



In 2006, North Carolina's mental health system received a grade of D. Three years later, the grade remains the same, but does not even begin to convey the chaos that now pervades the state's mental health care system.

NAMI warned three years ago that the state's reform initiatives were changing too much, too fast, resulting in an increasingly disorganized environment. This prediction was accurate. Fortunately, a change in governors in 2009 provides broader hope for the future.

Some bright spots exist. North Carolina enacted a mental health insurance parity law in 2007, a major step towards improving access to care. The state has taken jail diversion training seriously and has worked to build evidence-based practices. Assertive Community Treatment (ACT) is an acknowledged interest, although the state recently announced a seven percent cut in the program.

North Carolina has piloted granting resources to Local Management Entities (LMEs) to build local capacity, thereby reducing reliance on overcrowded state hospitals. It also has a promising pilot program that integrates mental and physical health care at four LMEs, including shared data systems and common measures to track results.

The state also gives feedback to doctors about their prescribing patterns, which is a positive development.

North Carolina certifies peer specialists and anticipates growing this area of its mental health workforce, if funding can be sustained.

Another strength is improvement in access to Medicaid for consumers who are incarcerated by suspending, rather than terminating, benefits.

North Carolina faces multiple challenges. One of the most complex changes that the state attempted was privatization of community mental health services, creating LMEs for geographic regions. After two years of billing, an auditor found that over \$400 million had been wasted; another level of review subsequently found that number was overstated. Billing issues contributed to both financial and clinical disarray and coincided with the resignation of the HHS secretary.

Currently, ValueOptions manages Medicaid funding, while other state dollars go to the LMEs, resulting in

Innovations

- Integrated physical and medical care pilot program
- Prescription pattern feedback
- Post-incarceration Medicaid reinstatement

Urgent Needs

- Restore confidence and order to overall system
- Improve state hospitals to enable transition to newer facility
- Restore ACT funding cuts

Consumer and Family Comments

- *"The state reorganized services several years ago . . . the psychiatrists all left the area."*
- *"The implementation of the peer support program has been the best thing since sliced bread."*
- *"It takes 24-48 hours to get a hospital bed if I need to be admitted."*
- *"Wake County has a crisis intervention program which I am grateful for."*

more complexity and fragmentation. Essentially, there is a dual system for outpatient care.

Additionally, in 2005, the U.S. Department of Justice (DOJ) documented numerous safety concerns in North Carolina's state hospitals. Efforts to remedy those issues have not been reassuring. DOJ monitors ongoing problems at Dix and Broughton Hospitals. Cherry and Broughton Hospital in Morganton have lost federal funding due to numerous concerns.

The newly-opened Central Regional Hospital (CRH) in Butner was put on notice in 2008 that it too was at risk of losing federal funds. The loss of federal funds for Cherry Hospital is estimated to cost the state \$800,000 per month.

The state's plan to close Dix Hospital and transfer staff and patients to CRH has aroused numerous concerns about safety and staff training. The move has been delayed five times to date.

The new governor, Bev Purdue, inherits a complex, disorganized, and difficult legacy, but at least her charge is clear—to restore confidence and order to the system. Cleaning up the mess and improving care for the state's citizens will require leadership, political determination and involvement of the legislature, and sound investments.