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SPECIAL REPORT



Reforming Mental Health Reform

The History of Mental Health
Reform in North Carolina

by Alison Gray



NORTH CAROLINA CENTER FOR PUBLIC POLICY RESEARCH

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Reforming Mental Health Reform

The History of Mental Health Reform in North Carolina

Executive Summary

Recent exposés about the severe problems in the implementation of North Carolina’s 2001 mental health reform legislation inevitably lead to the broader question of how North Carolina got where it is today—which in some, but certainly not all, respects is a malfunctioning mental health care system. A review of the evolution of mental health policy in the state illustrates that regardless of the nature of the reform, there are complex and not easily resolved core issues that remain to be addressed, involving (1) governance—which government entity has responsibility for the welfare of the mentally ill; (2) coverage—which individuals should be included in government-provided mental health care; (3) funding—how will the necessary services be paid for; and (4) work force—by whom will the treatment be provided? The history of reform shows that improving the treatment and care of the mentally ill is a complex process that evolves incrementally—sometimes with major leaps forward followed by substantial retreats. Finding solutions is not simple, but history can help illuminate the policy and funding parameters that in many ways help shape future reform, as well as stand as a testament to the fact that progress can be achieved as long as the public will and legislative commitment to reform are strong.

America’s Post-Revolutionary Period: The Asylum Movement

During America’s post-Revolutionary period, the Founding Fathers focused on creating a new governmental framework that limited the functions of the federal government and retained a large reservoir of power for state governments. Under this framework, responsibility for the health and social welfare of American citizens, including individuals who suffered from mental illness, was relegated solely to state and local, rather than the federal, government. The mere assignment of such responsibility, however, did not automati-

cally translate into the development by the states or local communities of coherent policies for the mentally ill. Rather, early approaches in caring for them tended to focus on families as caregivers and ad hoc charitable and community-based efforts. Although North Carolina authorized county courts to appoint guardians for the mentally ill in order to protect their property, the state refused to assume any further responsibility on their behalf until the mid-1800s.

The central role played by local communities in the care of the mentally ill shifted significantly in the early 1800s with the emergence of the asylum movement, which promoted the view that the older, ad hoc community ways, which had often resulted in cruel and inhumane treatment, should be replaced by a system of public mental hospitals to care for and treat citizens with severe and persistent mental disorders. In the first 50 years of the 19th century, 20 such institutions in 19 states were established whose focus was not only on the support and maintenance of the mentally ill, but also the development of methods for curing these patients. As a result of the asylum movement, the mental hospital became a public policy priority until after World War II.

Despite the efforts of several North Carolina governors in the 1820s and 1830s to make care of the mentally ill a legislative priority, North Carolina was next-to last among the original 13 colonies to enact legislation for the establishment of a state asylum, primarily because the cost of constructing an asylum was considered too high. Dorothea Dix, a crusader for the humane treatment of the mentally ill and ardent advocate of the asylum system, appealed to the hearts, minds, and pocketbooks of the state legislature, noting that the costs of treating, and in many instances curing, the mentally ill in state hospitals was 32 times less expensive to the state or local coffers than leaving them untreated in either poor houses, jails, or other unsuitable environments.

Construction of the North Carolina Insane Asylum in Raleigh was completed in 1856. Before the turn of the 20th century, two additional psychiatric facilities had been approved and built in North Carolina. Broughton Hospital in Morganton, which serves the 27 westernmost counties, admitted its first patient in 1883. Goldsboro's Cherry Hospital was named the "Asylum for the Colored Insane" when it opened in August 1880. Until the implementation of the Civil Rights Act 85 years later, this hospital served the entire black

population of the State of North Carolina. It now serves 33 eastern North Carolina counties.

After the Civil War: A State Responsibility

The post-Civil War years saw a dramatic increase in the number of mentally ill and demand for placement in the state asylum. In response, in 1868, for the first time the state constitution provided for the maintenance of penal and charitable institutions as follows:

Such charitable, benevolent, penal, and correctional institutions and agencies as the needs of humanity and the public good may require shall be established and operated by the State under such organization and in such manner as the General Assembly may prescribe.

For the first half of the 20th century, the emphasis on the use of asylums to address mental health issues and dual responsibility between the state and counties was the norm in North Carolina. Up until the 1940s, public hospitals cared for nearly 98 percent of all institutionalized mental patients, two-thirds of the members of the American Psychiatric Association practiced in public institutions, and there was little impetus to question the role of state mental hospitals in the treatment of the mentally ill, even if policymakers did not always agree on policy details or the quality of some institutions was sub-par.

Post-World War II: A Shift to Community-Based Care

During and after World War II, however, the paradigm started to shift when activists began to promote a new mental health policy that moved away from the care and treatment of the severely ill in state institutional settings and towards community-based alternative settings. Numerous factors propelled this change during the last half of the 20th century including: (1) the changing composition of the asylum population; (2) the changing nature of the psychiatric model; (3) the creation of effective psychotropic drugs; (4) the emergence of legal advocates for the mentally ill and a more active judiciary; (5) the decline in quality and image of state institutions; and, most significantly, (6) the federal government's foray into mental health policy-making and funding directly through mental health legislation and indirectly through Social Security entitlement programs.

Although the goal of the community-based movement was eventual elimination of state hospitals, during the 1950s most states supported both with attempts to improve state hospital conditions as well as expand community services. According to Gerald Grob, a professor at Rutgers University, in an article on the development of mental health policy in America, community-based initiatives that began to develop during the 1950s included “general hospital psychiatric units, outpatient clinics, halfway houses, day hospitals, social clubs for ‘ex-patients,’ family care, anti-stigma interventions, preventive services, and the use of visiting professional teams to go into patients’ homes, private doctors’ offices, or remote rural areas.” Problems remained, however, albeit in a different venue.

The Entrance of the Federal Government

The states remained solely responsible for mental health policy and, in most instances, continued mainly to pursue traditional institutional solutions while dabbling in community alternatives. The ultimate factor that tipped the balance from an institutionally-based to a community-oriented mental health policy was the decision of the federal government to take responsibility for promoting the mental health of all Americans. A series of post-World War II legislative enactments helped promote community mental health and deinstitutionalization practices. The federal government’s role as the key agent of reform and innovation in public mental health policy continued for approximately 35 years until the early part of President Reagan’s administration.

In reality, however, the state hospitals proved resistant to change due to several factors including (1) continuing support from community residents and hospital employees; and (2) the existence of a group of mentally ill individuals who were so disabled that institutional care appeared to be the only option. Thus, despite dehospitalization, state hospitals remained the largest provider of total inpatient days of psychiatric care and, in their common role as the system of last resort, their patients disproportionately came from the ranks of the uninsured, treatment resistant, the most difficult, troubled, and violence-prone, and those most difficult to relocate to alternative settings.

The Americans with Disabilities Act and the Olmstead Decision

The community-based movement gained further strength in the 1990s due to significant legislation at the beginning of the decade and a decision by the U.S. Supreme Court at the end. In 1990, Congress enacted the Americans

with Disabilities Act (ADA) to eliminate discrimination against those with disabilities. The ADA applies to all public entities and the use of public funds; therefore, it has implications for publicly-funded Medicaid services to people with mental and other disabilities.

Nine years after the enactment of the ADA, the U.S. Supreme Court held in *Olmstead v. L.C.* that the ADA requires states to provide placement in communities for individuals with disabilities if the state's treatment professionals have determined that such community-based placement is appropriate, if the individuals affected do not oppose such placement, and if such placement can reasonably be provided considering the state's resources and the need of others with disabilities. The decision challenged all levels of government to create "additional opportunities for individuals with disabilities through more accessible systems of cost-effective community-based services."

During the last decade of the 20th century, North Carolina's public mental health system consisted of: (1) state-operated services under the supervision of the N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services including the four psychiatric hospitals (built between the 1850s and the 1940s), developmental disability centers, and alcohol and drug rehabilitation centers; (2) 39 multiple or single-county semi-autonomous governmental area programs created in the 1970s that provided direct services; and (3) private, non-profit and for-profit providers who offered services through purchase of service contracts with area programs. This system's dysfunction, especially in light of the U.S. Supreme Court's *Olmstead* decision, became painfully evident in the 1990s.

North Carolina's 2001 Reform Legislation

A central outcome of North Carolina's 2001 reform legislation was (1) the transfer, over a multi-year period, of management and oversight functions of mental health, developmental disability, and substance abuse programs from the existing quasi-independent local area authorities to fully governmentally accountable local management entities; and (2) privatization of mental health services by divesting clinical services from public area authorities to private nonprofit and for-profit provider groups. As a result, North Carolina will effectively be operating dual systems—both state institutions and community centers—for anywhere from seven to 10 years, if not longer.

Like the asylum movement and federal community-based initiative, North Carolina's 2001 mental health reform has resulted in both successes and

failures and continues to be a work in progress with the threads of both prior movements still playing significant roles. The legislation's vision is to provide: (1) community-based rather than institutional services and support; (2) a system that is participant-driven, prevention-focused, outcome-oriented, reflective of best practices, cost-effective, community-integrated, with resource equity and fairness throughout the state; (3) screening, triage, and referral to everyone in need; and (4) other services and support to those most in need, including the most seriously mentally ill or disabled, racial/ethnic minorities, and individuals with more than one disorder. However, from the beginning, individuals involved in the reform effort have expressed concerns about how the vision would be implemented. According to Drs. Marvin Swartz and Joseph Morrissey, "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."

Conclusion

The current state of mental health reform in North Carolina cannot be viewed in a vacuum. Rather, the ghosts of past reforms continue to play a significant role from the continuing existence of state psychiatric hospitals to the creation of additional community options to the current funding patterns with interwoven threads of federal, state, and local dollars. An understanding of past policy decisions that have dramatically impacted the care and treatment of the mentally ill today should serve to guide future reform efforts which, as with past efforts, continue to focus on these central issues:

What is the role of the federal, state, and local governments in assisting the mentally ill?

Which among a vastly diverse population of the mentally ill should receive such help?

Where should such help be provided, who will provide it, and at what cost?

Going forward, reform has to be a state priority and not just on the front burner when there is a newspaper exposé or a leader committed to raising the profile of the issue. A system 200 years in the making cannot be reformed overnight. The success of reform efforts going forward will depend on leadership, funding, time and support for development, and a qualified work force.

Reforming Mental Health Reform

The History of Mental Health Reform in North Carolina

by Alison Gray

*“Whereof what’s past is prologue, what to come
In yours and my discharge.”*

—William Shakespeare, *The Tempest*

*“Historical knowledge can deepen the way in which we think about
contemporary issues and problems. It can also sensitize us to the
dangers of simplistic solutions.”*

—Gerald N. Grob, Ph.D.

*“Health organization and policy never arise anew. They evolve from
prior culture and understandings, health care arrangements, health
professional organizations, and political and economic processes.”*

—David Mechanic, Ph.D.

INTRODUCTION

Recent exposés about the severe problems in the implementation of North Carolina’s 2001 mental health reform legislation inevitably lead to the broader question of how North Carolina got where it is today—which in some, but certainly not all, respects is a malfunctioning mental health care system. The answer is inextricably linked to the history of mental health reform in our country. This includes earlier reforms such as the asylum movement in the 1800s, which led to the creation of the state psychiatric hospital system. It also includes the federal community-based initiatives beginning after World War II and blossoming in the 1960s, which shifted the mental health paradigm in a completely different direction and ushered in a greatly expanded federal role. The threads of these prior movements are still at play today

Alison Gray is an attorney living in Washington, D.C. She has written for North Carolina Insight since 1983. Lauren P. Knelson, a student at UNC-Chapel Hill working on her master’s degree in public health, served as the research associate for this report.

since state hospitals play, at a minimum, a vitally necessary “safety net” role in the provision of mental health services for the most severely and persistently mentally ill, even though community-based facilities have as a practical and legal matter supplanted the role of institutional care as the more advantageous approach to the care and treatment of the mentally ill.¹

A review of the evolution of mental health policy also illustrates that regardless of the nature of the reform, there are complex and not easily resolved core issues that must be addressed involving (1) governance—which government entity has responsibility for the welfare of the mentally ill; (2) coverage—which individuals should be included in government-provided mental health care; (3) funding—how will the necessary services be paid for; and (4) work force—by whom will the treatment be provided? As demonstrated below, at various times the answers provided were different, but all of these issues remain as central to today’s reforms as they were in 18th century America.

In addition, it is clear that providing an answer to the questions above does not always result in the consequences intended. This too is true of today’s more modern reforms in North Carolina where the most severely and persistently ill were certainly intended to be beneficiaries of the reform efforts but, as in the past, are often the ones who are most left out in the cold.

Finally, the prior reforms demonstrate that any major mental health reform evolves over time—sometimes decades or longer. The “Catch-22” (generally used to reference a no-win situation) of this reality is that the passage of time also inevitably involves other unexpected changes (such as state budgetary crises, changes in government administrations elected with different priorities, or scientific discoveries affecting the type and place of treatment and care) that can impact the success or failure of the reform either short or long-term.

The history of reform shows that improving the treatment and care of the mentally ill is a complex process that evolves incrementally—sometimes with major leaps forward followed by substantial retreats. Finding solutions is not simple, but history can help illuminate the policy and funding issues that in many ways help shape future reform, as well as stand as a testament to the fact that progress can be achieved as long as the public will and legislative commitment to reform are strong. As stated by mental health policy scholar Dr. David Mechanic, “Effective treatment of mental illness in future decades will depend on advances in knowledge and technology and on the social and political factors that affect social policies in general and mental health policies in particular.”² An awareness of why the mental health system functions as it does at present and what has and has not worked in the past also can play an invaluable role.

¹ The U.S. Surgeon General’s 1999 report, “Mental Health: A Report of the Surgeon General,” notes that

Mental illness is the term that refers collectively to all diagnosable mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. Alzheimer’s disease exemplifies a mental disorder largely marked by alterations in thinking (especially forgetting). Depression exemplifies a mental disorder largely marked by alterations in mood. Attention-deficit/hyperactivity disorder exemplifies a mental disorder largely marked by alterations in behavior (overactivity) and/or thinking (inability to concentrate). Alterations in thinking, mood, or behavior contribute to a host of problems—patient distress, impaired functioning, or heightened risk of death, pain, disability, or loss of freedom (American Psychiatric Association, 1994).

On the Internet at <http://www.surgeongeneral.gov/library/mentalhealth/chapter1/sec1.html>.

² David Mechanic, Chapter 7: “Mental Health Policy at the Millennium: Challenges and Opportunities” in *Mental Health, United States, 2000* by the Center for Mental Health Services, Manderscheid, R. W., and Henderson, M. J., eds., DHHS Pub No. (SMA) 01-3537, U.S. Government Printing Office, Washington, DC, 2001. On the Internet at <http://mentalhealth.samhsa.gov/publications/allpubs/SMA01-3537/default.asp>.

What's PC These Days? A Look at the Language of Mental Health

Senate Bill 208, People First, was introduced in the 2009 session of the N.C. General Assembly on February 18, 2009. It would require the use of words that are respectful when referring to persons with disabilities in regulations and laws. In recognition that “certain terms are demeaning and create an invisible barrier to inclusion as equal community members,” the bill proposes that handicapped be replaced with people with disabilities, mentally retarded be replaced with intellectual disability, crippled be replaced with physical disability, and mentally disabled be replaced with mental illness.

