
POLICY REPORT

# Mental Health Reform
# Steps Toward Improvement

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OCTOBER 2008

John Locke
FOUNDATION

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## Summary

Mental health reform began in 2001, but has had disappointing results. This paper examines major areas of the mental health system – care management, criminal justice, provider networks, supplemental services, and payment. It offers some evolutionary steps toward improvement:

- Expand the 1915(b) waiver currently used by Piedmont Behavioral Health to other local management entities (LMEs).
- Allow LMEs to compete and expand across geographic boundaries.
- Encourage more counties and LMEs to adopt crisis intervention teams as a way to improve the community-care system, improve public safety, and allow jails to be used for other offenses.
- Ease restrictions on scope of practice that limit the ability of nurses and other doctors to provide access to psychiatric care in more places at less cost.
- Keep Dorothea Dix Hospital open indefinitely and adjust staffing and training at state mental hospitals to the evolving role of hospitals as crisis centers with some long-term patients.

These steps change incentives for participants in the system, not their behavior. These incentives should, however, redirect the state mental health system's focuses to customers and outcomes rather than process and rules.

## Introduction: A Litany of Complaint

After seven years of reform, the state mental health system has yet to provide the hoped-for improvement in outcomes for those with serious mental illness. There is plenty of blame to go around.

- From the start, **legislators** tried to impose changes in every aspect of the system at once, failed to provide transitional funds, gave unclear directives to local mental health programs, and then created new services and tinkered with pieces of reform without considering the system as a whole once reform was in motion.

- Some **local mental health programs** dropped their crisis centers too soon without having alternatives in place, lost their care provision staff in the process of dividing into two entities, lost some of their focus on the consumer as they dealt with transitions, and did not develop the contract management skills needed to work with private providers when that became their focus as local management entities (LMEs).

- The **Division of Mental Health** failed to provide appropriate measures of local performance, focused on creating new programs without getting existing programs right, and mismanaged state mental hospitals.

- State lawmakers and **Medicaid** set payment levels too low to keep existing psychiatric providers and attract new providers into the system, set rates too high for poorly defined community support services, costing the state at least $400 million, according to one widely cited investigation. Community hospitals continued to close psychiatric beds, and other private providers also left the system.

- Gov. Mike Easley, Secretary of Health and Human Services Carmen Hooker Odom, and Mike Moseley in the Division of Mental Health together let the system languish instead of expanding successful experiments statewide.

## Background

This paper will provide a brief history of reform, detail some of the problems with the current system, and offer some recommendations for improvement. The focus here will be on the mental health system, excluding services for developmental disabilities and substance abuse except tangentially, although I readily acknowledge the high level of co-occurrence between substance abuse and mental illness, and the importance of meeting the needs of all three populations. Within mental health, too, the scope will be mostly confined to issues among individuals with severe mental illness. Even with those restrictions, the paper will deal with issues at a number of levels – state mental hospitals; community-based care options; interactions with the criminal justice system; regulation of health care providers; supplemental services; and the appropriate roles for federal, state, and local governments in paying for mental health services.

North Carolina's 2001 plan to move mental health patients from state hospitals to community-based providers was backed by plenty of research, a 1999 U.S. Supreme Court decision,[1] and a presidential executive order[2] in support of the concept. Since then, President Bush's New Freedom Commission (NFC) on Mental Health[3] praised North Carolina, saying its "Mandated reform act 'looks like' NFC recommendations,"[4] which some call privatization because of its reliance on private providers, although it is still government-funded and -managed.

Despite having years of evidence and numerous studies to draw on in designing reform, however, the state's mental health system faces charges today similar to those a decade ago. Continuity of care, quality of treatment, and use of state mental hospitals have not improved. Private providers are hard to find because of low reimbursement rates and a complex bureaucratic process. Few counties have 24-hour crisis services available. Some mental health advocates even long for the system before reform. The National Association for Mental Illness (NAMI) warned that North Carolina shows the "risks of imbalance" in the mental health system.[5] The U.S. Department of Justice also found multiple problems in the state's mental hospitals in 2004,[6] most of which still exist.

