NORTH CAROLINA GENERAL ASSEMBLY

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES

SUBCOMMITTEE ON MENTAL HEALTH

Co-chairs:
Senator Fletcher Hartsell, Jr.
Representative Susan Martin

FINAL REPORT
TO THE
FULL COMMITTEE

MARCH 11, 2014

TRANSMITTAL LETTER

March 11, 2014

To Members of the Joint Legislative Oversight Committee on Health and Human Services:

The Joint Legislative Oversight Committee on Health and Human Services, Subcommittee on Mental Health, respectfully submits the following final report.

Representative Susan Martin
Co-Chair

Senator Fletcher Hartsell, Jr.
Co-Chair

SUBCOMMITTEE MEMBERSHIP

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Senator Fletcher Hartsell, Jr., Chair	**Representative Susan Martin, Chair**
Senator Tommy Tucker	**Representative Donny Lambeth**
Senator Louis Pate	**Representative Carl Ford**
Senator Earline Parmon	**Representative William Brisson**

Committee Staff:	
Gerry Johnson, Senate Clerk DeAnne Mangum, Senate Clerk	Anne Harvey Smith, House Clerk
Jan Paul, Research Division	Barbara Riley, Research Division
Jennifer Hillman, Research Division	Susan Barham, Research Division
Patsy Pierce, Research Division	
Joyce Jones, Legislative Drafting Division	Ryan Blackledge, Legislative Drafting Division
Denise Thomas, Fiscal Research Division	Steve Owen, Fiscal Research Division
David Rice, Fiscal Research Division	

SUBCOMMITTEE PROCEEDINGS

The Joint Legislative Oversight Committee on Health and Human Services, Mental Health Subcommittee was created pursuant to G.S. 120-208.2(d). The Subcommittee was required to study the following issues:

(1) The State's progress in reforming the mental health system, with particular focus on the deinstitutionalization process and identifying the appropriate resources for mental health needs.
(2) Existing local supports for community health needs and the possible need for additional investments by the State.
(3) The appropriate capacity in State facilities and the need for additional investments by the State for those individuals with the most severe mental health needs. This may include a review of the current capacity, the growth in need for acute beds, staffing issues, and salary flexibility.
(4) The continuum of care for the State's mental health system, including the various points of entry.
(5) The State's mental health, alcohol and substance abuse disorder statutes related to civil commitments and their alignment with the statewide behavioral health crisis services delivery system.

The Subcommittee met three times from January 24, 2014 until March 7, 2014. This section of the report provides a brief overview of the subcommittee proceedings. Detailed minutes and copies of handouts from each meeting are online and on file in the legislative library. (http://www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=144)

OVERVIEW OF TOPICS AND PRESENTERS

January 24, 2014

- Subcommittee Charges
  Jan Paul, Research Division, NCGA
- An Overview of the North Carolina Mental Health and Substance use Disorders Service System
  Dave Richard, DHHS, Director, MH/DD/SAS
- Points of Entry: Role of the LME/MCO in Helping People Access the Right Mental Health Care
  Leza Wainwright, CEO, East Carolina Behavioral Health
- Inpatient Psychiatric Bed Inventory & Capacity
  Drexdal Pratt, Director, DHHS, Division of Health Service Regulation
- Issues Relating to State Operated Psychiatric Hospitals and ADATCs
  Laura White, DHHS, Team Leader, State Psychiatric Hospitals, Division of State Operated Healthcare Facilities

February 24, 2014

- Access to Behavioral Health Crisis in NC: Shortages and Solutions
  Marvin Swartz, MD, Director, Duke AHEC Program, Duke University School of Medicine
- Improving Healthcare in North Carolina
  David Swann, Chief Clinical Officer, Partners Behavioral Health Management
- Private and Public Roles, Resources and Responsibilities
  Dave Richard, DHHS, Director, MH/DD/SAS
- Provider Perspective on Billing Medicare/Insurance
  Peggy Terhune, PhD., Executive Director, Monarch NC
- Crisis Service Gaps
  Dave Richard, DHHS, Director, MH/DD/SAS
- Crisis Services: Do We Have the Services We Need?
  Pam Shipman, CEO, Cardinal Innovations
- Using Telepsychiatry to Improve Access to Evidenced-Based Care
  Sy Saeed, MD, Director, Center for Telepsychiatry, East Carolina University
- Concepts for Improving Mental Health Service for Children and Adolescents
  John Diamond, MD, Brody School of Medicine, Division of Child and Adolescent Psychiatry, East Carolina University
- Behavioral Health and NC Hospital Emergency Departments
  Erica Nelson, Director of Health Policy, NC Hospital Association
- Community Crisis Services
  Peggy Terhune, PhD, Executive Director, Monarch NC
- Crisis Delivery from a Provider Perspective
  Billy West, Executive Director, Daymark Recovery Services