Imbecile was a controversial term that is no longer used to classify a type of *mental retardation*—idiot applied to an IQ of 1-25, imbecile applied to an IQ of 26-50; and moron applied to an IQ of 51-70. It derives from the Latin word *imbecillus*, meaning weak, or weak-minded, and it was popularized by psychologist Henry H. Goddard. <http://en.wikipedia.org/wiki/Imbecile>—cite_note-goddard1915-3 The term imbecile quickly became a derogatory term, and it fell out of professional use in the 20th century. Excerpted from “Imbecile,” in *Wikipedia, The Free Encyclopedia*, on the Internet at <http://en.wikipedia.org/w/index.php?title=Imbecile&oldid=262090680>.

Insanity or madness is the behavior in which a person disregards societal norms and may become a danger to themselves or others. Greek tragedies and Shakespeare often refer to madness in this sense. It is commonly encountered as an informal, unscientific term, or in the narrow legal context of the *insanity defense*. When discussing mental illness in general terms, *psychopathology* currently is considered the preferred term. In the medical profession, insanity is now avoided in favor of more specific diagnoses of *mental illness*, such as *schizophrenia* and other psychotic disorders. Excerpted from “Insanity,” in *Wikipedia, The Free Encyclopedia*, on the Internet at <http://en.wikipedia.org/w/index.php?title=Insanity&oldid=271116150>.

Insane asylum also fell out of fashion in favor of mental institution or hospital. Excerpted from “Psychiatric hospital,” in *Wikipedia, The Free Encyclopedia*, on the Internet at http://en.wikipedia.org/w/index.php?title=Psychiatric_hospital&oldid=271186563.

Mental retardation is now referred to as intellectual impairment or disability. Excerpted from “Mental retardation,” in *Wikipedia, The Free Encyclopedia*, on the Internet at http://en.wikipedia.org/w/index.php?title=Mental_retardation&oldid=271024148.

Source: Provided for information only, not as original research. See also <http://www.nimh.nih.gov/>



MENTAL HEALTH POLICY AND REFORM: POST-REVOLUTIONARY PERIOD THROUGH WORLD WAR II

“Life is lived forward, but understood backward.”

—Søren Kierkegaard

“[O]ur predecessors who cared for psychotic patients were not quaint. Neither are we excessively wise.”

—A. Rosenblatt

Ad Hoc Local Community Care of the Insane During the Post-Revolutionary Period

The Tenth Amendment to the U.S. Constitution, which provides that powers not delegated to the United States by the Constitution are “reserved to the States respectively, or to the people,” is a testament to the Founding Fathers’ focus during America’s post-Revolutionary period on creating a new governmental framework that limited the functions of the new federal government and retained a large reservoir of power for state governments.³ *Under this framework, responsibility for the health and social welfare of American citizens, including individuals who suffered from mental illness, was relegated solely to state and local, rather than the federal, government.*⁴ The mere assignment of such responsibility, however, did not automatically translate into the development by the states or local communities of coherent policies for the mentally ill.⁵ Rather, early approaches in caring for the mentally ill tended to focus on families as caregivers and *ad hoc* charitable and community-based efforts.

In general, prior to 1800, “insanity was neither defined in medical terms nor identified as a pressing problem.”⁶ Many physicians believed that some disturbance of the blood flow, such as too much blood collecting in the head, created “an upset of reason” and treated such conditions by bleeding several areas about the head and shaving off the patient’s hair.⁷ Many theologians during this period viewed mental illness, as well as poverty, as divinely ordained conditions.⁸ Still others maintained a superstitious fear of the mentally ill as persons “possessed by the devil.”⁹ For the most part, however, regardless of the variance in views of the cause of the mental disorder, individuals suffering from these conditions in large part were not stigmatized or viewed as part of a “problem” population requiring intervention by the state.¹⁰

³ Gerald N. Grob, “Government and Mental Health Policy: A Structural Analysis,” *The Milbank Quarterly*, Vol. 72, No. 3, 1994, p. 472. The Tenth Amendment provides that the “powers not delegated to the United States by the Constitution . . . [were] reserved to the states respectively, or to the people.” See U.S. Const. Amendment X.

⁴ Grob, note 3 above, p. 472.

⁵ *Ibid.*

⁶ *Ibid.*

⁷ Guion Griffis Johnson, *Ante-Bellum North Carolina: A Social History*, University of North Carolina Press, Chapel Hill, NC, 1937, p. 708. On the Internet at <http://docsouth.unc.edu/nc/johnson/johnson.html>.

⁸ *Ibid.*; see also Grob, note 3 above, p. 472.

⁹ Johnson, note 7 above, p. 708.

¹⁰ Grob, note 3 above, p. 472.



Dorothea Dix

Although North Carolina authorized county courts to appoint guardians for the mentally ill in order to protect their property, the state refused to assume any further responsibility on their behalf until the mid-1800s.¹¹ The lack of state intervention meant that most efforts to care for this segment of society during the 1700s and early part of the 1800s arose on an *ad hoc* basis with the wealthier families sending their afflicted family members to state hospitals in neighboring states while those with fewer means were cared for in community households, where possible, or within the framework of “poor” laws and/or private religious or charitable organizations.¹²

During this time, some communities established almshouses to care for the poor and, as these became more prevalent, the mentally ill who either could not be adequately cared for at home or were destitute were often housed in these facilities or

¹¹ Johnson, note 7 above, pp. 708-09.

¹² Grob, note 3 above, p. 472; Johnson, note 7 above, p. 709.

common jails without any medical treatment or special care.¹³ On March 14, 1803, the *Raleigh Register*, after describing the horrific death of a mentally ill man who had been chained in the Salisbury county jail and died during a jailhouse fire, noted, “We think regret will not be the predominant sensation at the final termination of this most unfortunate creature’s sufferings.”¹⁴ Despite ever-present fiscal limitations, the underlying impetus for the various community efforts was “long-standing ethical and moral values that were predicated on the assumption that society had an ethical and moral obligation to assist those unable to survive independently.”¹⁵

State Intervention: The Asylum Movement During the 1800s

The central role played by local communities in the care of the mentally ill shifted significantly in the early 1800s with the emergence of the asylum movement, which promoted the view that the older, *ad hoc* community ways, which sometimes resulted in cruel and inhumane treatment, should be replaced by a system of public mental hospitals to care for and treat citizens with severe and persistent mental disorders.¹⁶ The roots of this movement trace back, at least in part, to 18th century Europe where a new medical paradigm known as “moral treatment” had been embraced.¹⁷ Advocates of this holistic approach—which has been described as “the use of compassion rather than chains to cure the insane”¹⁸—argued that the mentally ill could be restored “to reason and light by immersing them in a carefully controlled environment where they would be under the supervision of a physician and where all perverting influences were expelled.”¹⁹ Other scholars have theorized that the birth of asylums reflected “society’s desire to incarcerate misfits rather than maintain them within the community” and “the strong impulse toward discipline and incarceration was a reaction to social disorder of the period.”²⁰

Regardless of the exact underpinnings of the reform, its effects were noticeable. Prior to the 19th century, only one American institution, the Virginia Eastern Lunatic Asylum, established in 1773 in Williamsburg, Virginia, existed that was devoted ex-

¹³ Harry McKown, “This Month in North Carolina History—January 1949—Dorothea Dix Hospital.” On the Internet at <http://www.lib.unc.edu/ncc/ref/nchistory/jan2006/index.html>; and Johnson, note 7 above, p. 709.

¹⁴ Johnson, note 7 above, p. 709.

¹⁵ Grob, note 3 above, p. 472.

¹⁶ *Ibid.*, p. 473. Gerald Grobs says, “The assertion that community care and treatment in the 17th and 18th century was cruel and inhumane is inaccurate. In the rural society of that age, communities did the best they could and provided neither less nor more inhumane care. The auctioning out system was simply an effort by the community to find a family to care for a person with a severe mental disorder; in turn, the community provided a modest payment to the family.”

¹⁷ “Mental Health: A Report of the Surgeon General,” note 1 above. On the Internet at <http://www.surgeongeneral.gov/library/mentalhealth/chapter2/sec7.html>.

¹⁸ Julie Nicoletta, “The Architecture of Control: Shaker Dwelling Houses and the Reform Movement in Early Nineteenth-Century America,” *The Journal of the Society of Architectural Historians*, Vol. 62, No. 3, Sept. 2003, p. 378.

¹⁹ *Ibid.*, p. 370 (noting that author Michel Foucault, in his studies of the rise of the penitentiary and of the asylum, *Discipline and Punish* and *Madness and Civilization*, suggested that Enlightenment thought encouraged society to bring those who were deemed deviant under the control of reason.); see also p. 377 (“In the 1790s, independently of each other, Philippe Pinel, of the Bicetre and Salpêtrière hospitals in Paris, and William Tuke, a Quaker in York, England, implemented moral treatment of the mentally ill based on ‘minimal physical correction, incentives to self-control, and firm paternal direction.’”). Inspired by Tuke’s work and writings, Quakers in Pennsylvania opened the Friends’ Asylum outside Philadelphia in 1817. *Ibid.* The apparent success of this new approach in private asylums helped to spur the demand for state institutions. *Ibid.*

²⁰ *Ibid.*, p. 370 (citing Daniel J. Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic*, rev. ed., Boston, MA, 1990).

clusively to the care of the mentally insane.²¹ In the first 50 years of the 19th century, this number had expanded to 20

institutions in 19 states whose focus was not only on the support and maintenance of the mentally ill but also the development of methods for curing these patients.²²

As a result of the asylum movement, the mental hospital “became the first priority for public policy—a position that it would retain until after World War II.”²³

²¹ Dorothea Lynde Dix, “Memorial Soliciting a State Hospital for the Protection and Cure of the Insane, Submitted to the General Assembly of North Carolina. November, 1848.” House of Commons Document, No. 2, p. 45. On the Internet at <http://docsouth.unc.edu/nc/dixdl/menu.html>. The first hospital in the American colonies to provide public and private aid for the ill was established in 1751 by a group of Philadelphia civic leaders including Benjamin Franklin and Benjamin Rush. See Nicoletta, note 18, above, p. 377. Pennsylvania Hospital was the first to include a department for treatment of the mentally insane; it began accepting the insane in 1752. *Ibid.*; see also Dix, p. 45.

²² Dix, note 21 above, p. 45.

²³ Grob, note 3 above, p. 473.

When Regret Is Not Enough: Newspapers Report on Deaths of Mentally Ill Patients in the State’s Care

On March 14, 1803, after describing the horrific death of a mentally ill man who had been chained in the Salisbury county jail and died during a jailhouse fire, the *Raleigh Register* noted, “We think regret will not be the predominant sensation at the final termination of this most unfortunate creature’s sufferings.”ⁱ Four other criminals managed to escape after being “awakened to a sense of their imminent danger by the cries of the unfortunate sufferer.”ⁱⁱ

Over two hundred years later, another man suffering from mental illness died an inexcusable death while in the state’s care, and the state must recognize that regret is no longer enough. According to *The News & Observer* of Raleigh, on April 29, 2008, Steven Sabock, age 50, died at Cherry Hospital in Goldsboro, N.C. Sabock, who was being treated for bipolar disorder, was left overnight in a chair for 22 hours and 34 minutes in the hospital’s day room without food, water, or access to a bathroom before he died of a heart condition. In the background of a security video, health care workers can be seen playing cards, watching television, and talking on cell phones.ⁱⁱⁱ

Dempsey Benton, then Secretary of the N.C. Department of Health and Human Services, said, “On behalf of the Department of Health and Human Services and myself personally, we deeply regret that Mr. Sabock died, and that it occurred while a patient at Cherry Hospital. The Department finds the circumstances related to this tragic death at Cherry Hospital completely unacceptable.”^{iv} The adult admissions ward was closed, an independent hospital management team was brought in, and the hospital was decertified to provide Medicaid and Medicare services. The director of the hospital, Dr. Jack St. Clair, stepped down on December 31, 2008.

— *Mebane Rash, Editor, North Carolina Insight*

ⁱ Guion Griffis Johnson, *Ante-Bellum North Carolina: A Social History*, University of North Carolina Press, Chapel Hill, NC, 1937, p. 709. On the Internet at <http://docsouth.unc.edu/nc/johnson/johnson.html>.

ⁱⁱ *Ibid.*

ⁱⁱⁱ Michael Biesecker, “Tape shows progress of a death,” *The News & Observer*, Nov. 19, 2008, pp. 1A and 8A.

^{iv} “DHHS Secretary Takes Action for Patient Care at Cherry Hospital, Goldsboro,” Aug. 22, 2008. On the Internet at <http://www.ncdhhs.gov/pressrel/2008/2008-8-22-action-at-cherry.htm>.

North Carolina's Role in the Asylum Movement

Despite the efforts of several North Carolina governors in the 1820s and 1830s to make care of the mentally ill a legislative priority, North Carolina was next to last among the original 13 colonies (the last was Delaware) to enact legislation for the establishment of a state asylum.²⁴ In an oft-repeated pattern, the early governors' efforts to address the needs of the mentally ill simply resulted in an abundance of studies with few tangible results.

Initially, an 1825 resolution called upon two members in the legislature to collect information and report a plan for the creation of "a lunatic asylum."²⁵ In 1827, a joint legislative committee reviewed the resulting report and recommended another report.²⁶ While recognizing that it would "add luster to a government . . . to protect and cherish the unfortunate individual who by the visitation of God has been deprived of his reason," the joint committee feared that the costs of constructing an asylum would be too high and sought a study of the feasibility of establishing a penitentiary and asylum as one institution.²⁷ No other action was taken for the next 10 years until the closing month of the 1838-39 legislative session when another resolution was passed, in connection with a resolution seeking information about a penitentiary and an orphans' home, seeking information on the number of insane in North Carolina, whether they were "at large or in confinement and where and how long confined."²⁸

Five years later, in 1844, in response to Governor John Motley Morehead's recommendation that North Carolina establish asylums for the insane, blind, and deaf, the legislature appointed yet another special committee which subsequently recommended that money from the Internal Improvements Fund be used to establish the asylums.²⁹ The report noted that there were "801 insane persons and idiots in North Carolina in 1840" and urged the legislature to remove them from their "cold and noisome cells where they had been shut up 'to drag out the miserable remnant of their days, without fire to warm their benumbed limbs . . . and without friends . . . to soothe and calm the tempest raging within their distempered imaginations."³⁰ No legislation passed, however, because the legislature was unwilling to tamper with the Internal Improvements Fund and incur the wrath of the voting public by imposing a tax to raise the necessary funds.³¹

Another five years passed before North Carolina finally enacted a law for the establishment of an insane asylum at the urging of Dorothea Dix, a crusader for the humane treatment of the mentally ill and ardent advocate of the asylum system.³² In November 1848, Dix presented a "Memorial Soliciting a State Hospital for the Protection and Cure of the Insane" to the North Carolina General Assembly asking for "an adequate appropriation for the construction of a Hospital for the remedial treatment of the Insane in the State of North Carolina."³³ In this Memorial, Dix provided a county by county assessment of the often inhumane treatment of the mentally ill. As Dix noted,

²⁴ Dix, note 21 above, p. 4 ("North Carolina, hailed of her sons, 'the glorious Old North,'— North Carolina, unburdened by State debts, untouched by serious misfortunes, is last and latest of the 'old thirteen,' save the small territory of Delaware, to make provision for the care and cure of her insane citizens, and almost the last embracing all the New States in our broad Union."): see also McKown, note 13 above.

²⁵ Johnson, note 7 above, p. 711 (citing the *Raleigh Register*, Jan. 6, 1826).

²⁶ *Ibid.*, p. 711.