Our investigation revealed a number of constitutional and federal statutory violations at the four facilities [Dorothea Dix in Raleigh, John Umstead in Butner, Cherry in Goldsboro, and Broughton in Morganton] including: (A) inadequate mental health treatment; (B) inappropriate use of restraints and seclusion; (C) inadequate nursing and medical care; (D) failure to ensure the reasonable safety of patients; (E) unsafe physical plant conditions; and (F) inadequate discharge planning, as evidenced by the failure to provide services to discharged patients in the most integrated setting. A major cause of many of the unlawful conditions we identified stems from a fragmented, decentralized mental health system with unclear, unspecified standards of care, and an insufficient number of adequately trained professional and direct care staff to meet the needs of patients.[7]

Despite this broad indictment of the mental health system and deaths in state mental hospitals, however, privatization has received much of the blame, and some advocates speak longingly about the pre-reform system.

Privatization is not the problem, and neither returning to the old nor blindly increasing funding is the answer. Reformers have too often forgotten the main rule of medicine: First, do no harm. Each reform so far has provided an initial shock to the system followed by new problems and another round of revisions. Even when well intentioned, these changes have tended to make the system more complicated and less responsive to consumer needs.

Reforming the reform the right way depends on establishing responsibility at the right level for how those resources are allocated and providing the right incentives for everyone in the system to seek better patient outcomes, not returning to a system that was also found to violate the rights of patients. Although there is no perfect system to emulate, many states have achieved success in one area or another. Some local management entities (LMEs) within North Carolina also have developed practices that the state can expand fruitfully to other regions.

## HISTORY OF REFORM

Reviews of the state mental health system before 2001, including a John Locke Foundation paper[8] and a report from the state auditor's office,[9] generally agreed on some basic elements of any reform. The state could close one of its hospitals, likely the 150-year-old Dorothea Dix Hospital, and rely on three regional hospitals with fewer beds. Usage of beds in mental health wards at private hospitals and in state mental hospitals had been declining, so this seemed reasonable. As a way to help meet needs in community-based services, the state would set aside General Fund money to create a mental health trust fund.

These reviews also agreed counties should fund area mental health agencies, which should focus on their role as care managers and outsource provision to the private sector. Putting counties in charge of community service management and separating the roles of local agencies would ease some of the conflicts of interest and lack of accountability that had led to problems.

The General Assembly dropped most of these recommendations when it passed mental health reform legislation in 2001. County officials, who were already responsible for 15 percent of the state's ever-expanding Medicaid burden, balked at the prospect of taking on another function subject to state expansion. Legislators agreed not to force counties to fund local management entities (LMEs), so the newly created LMEs like the area mental health agencies they were to replace, still lacked accountability to a government or a market.

LMEs did eliminate one potential conflict of interest by separating the care provision function from care management, two functions that had been combined in area mental health agencies. Agencies separated their care providers into new nonprofits that were supposed to compete for patients from the LMEs. Mental health advocates say this reform went too far, and many LMEs also stopped providing crisis services.

Lawmakers created a $50 million mental health trust fund in their final bill, but eliminated its funding and raided other trust funds to meet a shortfall in the 2001-02 General Fund budget. This diversion meant fewer resources were available to build an adequate community-services infrastructure to handle the influx of patients being released from state hospitals.

As a final guarantee of trouble, lawmakers also decided to implement the final version of reform on a statewide basis with no pilot version, as is typically the case with such wide-ranging changes.

Fig. 1: Long-Term Discharges Spiked Early in Reform

(Discharges by Length of Stay Compared to FY200)

