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spotlight

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Reform the Reform

How mental health reform went wrong and what lies ahead

KEY FACTS: **• North Carolina's 2001 mental health reform was ambitious and well intentioned but flawed.**

• Many proven ideas did not make the final version of reform and lawmakers immediately raided the mental health trust fund to cover a General Fund fiscal crisis in 2001.

• Later changes targeting specific problems have left the entire system worse off.

• Money is spent poorly by local management entities (LMEs) with little oversight, leaving essential services with too little money.

• More money is not the solution. Pennsylvania spends more than three times as much per person as North Carolina with similar results.

• North Carolina's involuntary commitment law does provide better safety for patients and the community than does Virginia's.

• There is no single state to emulate, but many states have gotten specific policies right.

North Carolina's 2001 plan to move mental health patients from state hospitals to community-based providers had plenty of research, a 1999 U.S. Supreme Court decision,[1] and a presidential executive order[2] in support of the concept. Since then, the President's New Freedom Commission (NFC) on Mental Health[3] said that North Carolina's "Mandated reform act 'looks like' NFC recommendations."[4]

Despite having years of evidence and numerous studies to draw on in designing reform, however, the state's mental health system is facing charges today similar to those of 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 Associa-

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tion for Mental Illness 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.

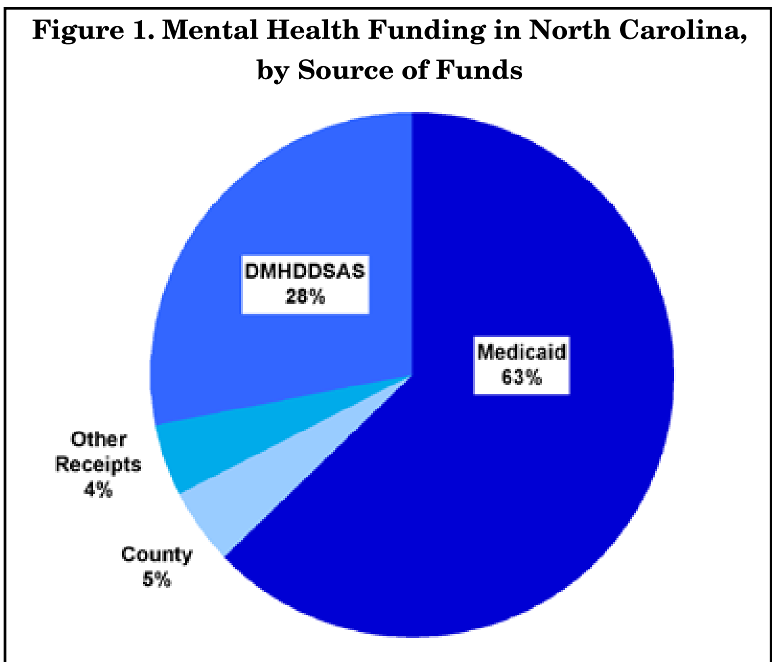

Figure 1. Mental Health Funding in North Carolina, by Source of Funds

What Went Wrong?

Reviews of the state mental health system through 2000, including a John Locke Foundation paper and a report from the state auditor's office, 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 create a mental health trust fund.

These reviews also agreed that 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 accepted this change, so local management entities (LMEs), like the area mental health agencies they were created to replace, still lacked accountability to a government or a market.

LMEs did eliminate one potential conflict of interest by separating care provision from management. The two were combined in area mental health agencies. Agencies separated their care providers into new non-profits 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 did include a mental health trust fund in their final bill, but it was among a number of funding sources tapped 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.

Reform the Reform

Admissions to state hospitals for a week or less began climbing in 2003. Community-based service providers did not provide the necessary follow-up to ensure released patients continued treatment. With no follow-up, patients often

ended up back in a hospital for another short stay.

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, but did not alleviate the pressure on other facilities.

"We all did address specific problems," said Rep. Verla Insko at a recent public forum on mental health, "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." One example she gave was expanding the provider network before ensuring the contract management abilities of the existing system.[6]

Lack of accountability has resulted in some LMEs returning their allocations from the state and others spending nearly all of their funds, but nobody having any idea why in either case. The ten-county Albemarle Mental Health Association in northeastern North Carolina is the most egregious example, and one cited by Gov. Mike Easley to illustrate the lack of fiscal controls over these entities by counties or the state. 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.[7] Franklin's top assistant has a $143,000 salary, higher than all but three directors in the state.[8]

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.[9] Even mental health advocates criticized the cheating by some providers, although they said the reimbursement cuts could make it more difficult for good providers to survive.