²⁷ *Ibid.*, p. 711 (citing Manuscript Legislative Papers, in Senate, Jan. 5, 1828).

²⁸ *Ibid.* (citing Manuscript Legislative Papers, engrossed in House, Jan. 7, 1839).

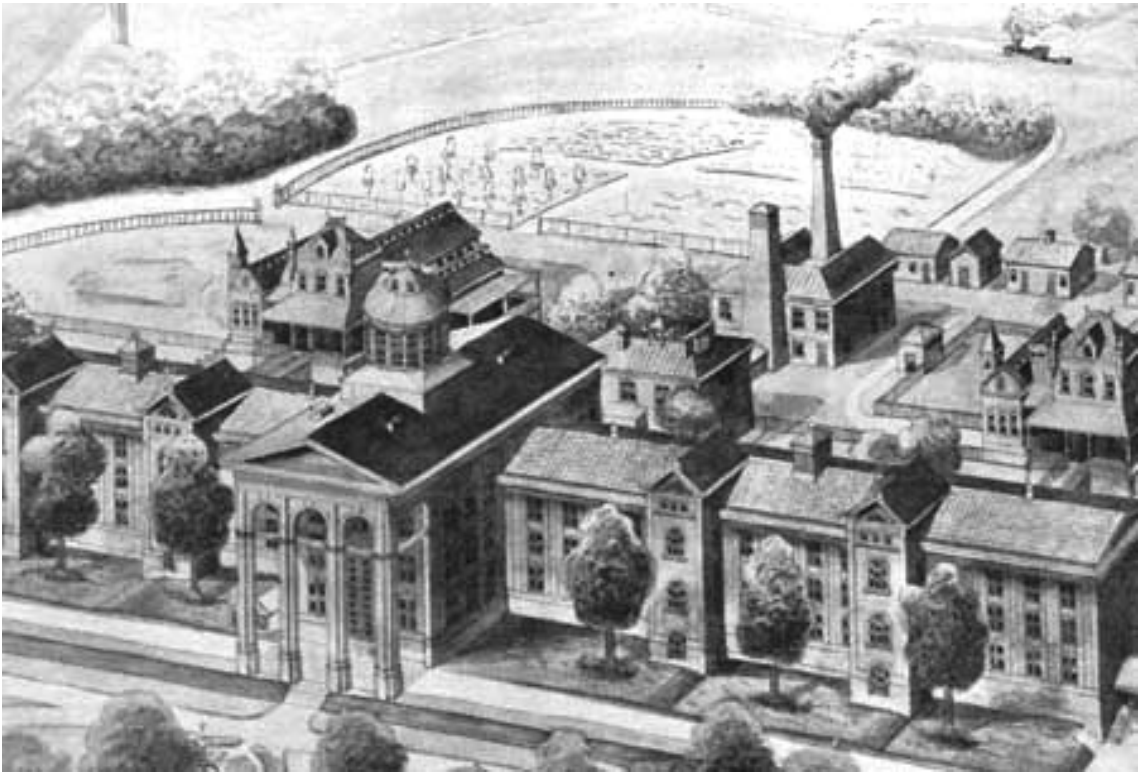
²⁹ *Ibid.*

³⁰ *Ibid.*, p. 712 (citing Report of the Select Committee Upon Asylums, Jan. 15, 1845).

³¹ *Ibid.*

³² As a direct result of her efforts, more than 30 mental hospitals were founded or enlarged in the United States and abroad. Albert Deutsch, "Dorothea Lynde Dix: Apostle of the Insane," *The American Journal of Nursing*, Vol. 36, No. 10, Oct. 1936, p. 987. See also Clark R. Cahow, "The History of the North Carolina Mental Hospitals: 1848-1960," Ph.D. dissertation, Duke University, 1967.

³³ Dix, note 21 above, p. 48.



Old Main, Dix Hospital

At present there are practiced in the State of North Carolina, four methods of disposing of her *more than one thousand* insane, epileptic, and idiot citizens, viz: In the cells and dungeons of the County jails, in comfortless rooms and cages in the county poor-houses, in the dwellings of private families, and by sending the patients to distant hospitals, more seasonably established in sister States. I ask to represent some of the very serious evils and disadvantages of each and all these methods of disposing of the insane, whether belonging to the poor or to the opulent classes of citizens.

It may be here stated that by far the larger portion of the insane epileptics, and idiots, are detained in or near private families, few by comparison, being sent to Northern or Southern State hospitals, and yet fewer detained in prisons and poor-houses, yet so many in these last, and so melancholy their condition, that were the survey taken of these cases alone, no stronger arguments would be needed to incite energetic measures for establishing an institution in North Carolina adapted to their necessities, and to the wants of the continually recurring cases, which each year swell the record of unalleviated unmitigated miseries.³⁴

³⁴ *Ibid.* pp. 4-5 (emphasis in original). In an especially poignant passage, Dix recalled the suffering of a Granville County man

who for years has been chained to the floor of a wretched room [in the county poor-house]; miserable and neglected, his now deformed and palsied limbs attest the severity of his sufferings through these cruel restraints; flesh and bone are crushed out of shape by the unyielding irons. He was a man of good character, industrious, frugal habits; a good citizen, and respectable as respected; he became insane, and soon the malady assumed a maniacal character: he was carried to the poor-house, loaded with chains, and left like a wild beast

Dix appealed to the hearts, minds, and pocketbooks of the state legislature noting that the costs of treating, and in many instances curing, the mentally ill in state hospitals was 32 times less expensive to the state or local coffers than leaving them untreated in either poorhouses, jails, or other unsuitable environments.³⁵

In an impassioned speech delivered in the North Carolina House of Commons in December 1848, Kenneth Rayner of Hertford, articulated the moral treatment viewpoint with respect to the state's responsibility for caring for her mentally ill citizens:

The object of government is to take care of all. And the Representative of a confiding and generous people can perform no more welcome task, than that of providing for a mitigation of one of the most awful calamities visited upon our race. . . . Until within the period of the existence of our own government, young as it is, the old plan of the dark ages . . . of treating the insane as outcasts, was the only one known. The dark and noisome cell, the chain and the hand cuff, the bar and the bolt, lash and the torture, the scanty meal and the time-worn vesture, were, for ages, the portion of these victims of misfortune. This cruel system, and the false idea upon which it rested, are now, and it is hoped, forever rejected, as unwise, unfeeling, unchristian. . . . [In properly treating the mentally ill], you must resort to comparatively isolated locations; you must obtain the services of those who devote their lives exclusively to this noble and praise worthy vocation, you must congregate those unfortunate victims, where time, opportunity, knowledge, and experience can all be commanded in ministering to their wants.³⁶

Although nearly defeated “amid political and financial brawls,” the legislation passed on a reconsideration vote on January 29, 1849, after James C. Dobbin, a political leader and member of the legislature “brought up an amendment to the original bill and in a great emotional speech united Whigs and Democrats to obtain passage of the measure.”³⁷ Dobbin's wife, who had been visited and cheered by visits from Dix as she lay dying, had urged her husband on her deathbed to support the legislation.³⁸ The *Raleigh Register* described Dobbin's speech as “one of the most touchingly beautiful efforts that we have ever heard.”³⁹

Construction of the North Carolina Insane Asylum in Raleigh was finally completed at a site, named Dix Hill in honor of Dix's father, in 1856.⁴⁰ Before the turn of the century, two additional psychiatric facilities had been approved and built in North Carolina. Broughton Hospital in Morganton, which serves the 27 westernmost counties, admitted its first patient in 1883.⁴¹ Goldsboro's Cherry Hospital was named the “Asylum for the Colored Insane” when it opened in August 1880. Until the implementation of the Civil Rights Act 85 years later, this hospital served the entire black population of the State of North Carolina. It now serves 33 eastern North Carolina counties.⁴²

to live or perish; no care was bestowed to advance his recovery or to secure his comfort!
Ibid., pp. 13-14.

³⁵ *Ibid.*, pp. 5-6.

³⁶ Kenneth Rayner, “Speech of Mr. Rayner, of Hertford, on the Bill to Provide for the Establishment of a State Hospital for the Insane in North Carolina; Delivered in the House of Commons, December 21st, 1848,” pp. 3, 5-6, and 8. On the Internet at <http://docsouth.unc.edu/nc/rayner/rayner.html>.

³⁷ Johnson, note 7 above, p. 712 (citing Boyd, *History of North Carolina*, pp. 253-57); see also McKown, note 13 above.

³⁸ Johnson, note 7 above, p. 712.

³⁹ *Ibid.* (citing the *Raleigh Register*, Dec. 27, 1848).

⁴⁰ McKown, note 13 above.

⁴¹ On the Internet at <http://www.broughtonhospital.org/>.

⁴² On the Internet at <http://www.cherryhospital.org/>.

The Effect of the Asylum Movement on the Relationship between State and Local Governments

The shift from autonomous local *ad hoc* efforts to a more centralized means of addressing the needs of a state's mentally ill population not only affected the actual care and treatment of the mentally ill but also resulted in a division of responsibility between state and local governments.⁴³ Although there were variations among the states, typically, state legislatures assumed responsibility for capital expenditures such as land acquisition and physical plant construction and in some instances administrative salaries, while local communities were required to reimburse the hospital for the costs of individual patient care.⁴⁴

In Rayner's 1848 speech before the North Carolina Legislature, he argued that it was economically preferable and likely less expensive to raise, through a slight increase in real estate and poll taxes, the necessary \$100,000 to build a "comfortable and commodious" facility that would provide relief to the indigent insane, as well as wealthy patrons who could use it at their own expense, than to continue the current system of county expenditures for keeping the mentally insane confined or providing allowances to destitute parents and friends who took care of mentally ill family members.⁴⁵ The bill that ultimately passed "called for a fund of \$87,000 to be raised by a tax of 1½ cents on the hundred dollar valuation of land and 5½ cents on the poll for the erection of a hospital to accommodate 150 patients."⁴⁶ In an effort to appease a large portion of the public that had always opposed mental health reform due to its costs, the bill also provided that the county courts could "make a corresponding reduction in the poor tax."⁴⁷ While satisfying one political contingent, it angered others who had supported the bill because they came to view the bill as robbing "the poor to care for the insane."⁴⁸ In 1856, the legislature made its first direct appropriation of \$20,000 per year to the North Carolina Insane Asylum and increased the appropriation in 1858 to \$25,000. During this two-year period, the asylum treated 242 cases.⁴⁹

The effect of the division of responsibility between state and local governments in North Carolina and elsewhere was significant. "Most important, the system tended to promote competition and rivalries that were inherent in overlapping jurisdictions."⁵⁰ Thus, for example, if the asylum system adopted by a state stipulated that communities remained financially responsible for poor and indigent residents, the county or other localities had an incentive to keep such individuals in local almshouses where per capita costs were lower.⁵¹ By contrast, if the state assumed more of the financial responsibility, then localities made greater use of the asylums because it lessened their financial burdens.⁵² Thus, the funding patterns in many states played a critical role in determining whether the mentally ill populace "would be placed in asylums, almshouses, or simply left on their own."⁵³ Dual responsibility also had an impact on the functioning of the asylums which often had to confront insufficient or marginal

⁴³ Grob, note 3 above, p. 473.

⁴⁴ *Ibid.*; see also Gerald Grob, Chapter 2: "Mental Health Policy in 20th Century America" in *Mental Health, United States, 2000* by the Center for Mental Health Services, Manderscheid, R. W., and Henderson, M. J., eds., DHHS Pub No. (SMA) 01-3537, U.S. Government Printing Office, Washington, DC, 2001. On the Internet at <http://mentalhealth.samhsa.gov/publications/allpubs/SMA01-3537/default.asp>.

⁴⁵ Rayner, note 36 above, pp. 10-12.

⁴⁶ Johnson, note 7 above, p. 713; see also "First Annual Report of the Board of Public Charities of North Carolina, February 1870," p. 9 (describing the initial funding). On the Internet at <http://docsouth.unc.edu/nc/char1870/char1870.html>.

⁴⁷ Johnson, note 7 above, p. 713.

⁴⁸ *Ibid.*

⁴⁹ *Ibid.*

⁵⁰ Grob, note 3 above, pp. 473-74.

⁵¹ Grob, note 44 above.

⁵² *Ibid.*

⁵³ Grob, note 3 above, p. 474.

patient fees set by the state legislatures, slow or delinquent payments by local authorities, and inadequate or late state appropriations.⁵⁴

Many states sought to address the problems resulting from the division of authority between state and local entities through various approaches, including (1) the assumption of all hospitalization costs; (2) the assumption of all such costs for indigent patients only; or (3) enacting legislation calling for annual fixed appropriations.⁵⁵ Even these measures, however, did not provide complete solutions because the demand for state beds nearly always exceeded the supply, which in turn forced localities to develop their own methods of addressing the needs of dependent mentally ill residents.⁵⁶

Many of these same patterns and tensions existed in North Carolina. The 24-year period between the construction of the North Carolina Insane Asylum in 1856 and Cherry Hospital in Goldsboro in 1880 was a time of great upheaval with the Civil War and its economic aftermath, which in turn impacted mental health issues. Although the North Carolina Insane Asylum was able to meet demands for the first 10 years of its existence, the original asylum advocates likely envisioned a gradual extension of the institution either through expansion of the original facilities or the building of additional asylums in other locations.⁵⁷ The advent of the Civil War, however, had halted all such endeavors.⁵⁸

The post-war years saw a dramatic increase in the number of mentally ill and a demand for placement in the state asylum.⁵⁹ In response, in 1868, for the first time the state constitution provided for the maintenance of penal and charitable institutions as follows:

Such charitable, benevolent, penal, and correctional institutions and agencies as the needs of humanity and the public good may require shall be established and operated by the State under such organization and in such manner as the General Assembly may prescribe.⁶⁰

Initial laws designed to carry this provision into effect provided that all the mentally ill should be cared for from the public treasury.⁶¹ Thus, the state not only supported the North Carolina Insane Asylum but, because it was crowded to its utmost capacity, the state also supported those who were caring for the insane at their homes.⁶² However, in order to prevent the bankruptcy of the state, this legislation was soon repealed because lack of oversight capabilities had resulted in wholesale fraud by individuals who sought funding for the care of individuals who could not legitimately be characterized as mentally ill.⁶³ New legislation was then passed which, in part, shifted financial responsibility back to the counties for all the mentally ill except for three groups: “such cases as presented prospect for recovery, those whose malady was accompanied by such violent demonstrations that they seemed dangerous to the community, and those who were adjudged insane when arraigned for crime.”⁶⁴

⁵⁴ *Ibid.*

⁵⁵ *Ibid.*

⁵⁶ *Ibid.*

⁵⁷ Isaac M. Taylor, “An Appeal for State Care of All the Insane from an Economic Standpoint,” The Report of the Chairman of the Section on State Medicine and Medical Jurisprudence Made to the Medical Society of the State of North Carolina, May 28, 1891, p. 1. On the Internet at <http://docsouth.unc.edu/nc/taylor/taylor.html>.

⁵⁸ *Ibid.*, p. 1.

⁵⁹ *Ibid.*, p. 2.

⁶⁰ See Art. XI, § 3 of the Constitution of North Carolina (Constitution of 1868); see also John L. Sanders, “Our Constitution: A Historical Perspective,” North Carolina Institute of Government. On the Internet at <http://statelibrary.dcr.state.nc.us/nc/stgovt/Preconst.htm>.

⁶¹ Taylor, note 57 above, p. 2.

⁶² *Ibid.*

⁶³ *Ibid.*

⁶⁴ *Ibid.*, pp. 2-3.

