SUBCOMMITTEE ON MENTAL HEALTH
FOR THE
JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON
HEALTH AND HUMAN SERVICES

September 10, 2012
Room 544, Legislative Office Building

The Subcommittee on Mental Health, a Subcommittee of the Joint Legislative Oversight Committee on Health and Human Services, held their first meeting on Monday, September 10, 2012 at 1:00 P.M. in Room 544 of the Legislative Office Building. Members present were: Senator Louis Pate and Representative Justin Burr, Co-Chairs; Senator Tommy Tucker; and Representatives Marilyn Avila and William Brisson. Representatives Verla Insko was also present.

Lisa Hollowell, Denise Thomas, Donnie Charleston, Theresa Matula, Jan Paul, Patsy Pierce, Susan Barham, Sara Kamprath, Barbara Riley, Joyce Jones, Rennie Hobby, and Candace Slate provided staff support to the meeting. A Visitor Registration Sheet is attached and made a part of the minutes (See Attachment 1).

Chairman Burr called the meeting to order and welcomed members and guests. He emphasized the importance of monitoring the issues regarding mental health in North Carolina, and said the Subcommittee would be looking at those issues to see that the State is moving in the right direction. Senator Pate said that he welcomed the opportunity to study the critical issues that affect the most vulnerable citizens of our State.

Denise Thomas from Fiscal Research reviewed the law establishing the charge to the Subcommittee. She explained that the 2012 Appropriations Bill provided the authorization for the Subcommittee in S.L. 2012-142, Section 10.11, Examination of the State's Delivery of Mental Health Services. (See Attachment No. 2)

Jan Paul from the Research Division provided background and historical information across the nation and on North Carolina's behavioral health system; history of the major Mental Health legislative and policy reform since early 2000, how the changes have affected the state facilities and the availability of community psychiatric beds and community hospitals, including the catchment areas that are served by the State hospitals. (See Attachment No. 3) Points of interest included the following:

- 1700's, 1800's - County governments permitted to confine persons with mental illness in jails or poorhouses.
- Mid 1800's - NC General Assembly opened the first "State Hospital for the Insane," which became Dorothea Dix.
- By 1914, two more state hospitals and a state facility opened for individuals with mental retardation.
- 1930's - Local mental health clinics established in Charlotte and Winston-Salem.

- 1946 - National Mental Health Act, PL 487, establishment of a National Institute of Mental Health.
- 1950 - NC' MH/DD/SAS consisted of four state psychiatric hospitals, four mental retardation centers, and other facilities for those with substance abuse problems and developmental disabilities. First of three Alcohol Treatment Centers established at Butner.
- 1963 - Movement towards creating community-based services to provide mental health treatment. In 1963, Congress passed and President Kennedy signed the Community Mental Health Centers Act, H.R. 58 that authorized federal funding to construct community mental health clinics. The NCGA authorized communities to create and operate mental health clinics in collaboration with state agencies.
- 1970 - Establishment of 42 area programs established the NC Drug Commission and first drug prevention treatment programs in the state.
- 1977 - The General Assembly required counties to establish "area authorities," which were local agencies charged with managing community-based mental health services and which answered to a locally-appointed governing board.
- 1980's - The federal government repealed the Community Mental Health Centers Act in 1981. The responsibility for providing mental health and substance abuse services moved to public behavioral health services, primary care providers, emergency departments, and law enforcement/the courts. The General Assembly created a Mental Health Study Commission.
- 1990 - Congress enacted the Americans with Disabilities Act.

Ms. Paul said that major Mental Health reform occurred in North Carolina in 2001. In response to *Olmstead* and because of problems faced by community mental health agencies and the demand on State hospital beds, the General Assembly enacted S.L. 2000-83, which:

- Established The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services.
- Directed the Oversight Committee to develop a plan to reform the State system for Mental Health, Developmental Disabilities and Substance Abuse Services.
- Directed the Secretary of DHHS to overhaul North Carolina's public system of MH/DD/SAS.