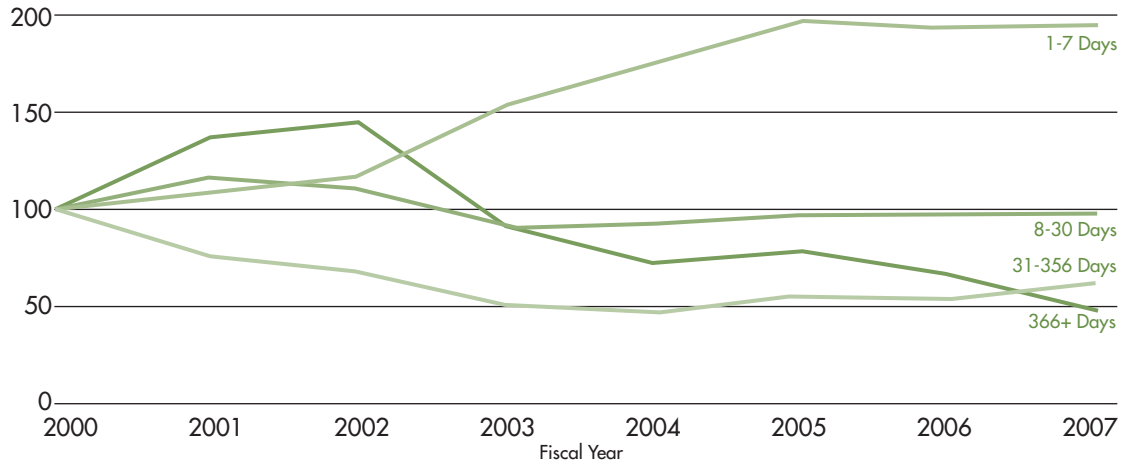
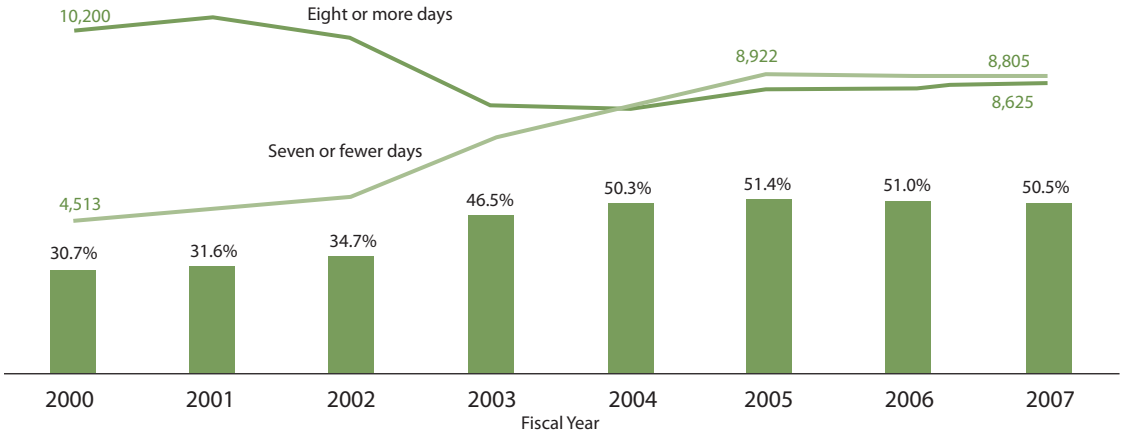


Fig. 2: Before Reform, Less than One-Third of Stays in State Hospitals Were One Week or Shorter; Since 2004, One-Half of Stays Have Been




## STATE HOSPITALS

The principal goal of the 2001 reforms was to move people from state mental hospitals into the community. This would also give the state a chance to consolidate the two hospitals in the central area of the state (Umstead and Dix) into a single Central Regional Hospital in Butner before replacing the other two state hospitals with new facilities. Research, the Supreme Court's *Olmstead* decision, pressure from advocate groups, and the federal Department of Justice confirmed the importance of this goal.

Poor planning and timing, however, have left state mental hospitals more taxed than before reform. Instead of building the community-based system first and ensuring its viability, the 2001 reforms counted being able to close beds and save money in state mental hospitals to pay for the new community care options. The result was a perverse incentive in 2001 and 2002 for state hospitals to reduce their resident populations by discharging long-term patients into the community and dealing only with the immediate crisis for many newly admitted individuals. By fiscal 2007, half of discharges were patients who had been hospitalized for one week or less, compared to less than one-third before reform.[10] This reduced average daily populations by as much as half, even as admissions climbed more than 15 percent.[11]

Because of the changes in discharge and admission patterns, hospitals now have more short-term patients who make up a larger proportion of the hospital population. (Half the average daily population across all hospitals in FY 2007 was from adult admissions or forensic patients.) Hospital psychiatrists, nurses, and other staff need different skills to work with a more crisis-prone population with high turnover. Most of the costs are also up front, particularly in determining the most appropriate treatment for a person.

It is no wonder, then, that safety in state hospitals, where there have been more than 80 questionable patient deaths since December 2000[12] and attacks on nursing staff, remains a key concern. The Department of Justice cited state hospitals again in 2004. Broughton Hospital in Morganton lost its federal funding in 2007 after one such death, and administrators then failed to report four deaths that occurred while the facility was going without those Medicaid and Medicare payments.[13] Cherry Hospital in Goldsboro was on the verge of losing its funding in September, but administrators were able to make changes to avoid that fate.[14] Both Dix and Umstead Hospitals also faced losing their status as Medicare and Medicaid providers.[15] Central Regional Hospital's very design raised safety concerns even before it opened.