The North Carolina General Assembly also passed a law in 1869 which established a Board of Public Charities consisting of five members who were responsible for investigating and supervising “the whole system of the charitable and penal institutions of the State;” and recommending “such changes and additional provisions as they may deem needful for their economical and efficient administration”⁶⁵ The Board issued its first report in 1870 praising the North Carolina Insane Asylum but noting that the state’s penal institutions and poorhouses were by and large in dismal condition.⁶⁶ The Board also advocated the enlargement of the “insane asylum” due to the large numbers of individuals (between 400-500) awaiting admission.⁶⁷ This recommendation did not come to fruition for 13 more years when the State Hospital at Morganton (Broughton) and the Eastern Hospital at Goldsboro (Cherry) were finally constructed and admitted their first patients.

Even then, however, demand exceeded supply and the tensions between state and county roles continued. As noted in the 1884 Report of the Board of Directors of the North Carolina Insane Asylum:

In the Eastern Division of the State, comprising fifty-six counties assigned to the North Carolina Insane Asylum, there are eight hundred and fifty white insane. This Asylum cannot accommodate more than two hundred and fifty patients. Our wards are constantly crowded with patients, five-sixth of whom are chronic cases. It is therefore evident, that only a few of the acute cases outside can be received, and that room for them can be obtained only by the discharge of the cured or the removal of the harmless incurables. . . . The returning of the harmless incurables to their counties of settlement, in obedience to Section 2260 of the Code of North Carolina, is often attended with delay from some of the sheriffs neglecting their duty, and when done, causes in many instances great distress and suffering to the unfortunate persons sent and trouble and expense to their families and friends, who are often unable to bear it. Therefore, the Board of Directors respectfully requests of the Legislature to make an appropriation to increase the hospital accommodation for the insane in this district . . . [and] amend Sections 2260 and 66 of the Code of North Carolina, as to relieve them of the burden of keeping the harmless incurables when ordered to be transferred to their counties of settlement.⁶⁸

In his 1891 “Appeal for State Care of All the Insane from an Economic Standpoint,” Isaac Taylor, the Assistant Physician at the Morganton asylum, noted that

It is probable that the intention of our Legislature when the Eastern Hospital at Goldsboro and the State Hospital at Morganton were projected, was for the State to again assume the direct care of all the insane. Since they have been opened the only increase of capacity has been made

⁶⁵ See Public Laws of 1868 and 1869, Chap. 170, § 2 (“An Act Providing for a Board of Public Charities, and Prescribing the Duties Thereof”). On the Internet at <http://docsouth.unc.edu/nc/char1870/char1870.html>. The Act also provided that:

Section 6. Whenever the Board shall have reason to believe that any insane person, not incurable, is deprived of proper remedial treatment, and is confined in any alms-house or other place, whether such insane person is a public charge or otherwise, it shall be the duty of said Board to cause such insane person to be conveyed to the State Asylum, there to receive the best medical attention. So also, it shall be their care that all the unfortunates shall participate in the charities of the State.

See *ibid.*, § 6.

⁶⁶ 1870 Report, note 46 above, pp. 7-9.

⁶⁷ *Ibid.*, pp. 106-07.

⁶⁸ “Annual Report of the Board of Directors and the Superintendent of the North Carolina Insane Asylum, for the Year Ending November 30, 1884,” pp. 3-4. On the Internet at <http://docsouth.unc.edu/nc/asylum1884/asylum1884.html>.

The Key Role of Leadership in Mental Health Policy

An important catalyst for mental health reform in the past has been the emergence of leaders who tackled the topic at various levels of government. The seven individuals profiled here all began their advocacy of improved mental health services after personal experiences with the mentally ill, either with acquaintances, family members, or through work with the mental health system. Leadership continues to be crucial to successful reforms in the delivery of mental health care services in the United States.

Dorothea Dix

Dorothea Dix, born April 4, 1802, was a teacher, nurse, and famous advocate for the mentally ill in the United States. After a childhood spent with her grandmother in Worcester and Boston, Massachusetts, she opened and taught at two schools from age 14 through 19 before she went abroad in 1836 to improve her tubercular medical condition. Her passion for teaching continued when she returned two years later. In 1841, she began her research and advocacy for the improved treatment of the mentally ill in asylums. Dix taught a Sunday school lesson for some women inmates in the Cambridge, Massachusetts jail. She insisted on touring the facility, where she witnessed “miserable, wild and stuporous men and women chained to walls and locked into pens-naked, filthy, brutalized, underfed, given no heat, sleeping on stone floors. It was this visit that started Dorothea on her life’s work to improve conditions for the mentally ill.”ⁱⁱ

Dix proceeded to travel around the country, as well as to other countries, to research the conditions of the mentally ill, report them to the various levels of government, and push for legislation based on what she found. In the late 1840s, the state of North Carolina had done very little in the way of creating hospitals or other space for those who needed services for chronic mental illness, despite recommendations from several state officials in the 1820s and 1830s. Dorothea Dix made her historic trip to North Carolina in 1848, where she “followed her established pattern of gathering information about local conditions which she then incorporated into a ‘memorial’ to the General Assembly.”ⁱⁱⁱ

She described the situation for people with mental illness: “In Lincoln County, near a public road... is a log cabin strongly built and about 10 feet square, and about seven or eight feet high; no windows to admit light... no chimney indicates that a fire can be kindled within, and the small low door is securely locked and barred... You need not ask to what uses it is appropriated. The shrill cries of an incarcerated maniac will arrest you on the way... Examine the interior of this prison [and] you will see a ferocious, filthy, unshorn half-clad creature, wallowing in foul, noisome straw. The horrors of this place can hardly be imagined; the state of the maniac is revolting in the extreme....” In Raleigh, she found emotionally disturbed persons locked in jails or living on the streets.

She faced a tough audience with the legislators who did not wish to spend large sums of funding on the mentally ill. By coincidence, in the midst of negotiations on the failed bill, Dix went to the aid of a fellow guest at the Mansion House Hotel in Raleigh, Mrs. James Dobbins, and nursed her through her final illness. Mrs. Dobbins’ husband was a leading Democrat in the House of Commons, and her dying request of him was to support Dix’s bill. James Dobbins returned to the House and made an impassioned speech calling for the reconsideration of the bill.ⁱⁱⁱ The General Assembly reconsidered the bill, and the legislation became law. After 100 years of operation, the name of the original 1856 hospital resulting from Dix’s legislative efforts was changed from the Dix Hill Asylum to the Dorothea Dix Hospital.^{iv}

John F. Kennedy and Robert F. Kennedy

During the 1960s, President John F. Kennedy moved forward on deinstitutionalization of patients from mental health hospitals. He signed the Community Mental Health Act of 1963, providing federal funding for the construction of centers to provide mental health services

locally. The purpose of the legislation was to establish community-based care for the mentally ill to replace services provided at state mental health institutions, and federal support made this a financially-feasible action.^v

As Attorney General of United States, Robert F. Kennedy also was involved in the formation of mental health care policies, testifying before Congress on the issue.^{vi} Both Kennedys cared about the mentally ill and sought ways during their public service careers to improve both access and quality of service. The brothers' passion on this issue is linked to their sister Rosemary, who was considered "mentally retarded" by her parents.^{vii} Rosemary's medical condition is far from clear, but after years of reportedly violent mood swings, she received a lobotomy at age 23 that left her of "infantile mentality."^{viii} She spent the rest of her life living in a convent in Wisconsin.^{ix} The following House testimony from Attorney General Kennedy on the conditions of a mental health hospital reflects his concerns about mental health care:

"The children were inside, standing in a room which was bare but for a few benches. The floor was covered with urine. Severely retarded patients were left naked in cubicles, which suggested kennels... The only toilets for the approximately seventy patients in a large ward were located in the middle of the room, permitting no privacy. The hospital's hard-working but inadequate staff could provide at best only custodial care."^x

Jimmy and Rosalynn Carter

President Jimmy Carter and his wife Rosalynn have been advocates for the improvement in the availability of mental health services and the reduction of stigma and barriers faced by the mentally ill and their families. Their separate past experiences help to explain their passion for the issue and the perspectives they brought to the Georgia governor's mansion and to the White House. Jimmy Carter describes both the situation of his cousin and the prevailing attitudes about the mentally ill while he was growing up in Plains, Georgia:

"[My cousin] Linton...had a mental problem; he would probably be diagnosed now as suffering from manic-depression (bipolar disorder). With modern medicine, he could have lived a normal and productive life, but in those days he was a problem for his parents. He was very intelligent but had a tendency to become increasingly hyperactive, and made the other citizens of Plains nervous with his antics. Linton [often] made brutally frank comments... and was a knowledgeable and unrestrained public commentator on the most sensitive and personal happenings in the community... The shocked or embarrassed townspeople finally convince[d] Uncle Jack to let Linton go back to the state mental institution until he calmed down and was permitted to return home. Some of us looked forward to those times when Plains was enlivened with his presence."^{xi}

Carter's wife Rosalynn is also renowned for her dedication to the issues of the mentally ill. After childhood experiences with "an individual with a developmental disability," Mrs. Carter was "made aware of how the state dealt with aid to those with mental and physical disability"^{xii} during the 1970 gubernatorial campaign. For instance, "[O]ne morning while Jimmy was campaigning for Governor of Georgia, Rosalynn saw an exhausted woman emerge from a cotton mill after having worked through the night. Rosalynn asked the woman if she was going home

to get some sleep. The woman confided that she had a mentally retarded child at home and that she had to work nights because her husband's income could not cover her son's expenses."^{xiii}

Rosalynn used her leadership positions to actively pursue better mental health care policies in the United States. She served on various study commissions on mental health, including a 1971 Governor's Commission to Improve Services to the Mentally and Emotionally Handicapped and as Active Honorary Chair of the President's Commission on Mental Health in 1977.^{xiv} Rosalynn sought reforms "that more directly provided state services," to the mentally ill, working with "social workers, medical experts, lobbyists, and psychiatrists, ... community activists, legislators and former mental health patients" to overhaul the 1963 Act and "strengthen community center services, erase state-federal overlaps and create changes to health insurance coverage, public housing, Medicaid and Medicare and state support for the chronically mentally ill."^{xv} In 2008, the 24th annual Rosalynn Carter Symposium on Mental Health Policy was held in Atlanta, Georgia, and it focused on the delivery of mental health services to children.

Ralph Scott

Ralph Scott, a state Senator from Alamance County, N.C., served from 1951 to 1980.^{xvi} Senator Scott became involved with the issue of mental health at the beginning of Governor Terry Sanford's administration in 1961. Scott was a leader in the legislative budget process in appropriating funds to meet the needs of the mentally ill and their families. A local man from Burlington named Emil Cortes told the story of his mentally ill granddaughter to Senator Scott, calling late one evening with a crisis and insisting to Scott that "there was no service available to him" for his granddaughter.^{xvii} Scott arranged for Cortes to have an audience in 1960 with gubernatorial candidate Terry Sanford. The Cortes crisis led Scott to begin work on mental health issues "that provided me with the most rewarding part of my public service."^{xviii}

Ken Royall

Kenneth C. Royall, Jr., served in the state House and later in the Senate from 1967 to 1992. He "was known for his intimidating girth, his growl of a voice and his fierce command of the state's budget—all of which led to his nickname, 'The Bear,'" writes columnist Ruth Sheehan in an article for *The News & Observer* of Raleigh.^{xix} "But when it came to mental health, he was not so much Bear as Mama Bear."

In the article, Royall's son recalls driving with his dad past Cherry Hospital, one of the state psychiatric hospitals. The father recounts to his son why it was important to him to take members of the budget committee to visit the hospitals. "Before we allocate any money for the state, all of us are going to go take a look at the people who can't care for themselves. We're going to tour the mental health care facilities and those facilities where people cannot care for themselves. ... We are going to take care of these people first." Royall visited all of the state psychiatric hospitals in North Carolina. He did not have family members who were mentally ill, "[b]ut he treated the mentally ill of this state as if they were family."

—by Lauren P. Knelson

ⁱ On the Internet at <http://www.dhhs.state.nc.us/mhddsas/DIX/dorothea.html>.

ⁱⁱ On the Internet at <http://www.lib.unc.edu/ncc/ref/nchistory/jan2006/index.html>.

ⁱⁱⁱ *Ibid.*

^{iv} *Ibid.*

^v Steven S. Sharfstein, M.D., "Whatever Happened to Community Mental Health?," *Psychiatric Services*, American Psychiatric Association, Arlington, VA, Vol. 51, May 2000, pp. 616-20, on the Internet at <http://www.psychservices.psychiatry-online.org/cgi/content/full/51/5/616>.

^{vi} Arthur M. Schlesinger, Jr., *Robert Kennedy and His Times*, Ballantine Books, New York, NY, 1978, p. 445.

^{vii} *Ibid.*, p. 14.

^{viii} Martin Weil, "Rosemary Kennedy, 86; President's Disabled Sister," *The Washington Post*, Washington, DC, Jan. 8, 2005, p. B6, on the Internet at <http://www.washingtonpost.com/wp-dyn/articles/A58134-2005Jan8.html>.

^{ix} Schlesinger, note 6 above, p. 62.

^x *Ibid.*, p. 445.

^{xi} Jimmy Carter, *An Hour Before Daylight: Memories of a Rural Boyhood*, Simon & Schuster, New York, NY, 2001, p. 143.

^{xii} “First Lady Biography: Rosalynn Carter,” on the Internet at <http://www.firstladies.org/biographies/firstladies.aspx?biography=40>.

^{xiii} On the Internet at http://www.abilitymagazine.com/seymour_carter.html.

^{xiv} *Ibid.*

^{xv} “First Lady Biography: Rosalynn Carter,” on the Internet at <http://www.firstladies.org/biographies/firstladies.aspx?biography=40>.

^{xvi} Jean Speck, *The Gentleman from Haw River*, Edwards & Broughton Co., Raleigh, NC, 1990, p. iv.

^{xvii} *Ibid.*, p. 49.

^{xviii} *Ibid.*, p. 50.

^{xix} Ruth Sheehan, “They’re all in our family,” *The News & Observer*, June 4, 2007, on the Internet at <http://www.newsobserver.com/front/v-print/story/590609.html>.

at the expense of the comfort of those cared for by the institutions and from funds originally appropriated for their support and saved by judicious economy.⁶⁹

However, any increased role by the State during the last decade of the 19th century was stymied by fiscal concerns and waning public support for additional mental health expenditures.⁷⁰

Neither the establishment of the asylums nor the passage of the Board of Public Charities Act in 1868, which had called for the transfer of all but the incurable insane to the state hospitals from local facilities, however, resulted in state-provided treatment. Local institutions and, to a large degree, home-based care, continued to play a significant role. In his 1891 “Appeal,” Taylor reported that:

There were in North Carolina in 1880 white insane 1,591, and colored insane 437, making a total of 2,208; of these 269 were in the one Asylum then open, 218 were in poor houses and 23 were confined in jails, leaving those cared for at home 1,518.⁷¹

Similarly, as noted in a 1925 Bulletin of the United States Bureau of Labor Statistics, even though most states had legislation providing for the removal of the mentally ill from almshouses and the care of such individuals in the proper institutions, little effort was made to enforce these laws and “there are few almshouses that do not contain some members of these classes. In some places, indeed, they form the majority of the inmates.”⁷² In North Carolina, the county superintendents of public welfare estimated that of the 1500 inmates of almshouses between 1920 and 1922, one-third (500) suffered some form of mental illness.⁷³

For individuals who were admitted to asylums, overcrowded conditions resulted in a decline in the quality of treatment. Overcrowding combined with the increasing number of chronic, incurable cases meant that the asylum movement’s original goals were subverted— “[t]he function of both prisons and asylums became incarceration rather than care and reform.”⁷⁴

⁶⁹ Taylor, note 57 above, p. 3.

