



Indicators of the Impact of North Carolina's "Mental Health Reform" on People with Severe Mental Illness

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**SUMMARY OF MAJOR FINDINGS – Full Report available for download at
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Hospital Admissions

- State psychiatric hospital admissions have decreased in SFY 07/08 by 24.1% from SFY 06/07, a decrease reflecting, among other things, state enforcement of bed-day allocations and capacity ceilings, and additional bed closures resulting from problems in hospital management. *The state has very limited data about how, and even if, those patients not being admitted are being served.* A report by the Treatment Advocacy Center presents a consensus opinion of experts that states a need of a minimum of 50 public beds for every 100,000 people. The report describes NC as having a severe shortage (over 1000 beds needed).
 - In FY 06/07, adult admissions to local community hospital psychiatric beds rose 5.4% from the previous year, and child/adolescent admissions rose only slightly. Data are not yet available for FY 07/08.
 - In the first three quarters of FY 08, 250,000 psychiatric patients visited emergency departments. Assuming the same rate for the fourth quarter, 332,000 people will have been treated in FY 08. This equates to roughly 69% of the seriously mentally ill population in NC (5.4% of the state population) seeking care in a local emergency department. (Note that some of these could be presenting multiple times.)

Other Important Indicators

- From 2002-2006, there has been a 79% increase in deaths related to mental illness and behavioral disorders. This increase is largely related to the increasing cases of dementia in the elderly (over age 75). Data about those discharged within 30 days from a psychiatric hospital are not available.

- Suicide rates are increasing across the state. In 54 counties, the suicide rate has increased during the time period studied. Fifty eight counties have a suicide rate above the national average of 11.01. Twelve of 25 LME's had suicide rates above the national average.
- Homeless rates for North Carolinians with mental illness increased by 5.3%, and, in FY 06/07, 1,291 people were discharged from state psychiatric hospitals directly to homeless shelters or the street. This represents an increase from 2002 of 30%.
- The cohort of mentally ill is increasing in our jails. According to a survey by the U.S. Department of Justice (James and Glaze, 2006), there are 11,000 mentally ill inmates in NC jails. Over 8,800 will receive no treatment.
- The State Department of Correction (DOC) has no data on the number of people with mental illness in state prisons. However, it has data on the number of psychiatric hospital beds in the DOC which has gone up greatly since 2001. The number of beds is roughly equivalent or possibly greater than the average daily census in all 4 state hospitals.

Impact on Sheriffs' Offices

- The number of transports for involuntary commitment is increasing.
- The number of hours law enforcement officers spend on involuntary commitments is skyrocketing, seriously impacting small sheriffs' departments across the state. Statewide, the average time spent per involuntary commitment is 8 hours. In some cases, counties are spending more money for deputy salaries to transport the mentally ill to hospitals than the county spends on mental health services

Other Important Findings

- Fewer mentally ill consumers are being served, and, of those being served, many are not receiving adequate evidence-based treatment.
- State and county funding for mental health services to consumers has declined since 2001 despite a significant increase in the population of North Carolina.

RECOMMENDATIONS:

- **Create a comprehensive and integrated state system for tracking and reporting data.** This system would integrate data from public health (morbidity, mortality, and suicide), data from our prison and jails, and data from financial management (budget trends, allocations, reimbursements for every type funds and service). For example, in addition to Unit Cost Reimbursement (UCR) billing data for Medicaid and IPRS (Integrated Payment and Reporting System) (DMH/DD/SAS), other funds, such as county-provided funding should be tracked and reported for each type of service, such as medication check, psychosocial rehabilitation (PSR), and Assertive Community Treatment Team (ACTT). The data system would provide information about the number of active providers for each of the services in every LME together with the number of consumers served. With the number of hospital admissions increasing and the number of involuntary commitments growing across the state (see subsequent chapters), it is clear that the level of consumer care is not adequate. However, it is virtually impossible to get a comprehensive picture of services that have been provided. The result is that even when some LMEs are having better outcomes than others, it is impossible to look at data to determine why and to replicate that success elsewhere in the system.

- **Increase the total number of psychiatric hospital beds (community & state).** In the FY 08/09 mental health budget, the Secretary of DHHS and the NC General assembly recognized this as a major need and provided \$8,121,644 for contracts with local community hospitals (Mental Health Association of NC). In the past 50 years, the number of public psychiatric beds in the US has been reduced by 95%. This reduction in psychiatric beds has become a serious problem for many states. A report by the Treatment Advocacy Center presents a consensus opinion of experts that states need a minimum of 50 public beds for every 100,000 people (Torrey, 2008). The report describes NC as having a severe shortage (over 1000 beds needed). Given the current state of the mental health system in NC, we urge state officials and our legislators to stop evaluating LMEs on keeping people out of state hospital beds, and to take an integrated approach to determining how many beds are needed. Such an approach would track and report on the occupancy of psychiatric beds in local community as well as in state hospitals. State psychiatric hospitals are needed until there are enough community hospital beds to accommodate people in crisis.
 - **Update the Certificate of Need process for psychiatric beds.** Currently, it does not address the availability of state hospital beds because those beds do not require a Certificate of Need. This process should be updated to consider the need and utilization of both community and state hospital beds, taking into account admissions at emergency departments as well as patient data for all hospitals (NC Division of Health Service Regulation).