Seven years into reform, state officials have accepted the need to keep Dorothea Dix Hospital open until at least 2011 to handle forensic and other patients for whom the Central Regional Hospital will not have room. This pushes the anticipated cost savings from hospital consolida-

tion even further into the future, which in turn leaves money to build the community system still out of reach, in turn leaving state hospitals as the primary location for care, and continuing the cycle of disappointment in reform.

## LMES AND COMMUNITY-BASED CARE

State-created and -funded, but with boards appointed by county commissioners, Local Management Entities (LMEs) are supposed to direct patients to the most appropriate source of care, work to build the network of providers available, and ensure that patients receive appropriate care from one of those providers. LMEs were created when reform split the care-management and care-provision functions of area mental health programs from each other in an attempt to reduce the conflicts of interest in recommending a provider and being a provider.

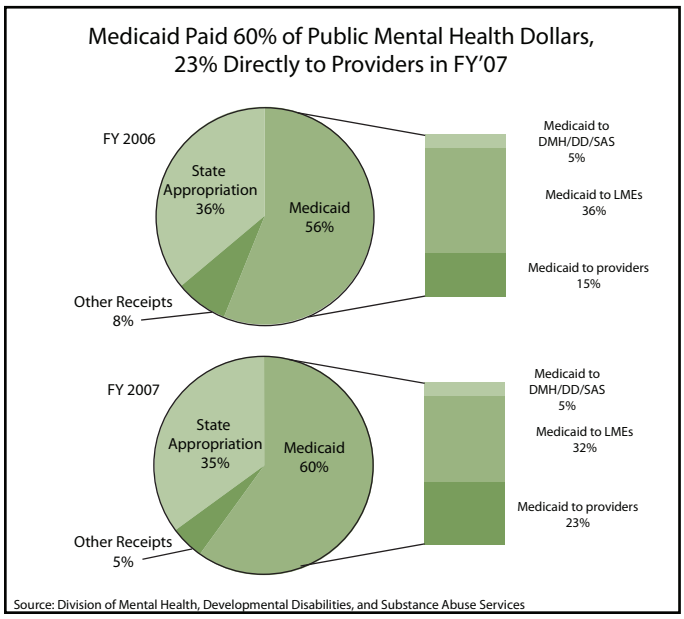
Neither the LMEs nor the provider organizations with whom they once shared offices had all of the skills needed for their new roles, such as contract management. Despite that, reform began by expanding the provider network, which left LMEs struggling to establish rules for the new providers. "We all did address specific problems," said Rep. Verla Insko, "without considering the impact those decisions would have on other parts of the system. When you do one thing to one part of the system it had a negative impact on the others."[16]

Local crisis centers closed as the providers formerly tied to LMEs lost their ability to cross-subsidize services. Some providers claim that the lower Medicaid reimbursement rates and delayed reimbursements have forced them to close because of financial difficulties.[17] The North Carolina Psychiatric Association says community psychiatrists also moved into other practices instead of taking a risk in an LME-funded provider. Despite these difficulties, North Carolina still ranked in the top twenty states for the number of psychiatrists per 10,000 persons in 2004, although with relatively fewer psychiatrists than in 1999.[18]

When care providers did emerge, former employees of the area mental health center with no managerial experience often staffed them. Staff who remained in the newly created local management entities (LMEs) had little experience in managing multiple providers. Without the care provision function, LMEs effectively were virtually shut out of a significant portion of the Medicaid payment system. This portion grew as providers realized that once they were approved by the LME for services they could bill straight to Medicaid. (see Fig. at left)

State Medicaid policymakers set payment levels too low for some services and too high for others, so psychiatrists left the system and more unskilled workers such as sitters entered, with one estimate of $400 million wasted to provide community support services.[19]

In April 2007, to gain some control over the mental health system, the Division of Medical Assistance cut Medicaid reimbursement rates for community support service providers to $51 an hour from $61.[20] Even mental health advocates criticized the cheating by some providers who took advantage of their ability to bill Medicaid directly for their services. But advocates and some LME officials said the reimbursement cuts could make it more difficult for good providers, who include more professional care in their community support services, to survive and thereby



exacerbate the very problem the rate cut was meant to address. A performance audit by the Office of the State Auditor released in July 2008 found that DHHS had been lax in managing its contract with utilization review contractor Value Options.[21]

Piedmont Behavioral Health (PBH) – the LME for Cabarrus, Davidson, Rowan, Stanly, and Union counties – receives payment from Medicaid for each person it serves through a state-level 1915(b) Medicaid Managed Care Waiver. This waiver allows PBH to combine not just state and local funds, as some other LMEs also do, but to control Medicaid funds as well. With three funding sources, PBH can adjust payments to providers to match services better with consumer needs, and can pay claims sooner than Medicaid can. PBH management has an incentive to find good care at an appropriate rate and reinvest the savings to expand access and provide essential support services to get mental health consumers engaged in the community.

