

Mental Health Care in North Carolina: Challenges on the Road to Reform

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National Highlights

Mental health care in the US is now at a crossroads. Fifty years of dramatic change in the technologies, organization, and financing of mental health services has led to dramatic improvements in the well-being of persons with mental illnesses. Yet, ironically, although we spend upwards of \$71 billion a year in the US on mental health treatments, a large gap remains between what we know how to do and what is actually done on an everyday basis for those most in need of mental health care.

Part of this gap is attributable to the declining financial support for mental health and substance abuse treatment in the private and public sectors. With rising costs of general health care, employers increasingly sought to control costs through various managed care cost containment strategies. Because mental health and substance abuse treatment was seen as over-utilized and as discretionary, mental health and substance abuse services were increasingly “carved out” and managed as a separate health care benefit. Often this entailed applying separate benefit and dollar limits to mental health and substance abuse treatment—a strategy made possible by the absence of a consistent legal mandate for insurers to provide mental health and substance abuse coverage on par with other health care benefits. These managed behavioral health efforts led to massive reductions in mental health spending over the past decade. Looking at trends between 1988 and 1998, the value of general health care benefits decreased by 11.5 percent. During that same period the value of behavioral health care benefits decreased by 54.7 percent. As a proportion of the total health care costs, behavioral health care benefits decreased from 6.1 percent in 1988 to 3.2 percent in 1998 (HayGroup, 1999). Managed behavioral health care companies enforced stringent utilization review guidelines, barring hospital admissions wherever possible and negotiating heavy discounts from providers. Many providers and hospital

services simply went out of business. Patients with limited mental health and substance abuse coverage—made possible by the lack of insurance parity laws—were pushed into public sector care, increasing the burden on public mental health and substance abuse services. In addition, this increasing financial pressure on general and mental care providers also dramatically reduced their ability to treat indigent and low-fee patients (Smith, 1997). In the absence of this private indigent and low-fee care capacity, emergency rooms with scant treatment resources themselves began seeing a growing number of psychiatrically indigent patients.

In 1999, the *Report of the US Surgeon General on Mental Health* (Office of the Surgeon General, 1999) reviewed the scientific evidence and showed there are a variety of effective treatments for various mental and behavioral disorders that occur across a person's life span. It cited studies showing that about 20 percent of the US population experiences a mental illness in any given year and that mental illnesses rank first among illnesses that cause disability in the United States, Canada, and Western Europe. The Report underscored how people with a mental illness are stigmatized and how they face disparities in the availability and access to services in comparison to other areas of health. The Surgeon General's core message to the nation was that mental illnesses are legitimate illnesses that are responsive to treatment, while recognizing the growing gaps in effective care.

In July 2003, the President's *New Freedom Commission on Mental Health* issued its final report (New Freedom Commission on Mental Health, 2003) after a year-long study of the care system for persons with a serious and persistent mental illness (SPMI). In any given year, the Commission found that about 5-7 percent of adults have a serious mental illness, and about 5-9 percent of children have a serious emotional disturbance. The report calls for transforming the mental health system so that it

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will be both consumer- and family-centered and recovery-oriented in its care for the many millions of adults and children who are disabled by mental illness every year.

The national challenges in such a system are how to finance it, and how to assure quality of care consistent with the best evidenced-based standards. North Carolina is faced with both of those questions as it is now struggles with a more fundamental structural reorganization of the care system that most other states addressed ten to twenty or more years ago. Can North Carolina deal with the weight of these three formidable challenges all at the same time? What are the prospects for mental health care reform in the Old North State?

North Carolina's Public Mental Health System

The public mental health system in North Carolina consists of three main components—state-operated services, Area Programs, and the services offered by a network of private, non-profit and for-profit providers. The State Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS)—a subunit of the NC Department of Health and Human Services—operates psychiatric hospitals, developmental disability centers, alcohol and drug rehabilitation centers on four campuses (that serve distinct regions) in Butner (north central), Goldsboro (east), Morganton (west), and Raleigh (south central). The 100 counties in NC are clustered into 39 multiple or single-county (major urban areas) Area MH/DD/SAS programs that were created in the 1970s as part of the community mental health centers legislation. Private agencies have expanded rapidly in the past decade as increasing emphasis has been placed on drawing these providers into the mental health care system through purchase of service contracts with Area programs.