Some providers claim that the lower Medicaid reimbursement rates and delayed reimbursements have forced them to close because of financial difficulties.[10] The North Carolina Psychiatric Association says community psychiatrists also moved into other practices instead of taking a risk in an LME-supported provider.

Figure 2. State Mental Health System Grades and Spending

		Spending Equivalent for North Carolina*	
	NAMI Grade	Per Capita	Total (millions)
District of Columbia	C	$241.85	$2,006.64
Pennsylvania	D+	$172.08	$1,427.73
New York	U	$148.28	$1,230.26
Vermont	C-	$139.94	$1,161.04
Montana	F	$134.43	$1,115.36
Arizona	D+	$132.91	$1,102.73
Maine	B-	$125.28	$1,039.43
Hawaii	C	$114.52	$950.16
Mississippi	D	$112.58	$934.03
Maryland	C+	$111.24	$922.97
Connecticut	B	$98.78	$819.53
Minnesota	C+	$97.61	$809.85
New Hampshire	D	$95.31	$790.78
California	C	$91.48	$758.97
Michigan	C+	$90.71	$752.62
Wyoming	D	$88.88	$737.41
New Jersey	C	$87.72	$727.83
Tennessee	C-	$86.55	$718.08
Wisconsin	B-	$83.14	$689.80
Utah	D	$80.16	$665.09
Rhode Island	C	$78.52	$651.44
North Dakota	F	$78.37	$650.23
Washington	D	$77.09	$639.64
Massachusetts	C-	$75.32	$624.93
South Carolina	B-	$72.59	$602.25
Iowa	F	$71.65	$594.47
Alaska	D	$71.55	$593.62
Indiana	D-	$70.99	$589.02
Kansas	F	$70.95	$588.65
Delaware	C-	$70.05	$581.21
Alabama	D	$65.34	$542.14
Missouri	C-	$64.96	$538.98
South Dakota	F	$63.64	$528.01
Ohio	B	$58.49	$485.29
Virginia	D	$57.48	$476.86
Nevada	D-	$56.70	$470.39
West Virginia	D	$56.45	$468.37
Louisiana	D-	$55.54	$460.82
Illinois	F	$55.41	$459.77
Kentucky	F	$55.14	$457.52
Colorado	U	$54.60	$453.04
Oregon	C+	$54.36	$451.04
Nebraska	D	$53.51	$443.96
North Carolina	D+	$50.26	$417.00
Georgia	D	$47.84	$396.90
Oklahoma	D	$41.77	$346.53
Texas	C	$37.51	$311.22
Idaho	F	$36.71	$304.60
Florida	C-	$35.23	$292.31
Arkansas	D-	$34.37	$285.20
New Mexico	C-	$31.84	$264.15

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

Despite these difficulties and a decline in the number of psychiatrists per 10,000 population since 1999, North Carolina still ranked in the top twenty states on this measure in 2004.[11]

All four state hospitals continue to operate. The increased demand for short-term acute admissions has left the state unable to reduce the number of beds. As long as these beds are used, the state cannot divert money to help build the community-services infrastructure needed to make successful transitions from the current hospital-centered system. Replenishing the mental health trust fund would be another important step.

Getting Control

Policymakers are not writing blank checks to reform the public mental health system. They have been cautious in providing new money to the system without accountability, which is one reason the budget proposals for fiscal year 2007-08 have only a small net increase in mental health appropriations. These proposals include allocations for specific types of care instead of system-wide spending.

While the state adds more accountability within the public mental health system, including Medicaid, lawmakers should also seek ways to help the private sector play a larger role in the provision and payment of services for the mentally ill. They can do this without burdening insured people with yet another mandate in their policies. One step to ease the burden is with a requirement to offer mental health coverage. However it is done, insurance companies should not be forced to pay for services outside substance abuse treatment and those with serious mental illness.[12]

Among the few bright spots in the state is that North Carolina's involuntary commitment law provides greater safety to the mentally ill and the community than Virginia's does. It is easier in North Carolina to demonstrate that a patient is a danger to self or others, which means a Virginia Tech situation is less likely to occur here. Other building blocks to an effective system are already in place in North Carolina, but need to be stronger to accommodate the increased demand as state hospitals close.

No state has built an ideal mental health system, but some of South Carolina's reforms have earned high marks from mental health advocates. Ohio and Connecticut have the best systems overall according to NAMI. Pennsylvania, Arizona, Kentucky, and Minnesota have also been commended for specific aspects of their mental health systems. What is clear from this list and the accompanying table showing per capita spending by state and the equivalent North Carolina would need to spend is that quality is not a function of spending. Finding policies that work is.

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End Notes

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13. Treatment Advocacy Center, www.psychlaws.org/LegalResources/statechart.htm.