- Child Welfare Clinical Services Program Model of Wilson County DSS
  Glenn Osborne, Director, Wilson County Department of Social Services
- NC Psychiatric Bed Need vs. Capacity
  Dave Richard, DHHS, Director, MH/DD/SAS
- Community Capacity Pilot Project
  Pam Shipman, CEO, Cardinal Innovations
- Certificate of Need Process for Inpatient Psychiatric Beds
  Martha Frisone, DHHS, Interim Section Chief, Certificate of Need Division of Health Service Regulation
- Certificate of Need and Psychiatric Hospital Bed Capacity
  Erica Nelson, Director of Health Policy, NC Hospital Association
- Alcohol and Drug Abuse Treatment Centers
  Jenny Wood, DHHS, Interim Team Leader, ADATC, Division of State Operated Healthcare Facilities

March 7, 2014

- Overview and Discussion of the Subcommittee Report

SUBCOMMITTEE FINDINGS AND RECOMMENDATIONS

In the mid-1990's, the U.S. Supreme Court ruled that States have an obligation to provide community-based treatment for persons with mental disabilities when: (1) State medical professionals determine community placement is appropriate; (2) placement would be less restrictive and is not opposed by the patient; and (3) community placement can be reasonably accommodated, given resources available to the State and the needs of others with mental disabilities. In response to this ruling, North Carolina began significant reforms to its publicly-funded mental health system. In 2000, there were four State-operated psychiatric hospitals with a total of 1,717 beds with annual operating costs totaling $189 million. Today, the State operates three hospitals with a total 866 beds costing $233 million annually. Hospital construction projects, currently under way at two of the State-operated hospitals, will add another 180 beds by 2016.

The State's original intent was that the money saved by closing hospital beds would be used to increase community-based prevention services and outpatient treatment. However, as shown above, these savings were never realized. Instead, the annual cost to operate the State hospital beds has increased by $40 million. In addition, overall funding for community-based behavioral health services have decreased nearly $80 million, from $417 million in 2000 to $340 million in the current fiscal year.

The importance of community-based, outpatient services in the behavioral health continuum of care was the common theme among the presentations heard by the Subcommittee. When viewed as a pyramid, widely available and accessible community-based prevention, intervention, and treatment services form the base with emergency response and hospitalization at the top. The findings and recommendations presented below are based on the information provided to the subcommittee.

FINDING 1: MENTAL HEALTH SUBCOMMITTEE SHOULD CONTINUE TO EXAMINE STATE'S BEHAVIORAL HEALTH ISSUES AND NEEDS

As indicated by the vast amount and variety of presentations listed in the proceedings section above, the State's behavioral health needs are complex, and encompass services for persons with mental illness, intellectual/developmental disabilities, and substance abuse disorders. There is an ongoing need for an array of services in both community-based and residential settings. The Subcommittee met three times during the 2013-14 interim and did not have sufficient time to deliberate and fully address all of the issues. The Subcommittee needs more time to gather information, identify options, and develop recommendations to increase access to effective, evidenced based behavioral health programs and services.

RECOMMENDATION 1: EXTEND MENTAL SUBCOMMITTEE THROUGH JANUARY 31, 2015

The Subcommittee on Mental Health, Joint Legislative Oversight Committee on Health and Human Services, recommends the Joint Legislative Oversight Committee reappoint the Subcommittee for continued study of the State's behavioral health needs during the 2014-15 interim.