North Carolina has lagged behind the rest of the nation vis-à-vis the big trends that have transformed the public mental health system nationally since the 1970s—deinstitutionalization, Medicaid expansion, managed care, and the shift to local mental health authorities. As a result, we avoided some of the disasters that other states found themselves in through rushing to implement these policy changes without an adequate management or alternative services infrastructure in place (Chang et al, 1998). But a price was paid for standing on the sidelines. A number of organizational and financing problems in North Carolina were allowed to intensify and reinforce each other until the system itself became dysfunctional.

Beginning in the mid-1990s, a series of events occurred that revealed a mental health care system that was teetering on collapse. Carolina Alternatives, the state's first effort at Medicaid managed mental health care, was terminated in the face of an inability to demonstrate the cost-neutrality of the program (offering child and adolescent services operated by Area programs) to Medicaid, a series of financial audits of Area programs showing lack of proper documentation for Medicaid billings, and a \$42 million payback to the Federal government because required state matching dollars for Medicaid services

were not made. At the same time, the Area programs began to be fiscally distressed due to expanding demands for services and repeated reductions in state reimbursement rates.

Signs of the gathering storm were not isolated to Area programs. A number of staffing and record keeping complaints at Dorothea Dix Hospital that threatened its certification and Medicaid reimbursement status led to changes in the hospital's top management personnel. The deteriorated physical plants of the four psychiatric hospitals were found to be incompatible with current life-safety standards and patient care requirements; if they were to remain operational, the state was faced with replacing them at a cost of several hundred million dollars. In 1999 the U.S. Supreme Court's Olmstead Decision mandated community care for many of the disabled patients served in state facilities, raising the prospects of additional dollars for community care and sizeable financial penalties to the state for noncompliance. In 2001 the U.S. Department of Justice initiated an investigation into violations of patients' civil rights at the four public psychiatric hospitals. All of these challenges to state control and management of the public mental health care system were occurring during a time of regular leadership turnover and appointment of acting directors at the Division of MH/DD/SAS. Bad press coverage and several exposés in the *Raleigh News and Observer* and the *Charlotte Observer* depicted a system badly out of control and in need of major reform.

Mental Health Reform in North Carolina

Faced with allegations of fraud and financial mismanagement in the public mental health system, the North Carolina General Assembly requested the Office of the State Auditor to conduct a fact-finding study on the physical condition of the state hospitals and to make recommendations about reforming the state and local care system. Public Consulting Group, a private consulting firm with a great deal of behavioral health experience in other states, was brought in to carry out these assignments. The State Auditor's final report (Office of the State Auditor, March, 2000) concluded that the four hospitals were beyond repair and they should be downsized and replaced with three new hospitals at a price tag of \$580 million in construction costs alone. The recommendations for reform called for a radical reorganization of the overall system with a dismantling of the area boards that were the hallmark of Area programs in North Carolina, as well as the original community mental health centers legislation, nationally.

In their place, the State Auditor's report called for a county-operated model similar to the ones Michigan, Ohio, Pennsylvania, California and other states had moved to a decade or two earlier. The cornerstone would be a "local management entity (LME)" that would play the lead administrative, quality assurance, and funding role at the local level. Importantly, LMEs would not provide any direct treatment or rehabilitative services to consumers as long as qualified private providers were available to do so, thereby avoiding the conflict of interest that many stakeholders believed was present when Area programs functioned as both provider and funder of services.

Much of the rationale for this new administrative model had to do with governance. Accountability in the Area program model rested with the citizen advisory boards that embodied the principle of local community accountability that was central to the community mental health legislation nationally passed during the Kennedy-Johnson administrations in the 1960s.

The original community mental health centers legislation envisioned a federal-local partnership that intentionally bypassed the states. Federal policymakers saw state authorities in the 1960s as petty bureaucrats, more interested in preserving their own mental hospitals than carrying out the vision of community-based care. The federal-local partnership was viable only as long as federal dollars went directly to local communities.

Shortly after entering office in 1980, President Reagan's administration declared the centers a resounding success and transferred their funding to the states in the form of block grants. Unexpectedly, this transfer brought the states into a dominant role in the community mental health movement. Over time, state involvement helped to correct a bias the early centers had toward not serving those with serious and persistent mental illness. The deinstitutionalization movement of the 1970-80s that led to the downsizing of the state hospitals had placed many thousands of former patients with serious and persistent mental illnesses into communities across the country. They became an increasing part of the centers' caseloads starting in the 1980s. Tellingly, although the federal-local partnership had changed, the centers continued to operate with a quasi-autonomous governance structure, without clear accountability to state funders, that was no longer compatible with the new funding realities.