⁷⁰ *Ibid.*

⁷¹ *Ibid.*, p. 4.

⁷² Bulletin of the United States Bureau of Labor Statistics No. 386, “The Cost of American Almshouses and Political Unit of Organization,” 1925, p. 5.

⁷³ *Ibid.*, p. 4 (quoting North Carolina, State Board of Charities and Public Welfare, Biennial Report, 1920-22, p. 38).

⁷⁴ Nicoletta, note 18 above, p. 383.

The Status of NC's Asylums and State and County Relations from the Turn of the Century Through World War II

“The real question is the care of the insane of the whole State in the most economical manner consistent with the best medical result.”

—Annual Report of the Board of Public Charities of North Carolina, 1908

“In any real democracy a state program of public welfare is as imperative for progress as a state program of public education or state program of public health. Each of these three essential activities looks towards the same objective, that is, the development of a citizenry robust in mind, body, and estate.”

—Biennial Report of the State Board of Charities and Public Welfare, December 1, 1920 to June 30, 1922

For the first half of the 20th century, the emphasis on the use of asylums to address mental health issues and dual responsibility between the state and counties was the norm in North Carolina. This paradigm continued, however, to raise thorny policy questions such as

(1) what should be the precise roles of the state and county governments in addressing mental health needs; (2) should current hospitals be expanded or additional hospitals built; and (3) which class of patients (*e.g.*, the chronically ill, the acutely ill, the criminally ill, or others who were not mentally ill but were deemed to require some form of treatment apart from society, such as epileptics and tubercular patients) should be addressed by state and which by county institutions.

State and County Roles

As reflected in a 1904 report by the Joint Committee of the State Hospitals at Raleigh and Morganton, defining the roles of state and county governments remained an issue:

We believe a certain and well-defined policy should be adopted by the State either to provide adequately for its insane citizens or decline to do so in unqualified terms. If the latter policy is followed, the authorities of the different counties, knowing they cannot depend on the State, will provide for their insane the best they can, and the insane will have some care that is now denied to many. Under the present plan the counties wait for the State to build and the State does not and thus the insane are left uncared for.⁷⁵

The 1908 Annual Report of the Board of Public Charities of North Carolina advocated the creation of separate institutions under appropriate boards of administration and supervision for “the insane, the defective, the poor, the physically ill and the criminal.”⁷⁶ Specifically, the Board asserted that

The complete evolution should be the General Board of Prison Commissioners, the State Board of Health, the State Board of Charity and

⁷⁵ “Report of the Board of Directors and Superintendent of the State Hospital, Raleigh, NC for the Two Years Ending November 30, 1904,” pp. 5 and 7. On the Internet at <http://docsouth.unc.edu/nc/statehospital1904/statehospital1904.html>.

⁷⁶ Annual Report of the Board of Public Charities of North Carolina, 1908, p. 12. On the Internet at <http://docsouth.unc.edu/nc/charities1908/charities1908.html>.



the State Board of Insanity, with their respective local boards of managers. The relation of the general to the local boards should be grounded on two principles: (1) local executive responsibility; (2) general supervisory review of executive acts, with power of investigation, recommendation and criticism, but no arbitrary authority of control in local matters. The absolute powers of the supervisory board should be limited to general interests and interrelations of multiple local units. The theory of operation presents these supervisory and administrative bodies distinct in function and independent in action. . . .⁷⁷

The 1908 Board also advocated smaller, separate institutions for the “feeble-minded,” the epileptic, the mentally ill criminal, and other mentally ill persons in different districts, while recognizing that “[t]he lower maintenance charge of the large institution is evident to the many, whereas the compensations of the small hospital in promoting better treatment of patients and higher medical and scientific attainment are recognized by only a minority.”⁷⁸ *This tension between economics and optimal care continues to date.*

In 1917, the old Board of Public Charities became the Board of Charities and Public Welfare after the General Assembly expanded North Carolina’s public welfare program to include numerous activities besides oversight of the state mental hospitals.⁷⁹ That same year, the legislature authorized a county unit welfare system of state-supervised, local administration of the state’s “care of its unfortunate.”⁸⁰ Under

⁷⁷ *Ibid.*, p. 12.

⁷⁸ *Ibid.*, p. 13.

⁷⁹ Biennial Report of the State Board of Charities and Public Welfare July 1, 1938, to June 30, 1940, p. 2. On the Internet at <http://docsouth.unc.edu/nc/charities1940/charities1940.html>.

⁸⁰ *Ibid.*, p. 11.

this system, counties with at least 32,000 residents were required to establish regular welfare departments, while school superintendents were responsible, on a part-time basis, for welfare duties in smaller counties.⁸¹ This system was the beginning of what eventually evolved into full-time departments in each county following the passage of the federal Social Security Act of 1935.⁸²

In the 1920s, the newly constituted State Board of Charities and Public Welfare was advocating a more centralized state role with more than mere supervisory responsibility:

State boards of charities and public welfare were organized originally merely for the supervision of state institutions for dependents and the correlation of efforts of various charitable agencies . . . [but] results all over the country apparently point to the fact that when the State Department of Public Welfare has a moderate amount of supervision and control with which to put into force its recommendations, the benefits are more evident than when the board's function is merely supervisory.⁸³

The State Board, however, recognized that there were some drawbacks to too much centralization:

Just how far the State should go in its efforts to carry out the constitutional mandate that all men shall have an opportunity for life, liberty, and the pursuit of happiness, and at the same time avoid lessening individual responsibility and discouraging initiative is a serious question. It is obvious that social progress will travel a very uneven road unless there is some general plan for the good of all, and some agency that has the power to supervise and execute to a limited extent.⁸⁴

At that time, the state bureaucracy had expanded to include five distinct bureaus, including (1) county organization; (2) child welfare; (3) institutional supervision, (4) mental health and hygiene and (5) promotion and education, operating under the State Board of Charities and Public Welfare,⁸⁵ but there were still inequities in how the various counties responded to the needs of their residents. The Board noted that 46 counties had full-time superintendents of public welfare, 11 counties had part-time superintendents, and 43 counties required the superintendent of public education to also serve as the superintendent of public welfare.⁸⁶

The Ever-Present Problem of Demand Exceeding Supply and the Various Mentally Ill Populations Vying for Treatment

Another common theme from this era was the continued problems of overcrowding and the changing population of those requiring care and treatment. As the 1904 Joint Committee noted, "It is well known that North Carolina has not erected enough buildings to house all its white insane, but it is not certain how many are in their homes, in jails and alms-houses or roaming the country at large."⁸⁷

⁸¹ *Ibid.*

⁸² *Ibid.*

⁸³ Biennial Report of the State Board of Charities and Public Welfare, December 1, 1920, to June 30, 1922, p. 9. On the Internet at <http://docsouth.unc.edu/nc/charities1922/charities1922.html>.

⁸⁴ *Ibid.*, p. 14.

⁸⁵ *Ibid.*, p. 12. The active history of the Bureau of Mental Health and Hygiene dates from September 1921 when the employment of the first director of the bureau became effective. *Ibid.*, p. 40.

⁸⁶ *Ibid.*, p. 16.

⁸⁷ 1904 Report, note 75 above, pp. 5 and 7; see also 1920-22 Report, note 83 above, pp. 14-15 ("Another great handicap in organizing the public welfare work has been the wide gap between our progressive social legislation and our facilities for carrying out the same. . . . The institutions for the insane and epileptics were totally inadequate to care for the number of applications. . . . This is a condition that is being gradually

After the construction of three asylums in the 1800s, North Carolina did not provide another independent asylum until 1947 when it purchased a hospital in Butner from the federal government which had built the facility as an army hospital for wounded American servicemen returning from the European front during World War II.⁸⁸ John Umstead Hospital serves the 16 counties of the North Central Region of the state.⁸⁹ Prior to that purchase, the state had repeatedly approached overcrowding issues by either doing nothing or expanding the current asylums on a piecemeal basis.⁹⁰

Although the asylums were treating and releasing large numbers of patients, there also was an increase in the number of chronic patients who were not leaving. The Biennial Report of the State Hospital at Raleigh, from July 1, 1924, to June 30, 1926, reflected that (1) between 1856, when the hospital first opened, and 1926, 10,729 individuals had been admitted for treatment; and (2) the number residing at the hospital during any given year increased from 80 in 1856 to 1,505 at the end of June 1926.⁹¹

With increased demand not only for services for the mentally ill but also for other populations such as epileptic and tubercular patients (who also were deemed to need separation from society), and the rise in chronic mentally ill cases, determining which

overcome, and it is safe to say that better and increased facilities have come about as a result of the welfare work which has shown the pressing need for the same.”)

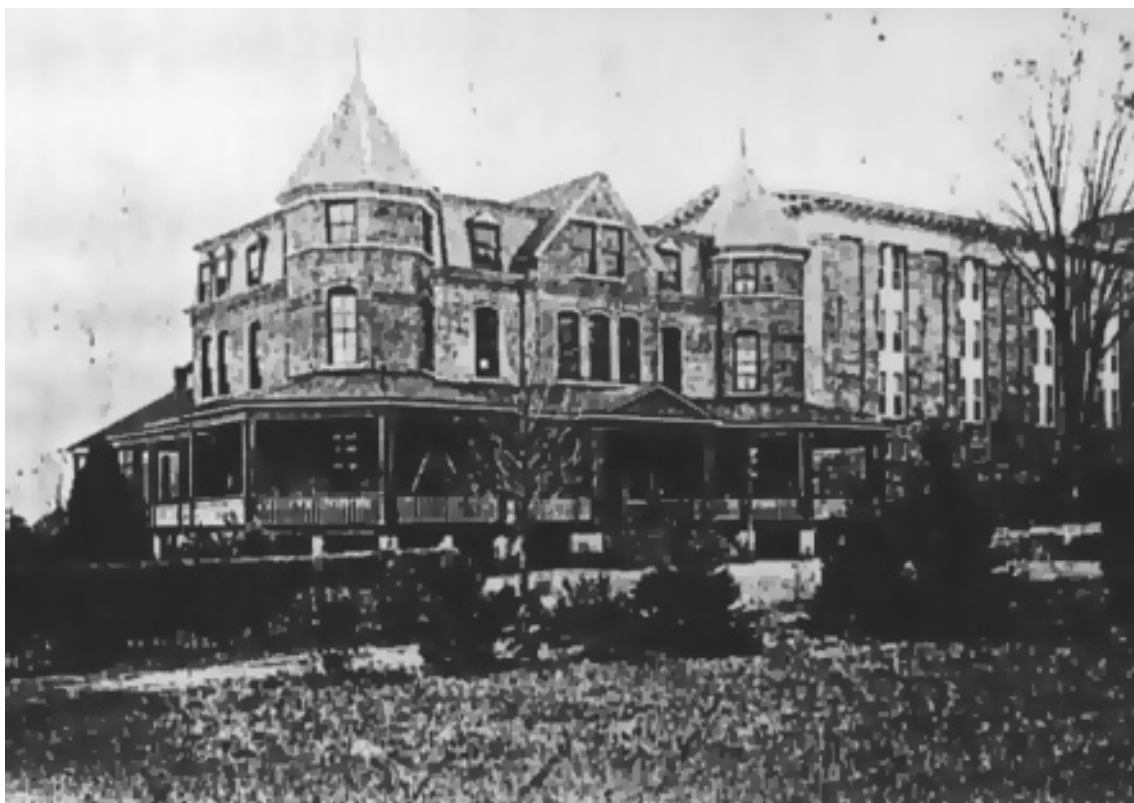
⁸⁸ On the Internet at <http://www.dhhs.state.nc.us/mhddsas/umstead.htm>.

⁸⁹ *Ibid.*

⁹⁰ See “Report of the State Hospital at Goldsboro, NC, from November 30, 1902, to November 30, 1904,” p. 6. On the Internet at <http://docsouth.unc.edu/nc/statehospital1904/statehospital1904.html> (noting appropriation of \$50,000 by Legislature of 1899 for enlargements of the hospital).

⁹¹ Biennial Report of the State Hospital at Raleigh, Raleigh NC, from July 1, 1924 to June 30, 1926, Table 2, pp. 17-18, on the Internet at <http://docsouth.unc.edu/nc/raleigh24/raleigh24.html>.

The Annex, Dix Hospital



“type” of patient should receive treatment became another central policy issue. The 1904 Joint Committee recommended that

in consideration of the large number of insane outside the walls of the Hospitals, who are in need, and the difficulty and expense of providing for so many at once, that dotards, paralytics, idiots, imbeciles and epileptics for the present be excluded or accommodations prepared for them in other places.⁹²

With respect to the criminally insane, as of 1922, these individuals were kept at the state penitentiary which had neither facilities nor staff for the specialized care of these individuals.⁹³ The Board noted that many of these individuals were no more dangerous than patients at the state hospital and some were not insane at all but merely low grade cases of feeble-mindedness.⁹⁴ The Board recommended that “there be established at one of the State hospitals a special ward for the dangerous criminal insane;” and that a special commission review each case and determine where the individual at issue should best be placed—in the special ward, the regular hospital ward, or elsewhere.⁹⁵ Subsequently, the legislature passed an act that criminally insane patients should be cared for in separate buildings or wards on the grounds of the asylums. The Goldsboro asylum received its first criminal insane patients in September 1924; the North Carolina Insane Asylum received its first transfers from the state prison in January 1925.⁹⁶

Other Considerations

In addition to these policy issues, the State Board of Public Welfare also was grappling with (1) an ignorant and indifferent public as to social disqualifications; (2) a sentimental attitude rather than scientific approach to mental health and other social welfare issues; (3) “short-sighted economic policy in handling social problems”; and (4) the lack of trained leadership.⁹⁷ Many of these same themes still existed 60 years later after yet another evolutionary watershed in the mental health arena—the federal community-based treatment movement that came to fruition after World War II.

⁹² 1904 Report, note 75 above, pp. 5 and 7.

⁹³ 1920-22 Report, note 83 above, p. 57.

⁹⁴ *Ibid.*

⁹⁵ *Ibid.*

⁹⁶ Biennial Report of the State Hospital at Goldsboro: Goldsboro, NC, July 1, 1924, to June 30, 1926, p. 6. On the Internet at <http://docsouth.unc.edu/nc/goldsboro24/goldsboro24.html>; 1924-26 Report, note 91 above, pp. 7-8.

⁹⁷ 1920-22 Report, note 83 above, p. 15.

POST-WORLD WAR II MENTAL HEALTH POLICY: THE COMMUNITY-BASED MOVEMENT AND THE ENTRANCE OF THE FEDERAL GOVERNMENT INTO THE MENTAL HEALTH ARENA

“Our only real crystal ball is a rearview mirror.”

—James H. Billington, U.S. Librarian of Congress

“Substantive changes in mental health policy within the American context often create incentives to shift responsibilities to other levels of government. This, in turn, transforms and distorts coverage patterns and thus inadvertently alters both costs and policy goals.”

—Gerald N. Grob, Ph.D.