FINDING 2: INSUFFICIENT COLLABORATION AND COORDINATION AMONG THE VARIOUS DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) DIVISIONS

DHHS has five separate operating divisions that have a significant impact on the State's behavioral health system:

- Division of Aging and Adult Services (DAAS) – administers services and programs for adults with disabilities, a significant number of whom have behavioral health needs
- Division of Health Services Regulation (DHSR) – certifies and monitors medical, mental health, and adult care facilities
- Division of Medical Assistance (DMA) – administers the NC Medicaid Program which pays for most of the State-funded behavioral health services
- Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS – administers State-funded mental health, developmental disability, and substance abuse services programs
- Division of Public Health (DPH) – administers an array of services, in partnership with the 85 local health departments, to promote healthcare, including community-based risk reduction and disease prevention, promoting healthy lifestyles, and promoting the availability and accessibility of quality health care services
- Division of State-Operated Healthcare Facilities (DSOHF) – manages 14 State operated health care facilities that provide residential treatment for adults and children with mental illness, developmental disabilities and substance abuse disorders

While DMH/DD/SAS is the lead agency for management of behavioral health services, testimony and committee discussion indicated that each of these five divisions play a significant role in the delivery of State funded behavioral health services. However, it appears that more communication and coordination among the divisions is needed. For example, DHSR produces an annual *State Medical Facilities Plan* which provides an inventory of medical facilities and services, including mental health, developmental disabilities and substance abuse; inpatient psychiatric services, and intermediate care facilities for individuals with intellectual disabilities. In addition to the inventory, the plan addresses the adequacy of services, indicating gaps and shortages. However, it appears that there is no follow up coordination between DHSR and DMH/DD/SAS to develop a strategy to address the needs identified by the plan.

RECOMMENDATION 2: DHHS SHOULD IMPROVE COMMUNICATION AND COORDINATION AMONG THE DIVISIONS THAT HAVE A ROLE IN THE DELIVERY OF STATE AND FEDERALLY-FUNDED BEHAVIORAL HEALTH SERVICES

The Subcommittee on Mental Health, Joint Legislative Oversight Committee on Health and Human Services, recommends the Joint Legislative Oversight Committee direct the Department of Health and Human Services to develop a strategy to improve communication and coordination among DHHS divisions that are responsible for the administration of funds or programs related to behavioral health services, especially regarding the use of public and private facilities. The strategy shall include a process to address shortages and deficiencies identified in the annual State Medical Facilities Plan. DHHS shall report to the Committee on or before December 31, 2014.

FINDING 3: COMMUNITY-BASED CRISIS SERVICE PROGRAMS ARE COST-EFFECTIVE ALTERNATIVES TO EMERGENCY DEPARTMENTS AND LONG-TERM HOSPITALIZATION

Community-based crisis stabilization services are an alternative to the use of local hospital emergency departments or inpatient services in State-operated facilities. These services include psychiatric outpatient clinics, 24-hour crisis walk-in clinics, psychiatric urgent care units, facility-based crisis treatment, 23-hour observation, and non-hospital detoxification. In many counties, these types of service are limited or non-existent.

RECOMMENDATION 3A: INCREASE OUTPATIENT, CRISIS STABILIZATION AND TREATMENT OPTIONS

The Subcommittee on Mental Health, Joint Legislative Oversight Committee on Health and Human Services, recommends the Joint Legislative Oversight Committee direct the Department of Health and Human Services to work with the LME/MCOs to increase community-based outpatient and crisis service and treatment programs which allow individuals in crisis to be stabilized and treated in settings other than emergency departments and hospitalization.

RECOMMENDATION 3B: APPROPRIATE FUNDS TO INCREASE FACILITY-BASED CRISIS SERVICES FOR CHILDREN, ADOLESCENTS, AND ADULTS

The Subcommittee on Mental Health, Joint Legislative Oversight Committee on Health and Human Services, recommends the Joint Legislative Oversight Committee support the enactment of legislation by the General Assembly to appropriate additional community services funds to be used by the LME/MCOs to establish facility-based crisis units.

RECOMMENDATION 3C: APPROPRIATE FUNDING TO PILOT A BEHAVIORAL HEALTH OBSERVATION UNIT IN EASTERN NORTH CAROLINA

The Subcommittee on Mental Health, Joint Legislative Oversight Committee on Health and Human Services, recommends the Joint Legislative Oversight Committee support the enactment of legislation by the General Assembly to appropriate funds to pilot a 12-bed behavioral health observation unit at Vidant Medical Center in Greenville, NC. The purpose of the unit is to stabilize persons who are in crisis and to determine the need for further treatment or hospitalization.