PBH shows better performance in a number of areas than the rest of the state does. Also, because of its ability to control and monitor Medicaid funds directly, PBH avoided much of the problem the rest of the system had with community support services.[22] There has been little apparent effort by DHHS or the legislature to expand this program to other LMEs, which still are not able to hold providers as accountable for results.

Just as most LMEs cannot hold providers accountable for their Medicaid-reimbursed services, some LMEs also return their allocations from the state, and others spend nearly all of their funds. Nobody has any idea why in either case. In the case of Southeastern Center for Mental Health, Developmental Disabilities, and Substance Abuse Services, it failed to spend $2.4 million (34 percent of its state funding) in fiscal year 2007, so had its state allocation cut by that amount in fiscal 2008. Then the center started warning providers in February 2008 that it could serve only new cases that were urgent.[23] By June, management said it could make it through the end of the fiscal year, but already warned that fiscal 2009 would be difficult. Sen. Julia Boseman called for an audit of the Center to determine how it could spend money that erratically from one year to the next.[24] No audit was complete at this writing.

The ten-county Albemarle Mental Health Association in northeastern North Carolina had been the most egregious example of poor financial controls among LMEs, and one criticized by Gov. Mike Easley. Its director, Charlie Franklin, has a yearly salary of $319,000 to manage care for 4,700 individuals, more than twice as much as the next highest-paid director.[25] Franklin's top assistant has a $143,000 salary, higher than all but three directors in the state.[26]

Secretary of Health and Human Services Dempsey Benton presented a plan in April 2008 that would give much more power to state government in overseeing LMEs. One criticism from state officials stemmed from county governments' ability to appoint the board of directors for the area authorities. Benton also sought to speed the process to remove functions from local management. The stated goal of these moves is to make mental health more of a system. While they change the structure of mental health care in the state, however, they do little to improve monetary controls or other incentives.

Another effort would combine LMEs into regional authorities. This is something that some LME directors also support, noting that the original reform plan anticipated more mergers more quickly than has been the case, as well as more county funding. County officials may be too vested in the existing LME structure to allow mergers otherwise, according to one version of this argument. One factor that likely has also slowed mergers among LMEs is that they are geographically protected. Local entities cannot provide services to individuals who live outside their prescribed territories, which means less competition among LMEs and less incentive for inefficient care managers to merge.

The number and geographic scope of care management organizations is less important than the ability of those organizations actually to manage care. This means not just getting

control of the multiple money streams, but also ensuring that staff members in the organization have the authority and resources to work with consumers in an effective way. Without effective care management and an appropriate community network, patients end up cycling through emergency rooms and state hospitals.

**Alleghany County, Penn., Mental Health Court: Net Annual Cost Saving / Increase Per Participant**

| | One Year After Diversion | Two Years After Diversion |
|---|---|---|
| Total costs[a] | -$1,804 | **-$9,584** |
| Mental health costs | -$1,920 | **-$6,876** |
| Jail costs | -$5,656 | **-$5,948** |

[a] Total cost includes the costs of arrests, prison, probation, cash assistance, and MHC administration in addition to mental health and jail costs.

Source: Ridgely, et al., "Justice, Treatment, and Cost," RAND Corporation, 2007

Many of the most seriously ill patients end up in jail for public nuisance crimes, and sometimes for violent crimes. A reformed mental health system will be able to catch more of these people and direct them to care instead of incarceration.