Up until the 1940s, public hospitals cared for nearly 98 percent of all institutionalized mental patients, two-thirds of the members of the American Psychiatric Association (APA) practiced in public institutions, and there was little impetus to question the role of state mental hospitals in the treatment of the mentally ill, even if policymakers did not always agree on policy details or the quality of some institutions was sub-par.⁹⁸ In addition, in conformance with the Founding Fathers’ vision, the federal government had no role in the development or funding of mental health policy.⁹⁹

This status quo nearly changed in 1853, when, after six years of advocacy by Dorothea Dix, Congress passed legislation granting millions of acres of federal land to states for use in raising capital to address the needs of the indigent mentally ill.¹⁰⁰ However, President Franklin Pierce (1853-57) vetoed the legislation observing that, if the bill became law

The fountains of charity will be dried up at home, and the several States, instead of bestowing their own means on the social wants of their own people, may themselves, through the strong temptation, which appeals to States as to individuals, become humble supplicants for the bounty of the Federal Government, reversing their true relation to this Union.¹⁰¹

This presidential veto ensured that the federal role would remain virtually non-existent. In fact, the sole federal involvement in the mental health arena during the 1800s was the enactment of legislation establishing the Government Hospital for the Insane (later St. Elizabeth’s Hospital) in the District of Columbia and legislation excluding insane immigrants from entering the United States.¹⁰² The states continued

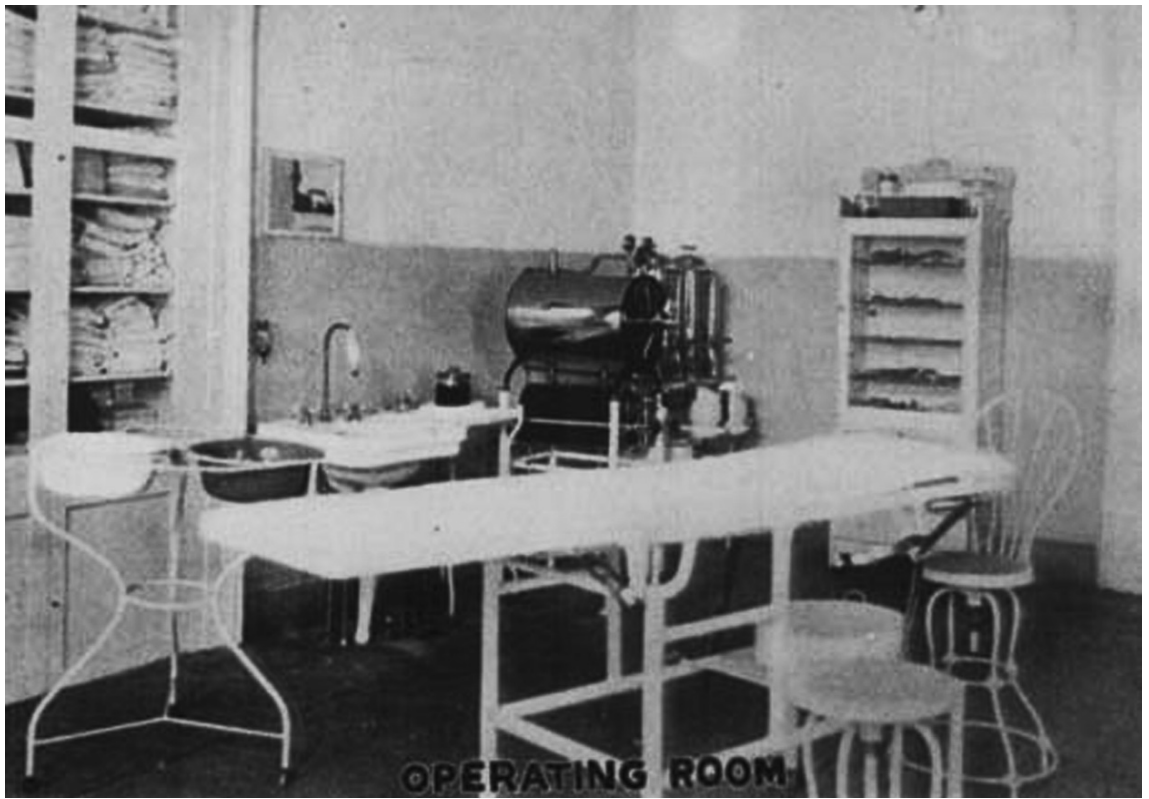
⁹⁸ See Gerald N. Grob, “The Forging of Mental Health Policy in America: World War II to New Frontier,” *The Journal of the History of Medicine and Allied Sciences, Inc.*, 1987, p. 410.

⁹⁹ Grob, note 3 above, p. 474.

¹⁰⁰ *Ibid.*, p. 475; see also Deutsch, note 32 above, p. 994.

¹⁰¹ Grob, note 3 above, p. 475.

¹⁰² Grob, note 3 above, p. 475.



to set mental health policy with emphasis on state psychiatric hospitals and shared responsibility with local communities.¹⁰³

During and after World War II, however, the paradigm started to shift when activists began to promote a new mental health policy that shifted focus away from the care and treatment of the severely ill in state institutional settings and towards community-based alternative settings.¹⁰⁴ Numerous factors propelled this change during the last half of the 20th century including: (1) the changing composition of the asylum population; (2) the changing nature of the psychiatric model; (3) the creation of effective psychotropic drugs, such as chlorpromazine (marketed in the United States as Thorazine); (4) the emergence of legal advocates for the mentally ill and a more active judiciary; (5) the decline in quality and image of state institutions; and, most significantly, (6) the federal government's foray into mental health policymaking and funding directly through mental health legislation and indirectly through Social Security entitlement programs.

Factors Contributing to the Decline of the Social and Medical Legitimacy of State Institutions and the Rise of Community-Based Treatment

The Changing Composition of the Asylum Population

The changing composition of the patient population post-1890 was one of the undercurrents that carried the community treatment movement forward during and after the post-World War II era.¹⁰⁵ During the 1800s, most asylum patients were non-elderly acute cases requiring short-term institutionalization—typically less than one year.¹⁰⁶ After 1890, however, the proportion of acute cases declined while chronic cases requiring long-term care began to increase so that by 1923 more than half of all patients had been institutionalized for five years or more.¹⁰⁷ Nationally, this increase was partially due to “transinstitutionalization,” moving patients from institution to institution—in this case, the moving of elderly patients from county institutions (*e.g.*, almshouses or poorhouses) to state hospitals in those states which had passed laws mandating that all mentally ill persons were to be wards of the state.¹⁰⁸ *As a result of such laws, which were passed by a majority of states, many counties began to redefine senility in psychiatric terms to justify such transfers and lower the counties' economic burden.*¹⁰⁹ As discussed subsequently, a reverse pattern of transinstitutionalization occurred in the 1960s and thereafter when the federal government began subsidizing care in facilities other than state psychiatric hospitals which led to the transfer of patients *out* of state hospitals and primarily into local nursing homes.

In a related vein, the number of patients in state asylums whose abnormal behavior reflected an underlying severe organic disorder (*e.g.*, senility, cerebral arteriosclerosis, partial paralysis, Huntington's chorea, and brain tumors) for which there was no effective treatment also had risen.¹¹⁰ Between 1922 and 1940, the percentage of such patients increased from 33.4 to 42.4, and in 1946, nearly half of all first admissions consisted of patients with various forms of senility and partial paralysis.¹¹¹

¹⁰³ *Ibid.*

¹⁰⁴ Grob, note 98 above, p. 411.

¹⁰⁵ *Ibid.*

¹⁰⁶ *Ibid.*

¹⁰⁷ *Ibid.*

¹⁰⁸ Grob, note 3 above, p. 477.

¹⁰⁹ *Ibid.*; see also Grob, note 44 above.

¹¹⁰ Grob, note 44 above.

¹¹¹ *Ibid.* (citing U.S. Bureau of the Census, 1925, 1930, 1943).

Like most states, North Carolina's chronic institutional-based cases increased over time. However, the state's chronic population was not heavily weighted towards the elderly during the first part of the 20th century because North Carolina did not pass laws assuming full responsibility for the mentally ill. Rather, as noted above, it continued the dual responsibility system of state and county involvement.

As reflected by the Biennial Report of the State Hospital at Raleigh from July 1, 1924, to June 30, 1926, the number of patients remaining in the hospital during any given year steadily increased from 80 in 1856, to 294 in 1890, to 842 in 1920, and 1,505 as of 1926.¹¹² The report also noted that the top three lengths of duration of insanity of those admitted between 1924 and 1926 were (1) 132 patients with durations of 5 to 10 years; (2) 111 patients with durations of 3 to 5 years; and (3) 105 patients with durations of 10 to 20 years.¹¹³ Patients over 70 constituted only a small percentage of those admitted (33 patients out of 1036).¹¹⁴ The largest percentage of patients admitted between 1924 and 1926 were between 30 and 40 years of age (252 patients) followed closely in highest percentages by individuals 40-50 years of age (218 patients) and 20-30 years of age (208 patients).¹¹⁵ That North Carolina's trends did not follow in perfect lockstep with other states was not, however, overly significant because the trends in other states resulted in changes at the national level which ultimately impacted mental health policy in all states.

The alteration in patient populations nationwide had several consequences. Although asylums regularly admitted, treated, and released large numbers of patients every year, the ever-growing chronic population which required comprehensive care "fostered a belief that mental hospitals were simply serving as warehouses that were far removed from the mainstream of modern scientific medicine."¹¹⁶ That much of the work in mental institutions had, in fact, turned to custodial, long-term care also served to weaken the ties between psychiatrists and the institutions in which they practiced because psychiatrists, who were trained medical practitioners, "clearly preferred a therapeutic rather than custodial role."¹¹⁷ This was a shift from the early years of the asylum movement where the links between the medical profession and institutions had lent credence to the practice of institutionalization—the first generation of asylum superintendents, who, also being medical professionals, "legitimized the social forces impelling the insane out of the household and community."¹¹⁸

By 1956, only 17 percent of the American Psychiatric Association's nearly 10,000 members practiced in state institutions or Veterans Administration (VA) facilities.¹¹⁹ The remaining 83 percent were in private practice or employed in governmental or educational agencies, community centers, or medical schools.¹²⁰ This shift went hand-in-hand with the increased focus on psychodynamic and psychoanalytic psychiatry.¹²¹

¹¹² 1924-26 Report, note 91 above, Table 2, pp. 18-18(a).

¹¹³ *Ibid.*, p. 19, Table 4.

¹¹⁴ *Ibid.*, p. 20, Table 5.

¹¹⁵ *Ibid.*

¹¹⁶ Grob, note 3 above, p. 478.

¹¹⁷ Grob, note 98 above, p. 412; Grob, note 44 above.

¹¹⁸ Nicoletta, note 18 above, p. 378 (citing Nancy Tomes, *A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum-Keeping, 1840-1883*, Cambridge, England, 1984, p. 89).

¹¹⁹ Grob, note 98 above, p. 421. Psychiatric patients constituted 60 percent of the VA's total hospital population in 1946. Eva Moskowitz, *In Therapy We Trust: America's Obsession with Self-Fulfillment*, The Johns Hopkins University Press, Baltimore, MD, 2001, p. 150.

¹²⁰ Grob, note 98 above, p. 421.

¹²¹ *Ibid.*

The Changing Nature of the Psychiatry Model

Another factor contributing to the erosion of the priority previously placed on state institutionalization was a shift towards a model of psychiatry that emphasized life experiences and socioenvironmental factors.¹²² Sigmund Freud and Adolf Meyer and other pioneers in psychiatry asserted that “behavior occurred along a continuum that commenced with the normal and concluded with the abnormal. Psychodynamic psychiatry elevated the significance of the life history and prior experiences of the individual, thereby blurring the demarcation between health and disease.”¹²³ In its 1940 Biennial Report, the North Carolina State Board of Charities and Public Welfare acknowledged this approach and advocated additional research into the issues raised by the evolving theories:

The view of modern psychiatry is that mental diseases in common with other diseases have a cause, a beginning, a course of development and are as susceptible to prevention and treatment. Psychiatry is a comparatively new specialty and on the above points its fund of information is woefully inadequate. It is to the intensive studies carried on by state hospital staffs that the medical profession must look for increased knowledge in this field.¹²⁴

In addition to making state hospitals centers of research, the 1940 Report also highlighted the need for (1) an increased role in educating the public and community organizations, as well as medical students and professionals; and (2) the use of outpatient clinics in conjunction with the state hospitals to (a) assist discharged and paroled patients in readjusting to their communities, and (b) providing psychiatric consultation services to surrounding communities.¹²⁵ The Report noted, however, that the fulfillment of such goals was “impossible” in light of present understaffing and inadequate appropriations.¹²⁶

The implications of this theory of mental illness were significant because if a continuum of behavior existed rather than simply a sharp demarcation between normal and abnormal behavior and health and illness, then “the possibility existed that before the process had run its course psychiatric interventions could alter the outcome.”¹²⁷ Early proponents of community psychiatry believed that the field of psychiatry had the wherewithal to identify appropriate social and environmental changes that would most fully enhance mental and physical health.¹²⁸ They advocated a proactive and two-fold approach of (1) treating individuals, ideally in a community setting, as well as (2) establishing, in collaboration with social scientists, programs to address negative socio-environmental influences that could adversely impact personality.¹²⁹ One leading advocate asserted that psychiatry had an obligation to ““go out and find the people who need help—and that means, in the local communities.””¹³⁰ Of particular concern was early identification of individuals with potentially severe mental illness, such as schizophrenia, which if caught early enough in a community setting might preclude future institutionalization.¹³¹ In short, “the theory was that early treatment

¹²² Grob, note 44 above.

¹²³ Grob, note 98 above, p. 412.

¹²⁴ 1938-40 Report, note 79 above, pp. 108-09. By 1940, the State Board consisted of the following five divisions: (1) child welfare; (2) public assistance; (3) case work training and family rehabilitation; (4) mental hygiene; and (5) institutions and corrections. *Ibid.*, p. 29.

¹²⁵ *Ibid.*, pp. 108-09.

¹²⁶ *Ibid.*, p. 109.

¹²⁷ Grob, note 98 above, p. 413 (emphasis added); Grob, note 44 above.

¹²⁸ Grob, note 98 above, p. 416.

¹²⁹ *Ibid.*, pp. 416-17.

¹³⁰ *Ibid.*, p. 417 (citing Robert Felix, head of the U.S. Public Health Service’s Division of Mental Hygiene and later Director of the National Institute of Mental Health).

¹³¹ *Ibid.*, p. 417.

in community facilities might *prevent* the onset of the severe mental diseases that required institutionalization”¹³²

Experiences during World War II, including evidence that “prolonged stress associated with warfare led to mental breakdowns even among those who had manifested no prior symptomatology,” enhanced the interrelated beliefs that (1) social and environmental factors rather than the structure of personality were key factors in the etiology of mental maladjustment; (2) greater focus should be placed on neuroses rather than psychoses;¹³³ and, (3) human interventions could alter psychological outcomes.¹³⁴ In the context of war, this meant, for example, that mental breakdowns could be reduced by instituting fixed tours of duty so that actual combat time would be reduced, promoting group cohesion, and mandating regular rest periods.¹³⁵

In addition, wartime experience demonstrated that the highest and lowest rates of success in treating service personnel with psychological symptoms took place at the battalion aid station level and the rear echelon unit level, respectively.¹³⁶ “A logical conclusion followed; treatment in civilian life, as in the military, had to be provided in the family and community setting rather than in a remote or isolated institution. The implication for psychiatry was clear; community and private practice would replace institutional employment.”¹³⁷

The Emergence of Psychotropic Drugs

An additional factor in promoting the community-based movement was the emergence of psychological and somatic therapies such as psychotropic drugs¹³⁸ that “held out the promise of a more normal existence for patients outside of mental institutions.”¹³⁹ Prior to 1950, most drugs that were used in the treatment of mental illness were various types of sedatives. In the mid-1950s, anti-psychotic drugs such as the phenothiazines came into use and assisted in the “control of patients’ most disturbing psychotic symptoms and gave hospital staff and families confidence in the potential of less coercive care and hopes of greater predictability of patients’ behavior.”¹⁴⁰

Dr. Kate Knutson, a psychiatrist, says, “Psychotropic medications allow many patients to function independently in society, so they can live independently and maintain employment, for instance. Without these drugs, many patients need much more care and support in basic activities of daily living. Psychotropic medications also facilitate transitions out of long-term hospital care.”