Since the early 1970s, most Area programs in North Carolina were organized on a multi-county basis (to meet federal catchment area population requirements) and then chartered as private non-profit 501(c)(3) corporations. (Those in Mecklenburg, Guilford, Durham, and Wake counties had a large enough population base to warrant a single-county status, but even these operated through a governing board. Recently, even prior to statewide reform efforts, first Mecklenburg and then Wake County essentially disbanded the governing board and made the Area program a unit of county government.)

When the complexities associated with managing and financing an ever-growing caseload intensified with Medicaid expansion and other managed care-like practices, this autonomy made it difficult to develop quick fixes for some glaring inadequacies in local program management practices highlighted in program audits. In 1995, for example, two multi-county Area programs were disbanded after going bankrupt without the prior knowledge of local county commissioners. In 1997, county commissioners had to bail out another single-county Area program to the tune of \$400,000.

The other anomaly that came under scrutiny in the State Auditor's report was the way state mental hospitals operated completely independently of the Area programs. In many parts of the state, these hospitals provided both acute and long-term care services for Area programs, but the local programs had no

budgetary or management say in how they functioned. Nor was there any explicit arrangement for holding Area programs accountable for the number of patients admitted to these hospitals. The fear in many quarters was that Area programs had used the hospitals as safety valves, transferring difficult to manage patients to the hospitals in times of fiscal shortfalls in their outpatient and case management rolls.

The Auditor's Report presented a vision for a unified state-local service system in which the new LMEs would have budgetary control over down-sized state hospitals. This would allow LMEs to decide how these hospitals were to function in the local continuum of care, including diverting dollars to local general hospital inpatient care in lieu of a continued reliance on state facilities. The report also stated that three regional state hospitals could handle the needs of the entire state. Dorothea Dix hospital in Raleigh was identified as the facility that would make most sense to close with its care functions transferred to an expanded John Umstead Hospital in Butner where a new patient care building had opened a few years ago.

The Auditor's Report to the Legislature was generally well received by stakeholder groups throughout the state, aided in large part by the careful efforts PCG staff had employed to solicit input and to share its assessments with stakeholders throughout the study process. In July 2000, House Bill 1519 created a Legislative Oversight Committee for MH/DD/SAS to develop a plan for implementing the Auditor's Report. The Committee drafted enabling legislation and guidelines for the new care system over a five-year period (2001-06). The mental health reform legislation (HB 381—Session Law 2001—437) was enacted in 2001.

Ultimate responsibility for overseeing the reform process fell to the Department of Health and Human Services and to its Secretary, Carmen Hooker Odom. At the time, the Division of MH/DD/SAS was operating without a permanent director, but staff began developing the vision and values statement and initial guidelines required by the new legislation. The Secretary's *State Plan 2001: Blueprint for Change* was delivered to the Legislative Oversight Committee in December 2001. In May 2002, after a national search, Richard Visingardi, PhD, was appointed director of the Division of MH/DD/SAS effective July 1, 2002. A strong feature of his resume was extensive administrative and clinical experience in both developmental disabilities and mental health at the state and local authority levels in Michigan, a state that in the 1980s had adopted the type of county-operated system that North Carolina was seeking to implement. An update on the reform implementation, *State Plan 2003*, is now available via the Division's website (<http://www.dhhs.state.nc.us/mhddsas/>).

The Promise and Pitfalls of Mental Health Reform in North Carolina: Managing a Privatized System

A key premise of North Carolina's mental health reform is that the management and oversight of public MH/DD/SAS programs is transferred from the current quasi-independent

mental health area authorities to fully accountable single-county or multi-county programs—so-called Local Management Entities (LMEs). Under the current system, most MH/DD/SA clinical services are directly provided by Area authorities. The reform plan calls for full divestiture of clinical services from public providers to non-profit and for-profit provider groups. In this privatization of clinical services, LMEs purchase services from a broad array of providers and vendors. Privatization is not unique to North Carolina and represents a common shift nationally in management of human services over the past three decades (Dorwart and Epstein, 1993). Indeed, even in North Carolina, many services provided by area programs are already contracted out to community providers.