RECOMMENDATION 3D: DHHS SHOULD DEVELOP PLAN FOR A COMPREHENSIVE ARRAY OF OUTPATIENT TREATMENT AND CRISIS PREVENTION AND INTERVENTION SERVICES AVAILABLE STATEWIDE

The Subcommittee on Mental Health, Joint Legislative Oversight Committee on Health and Human Services, recommends the Joint Legislative Oversight Committee direct the Department of Health and Human Services to develop a plan to ensure that a comprehensive array of outpatient treatment and crisis prevention and intervention services, are available and accessible to children, adolescents, and adults in every LME/MCO. The plan shall ensure that an adequate number of crisis stabilization units are available in each LME/MCO. DHHS shall report to the Committee on or before December 31, 2014.

FINDING 4: THERE IS AN INSUFFICIENT INVENTORY OF LICENSED ADULT PSYCHIATRIC INPATIENT BEDS

North Carolina has a shortage of inpatient psychiatric and substance abuse treatment beds. North Carolina has 21.4 adult inpatient psychiatric beds per 100,000 persons, a total of 2,040 State operated and community hospital beds. The Subcommittee heard testimony which indicated that national experts recommend 22 – 50 beds per 100,000. An additional 52 beds are needed to reach 22 per 100,000 while an additional 2,714 beds would be needed to achieve 50 beds per 100,000. The January 2013 Joint Legislative Health and Human Services Oversight Committee Report to the 2013 General Assembly included recommendations to determine the cost of increasing the number of beds in State psychiatric hospitals and to investigate the possibility of placing a new psychiatric facility in the south central region of the State.

RECOMMENDATION 4A: DHHS ASSESS NEED AND RECOMMEND OPTIONS TO INCREASE PSYCHIATRIC AND SUBSTANCE ABUSE INPATIENT SERVICES

The Subcommittee on Mental Health, Joint Legislative Oversight Committee on Health and Human Services, recommends the Joint Legislative Oversight Committee direct the Department of Health and Human Services to study the need for and recommend options to increase the inventory of psychiatric and substance abuse inpatient services, including additional State-operated facilities, community hospital beds, community-based services that decrease the need for inpatient treatment. DHHS shall report to the Committee on or before December 31, 2014.

RECOMMENDATION 4B: DEVELOP AND IMPLEMENT INCENTIVES TO INCREASE THE INVENTORY OF LICENSED INPATIENT PSYCHIATRIC SERVICES

The Subcommittee on Mental Health, Joint Legislative Oversight Committee on Health and Human Services, recommends the Joint Legislative Oversight Committee direct the Department of Health and Human Services to develop a plan to incentivize hospitals and other entities to 1) apply for licenses for new inpatient behavioral health services and 2) to begin operating existing beds that are currently licensed but unstaffed. DHHS shall report to the Committee on or before December 31, 2014.

RECOMMENDATION 4C: PROGRAM EVALUATION DIVISION STUDY AND MAKE RECOMMENDATION TO IMPROVE THE CERTIFICATE OF NEED PROCESS

The Subcommittee on Mental Health, Joint Legislative Oversight Committee on Health and Human Services, recommends the Joint Legislative Oversight Committee direct the Program Evaluation Division (PED) to review the Certificate of Need (CON) process to determine if it is a barrier to increasing the availability of inpatient psychiatric and substance abuse treatment services in the State. As part of the review, PED shall seek the input of DHHS, the NC Hospital Association, and other inpatient service providers to develop recommendations for streamlining the CON process. The Program Evaluation Division shall report its findings and recommendations no later than April 1, 2015.

