

# Overview of Goals of Mental Health Reform in North Carolina

**Joint Legislative Oversight Committee for Mental Health, Developmental Disabilities, and Substance Abuse Services**

Research Division  
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# Historical Context for Reform

## State Context (mid-1990s)

- Lack of oversight and control of the 40 Area Authorities with some experiencing severe financial difficulties and even bankruptcy
- State psychiatric hospitals were in danger of losing federal funds due to severe staffing shortages and record keeping violations

## Federal Context

### Olmstead (U.S. S.Ct., 1999)

- Undue institutionalization of persons with mental disabilities constitutes "discrimination" under the ADA.
- States are required to provide community-based treatment for persons with mental disabilities when (1) State treatment officials determine community placement is appropriate; (2) the affected person does not oppose community-based treatment; and (3) placement can be reasonably accommodated taking into account the resources available to the State and the needs of others with mental disabilities

# Historical Context for Reform

## General Assembly's Response

- Commissioned several studies (1995-1999)
  - MGT regarding management and operation of State Psychiatric Hospitals (1997)
  - State Auditor regarding Psychiatric Hospitals and the overall structure of the mental health delivery system (1998)
  - DHHS regarding the organizational structure for DD administration (1999)

# Historical Context for Reform

## Study Findings

- Governance and funding structures of area authorities did not promote accountability to local governments or the State
- Use of State hospital inpatient beds in NC was significantly higher than peer group states
- Accessibility and quality of clinical assessment varied widely

## Study Recommendations

- Transform the State and local governance structure
- Create benefit packages for community assessment and acute care services for all MH and SAS clients entering the State system
- Create specialized services to target populations who have been appropriately served in State hospitals
- Downsize State psychiatric hospitals
- Create a financing process for moving funding from the State hospitals to county programs

# Reform Legislation

## HB381 - Mental Health System Reform

- Addressed issues of State and local governance
- Increased accountability
- Emphasized community-based services that are consumer driven
- Required that State and local governments provide, within available resources, certain core services:
  - "Front end services" - screening, assessment, referral, emergency triage, and service coordination
  - 'Indirect services' such as prevention, education, and consultation at the community level
- Shifted the role of local public MH/DD/SAS agencies from direct service providers to managing and coordinating services
- Established a Consumer Advocacy Program to operate at the State and local levels (contingent upon funds being appropriated)

# Role of LME

- As directed in HB 381, DHHS included in the State Plan a method for transforming the area and county mental health programs from primarily service delivery organizations to service management organizations.
- Pre-reform area programs delivered a full range of services and contracted for the delivery of services. They were also responsible for coordinating and managing the quality and quantity of services in the community.
- Each public community mental health program referred to as a Local Management Entity ("LME"). LME is not a statutory term and it identifies the purpose of the public agency rather than describing its governance structure.
- G.S. 122C-141 no longer authorizes an area and county authority to be a service provider. Instead, area and county authorities are expected to contract with private and other public providers to deliver services.

# Role of LME

In managing services, an LME would :

- Identify the client base within its catchment area;
- Understand the need for community-based services and identify service gaps;
- Develop a qualified provider community;
- Contract with qualified providers; and
- Approve the service plans for individual clients.

# Role of LME

## **Counties were required to develop business plans for implementing and operating the reformed community system**

- Planning – Identify service gaps and strategies for addressing those gaps, equitable delivery of services, and a means for public input.
- Developing a Provider Network – Service development, performance contracting, and provider monitoring.
- Service Management – Implement uniform portal for accessing services, monitor the level and appropriateness of services, and monitor the use of state institutions.
- Financial Management and Accountability
- Evaluation – Establish capacity for self-evaluation to determine whether the LME is meeting state outcome standards.
- Collaboration
- Access – guaranteeing the availability of core and targeted services for clients.

# Service Definitions/Best Practices

- G.S. 122C-102 requires that the State Plan provide for uniform service standards, the promotion of best practices, outcome-based monitoring, and the evaluation of services.
- DHHS is is in the process of implementing a new array of services.