Privatization offers the promise of increased administrative efficiency by separating management and oversight from the provision of services, allowing decentralization of administrative functions through regional contracting, and a way to buffer clinical services from the constraints of government personnel policies. Advocates of privatization argue that private sector providers, incentivized to maximize productivity, are quicker to innovate and bring new treatment technologies to the clinical arena. It is also promoted as a mechanism to increase competition among service providers, and further stimulate innovation, new efficiencies and create less costly, more flexible service delivery (Clark, Dorwart & Epstein, 1994; Dorwart, Schlesinger & Pulice, 1986). The competitive process, by this reckoning, will also weed out inefficient and ineffective providers. All of this, it is further argued, should lead to lower cost and higher quality of care.

Despite several decades of experience with human service privatization many questions about its advantages remain unanswered. Key among these is: Will MH/DD/SAS privatization: 1) promote innovation in services provision? 2) enhance provider quality? 3) lead to meaningful competition?; 4) fragment care? and, 5) co-opt advocates?

Promoting innovation vs. maintaining accountability

Private sector providers with good access to training resources, driven by market demands to hone skills, are seen as a ready source for change and innovation. Unfortunately, this view of private sector providers may be seriously flawed. Private providers may not be well trained for this role. Lower reimbursement rates and higher productivity demands of private managed care programs have eroded training time and resources. Private providers, largely geared toward working with general outpatients, may not have key treatment skills needed for complex target population patients. Many private providers lack the expertise and resources to provide coordinated multidisciplinary care. Many counties have few private group integrated practices. There may also be a dearth of non-profit mental health agencies poised to develop new provider practices. In many cases, treatment capacity will have to come from newly formed provider groups, many of whom formerly worked for Area programs. Will former public providers land in these new non-profit groups? How many former area mental health providers will leave the field entirely?

This brand of purchase-of-service privatization bears the additional responsibility of public accountability. Regulatory burdens, especially documentation requirements, may discourage flexibility and innovation in service delivery models. For example, some nontraditional community services, such as Assertive Community Treatment (multi-disciplinary teams providing treatment in the community on a 24/7 basis) are inherently difficult to codify. The countervailing pressures of service flexibility and public accountability may seriously undermine dissemination of this nontraditional treatment model.

As an additional concern, purchase-of-service contracts often severely constrain administrative overhead paid to providers. In a purchase-of-service, fee-for-service environment, administrative overhead may be the sole source of start-up funds, discouraging new treatment program development. Hence, private providers may lose their bent for service innovation under regulatory pressure, particularly if they also lack new treatment development resources.

Enhanced provider quality

The state reform plan sets out an ambitious program of quality improvement activities. The goal is to enhance provider quality by making providers compete on quality and value of services, not price. Will this competition enhance provider quality? A key driver of quality will be the ability of LMEs to effectively monitor hundreds of contracts and successfully identify high quality providers, but such quality monitoring may be unwieldy. An additional consideration is the extent of true competition within service categories. Will there be multiple providers vying to provide the same service? This is a particular concern for services reimbursed close to or below cost. Skeptics wonder how vigorous the competition will be for under-funded services. In some states, past experience with purchase-of-service contracts reveals little true competition for service contracts (Dorwart, Schlesinger & Pulice, 1986).

Competition vs. continuity of care

Attempts to stimulate competition among providers may conflict with the desire to maintain continuity of care. Transferring contracts for key services may be quite disruptive to consumers. For example, transferring a contract for a rehabilitation program from one provider to another may greatly disrupt care. Privatization also threatens to fragment care. The service integration needed for target population patients may be undermined by competitive contracting of individual services and further exacerbate service fragmentation. The reform plan proposes methods of service integration, but for some consumers, the loss of a “one-stop shop” will be a difficult transition.

Co-opting the advocates

In a publicly operated system of care, advocates serve the role of watchdogs over quality of care (Mollica, 1983). Increasingly, consumer advocate groups have diversified into the role of service providers, offering a wide range of services. A dual relationship as vendor and advocate creates at least a potential conflict of interest. Advocates may be silenced as

watchdogs, particularly in relation to services they provide. For example, demands to increase the quality of care from advocates/vendors could be seen as self-serving attempts to raise reimbursement. Thus, a dual relationship threatens to diminish the influence of advocates. This is a particular concern because in a competitive privatized system, some consumers may not be able to evaluate the quality of care, relying on advocates as key arbiters of quality.

In sum, privatization sets up series of tradeoffs that require careful attention: 1) encouraging competition vs. continuity of care; 2) establishing a stable set of large multi-service vendors vs. many competitive providers; and, 3) promoting innovation vs. ensuring accountability.