## JAILS, COURTS, AND PRISONS

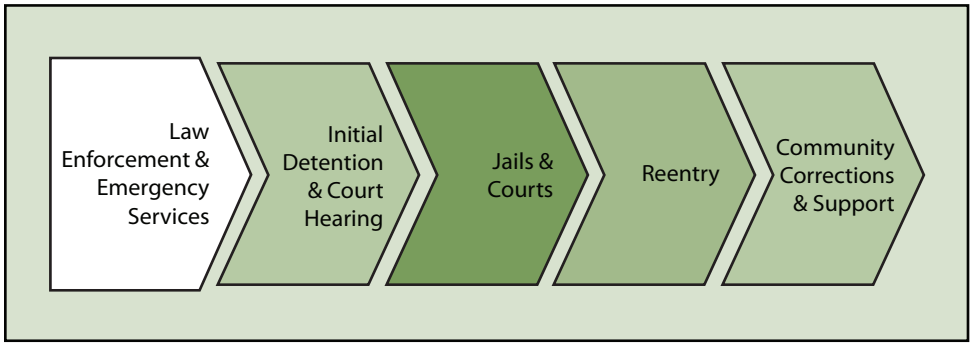
Nationally, roughly16 percent of jail and prison inmates suffer from severe mental illness, and 10 percent of police encounters involve a mentally ill individual.[27] North Carolina has as many as 20,000 people in jail awaiting trial at any time, which means that about 3,200 of them are likely to have a mental illness. If counties and the state could move a fraction of these people to community care systems where they actually received treatment, the systemwide potential for savings would be significant. The potential to return individuals to the community successfully is even greater.

Memphis, Tennessee, has developed two programs that can help achieve these goals. One is called crisis intervention teams (CIT) and involves training police how to respond to situations and de-escalation techniques.[28] Wake and Durham counties have implemented CIT programs, and the state chapter of the National Alliance on Mental Illness (NAMI NC) recently co-hosted a statewide seminar on the program. The public defenders' office in Memphis also has created the Jericho Project to divert mentally ill individuals from jail into treatment.[29]

Both of these programs and other activities, such as mobile crisis teams and mental health courts, fit into the sequential intercept model, a way of thinking about the interaction between the mentally ill and the criminal justice system. This model relies on a strong community-based mental health system that can keep people in treatment and avoid arrest, or to accept inmates upon their release from jail or prison.

There are three significant benefits of CIT compared to mental health courts and other interventions, all of which improve treatment outcomes and public safety with less recidivism. First, the police officer or deputy trained in this technique can evaluate a situation himself and act instead of waiting for a social worker or others to arrive. Second, the officer can keep a situation in check without violence or injury. Third, because the intervention occurs in the field, it can preempt all of the costs of jail. This last is significant because jail inmates with mental illness cost more to detain per day

Sequential Intercept Model



and have longer detentions than other inmates.

Once a CIT program is in place, the next step in jail diversion is a mental health court or program like Memphis' Jericho Project. Programs like these can help individuals who could not be diverted before booking because of the nature of their crime. These programs work with a court order and consider mental health treatment as an alternative to a criminal sentence, with actual prison time the next step if a person does not comply.

The jails themselves should also be in touch with the local care manager to see if an inmate is in treatment and what medications he is taking. In addition to providing treatment while in custody, some of the more active jails in dealing with mental illness also work to ensure follow-up care for the inmate upon release.

## PROVIDERS

The state can do more to incorporate primary care physicians and allied health professionals such as nurse practitioners in the continuum of care as a step to improve that community-based system.[30] This would address some of the stigma associated with mental illness, which is as much a physical problem as heart disease is. It could also address the access issue for patients in the 17 counties with no psychiatrists and the other 65 counties with less than one psychiatrist per 10,000 residents. There is no logical reason properly trained nurse practitioners cannot provide referrals to specialists or refill prescriptions. State-imposed scope-of-practice regulations that limit the ability of health professionals to use skills and knowledge they have, however, make such common-sense recommendations difficult to implement.

Legislators included more than $6 million for walk-in crisis care and telepsychiatry equipment in their proposed fiscal 2009 budgets, but did nothing to improve the access individuals can have to some aspects of mental health care through medical providers