FINDING 5: THERE IS AN INSUFFICIENT INVENTORY OF LICENSED CHILD/ADOLESCENT PSYCHIATRIC INPATIENT BEDS

The 2014 Annual Medical Facilities Plan indicates that there are 291 licensed non-State operated child/adolescent beds in North Carolina. However, three LME/MCOs (ECBH, Eastpointe, and Smoky Mountain) have no licensed child/adolescent inpatient psychiatric services available within their catchment areas. For example, there are no beds in a catchment area covering 31 counties in eastern North Carolina served by two LME/MCOs. Other LME/MCOs have beds available to them but the inventory is not sufficient to meet the need within their catchment areas. Children and adolescents who reside in these areas and need inpatient psychiatric treatment must leave their communities to access these services. DHSR estimates that 72 child/adolescent beds are needed statewide. However, for the past two fiscal years, DHSR has not received any Certificate of Need (CON) applications for child/adolescent inpatient psychiatric beds.

RECOMMENDATION 5A: EXPAND AND TARGET THREE-WAY CONTRACT FUNDING TO INCREASE THE NUMBER OF LICENSED CHILD/ADOLESCENT PSYCHIATRIC BEDS

The Subcommittee on Mental Health, Joint Legislative Oversight Committee on Health and Human Services, recommends the Joint Legislative Oversight Committee support the enactment of legislation by the General Assembly to appropriate expansion funding for the three-way contracts that will be targeted specifically to increase the number of licensed

child/adolescent psychiatric beds in areas of the State that have the greatest need for these beds.

RECOMMENDATION 5B: DHHS TO DEVELOP STRATEGY TO INCREASE CHILD/ADOLESCENT BEHAVIORAL HEALTH INPATIENT BEDS

The Subcommittee on Mental Health, Joint Legislative Oversight Committee on Health and Human Services, recommends the Joint Legislative Oversight Committee direct the Department of Health and Human Services collaborate with the relevant stakeholders to develop a comprehensive strategy to address the dearth of licensed child/adolescent inpatient psychiatric beds throughout the State. The strategy shall ensure that an adequate inventory of child and adolescent beds are available in the catchment areas of each LME/MCO. The plan shall include the development and implementation of a child/adolescent psychiatric bed registry to provide real-time information on the number of beds available at each licensed inpatient facility in the State. The Department of Health and Human Services shall report to the Committee on or before March 1, 2015.

RECOMMENDATION 5C: DHHS SHOULD TRACK AND SEPARATELY REPORT ON THE INVENTORY OF CHILD BEDS AND ADOLESCENT BEDS SEPARATELY

The Subcommittee on Mental Health, Joint Legislative Oversight Committee on Health and Human Services, recommends the Joint Legislative Oversight Committee direct DHSR to begin tracking and providing separate reports on the inventory of inpatient behavioral health beds for children ages six through 12 and for adolescents over age 12.

RECOMMENDATION 5D: PROGRAM EVALUATION DIVISION STUDY AND MAKE RECOMMENDATION TO IMPROVE THE CERTIFICATE OF NEED PROCESS FOR CHILD AND ADOLESCENT INPATIENT PSYCHIATRIC BEDS

The Subcommittee on Mental Health, Joint Legislative Oversight Committee on Health and Human Services, recommends the Joint Legislative Oversight Committee direct the Program Evaluation Division (PED) to review the Certificate of Need (CON) process to determine if it is a barrier to increasing the availability of child and adolescent inpatient psychiatric beds in the State. As part of the review, PED shall seek the input of DHHS, the NC Hospital Association, and other inpatient service providers to develop recommendations for streamlining the CON process and providing incentives to increase CON applications for child and adolescent psychiatric beds. The Program Evaluation Division shall report its findings and recommendations no later than April 1, 2015.

FINDING 6: JUDICIAL ACTIONS AFFECT THE AVAILABILITY OF BEDS IN THE STATE OPERATED PSYCHIATRIC HOSPITALS

When a person suffering a behavioral health crisis is arrested and taken before a magistrate, the magistrate may issue an involuntary commitment order. LME/MCOs and providers report that in many cases, these orders are inappropriate and the best treatment option is community-based. However, providers must comply with the judgments. The courts may

also determine that an individual's mental health status renders the individual incapable of proceeding to trial. The incapacity to proceed orders, in turn, affect the availability of State hospital beds for persons who are being held at hospital emergency departments while awaiting admission to one of the State psychiatric hospitals.

