockingham) and Speaker of the House Thom Tillis (R-Mecklenburg) top the rankings for the second time in a row.

Rep. Thom Tillis

The biennial rankings are a mirror of what happens in the legislature and who makes it happen. Over the years, the key factors in a higher effectiveness ranking are being in the majority party, how long the legislator has served, being chair of a committee, and their personal skills in moving legislation.

In the 2013–2014 legislative session, Republicans hold a supermajority in both the Senate (33–17) and the House of Representatives (77–43). This follows a shift in control from a Democratic majority in 2010 to Republican control in 2011. By 2014, 97 (57%) of the current 170 legislators were not in the legislature just four years ago.

Second-Term Republicans Make Big Gains

Republicans who were first elected in 2010 and who are serving their second term in 2013–2014 made big gains in the rankings this year. Second-term Republicans in the 50-member Senate jumped an average of 11 spots in the rankings, while second-term Republicans in the 120-member House went up an average of 27 places. Sen. Rick Gunn (R-Alamance) rose 22 places from 33rd in 2012 to 11th this year. Sen. Brent Jackson (R-Sampson) moved up 19 places to 8th in effectiveness, while Sen. Bill Rabon (R-Brunswick) moved up 11 places to 7th. Both Jackson and Sen. Kathy Harrington (R-Gaston), the highest-ranked female in the Senate, were named Co-Chairs of the powerful Senate Appropriations Committee for the 2014 session, along with Sen. Harry Brown (R-Onslow), who ranks 4th.

In the House, second-term Republican Representatives Craig Horn (R-Union) and Harry Warren (R-Rowan) each rose 46 places in effectiveness. Horn jumped from 66th to 20th and Warren from 82nd to 36th. However, the biggest jumps in the House were by Democratic Representatives Susi Hamilton (D-New Hanover), up 60 places from 102nd to 42nd, and by Larry Hall (D-Durham), up 49 places from 72nd to 23rd. Hall is the Democratic Minority Leader in the House.

Paige Worsham is the policy analyst and Ran Coble is the executive director of the N.C. Center for Public Policy Research.

Speaker Hopefuls Also Move to Top Echelon

Speaker of the House Thom Tillis is the Republican nominee for the U.S. Senate in the November elections and is not seeking re-election to the state legislature, so the House will have a new leader in 2015. At least seven House members have been mentioned as possible candidates for Speaker in 2015, and all seven finished in the top 13 in effectiveness.

Sen. Kathy Harrington (R-Gaston) is the highest ranked female in the Senate.

They are Rep. Tim Moore (R-Cleveland), Chair of the powerful Rules Committee, finished 2nd behind Tillis; David Lewis (R-Harnett), Co-Chair of the Finance Committee and the Elections Committee, ranks 4th; Appropriations Committee Senior Chair Nelson Dollar (R-Wake) ranks 6th; and Republican Majority Leader Edgar Starnes (R-Caldwell) ranks 8th; Public Utilities and Energy Committee Chair Mike Hager (R-Rutherford) ranks 11th; and Regulatory Reform Committee Chair Tim Moffitt (R-Buncombe) ranks 12th; followed by Leo Daughtry (R-Johnston), Co-Chair of the Appropriations Committee on Justice and Public Safety and Chair of the Judiciary Committee, at 13th.

Highly Ranked, Regardless of Whether Their Party Is in Power

Over the years, some legislators have consistently ranked highly in effectiveness, regardless of whether their political party was in the majority or minority. Democrats held a majority in three sessions in the last 10 years, while Republicans have had a majority since 2011. Sen. Fletcher Hartsell (R-Cabarrus), who ranks 12th this year, has ranked in the top 12 in every survey since 2003. In the House, Rep. Rick Glazier (D-Cumberland), who ranks 16th this year, has ranked in the top 25 since 2005. And, Rep. Paul Stam (R-Wake), who ranks 7th this year, has ranked in the top 10 since 2007.

Rep. Susi Hamilton (D-New Hanover), jumped up 60 places from 102nd to 42nd.

Turnover Continues: Some of the Most Effective Legislators Will Not Return

High turnover in the legislature continues this year, even before the 2014 elections are held. At least 21 legislators who started the 2013 session will not be back in 2015. This includes some of the most effective members of the Senate and House.

Eight Senators — four Republicans and four Democrats–will not return in 2015. This includes Sen. Pete Brunstetter (R-Forsyth), who ranks 3rd in the latest rankings, but who resigned after the 2013 session to take a position with Novant Health. Senate Appropriations Committee Co-Chair Neal Hunt (R-Wake), who ranks 10th, and Thom Goolsby (R-New Hanover), who ranks 14th, both decided not to run for re-election, as did the Senate's longest-serving member, Sen. Austin Allran (R-Catawba), who has been in the Senate since 1986. Four Senate Democrats also will not return, including Minority Leader Martin Nesbitt (D-Buncombe), who died on March 6th.