# Service Definitions/Best Practices

- The rationale behind the new service array is that the service definitions would be science-based. Not only does the service need to be demonstrably effective, but effective for the defined populations that will be served in the reformed system.
- Another purpose for creating the new service array is to create one seamless set of definitions for services that are reimbursed both by the Medicaid Program and through State funds.

# Service Definitions/Best Practices

- In 2002, the Division received a planning grant from SAMSA/NIMH to produce the “North Carolina Science to Service Project”
- Looked at how to implement Evidence-Based Practices for Adults with Mental Illness.
- LOC received a report on those findings and recommendations last year.

# Mental Health, Developmental Disabilities, and Substance Abuse Services

## Trust Fund

- Created in 2000
- Purposes
  - Provide start-up funds for programs and services that are community alternatives for individuals currently residing in state institutions
  - Facilitate the State's compliance with Olmstead law
  - Facilitate Reform
  - Pay one-time expenditures
  - Establish or expand community-based services if on-going expenses can be covered from within the existing budget
- Director of Budget approves expenditures from reserve

# Mental Health, Developmental Disabilities, and Substance Abuse Services Trust Fund

- Total Appropriations since FY2000-2001  
\$92,168,727 (includes FY2005-06 funding)
  - Total Adjusted Availability since FY2000-2001  
\$57,650,199 (includes FY2005-06 funding)
  - Total Approved Expenditures - \$43,682,883  
(through June 30, 2005) Additional Commitments  
\$21,496,157 through FY2005-2006
  - Deficit of (\$7,528,841)
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- Figures provided by the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

# Mental Health, Developmental Disabilities, and Substance Abuse Services

## Trust Fund

- Uses
  - Transition Bridge Funding for Community Services
  - Child Mental Health Planning
  - New Regional Hospital
  - Housing Initiatives
  - Olmstead Planning, Assessments and Oversight
  - Capital Modification for Black Mountain Center
  - ADATC's Capital and Acute Detox Operations
  - System Reform Training

# Accountability

## Legislative

- Creation of Joint Legislative Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services
  - Charged with the ongoing examination of system wide issues
- Budget Process

# Accountability

## Division

- Review and approve local business plans,
- Oversight of area authorities, county programs and providers of public services;
- Development of a unified system of services to be provided in local programs, State facilities and private providers;
- Monitoring fiscal and administrative practices of area authorities and county programs;

# Accountability

## Division (continued)

- Suspending funding and assuming service delivery or management functions of an area authority or county program that is not providing minimally adequate services to persons in need in a timely manner.

# Accountability

County-Level - Commissioners given authority to:

- Chose the governance structure (area authorities or county programs)
- Dissolve an area authority
- Approve the hiring of area authority and county program directors, the local MH/DD/SAS budget, and the local business plan

# Accountability

## LME level

- Contracts with providers
- Outcome goals
- Business Plan and State contract
- Consumer and Family Advisory Committees (CFACS)

# Consumer Participation

## CFACS

- Involved in System Design and Operation
- Requirement for LME Certification
- Review of Local Business Plans
- "Eyes and Ears of the Service System"

# Downsizing State Institutions

- Response to the US Supreme Court Olmstead Decision (1999) and the 1999 State Auditor's Report
- Shift funding from state institutions into community services as state institutions downsize

# Downsizing State Institutions

Facility Bed Type	Broughton Hospital	Cherry Hospital	Dorothea Dix Hospital	John Umstead Hospital	<b>Totals</b>
Nursing Facility	13	115	0	25	153
Geriatric Longterm	50	0	15	17	82
Adult Longterm	25	31	63	60	179
<b>Totals</b>	<b>88</b>	<b>146</b>	<b>78</b>	<b>102</b>	<b>414</b>

# Area Programs/LME Consolidations

- HB381 - Required catchment area consolidation “no more than 20 area authorities and county programs”
  - 40 Area Programs in 2001
  - As of July 1, 2005 there are 33 Area Programs/LME’s through voluntary consolidations
  - By July, 2006 there are 29 LME’s planned (through voluntary consolidation process)
- The LME’s responsibilities have increased, single portal of entry for services, oversight for quality and appropriateness of services provided, case management