RECOMMENDATION 6A: ESTABLISH A LEGISLATIVE STUDY COMMITTEE TO EXAMINE THE IMPACT OF JUDICIAL ACTIONS ON THE STATE PSYCHIATRIC HOSPITALS

The Subcommittee on Mental Health, Joint Legislative Oversight Committee on Health and Human Services, recommends the appointment of a legislative committee during the 2014-15 interim for the continued study of how judicial actions impact the inventory of available beds at State operated psychiatric hospitals.

RECOMMENDATION 6B: PROGRAM EVALUATION DIVISION STUDY THE IMPACT OF INVOLUNTARY COMMITMENTS AND INCAPACITY TO PROCEED ORDERS ON THE STATE PSYCHIATRIC HOSPITALS

The Subcommittee on Mental Health, Joint Legislative Oversight Committee on Health and Human Services, recommends the Program Evaluation Division study the impact of judicial actions on admissions to the State-operated psychiatric hospitals and report its findings no later than April 1, 2015.

FINDING 7: THERE IS AN INSUFFICIENT BEHAVIORAL HEALTH WORKFORCE TO MEET CURRENT AND FUTURE SERVICE DEMAND

There is a shortage of psychiatrists and other licensed behavioral health providers throughout the State, particularly in rural areas. Options to address these shortages include increasing psychiatrist employment and retention incentives and expanding telepsychiatry to primary care settings such as clinics, health departments, and private primary care providers.

RECOMMENDATION 7A: APPROPRIATE FUNDS TO EXPAND THE STATE TELESPSYCHIATRY PROGRAM TO PRIMARY CARE SETTINGS

The Subcommittee on Mental Health, Joint Legislative Oversight Committee on Health and Human Services, recommends the Joint Legislative Oversight Committee support the enactment of legislation by the General Assembly to appropriate funds to expand State-funded telepsychiatry services to primary care settings.

RECOMMENDATION 7B: APPROPRIATE FUNDS TO ESTABLISH ADDICTION PSYCHIATRY FELLOWSHIPS AT EAST CAROLINA UNIVERSITY OUTPATIENT PSYCHIATRIC CLINIC

The Subcommittee on Mental Health, Joint Legislative Oversight Committee on Health and Human Services, recommends the Joint Legislative Oversight Committee support the enactment of legislation by the General Assembly to appropriate funds to establish two addiction psychiatry residency fellowships at the ECU outpatient psychiatry clinic. The

fellowships will prepare two psychiatrists per year as subspecialists in addiction medicine to meet an expanding need for prevention, direct patient care, teaching and research into recognition, diagnosis, and treatment of substance use disorders.

RECOMMENDATION 7C: FULLY IMPLEMENT THE 2008 MENTAL HEALTH COMMISSION WORKFORCE DEVELOPMENT PLAN

The Subcommittee on Mental Health, Joint Legislative Oversight Committee on Health and Human Services, recommends the Joint Legislative Oversight Committee direct DHHS to report on the status of the implementation of the 2008 Mental Health Commission Workforce Development Plan no later than November 1, 2014.

FINDING 8: INADEQUATE OUTCOME DATA AVAILABLE FOR THE STATE OPERATED ALCOHOL AND DRUG TREATMENT CENTERS (ADATC)

DHHS operates three ADATCs, which are licensed inpatient psychiatric hospitals that provide medical detoxification, medical treatment, and intensive counseling services to persons addicted to drugs or alcohol. The annual cost of the three ADATCs is $40 million in General Fund appropriations. Most of the individuals served by the ADATCs are indigent, unemployed, and uninsured, so the ADATCs collect minimal revenue to offset the State's cost. However, DHHS is unable to assess the ADATCs' long-term impact on individuals' alcohol or drug use once they are discharged back into their communities.

RECOMMENDATION 8: DHHS SHOULD DEVELOP MEANINGFUL OUTCOME MEASURES ON THE IMPACT OF ADATC TREATMENT AND SERVICES

The Subcommittee on Mental Health, Joint Legislative Oversight Committee on Health and Human Services, recommends the Joint Legislative Oversight Committee direct DHHS to develop and report meaningful outcome measures of the impact of ADATC treatment on individuals' alcohol and drug use following discharge. DHHS shall report on the measures and implementation plan no later than March 1, 2015.