The reform plan also poses a challenge to government business infrastructure. Single-county or multi-county LMEs must be transformed into management entities that perform a wide range of administrative services: create and manage diverse provider contracts, assure quality for the divested provider network, etc. For many counties, this transition to a managed care business capability will require a steep learning curve and make heavy demands on county governments to reinvent themselves as nimble business entities. Some counties have developed these broad managerial capabilities, but for many counties developing this business infrastructure will be a substantial challenge.

Providers will look to LMEs for efficient operations, network management expertise and efficient and timely claims adjudication and payment. Many providers with scant cash reserves will only be able to do business with LMEs that can pay claims on a timely basis. Some LMEs already have considerable expertise in business operations, but for those LMEs new to these processes, and especially for those LMEs deeply embedded in county government, operating challenges may be daunting.

Financing the reformed system

The political pressures to reform the NC MH/DD/SA service system propelled the reform process faster than prudent planning would dictate. The reform plan clearly proposed targeting care to those most in need; but defining the population most in need, estimating their clinical needs and proposing a financing plan to address these needs are a daunting set of challenges. This is made all the more difficult by the dizzying array of separate and poorly integrated federal, state, and local funding streams now paying for care. The Holy Grail of the MH/DD/SA service system has been integrated funding so that service “dollars follow patients.” Integrated funding is needed because the bulk of hospital services are financed with state dollars, while community services are increasingly funded by Medicaid dollars, shifting approximately two-thirds of the cost of care to the federal government. Hence, new community service capacity hinges on saving state hospital dollars for reinvestment in Medicaid-funded community services. As a result, the lynch pin of a viable financing plan is the integration of funding streams combined with an overhaul of the state mental health Medicaid plan. The reform finance planning has had to play catch-up with the ambitions of system reform. In its most tangible form, counties have been thwarted in planning efforts

until they understand the plan’s payment mechanisms and rates. Providers may be reluctant to step into the fray until they understand the rates paid for services.

As a result, the financing plan is a vexing unknown to the entire system. Will there be adequate funds for services to target populations? Will the rates proposed cover costs to providers? Will start-up or bridge funding to build community treatment capacity be adequate to the task? In a period of severe state funding shortfalls, can community capacity growth rely on growing Medicaid revenue?

The most fragile piece of the financing plan is bridge funding. System reform is a promise: closure of state hospital beds will be used to fund new comprehensive community services. Stakeholders must accept this promise as they anxiously watch the closure of safety-net hospital beds. In far too many states, this promise has collided with state fiscal shortfalls—beds are closed but new community treatment capacity has not been realized. Michigan is one of the most recent examples of the failure to preserve the hospital safety net while building community capacity (*The Detroit News*, 2003).

In North Carolina, bridge funding relies on several sources, but most critical is the downsizing of state hospital beds for reinvestment in community services. Thus, as a state hospital ward is closed, those funds can be allocated to new community services. In many cases, the state hospital dollars can leverage far more community-based Medicaid services. The unknown is whether this leveraging will create viable alternatives to state hospital care. Dollars mobilized from closure of hospital services will not grow with inflation so that in just a few years bridge funds from this source will shrink with inflation. Community hospital bed capacity will also be hard to find. North Carolina has lost approximately 500 general hospital psychiatry beds under pressures from private sector managed care. Shortages in child psychiatry and child and adult substance abuse beds are particularly acute. In many states (New York being the most recent example), adequate community residential care has not been forthcoming and residential care in New York for the seriously mentally ill has been scandalously poor (*New York Times*, 2003).

One additional source of bridge funding is the Dorothea Dix Hospital land which should be freed up by the planned closure of the hospital. Governor James B. Hunt set a precedent of transferring the Dix land for non-MH/DD/SA treatment purposes, such as the N.C. State University Centennial Campus. The recent State Auditor’s Report called for the creation of a Dorothea Dix Hospital trust fund to assure that the value of this land would be used for the MH/DD/SA service system. Is there legislative will to create and preserve such a trust fund for the mentally ill? In recent history, other potential revenue sources—such as revenue from Disproportionate Share funds earned under Medicaid by state hospitals—have gone into the N.C. General Fund. Will these dollars or other revenue sources, such as a proposed alcohol tax, be used to support the reformed system? Without new revenue, the MH/DD/SA service system cannot keep the promise of hospital downsizing.