The cost of such drugs also promoted a community care approach. During the 1950s, the average state hospital operated at an average per capita per day cost of \$2.70.¹⁴¹ The introduction of chlorpromazine increased hospital pharmacy costs

¹³² *Ibid.*, p. 413 (emphasis added); Grob, note 44 above.

¹³³ *Neuroses* are defined as mental disorders such as obsessive compulsive behavior, anxiety and phobias that can significantly impair but do not prevent rational thought or daily functioning. On the Internet at http://hubpages.com/hub/Psychosis_Vs_Neurosis. In contrast, *psychoses* are defined as those mental disorders such as schizophrenia and bipolar disorder which, if left untreated, involve the loss of contact with reality, and impair normal social functioning. *Ibid.*

¹³⁴ Grob, note 98 above, pp. 414-15.

¹³⁵ *Ibid.*

¹³⁶ *Ibid.*, p. 416.

¹³⁷ *Ibid.*; see also David Mechanic and David A. Rochefort, “Deinstitutionalization: An Appraisal of Reform,” *Annual Review of Sociology*, Vol. 16, 1990, p. 303 (“The experience of psychiatrists during the war in dealing with neuropsychiatric problems during combat promoted a preventive ideology and the translation of military psychiatric techniques to civilian practice.”).

¹³⁸ Psychotropic drugs are drugs “capable of affecting the mind, emotions, and behavior.” On the Internet at <http://www.medterms.com/script/main/art.asp?articlekey=30807>.

¹³⁹ Grob, note 44 above; see also Jeffrey Geller, “The Last Half-Century of Psychiatric Services as Reflected in Psychiatric Services,” *Psychiatric Services*, Vol. 51, No. 1, Jan. 2000, p. 42.

¹⁴⁰ Mechanic and Rochefort, note 137 above, pp. 303-04; see also Joanna Moncrieff, “Drug Treatment in Modern Psychiatry: The History of a Delusion,” April 26, 2002. On the Internet at <http://www.critpsynet.freeuk.com/Moncrieff.htm>.

¹⁴¹ Geller, note 139 above, p. 51.

Mental Health in the Movies

Hollywood has long had a love/hate relationship with the human mind, and many movies over the years have featured mental illness, developmental disabilities, or substance abuse as major themes. According to the book, *Psychiatry and the Cinema*, “The changing images of psychiatry during some ninety years of American cinema offer a unique opportunity to assess the complex interactions between different currents in twentieth century American culture.” All too often, unfortunately, the stereotypes portrayed in the movies are negative and misinformed, be it of particular illnesses, the role of the psychologist and/or psychiatrist, treatments, or place in society. As a cultural lens, the following movies offer a glimpse of mental health as depicted on the big screen:

Of Mice and Men, 1939. Based on the novel by John Steinbeck, a mentally retarded man finds himself working on a cowboy ranch during the Depression. Nominated for four Academy Awards.

The Snake Pit, 1948. A woman who has a nervous breakdown finds herself in a mental hospital. Olivia de Havilland was nominated for an Academy Award for Best Actress.



One Flew Over the Cuckoo's Nest, 1975. Jack Nicholson plays a criminal transferred to a mental institution, where he rallies the other patients against Nurse Ratched. Won the five top Academy Awards: Best Picture, Best Director, Best Actor, Best Actress, and Best Adapted Screenplay.

Ordinary People, 1980. A family copes with depression after the accidental death of their older son. Won four Academy Awards, including Best Actor in a Supporting Role for Timothy Hutton's performance as the younger son and Best Director for Robert Redford.

Forrest Gump, 1994. The story of a man with low intelligence, his journey through life, and his experience of popular culture as well as historical events. Nominated for 13 Academy Awards, of which it won six, including Best Actor for Tom Hank's performance as Forrest.

A Beautiful Mind, 2001. Russell Crowe stars as John Forbes Nash, a brilliant MIT mathematician who wrestles with schizophrenia, delusions, and the side effects of anti-psychotic drugs, and eventually wins the Nobel Prize for Economic Sciences. Won four Academy Awards, including Best Picture.

—*Mebane Rash, Editor, North Carolina Insight*

Sources: The Internet Movie Database, on the Internet at <http://www.imdb.com/>; Glen O. Gabbard and Krin Gabbard, *Psychiatry and the Cinema*, 2nd ed., American Psychiatric Publishing, Inc., Washington, DC, March 1999, p. 3. A complete filmography on psychology, psychiatry, and the movies by Susan Nicosia, professor at Daniel Webster College, is available on the Internet at <http://faculty.dwc.edu/nicosia/moviesandmentalillnessfilmography.htm>.

Forrest Gump: *Will you marry me?*
[Jenny turns and looks at him]

Forrest Gump: *I'd make a good husband, Jenny.*

Jenny Curran: *You would, Forrest.*

Forrest Gump: *...But you won't marry me.*

Jenny Curran: [sadly] *... You don't wanna marry me.*

Forrest Gump: *Why don't you love me, Jenny?* [Jenny says nothing]

Forrest Gump: *I'm not a smart man... but I know what love is.*

20-fold and highlighted the economic advantages of community care. Initially, chlorpromazine, marketed as Thorazine in the United States, was regarded as another form of tranquilizer. “The effect of taking these drugs was explicitly compared to having a lobotomy, and they were thought to induce ‘chemical lobotomies.’” Only in the 1960s was this type of drug suggested to be a specific treatment for psychoses, such as schizophrenia. Thus, the name anti-psychotic.¹⁴²

The Emergence of Mental Health Legal Advocates and a More Active Judiciary

Legal advocacy groups and the courts also played a fundamental role in shaping the changes in mental health policy that ensued during and after World War II—especially in the wake of the civil rights movement in the 1960s.¹⁴³ Legal advocates schooled in the civil rights movement turned their focus to the rights of the mentally ill with challenges to civil commitment laws and the creation of legal theories relating to patient rights and the concept of the least restrictive alternative for the location of treatment and care.¹⁴⁴ Such challenges contributed to the impetus to change mental health policy by weakening the role of mental hospitals.¹⁴⁵

A number of important decisions were issued by federal and state courts that

defined a right to treatment in the least restrictive environment; shortened the duration of all forms of commitment and placed restraints on its application; modified the right of psychiatrists to make purely medical judgments about the necessity of commitment; accepted the right of patients to litigate both before and after admission to a mental institution; and defined a right of a patient to refuse treatment under certain circumstances.¹⁴⁶

These decisions resulted in the weakening of both psychiatrists’ and mental hospitals’ authority, and they conferred legitimacy on the view that extended hospitalization was detrimental to patients, and community care and treatment was the more desirable policy choice.¹⁴⁷

During the last decade of the 20th century, after community-based principles were well-established in national mental health policy, Congress enacted the Americans with Disabilities Act (ADA) to eliminate discrimination against those with disabilities. The earlier legal decisions then paved the way in 1999 for the U.S. Supreme Court to hold that the ADA requires states to provide placement in communities for many individuals with mental disabilities.¹⁴⁸

The Decline in the Quality and Image of State Institutions

Support for alternative approaches was further enhanced by declines in (1) the quality of care in state hospitals due to budgetary restraints starting with the Great Depression and continuing through WWII; and (2) the image of state hospitals due to a series of dramatic magazine exposés in the late 1940s in *Life*, the *Saturday Evening Post*, and *Readers’ Digest*, as well as radio (CBS’s “Mind in the Shadow”) and film (“The Snake Pit”) regarding the inhumane conditions in some state mental health hospitals.¹⁴⁹ Such exposés and an increasingly influential mental health lobby placed pressure on elected officials to take action.¹⁵⁰

¹⁴² Moncrieff, note 140 above; see also Geller, note 139 above, p. 51.

¹⁴³ *Ibid.*, p. 42.

¹⁴⁴ Mechanic and Rochefort, note 137 above, p. 304.

¹⁴⁵ Grob, note 98 above, p. 445.

¹⁴⁶ *Ibid.*, p. 445; see also Geller, note 139 above, pp. 43-45; Grob, note 44 above.

¹⁴⁷ Grob, note 44 above.

¹⁴⁸ See *Olmstead v. L.C.*, 527 U.S. 581, 119 S. Ct. 2176, 144 L.Ed.2d 540 (1999).

¹⁴⁹ Moskowitz, note 119 above, p. 152; Grob, note 98 above, p. 426.

¹⁵⁰ Moskowitz, note 119 above, p. 152.

In 1949, the Council of State Governments conducted a study, *The Mental Health Programs of the Forty-Eight States: A Report to the Governors' Conference*, that detailed numerous problems faced by the state institutions including (1) staff shortages; (2) poor training; (3) large numbers of elderly who did not belong in mental hospitals; (4) obsolete commitment procedures; (5) the lack of effective state agency supervision and coordination; (6) budgetary concerns that negatively impacted patients; (7) irrational dual governing systems between local and state governments; (8) lack of space, equipment, and therapeutic programs; and (9) too few research resources.¹⁵¹ The report expressed concern for improving existing institutions but also advocated more economical, clinical, and community care alternatives and programs that emphasized prevention and the maintenance and strengthening of mental health.¹⁵² In 1953, in response to these findings and vision, the southern states joined together to establish the "Mental Health Training and Research Project, which sought to help southern states deal with the shortage of personnel and to evaluate demonstration projects."¹⁵³

At the time of the 1949 study, North Carolina's four hospitals reported their average daily resident population as follows: (1) State Hospital, Butner: 1,108; (2) State Hospital, Goldsboro: 2,756; (3) State Hospital, Morganton: 2,530; and (4) State Hospital, Raleigh: 2,245.¹⁵⁴ Among the southern states, North Carolina (\$6,395,563) was second only to Virginia (\$8,496,610) in terms of state expenditures for all mental health and hospital facilities and services for the mentally ill for fiscal year 1949.¹⁵⁵ Thirty-seven of the states, which were not ranked by population, had budgets under \$9,000,000 while a handful of the more populous states had far more substantial budgets and more facilities for the mentally ill, including New York (\$81,627,578), California (\$42,971,197), and Illinois (\$34,492,064).¹⁵⁶

In terms of staffing, North Carolina reported the following patient to care provider ratios: (1) patient to doctor—(a) Butner—222 to one; (b) Goldsboro—344 to one; (c) Morganton—281 to one; and (d) Raleigh—224 to one; (2) patient to graduate nurse—(a) Butner—138 to one; (b) Goldsboro—459 to one; (c) Morganton—126 to one; and (d) Raleigh—66 to one; and (3) patient to attendant—(a) Butner—eight to one; (b) Goldsboro—16 to one; (c) Morganton—seven to one; and (d) Raleigh—nine to one.¹⁵⁷ Butner and Morganton also had one social worker, one psychologist, and two occupational therapists for 1,108 and 2,530 patients, respectively.¹⁵⁸ Goldsboro had one social worker, one psychologist, and no occupational therapist for 2,756 patients.¹⁵⁹ Raleigh had three social workers, one psychologist, and two occupational therapists for 2,245 patients.¹⁶⁰

As of 1949, all four state hospitals were using electroshock therapy.¹⁶¹ Morganton and Raleigh also used insulin shock therapy.¹⁶² Raleigh was the only facility using psychosurgery;¹⁶³ and Goldsboro was the only North Carolina facility (and one of

¹⁵¹ See generally *The Mental Health Programs of the Forty-Eight States*, The Council of State Governments, Chicago, IL, 1950; see also Grob, note 98 above, p. 426.

¹⁵² Grob, note 98 above, p. 426; see also Moskowitz, note 119 above, p. 155.

¹⁵³ Moskowitz, note 119 above, p. 155.

¹⁵⁴ *The Mental Health Programs of the Forty-Eight States*, note 151 above, Table 31, p. 326.

¹⁵⁵ *Ibid.*, Table 10, p. 259. The statistical analysis covered Virginia's four state hospitals and one sanitarium. *Ibid.*, Exhibit 1, p. 236.

¹⁵⁶ *Ibid.*, Table 10, p. 259. At the time of the study, (1) New York had 20 facilities, including 18 state hospitals, a psychiatric institute, and a psychopathic hospital; (2) California had 10 facilities, including nine state hospitals and one clinic; and (3) Illinois had 10 facilities, including nine state hospitals and one neuropsychiatric institute. *Ibid.*, Exhibit 1, pp. 232 and 234.

¹⁵⁷ *Ibid.*, Table 20, p. 282.

¹⁵⁸ *Ibid.*, Table 20, p. 283.

¹⁵⁹ *Ibid.*

¹⁶⁰ *Ibid.*

¹⁶¹ *Ibid.*, Table 28, p. 308.

¹⁶² *Ibid.*

¹⁶³ *Ibid.*

only 11 out of 187 facilities nationwide) that reported using psychoanalysis.¹⁶⁴ The other three hospitals indicated that they lacked the staff for psychoanalysis but only Butner indicated an interest in this relatively new form of therapy if staffing were available.¹⁶⁵

The report also noted that half the states, including North Carolina, had recently modernized their statutory references from “insane” to “mentally ill.”¹⁶⁶ The report noted that most psychiatrists now believe that the use of prior phrases such as “insanity” or “insane asylum” “acts as an emotional bar to the patient and as a serious hindrance to the treatment and ultimate recovery of such persons” and improperly connoted something other than illness or disease.¹⁶⁷ North Carolina’s 1940 Biennial Report also reflected the above philosophy:

the implication involved in the change of name from “asylums” to “hospitals” should be taken seriously and the institutions concerned should devote themselves to the ideal of treating patients for their mental disorders with a view to getting them well. To this end superintendents should seek to build up staffs of doctors who have the outlook of modern psychiatry and are interested in the practice of it. Doctors who hold to the old idea that the business of state hospitals consists of labeling patients and keeping them locked up for the rest of their lives have no place on the staff of a modern mental hospital.¹⁶⁸

Although the goal of the community-based movement was eventual elimination of state hospitals, during the 1950s most states supported both with attempts to improve state hospital conditions as well as expand community services.¹⁶⁹ Community-based initiatives began to develop during the 1950s, including “general hospital psychiatric units, outpatient clinics, halfway houses, day hospitals, social clubs for ‘ex-patients,’ family care, anti-stigma interventions, preventive services, and the use of visiting professional teams to go into patients’ homes, private doctors’ offices, or remote rural areas.”¹⁷⁰ The development of such programs, however, did not alleviate earlier problems such as staffing shortages—“such problems simply moved into the new loci of care and treatment.”¹⁷¹

Within the state hospital system, one of the more positive movements was psychosocial and vocational rehabilitation, which sought to advance the role of hospitals as places which could prepare the patient, through the teaching of work and social skills, to live in the community.¹⁷² However, ultimately such efforts could not be sustained in light of rampant overcrowding and underfunding during this period.¹⁷³

The Entrance of the Federal Government: National Mental Health Legislative Enactments

Although important preconditions to changes in mental health policy, none of the factors above independently or in conjunction were enough to sway the public or elected officials to make dramatic changes in longstanding patterns of care.¹⁷⁴ *The states remained solely responsible for mental health policy and, in most instances, continued mainly to pursue traditional institutional solutions while dabbling in community al-*

¹⁶⁴ *Ibid.*, Table 28 on p. 308, and p. 346.