Laura White, Hospital Team Leader for the Division of State Operated Healthcare Facilities, DHHS, explained the impact of reform on the State facilities and Community Psychiatric Hospitals. (See Attachment No. 4) Ms. White addressed community capacity expansion and hospital downsizing; State hospitals and Community Inpatient Bed capacity over the past 12 years; where we are today regarding referrals to hospitals and the delays that are being experienced; and the State Facility admission regions. Points of interest included:

- After the Olmstead decision, DHHS and the Division of MH/DD/SAS developed a plan to expand community capacity and then reduce the size of the State Psychiatric Hospitals.
- Five hundred beds were closed rather than the seven hundred that was originally established. Those beds closed included the adult long term, geriatric long term, and skilled nursing beds.
- $28 million was provided to the LMEs both on a one-time and recurring basis in order to support the services that were established for those both being discharged from hospitals into the community and to support those who otherwise would have needed those hospital beds.

- There is one facility type in each of the 3 regions – Psychiatric Hospital, Developmental Centers, Neuromedical Treatment Centers, and Alcohol and Drug Abuse Treatment Centers.

Ms. White was asked to provide the average mean wait times, and to provide more detailed information (what type of disability do they have and are they receiving treatment) on the 53% discharged to home or self-care, and the 28% admitted to community psychiatric beds. Chairman Burr also asked Ms. White to provide the committee with a copy of the chart depicting the plan of the hospital downsizing establishing the target number of beds for each of the services in each of the State hospitals.

Pam Shipman, CEO of Piedmont Behavioral Health provided a perspective on how the major reform and policy changes have affected the LMEs. (See Attachment No. 5) Ms. Shipman provided background information on how the Community Mental Health System began including how Area Programs were established, the role of State funding, and how Medicaid began in North Carolina. She also highlighted items of interest from the PCG Report in 2000 which led to the System Reform Legislation of 2001. She then addressed what was happening at PBH and what was going on in North Carolina from 2002-2012, and how the shortfalls due to the 2007recession affected North Carolina. Ms. Shipman reviewed the past decade including how divestment by the LMEs of the delivery of services affected the system and how reform impacted the LMEs, and went on to explain the current system. She also gave her opinion of the challenges facing the system. In conclusion, she addressed the positive aspects of the Managed Care system which is being expanded via the B-C waiver throughout the state.

Ms. Shipman was asked if there were enough pediatric beds in the system. She responded that there were not enough in her catchment area and that they were hard to get at times. Senator Tucker made the point that through the PBH model the other LMEs across the State would have the same computer systems, the same data, the same shared data and transfer data, so the system would be more efficient in order for the Department to be better able to manage the money as well as services to eligible individuals. If the MCO model does not work, the only option would be to go to a private for-profit provider as other states have done. There will be no public entity any longer; it would be a private entity only.

Tony Perry, Sheriff of Camden County and President of the North Carolina Sheriffs' Association, addressed the impact of Mental Health reform on the law enforcement community. Sheriff Perry stated that the responsibility of transporting mental patients to and often from facilities is a State mandated law. He said that it was not unusual to transport a patient to the hospital just to find they need to go to another facility. He said the facility could be as much as five hours away and that an officer could spend as much as 20 to 24 hours in transporting and in wait time. As a small county, Sheriff Perry said that there were only two deputies working at a time and one would have to be pulled off the road in order to transport a patient. If a patient is determined by the hospital to be safe the officer can leave them there but if not, an officer must stay with the patient until a bed can be found. He said that could be as much as three days. He said that his hope was that a good solution could be found to help with this problem.

Senator Tucker asked if there was a way to look at the law to see if there is another way to transport patients to facilities. Jan Paul said that the issue was discussed during a recent study committee. She said there are some suggestions that could possibly be statutorily implemented in order to relieve

some of the pressure on law enforcement. Chairman Pate asked Sheriff Perry what the standard transportation was in other states. He replied that he did not know but could get the information.

There being no further business, the meeting adjourned at 4:00 PM.

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Senator Louis Pate, Co-Chair

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Representative Justin Burr, Co-Chair

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Rennie Hobby, Committee Clerk