Even before the 2014 elections, 13 Representatives will not return to the state House — 6 Republicans and 7 Democrats. Those not returning include highly-ranked Speaker Tillis and Republican Conference Leader Ruth Samuelson (R-Mecklenburg), who ranks 5th in effectiveness, as well as Appropriations Health and Human Services Committee Co-Chair Mark Hollo (R-Alexander), who ranks 41st. Two House members — former Representatives Jerry Dockham (R-Davidson) and Deborah Ross (D-Wake) — moved to other jobs during the 2013 session. Two House members — Representatives Jim Fulghum (R-Wake) and Andy Wells (R-Catawba) — are running for state Senate seats. In July 2014, Fulghum announced he had cancer and was withdrawing from his Senate race. He passed away on July 20, 2014.

However, the 2014 elections are unlikely to see as much turnover as the past two elections because redistricting has created a lot of safe seats. Eighteen incumbent

Senators have no opposition in the November general election, and 52 House incumbents also face no opposition.

Most Effective Freshmen

In the Senate, Sen. Jeff Tarte (R-Mecklenburg) ranks as the most effective freshman at 24th this year. Among freshmen in the House who were new to the legislature in 2013, Rep. Dean Arp (R-Union) and Rep. Jim Fulghum (R-Wake) rank as the highest freshmen, at 38th and 39th, respectively.

Most Effective Females and African Americans

Sen. Kathy Harrington (R-Gaston) is the highest-ranked female in the Senate at 13th. Rep. Julia Howard (R-Davie), who is serving her 13th term, is again the highest-ranked woman in the House at 3rd. Rep. Ruth Samuelson, who is not running for re-election this year, ranks 5th, moving up 13 spots.

Sen. Dan Blue (D-Wake) at 23rd and Rep. Larry Hall (D-Durham) at 23rd are the top-ranked African American legislators in the Senate and House, respectively.

Sen. Dan Blue

Sen. Dan Blue (D-Wake) at 23rd and Rep. Larry Hall (D-Durham) at 23rd are the top-ranked African American legislators in the Senate and House, respectively.

Legislators with Perfect Attendance

This marks the seventh time the Center has tabulated rankings of attendance and roll call voting participation, using official records from the N.C. General Assembly. Six Senators had perfect attendance: Chad Barefoot (R-Wake), Ben Clark (D-Hoke), Floyd McKissick Jr. (D-Durham), Shirley Randleman (R-Wilkes), Norm Sanderson (R-Pamlico), and Jeff Tarte (R-Meckenburg). In the House, 21 members had 100 percent attendance. Rep. Nelson Dollar (R-Wake) had perfect attendance for the third consecutive session, while Rep. Mickey Michaux (D-Durham) missed one day, his first absence in six sessions.

The Center praised the dedication of most legislators in attending the session last year. Forty-three of 49* Senators and 102 of 120 Representatives attended more than 90 percent of the days in session. For part-time legislators — many with other jobs back home and often long drives to Raleigh — this attendance record is a significant accomplishment.

Legislators with Perfect Roll Call Voting Participation

Two Senators voted in all 916 recorded Senate votes with no absences or excuses from voting — Sen. Ben Clark and Sen. Shirley Randleman. All 49 Senators included in the rankings had voting participation percentages over 95 percent.

Only one Representative voted in all 1,354 electronically-recorded roll call votes with no absences or excuses from voting — Rep. Nelson Dollar. Dollar has participated in every vote for five consecutive sessions.

Rep. Larry Hall

Five Different Measures of Legislators' Performance

The Center compiles the three sets of rankings to give citizens different ways to evaluate the performance of their legislators. The rankings of attendance and voting participation tell citizens how often their legislator was there to represent them. The effectiveness rankings tell citizens how effective their legislator was when he or she was there.

In odd-numbered years, the Center publishes additional evaluations of legislative performance. *Article II: A Citizen's Guide to the Legislature* includes data on how many bills each legislator introduced and how many of those he or she got passed.

The guide also includes all members' votes on what legislators said were the 12 most important bills of the session. The Center now publishes a total of five different measures of legislators' performance: effectiveness, attendance, voting participation, success in getting bills passed, and votes on the most significant bills of the session.

How the Effectiveness Rankings Are Done

The Center's effectiveness rankings are based on surveys completed by the legislators themselves, by registered lobbyists who are based in North Carolina and who regularly work in the General Assembly, and by capital news reporters. These three groups are asked to rate each legislator's effectiveness on the basis of participation in committee work, skill at guiding bills through committees and in floor debates, and general knowledge or expertise in specific fields. The survey respondents also are asked to consider the respect legislators command from their peers, his or her ethics, the political power they hold (by virtue of office, longevity, or personal skills), their ability to sway the opinions of fellow legislators, and their aptitude for the overall legislative process.

This year's rankings mark the 19th time the Center has undertaken this comprehensive survey. The first edition evaluated the performance of the 1977–78 General Assembly. The response rate to the survey continues to be very high. Sixty-three of the 120 House members (53 percent) responded to the Center's survey, as did 33 (66 percent) of the 49 Senators, 159 of the 438 registered lobbyists who regularly work in the legislature and are based in North Carolina (36 percent), and 6 of 36 capital news correspondents (17 percent)—all well above accepted standards of statistical validity. The overall response rate was 40 percent, the same as in 2012 and 2010.

*Sen. Martin Nesbitt died on March 6, 2014 and is not included in the rankings.

Memorable Photo

Sheila Davies

North Carolina is on the cutting edge of telemedicine initiatives nationally, but local communities enjoy the creative marketing as well.

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