### State Spending on Mental Health has Little Relationship to System Effectiveness

| | | Spending Equivalent for North Carolina* | |
|---|---|---|---|
| | NAMI Grade | Per Capita | Total (millions) |
| District of Columbia | C | $241.85 | $ 2,006.6 |
| Pennsylvania | D+ | $172.08 | $ 1,427.7 |
| New York | U | $148.28 | $ 1,230.3 |
| Vermont | C- | $139.94 | $ 1,161.0 |
| Montana | F | $134.43 | $ 1,115.4 |
| Arizona | D+ | $132.91 | $ 1,102.7 |
| Maine | B- | $125.28 | $ 1,039.4 |
| Hawaii | C | $114.52 | $ 950.2 |
| Mississippi | D | $112.58 | $ 934.0 |
| Maryland | C+ | $111.24 | $ 923.0 |
| **Connecticut** | **B** | **$98.78** | **$ 819.5** |
| Minnesota | C+ | $97.61 | $ 809.9 |
| New Hampshire | D | $95.31 | $ 790.8 |
| California | C | $91.48 | $ 759.0 |
| Michigan | C+ | $90.71 | $ 752.6 |
| Wyoming | D | $88.88 | $ 737.4 |
| New Jersey | C | $87.72 | $ 727.8 |
| Tennessee | C- | $86.55 | $ 718.1 |
| Wisconsin | B- | $83.14 | $ 689.8 |
| Utah | D | $80.16 | $ 665.1 |
| Rhode Island | C | $78.52 | $ 651.4 |
| North Dakota | F | $78.37 | $ 650.2 |
| Washington | D | $77.09 | $ 639.6 |
| Massachusetts | C- | $75.32 | $ 624.9 |
| South Carolina | B- | $72.59 | $ 602.2 |
| Iowa | F | $71.65 | $ 594.5 |
| Alaska | D | $71.55 | $ 593.6 |
| Indiana | D- | $70.99 | $ 589.0 |
| Kansas | F | $70.95 | $ 588.6 |
| Delaware | C- | $70.05 | $ 581.2 |
| Alabama | D | $65.34 | $ 542.1 |
| Missouri | C- | $64.96 | $ 539.0 |
| South Dakota | F | $63.64 | $ 528.0 |
| **Ohio** | **B** | **$58.49** | **$ 485.3** |
| Virginia | D | $57.48 | $ 476.9 |
| Nevada | D- | $56.70 | $ 470.4 |
| West Virginia | D | $56.45 | $ 468.4 |
| Louisiana | D- | $55.54 | $ 460.8 |
| Illinois | F | $55.41 | $ 459.8 |
| Kentucky | F | $55.14 | $ 457.5 |
| Colorado | U | $54.60 | $ 453.0 |
| Oregon | C+ | $54.36 | $ 451.0 |
| Nebraska | D | $53.51 | $ 444.0 |
| **North Carolina** | **D+** | **$50.26** | **$ 417.0** |
| Georgia | D | $47.84 | $ 396.9 |
| Oklahoma | D | $41.77 | $ 346.5 |
| Texas | C | $37.51 | $ 311.2 |
| Idaho | F | $36.71 | $ 304.6 |
| Florida | C- | $35.23 | $ 292.3 |
| Arkansas | D- | $34.37 | $ 285.2 |
| New Mexico | C- | $31.84 | $ 264.2 |

*adjusted for personal income and population
Source: NAMI, author calculations

or psychiatric nurse practitioners.

If, as providers and LME officials have indicated, Medicaid reimbursement rates for some activities are too low to attract sufficient provision, the state should look more closely at expanding the waiver under which Piedmont Behavioral Health currently operates to allow care managers to set appropriate rates for providers in their areas.

## SUPPLEMENTAL SERVICES

Some of the mentally ill continued, as before the reform, to be housed in long-term care facilities with the frail and elderly, raising safety concerns. The budget for fiscal year 2006-07 set aside funds to provide 400 apartments for mentally ill and developmentally disabled persons, which was a goal of advocates.

Job placement is another area in which mental health advocates argue more should be done. The Medicaid definition of community support services was intended to provide payment for some of these supplemental services, but its loose definition and the lack of oversight of the program made it ripe for abuse. Such programs are needed to help integrate the mentally ill into the community, but their effectiveness should be under continuous review. This is unlikely to happen until mental health is funded in the appropriate way – which is a different question than the appropriate amount.

## PAYING FOR CARE

Neither the state nor Medicaid, however, pays appropriately for mental health care. This should not be surprising – Medicaid subsidizes providers instead of patients and pays for procedures instead of care. Fiscal conservatives often suggest saving money by freezing reimbursement rates, but this simply acts as a tax on providers who then face the dilemma of not treating Medicaid patients or passing along even more costs to their private patients.

State policymakers exacerbated the Medicaid problem by failing to provide enough funding early on to help create a better community-based network of mental health care providers.[31]

If counties are to have a voice in managing the mental health system, they should also have some investment in the system, as suggested in early drafts of reform. The alternative is to allow LMEs to compete in counties outside their assigned territory. Counties may also find it in their interest to pay for mental health care if they see it as an alternative to their overcrowded jails.