- **Mandate through legislation that both for-profit and non-profit general hospitals be required to provide a certain ratio (as determined by the NC DHHS) of psychiatric beds to acute care medical beds.** Such mandates should apply whenever a CON for additional beds is requested in a region of the state with a shortage of psychiatric beds or with other gaps in services, such as a lack of psychiatric beds for adults insured by Medicaid or for the elderly with co-morbid conditions. Many hospitals are refusing to serve people with mental illness because caring for them is not as lucrative as serving other patients, such as coronary patients. In addition, because of the disabling nature of the illness and the onset in early adulthood, many adults with severe and persistent mental illness are unable to work and have no insurance. And they are likely to have concurrent medical problems that may require hospitals to provide even more indigent care. When hospitals are in a competitive market like that in Wake County, experience has demonstrated that unless required to do so, hospitals will not open psychiatric units. In Wake County, the second largest county in NC with three large hospital corporations expanding to almost every municipality in the county, there is no psychiatric hospital/unit that accepts psychiatric adult consumers between the ages of 22 and 64 insured by Medicaid. In 2008, 1,155 psychiatric /substance patients were transported outside the Wake County for care (NCHA PDS). Revising state CON requirements could help people across the state get the care they need closer to home.

- **Hire, with adequate pay, a qualified mental health workforce throughout the system.** There is a shortage of qualified people with the Division of MHDDSAS to competently manage such a complex organization. Additional staff should be hired at a high enough salary grade to recruit and maintain quality staff. Establish appropriate mechanisms within DHHS to ensure that Division of Medical Assistance and Division of Mental Health functions are fully integrated.

- **Note the growing gaps in mental health care as our population ages, and build facilities to treat the elderly who present both physical and psychiatric symptoms.** This report presents data showing that elderly people with psychiatric illness are dying at a much higher rate. Many of these older consumers have behavioral disorders that make it difficult for them to live in assisted living homes or to be cared for in their own homes. If they become violent, they may need a more restricted or institutionalized setting. If other medical conditions co-exist, the choice for care becomes extremely limited.

State Sheriff's Offices

- **Set up a uniform procedure throughout the state that allows deputies to drop off patients at hospitals, transferring custody to the hospital security.** This includes transports for medical evaluation as well as transports to psychiatric hospitals. We recommend that the legislature appropriate funding for LMEs to compensate off-duty sworn officers at hospitals. This approach places the cost and the treatment responsibility on the health care system, and not on local law enforcement.
- **Set up an alternative mechanism (such as a state-wide contract) for transporting involuntarily committed patients when they are discharged from the hospital.**
- **For counties with fewer than 5 deputies on duty at a time, establish an alternative mechanism for transporting patients under involuntary commitment procedures.** Alternatives might include using EMS responders, with provisions for including off-duty law enforcement if deemed appropriate. This change is important to ensure an adequate number of law enforcement officers is available for community safety.
- **Develop stronger ties between the sheriffs' offices and the LME so that issues related to people with mental illness can be addressed before they become problems.** One problem expressed by many of the sheriffs was that communication between the old area programs in the county worked better than communication with the current LMEs, whose headquarters can be a long distance away and often in another county. Regular meetings between both groups should be convened, results reported, and progress tracked by the LMEs.
- **Continue to encourage Crisis Intervention Team (CIT) training for all law enforcement across the state.** Not only does this jail-diversion program reduce the numbers of mentally ill incarcerated, it also establishes a location where the deputy (or local officer) can transfer custody of an individual to on-site sworn officers.
- **Focus More Intense Efforts on Most Severe & Persistently Mentally Ill**
 - **Designate "high priority" patients.** Consider designating certain SPMI patient populations as high priority patients. These may include those who are discharged from the Department of Corrections or from the jails.

- **Develop ‘treatment malls’ for outpatients based on models at Dorothea Dix and other state hospitals.** Explore potential collaborations between the state hospitals and the LME’s about use of the hospital “treatment malls” for outpatients. In the past there were a number of Day Hospital Programs which helped to facilitate a more stable transition to the Community. This level of service is typically no longer available but the State Hospital treatment malls may be a cost effective alternative.
- **Co-morbid substance abuse problem.** National data would suggest that conservatively 33% of the SPMI population has a co-morbid substance abuse problem. Consideration should also be given to immediately assessing increasing the availability of integrated dual diagnosis treatment to the citizens of NC.
- **Monitoring program fidelity.** Programs administering evidence based treatments should be required to monitor fidelity to the models. There is a likelihood that a shortage of funding may result in treatments that are different than the original model and therefore may not result in the expected outcomes.