An additional area of concern is how providers will be

reimbursed for services. Recent experiences in other states with capitated mental health financing have been criticized for incentivizing undertreatment and diverting savings to managed care profits (Chang et al, 1998). North Carolina has resisted wholesale management by for-profit managed care organizations. With the exception of the Carolina Alternatives Program, a capitated child mental health pilot program, North Carolina has also shied away from capitated financing. However, the alternative of traditional fee-for-service financing is problematic, since, absent some provider risk sharing, reimbursement rates may be discouragingly low. Can North Carolina find alternative payment/management methods that provide a balance between incentivizing undertreatment vs. bogging the system down in fee-for-service care?

A final financing concern: counties provide an important share of local treatment dollars, although there is great variability across counties. Attempts to address disparities in care across counties rest on the assumption that no county will reduce its current funding. Reform plan legislation (HB 381) requires counties to maintain their current financial effort, but enforcement may be difficult given the complex financial relationship between the state and counties, especially at a time when state funding to counties is being reduced.

Clinical capacity and workforce needs

North Carolina, like other states, has severe public mental health workforce shortages, hampered by high turnover and attrition. The current workforce has considerable training needs due to historically little investment in workforce training. Ironically, at a time of burgeoning interest in empirically validated treatment, the MH/DD/SA service system workforce has had limited access to training in these new treatments. The President's New Freedom Commission on Mental Health highlights these workforce needs in its recent report (New Freedom Commission on Mental Health, 2003). The primary sources of MH/DD/SA service system workforce training is the North Carolina Area Health Education Centers Program, combined with other training offered by universities and community colleges—all of whom are under severe budget constraints. The mental health reform laudably calls on clinicians to deploy evidence-based treatments and emerging “best practice” treatment paradigms, but is silent on a plan to fund and implement needed training. Several promising initiatives are underway to augment training resources in these new practice skills, but a major and serious investment in workforce retraining is sorely needed.

Given these existing workforce shortages, many wonder about the career path of former Area program providers leaving public care settings by dint of divestiture. Will they transition to new non-profit provider groups equipped to provide care for these populations, and will these groups improve the distribution of care across the state? Will private providers join with these transitioning employees to fill gaps in needed services? Further, who will step into the void in caring for the non-target indigent patients? Will counties find the resources to provide for their care? Will new provider groups accept responsibility for complex patients for whom the current system is the last resort? Given

the loss of indigent and low-fee care capacity in the private provider sector, many critics are concerned that general hospitals and their emergency departments will be overwhelmed with an influx of patients with nowhere else to go.

In sum, reform poses a major challenge to revitalize the MH/DD/SA service workforce. Bold training, recruitment and retention initiatives will be required to retool the workforce for the needs of the target populations.

Leadership

A sustained effort to reform the MH/DD/SA service system also requires skillful leadership from the Governor, General Assembly, NC Department of Health and Human Services, advocates and local leaders. Governors Hunt and Easley have focused their attention on other pressing human service issues and devoted relatively little attention to the MH/DD/SA service system. For decades, the late Senator Kenneth Royall, a powerful legislative leader, did focus attention on the MH/DD/SA service system and was a powerful force for progress. Since his retirement, several legislators such as Representative Verla Insko and Senator Stephen Metcalf and others have provided exemplary leadership, but none have been as influential as Senator Kenneth Royall. The MH/DD/SA service system needs sustained interest from influential legislative leaders. To paraphrase a comment made a few years ago by Lt. Governor Beverly Perdue at a NC Institute of Medicine annual meeting, “The biggest problem facing mental health in North Carolina is that no one in the General Assembly has been carrying water for mental health.” The system clearly awaits several influential water-carriers.

Continued leadership is also needed at the NC Department of Health and Human Services and the Division of MH/DD/SAS. Secretary Odom has provided effective leadership for system reform. Will that effective leadership spread across her department, especially in the Division of MH/DD/SAS and the embattled Division of Medical Assistance? Effective local leadership is also needed, within and outside the existing advocacy community. Past Secretary of DHHS, Dr. H. David Bruton, during the peak of MH/DD/SAS fractional disarray, was fond of referring to the self-defeating behavior of stakeholders as a mental health firing squad, where all parties formed a circle and fired at each other. Leadership will require a broad consensus and a positive, united front among mental health advocates in convincing the General Assembly and other stakeholders that a sustained effort to strengthen the state's MH/DD/SA service system is a worthwhile and compelling social investment.

Can North Carolina achieve the promise of mental health reform? The challenges we have laid out are formidable, but surmountable. It will take commitment from leaders at all levels and thoughtful implementation efforts, but tangible advances are clearly within reach.

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