Most important, however, is not the amount of spending but the quality of spending and the appropriate level of authority to determine spending. Ohio spends 16 percent more per person adjusted for personal income than North Carolina on its top-rated mental health system, but Pennsylvania spends nearly three-and-a-half times as much per person for the same result as North Carolina, according to NAMI. (See table on page 9.)

## Recommendations

The North Carolina mental health system has room to improve. Reform has not delivered on its promise. The problem has less to do with the system's structure and more to do with the separation of decisions about money from decisions about care. When local care management organizations can provide indefensibly high salaries to their executives, when they neglect to spend one-third of their state allocations one year and spend that same amount in six months the next year, or when providers can completely avoid LMEs in seeking clients or billing for services, there are significant problems with accountability.

Giving more power to the governor, Department of Health and Human Services, or Division of Mental Health/Developmental Disabilities/Substance Abuse Services, however, will just add another layer of bureaucracy and put another obstacle between good managers and their clients. Instead, the state should allow local management entities to opt into the existing Medicaid waiver currently used by Piedmont Behavioral Health, to consolidate care management and payment in a single source close to the person in need of care.

Competition among care managers across predefined borders could also improve efficiencies and help spread best practices more rapidly. CIT expansion provides another positive step to improve public safety and build the community care network. Finally, the state should consider inexpensive ways to expand access and lower cost. For example, the state could ease restrictions on the ability of non-psychiatrists to offer psychiatric service such as triage.

Until the community system is strong enough, it would be counterproductive to rush cost savings among state mental hospitals. Staffing and training needs should be evaluated to meet the changing role of hospitals to become short-term crisis treatment facilities with some long-term beds.

If the progress of reform has demonstrated anything, it is the difficulty of moving directly to an ideal state. These simple steps are not radical departures from the current path, but provide some room for flexibility that can lead to evolutionary changes that help the mentally ill become full productive members of society instead of wards of the state.

## Notes

[1] *Olmstead v. L.C.* http://www.bazelon.org/issues/disabilityrights/incourt/olmstead/index.htm.
[2] Executive Order, "Community-based Alternatives for Individuals with Disabilities," June 19, 2001, http://www.whitehouse.gov/news/releases/2001/06/20010619.html.
[3] President's New Freedom Commission on Mental Health, http://www.mentalhealthcommission.gov/reports/reports.htm.
[4] "State Implementation Activities," President's New Freedom Commission on Mental Health.
[5] *Grading the States: A Report on America's Health Care System for Serious Mental Illness*, National Alliance on Mental Illness, 2006.
[6] U.S. Department of Justice letter to Gov. Mike Easley regarding North Carolina's Mental Hospitals, March 17, 2004. http://www.usdoj.gov/crt/split/documents/nc_mh_hosp_findlet.pdf.
[7] *Ibid.*, p. 3.
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Joseph Coletti is Fiscal and Health Care Policy Analyst at the John Locke Foundation. In addition to the biennial Freedom Budget, he has authored reports on the state's spend-and-tax budgeting cycle, better ways to fund roads and schools, the earned-income tax credit, business incentives, tax-increment financing, government employee compensation, and an early look (in July 2005) at the infamous feasibility study behind the Randy Parton Theatre in Roanoke Rapids.

In health policy, Coletti has examined Medicaid spending, offered ways to fund the state's High Risk Pool without new taxes, critiqued the current system of employer-based health insurance, assessed long-term care, and is currently trying to find a way out of the state's mental health madness.

His writing has been in publications such as *Health Care News, Global Corporate Xpansion,* and the *Charlotte Observer.* He has spoken at health care and tax policy conferences and to civic groups across the state. He has appeared on radio and television, including WUNC's "The State of Things" and CNBC Asia.

Before joining the Locke Foundation, Coletti was the Director of Policy and Communications for the U.S.–Japan Business Council in Washington, D.C., where he helped Fortune 1000 companies work with the U.S. and Japanese governments. He also led marketing research and forecasting projects with J.D. Power and Associates in Detroit and Tokyo.

Coletti received a bachelor's degree from the University of Michigan and a master's degree from the Johns Hopkins University Paul H. Nitze School of Advanced International Studies (SAIS). He lives in Cary with his wife and their two children.

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*"To prejudge other men's notions before we have looked into them is not to show their darkness but to put out our own eyes."*

JOHN LOCKE (1632–1704)

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