¹⁶⁵ *Ibid.*, pp. 308-09.

¹⁶⁶ *Ibid.*, p. 47.

¹⁶⁷ *Ibid.*

¹⁶⁸ 1940 Report, note 79 above, p. 108.

¹⁶⁹ Grob, note 98 above, p. 427.

¹⁷⁰ Geller, note 139 above, p. 47.

¹⁷¹ *Ibid.*

¹⁷² *Ibid.*, p. 46.

¹⁷³ *Ibid.*

¹⁷⁴ Mechanic and Rochefort, note 137 above, p. 309.

*ternatives. Rather, the ultimate factor that tipped the balance from an institutionally-based to a community-oriented mental health policy was the decision of the federal government to take responsibility for promoting the mental health of all Americans.*¹⁷⁵

A series of post-World War II national legislative enactments helped promote community mental health and deinstitutionalization practices.¹⁷⁶ The federal government's role as the key agent of reform and innovation in public mental health policy continued for approximately 35 years until intergovernmental changes during the early part of President Ronald Reagan's first term "reestablished the states' primacy in the design and control of local mental health services."¹⁷⁷

THE NATIONAL MENTAL HEALTH ACT OF 1946

In July 1946, at the behest of a small cadre of influential federal officials—including Robert Felix, the head of the U.S. Public Health Service's Division of Mental Hygiene, concerned laypersons, and a group of psychiatrists who had been influenced by their World War II experiences—the National Mental Health Act (NMHA) became law.¹⁷⁸ Advocates of the legislation criticized not only mental hospitals' shortcomings but also the mission of custodial care. The goal of prevention was their touchstone.¹⁷⁹ In addition to establishing the National Institute of Mental Health (NIMH), the NMHA provided grants and fellowships for training mental health professionals; "research relating to the cause, diagnosis, and treatment of neuropsychiatric disorders"; and the development by the states of pilot community care programs and demonstration studies concerning prevention, diagnosis, and treatment of neuropsychiatric disorders.¹⁸⁰ It was not interpreted to include financial support for institutional care and treatment of the mentally ill.¹⁸¹ The clear emphasis of the Act was on community-based treatment and research primarily based on the assumption that broad social and environmental factors were the roots of mental illness.¹⁸²

Felix, who was the Director of the NIMH from 1949 to 1964, broadly viewed mental disorders as a significant public health problem that would not be conquered without more knowledge about its causes, more effective prevention and treatment, and better trained personnel.¹⁸³ Although he conceded that the mental hospital would be necessary for the foreseeable future, he insisted that

the greatest need was for a large number of outpatient community clinics (probably modeled after pre-war child guidance clinics) to serve individuals in the early stages of any mental disease. Not only would these clinics avoid the stigmatization associated with mental hospitals, but they would point the way to effective preventive programs.¹⁸⁴

Variations on some of these themes had begun to appear in North Carolina's reports as early as 1908 and into the 1920s and 1940s. Specifically, the 1908 Annual Report of the Board of Charities noted that prevention was the "new keynote to philanthropy."¹⁸⁵

¹⁷⁵ Grob, note 44 above; Mechanic and Rochefort, note 137 above, pp. 304 and 309; Moskowitz, note 119 above, p. 156.

¹⁷⁶ Mechanic and Rochefort, note 137 above, p. 304.

¹⁷⁷ *Ibid.*

¹⁷⁸ Grob, note 98 above, p. 423.

¹⁷⁹ Moskowitz, note 119 above, p. 153.

¹⁸⁰ On the Internet at <http://www.nih.gov/about/almanac/organization/NIMH.htm>; see also Grob, note 98 above, pp. 423-24; Mechanic and Rochefort, note 137 above, p. 305.

¹⁸¹ Moskowitz, note 119 above, p. 153; Grob, note 98 above, p. 424. Gerald Grob says, "Robert Felix, the first head of NIMH, interpreted the act as precluding support for institutional care, largely because he intensely disliked mental hospitals and wanted to move policy in a different direction."

¹⁸² Grob, note 98 above, p. 424. The NIMH's initial budget of \$8.7 million in 1946 had increased to \$100 million by 1960. Moskowitz, note 119 above, p. 154.

¹⁸³ Grob, note 98 above, p. 424.

¹⁸⁴ *Ibid.*

¹⁸⁵ 1908 Report, note 76 above, p. 5.



Surgery at Dix Hospital

more centralization of power, modern tendencies in the field included the recognition that (1) more emphasis must be placed on “prevention rather than temporary alleviation and palliation as the most important aspect of social work;” and (2) workers in public welfare activities should be specially trained in sociology and the practice of case work because the problems they are addressing are essentially scientific and thus require not only intelligence and “tactful personality” but clear knowledge of the field.¹⁸⁸

Despite the NMHA’s modest initial appropriations, by 1949, all but five states had one or more outpatient community clinics.¹⁸⁹ Prior to 1948, more than 50 percent of the states had no such facilities.¹⁹⁰ During this period, North Carolina appears to have been on the more progressive side of this issue even prior to passage of the NMHA. It had several community administered, controlled, and financed clinics, including community mental hygiene clinics in Charlotte, in Raleigh under the Wake County Council of Social Agencies, and in a child guidance clinic in Winston-Salem—all of which provided some form of psychiatric services to the community.¹⁹¹

The number of community health programs throughout the nation also began to expand with matching funding from the NIMH’s Community Services Branch.¹⁹² Although state mental health budgets remained heavily weighted toward state mental hospitals, “the assumption was that an alternative community program based on prevention and early treatment would eventually diminish or eliminate the need for hospitalization by identifying pathology in its early stages.”¹⁹³

State level policy changes were driven in part by funding from NIMH to assist states in extending or creating mental health authorities.¹⁹⁴ By 1950, every state had responded to NIMH’s request to create a state mental health agency which in turn was required to submit a plan to the Institute for how it would use the newly available federal funds.¹⁹⁵ NIMH specifically barred states, however, from using federal funds

In terms of “borderline or incipient insanity”—preventive efforts meant providing early treatment, diagnosis, and care so that chances of recovery were heightened.¹⁸⁶ The Board also recommended other prevention-related efforts such as establishing a psychopathic institute “where there may be research looking into the causes of insanity, where all the physicians connected with the various institutions can spend some time in turn.”¹⁸⁷ Subsequently, the Biennial Report of the State Board of Charities and Public Welfare, December 1, 1920, to June 30, 1922, noted that, in addition to

¹⁸⁶ *Ibid.*, p. 6. For other “classes” such as “imbeciles” and “epileptics,” the Board recommended segregation and strict marriage laws. *Ibid.*

¹⁸⁷ *Ibid.*, p. 6.

¹⁸⁸ 1920-22 Report, note 83 above, p. 9.

¹⁸⁹ Grob, note 44 above.

¹⁹⁰ *Ibid.*

¹⁹¹ 1940 Biennial Report, note 79 above, p. 110.

¹⁹² Grob, note 98 above, p. 425.

¹⁹³ *Ibid.*

¹⁹⁴ Moskowitz, note 119 above, p. 155.

¹⁹⁵ *Ibid.*

for state mental hospitals; rather, plans had to focus on outpatient services and the corresponding emphasis on “prevention and the new therapeutic ideal of mental health.”¹⁹⁶ NIMH regulations specified that for every dollar provided by the Institute to the state mental health agency, the state had to provide 50 cents.¹⁹⁷ “By 1951, the NIMH had assisted in the establishment of 342 community clinics nationwide.”¹⁹⁸

THE MENTAL HEALTH STUDY ACT OF 1955

Building on the momentum of President Harry Truman’s National Mental Health Act in 1946, the interest of private foundations in the issue, the first research grants for mental health projects, and the establishment of the NIMH in 1949, proponents of community-based care next set their sights on expanding the role of federal government even further. They wanted legislation providing for a “national program to improve methods and facilities for the diagnosis, treatment, and care of the mentally ill and mentally retarded” and the provision of direct federal subsidies for mental health services.¹⁹⁹ The initial result of their efforts was the passage of the Mental Health Study Act of 1955 (Public Law 84-182) which called for “an objective, thorough, nationwide analysis and reevaluation of the human and economic problems of mental health” and authorized the Public Health Service to provide grants for the study.²⁰⁰ The act endorsed and provided some grant support for the private undertakings of the Joint Commission on Mental Illness and Health, which issued its final report, *Action for Mental Health*, in March 1961.²⁰¹ The final report set forth the basis for “wholesale system reform, including a redefined role for state mental hospitals as smaller, more intensive treatment sites.”²⁰²

Although *Action for Mental Health* embraced in large measure many of the components of the community-based movement, it received mixed reviews from various constituencies because its breadth and vague language offered something to both the institutional and community care camps—thus, no one was entirely satisfied with the result.²⁰³ The most ardent proponents of the community-based movement objected to the portions of the report advocating the strengthening of existing state systems and the report’s view that state hospitals had a continuing, albeit more limited and altered role.²⁰⁴ In contrast, those long associated with the state hospital system insisted that such institutions were essential to the care and treatment of psychotic patients who were often ignored by those in private practice and objected to the report’s implicit criticisms of state facilities.²⁰⁵ The response of state officials tended to focus on the cost-sharing recommendations given the significant proportion of state budgets devoted to existing mental hospitals.²⁰⁶

¹⁹⁶ *Ibid.*

¹⁹⁷ *Ibid.*

¹⁹⁸ *Ibid.*

¹⁹⁹ See “Important Events in NIMH History” on the Internet at <http://www.nih.gov/about/almanac/organization/NIMH.htm>; see also Grob, note 98 above, pp. 430-31.

²⁰⁰ On the Internet at <http://www.nih.gov/about/almanac/organization/NIMH.htm>; see also Grob, note 98 above, p. 432.

²⁰¹ On the Internet at <http://www.nih.gov/about/almanac/organization/NIMH.htm>; see also Grob, note 98 above, p. 435. In addition to the final report, between 1958 and 1962, eight volumes addressing a number of separate issues were published. Grob, note 98 above, p. 435. A ninth was published three years after the Joint Commission had completed its overall report. *Ibid.*

²⁰² Mechanic and Rochefort, note 137 above, p. 305.

²⁰³ Grob, note 3 above, p. 485.

²⁰⁴ Grob, note 98 above, p. 443.

²⁰⁵ *Ibid.*, p. 437.

²⁰⁶ *Ibid.*, p. 439.

MENTAL RETARDATION FACILITIES AND COMMUNITY
MENTAL HEALTH CENTERS CONSTRUCTION ACT OF 1963

Ultimately, the voice of those in the NIMH, which were generally critical of the Joint Commission's proposals, prevailed in the subsequent efforts to transform its vision into viable mental health legislation. These individuals believed that the federal government had to play a critical role in developing new policies and programs because the states had failed to meet their social welfare responsibilities.²⁰⁷ Thus, they "promoted policies designed to *diminish the role and authority of state government and to forge direct relations between the federal government and local communities.*"²⁰⁸

By the early 1960s, this community-based agenda was clear: (1) whenever possible, care and treatment should be provided in a patient's own home community; (2) hospitalization, if required, should be non-lengthy and the patient should be returned expeditiously to outpatient services; (3) early intervention should be available so fewer hospitalizations would be necessary; and (4) alternative programs to hospitalization should be fostered because they will be more economical and therapeutic.²⁰⁹

The inauguration of President John F. Kennedy provided an opportunity for the presentation of their agenda.²¹⁰ In 1961, Kennedy created an interagency task force on mental health to consider the recommendations contained in the Joint Commission Report.²¹¹ At the same time, the NIMH offered its own program, which veered away from the Joint Commission's emphasis on the *care and treatment of the mentally ill* and toward the improvement of the *mental health of Americans* through a continuum of services rather than solely treatment and rehabilitation.²¹² The NIMH's program called for a

veritable revolution in policy—a comprehensive community program that would make it possible "*for the mental hospital as it is now known to disappear from the scene within the next twenty-five years.*" In its place would be a mental health center offering comprehensive services.²¹³

Kennedy accepted the task force's recommendations and, in 1963, signed into law the Mental Retardation Facilities and Community Mental Health Centers Construction Act (CMHC Act) (Public Law 88-164) which "sponsored the creation of a new type of community-based facility providing inpatient, outpatient, emergency and partial hospitalization services, as well as consultation and education to other community organizations."²¹⁴ Two years later, the Act was amended to establish a grant program to cover initial staffing costs for community mental health centers.²¹⁵ The Act, however, as actually implemented had its deficiencies. Although the initial legislation envisioned the construction of 1,500 centers, by 1980, the number of CMHCs actually constructed was only slightly more than 700.²¹⁶ In addition, as discussed below, because the new CHMCs generally (1) failed to coordinate with existing state institutions, and (2) underserved the most severe and chronic patients, the CMHCs "constituted more of a parallel to existing state care systems than a complementary network of services."²¹⁷

²⁰⁷ Grob, note 3 above, p. 485.

²⁰⁸ *Ibid.* (emphasis added).

²⁰⁹ Geller, note 139 above, p. 47.

²¹⁰ Grob, note 3 above, p. 486.

²¹¹ *Ibid.*

²¹² *Ibid.* (emphasis added).

²¹³ *Ibid.* (emphasis in the original).

²¹⁴ Mechanic and Rochefort, note 137 above, p. 305; see also Grob, note 3 above, p. 486; and on the Internet at <http://www.hhs.gov/newfreedom/prelim/append.html>. The CMHC Act also provided grants for the construction of mental retardation research centers and facilities and provided for training of educational personnel involved with youth with disabilities. See Grob, note 3 above, p. 486.

²¹⁵ On the Internet at <http://www.hhs.gov/newfreedom/prelim/append.html>.

²¹⁶ Mechanic and Rochefort, note 137 above, p. 305.

²¹⁷ *Ibid.*

The Entrance of the Federal Government: National Social Welfare Legislation Indirectly Impacting Mental Health Policy

THE AMENDMENTS TO THE SOCIAL SECURITY ACT OF 1965: MEDICARE AND MEDICAID

In 1965, Title 18 (Medicare) and Title 19 (Medicaid) of the Social Security Act were enacted into law to offer health insurance protection to the elderly, the poor, and the disabled. This law also had a significant impact on the organization and financing of mental health policy.²¹⁸ Medicare, which addressed the needs of the aged and disabled, paid for facility-based care (Part A) and physician services (Part B), while Medicaid offered matching grants to states if they satisfied basic national standards in creating programs to pay for health care for the poor.²¹⁹

From its beginning, Medicare has restricted coverage for care in private and public psychiatric hospitals to a 190-day lifetime limit in order to limit the federal government's financial responsibility for the provision of long-term custodial care of mentally ill individuals—a role state mental hospitals had filled for more than a century.²²⁰ The authors of the Medicare language essentially adopted the community psychiatry ideology that advocated active treatment in short-term hospitals within the patient's community.²²¹

Similarly, Medicaid, which is a joint federal and state program that pays for acute care and long-term care in nursing homes and other settings, specifically excludes payment for care of non-elderly adults in state psychiatric hospitals and other "institutions for mental disease" (IMDs).²²² An IMD is defined as "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services."²²³ As with the 190-day lifetime limitation for Medicare, the IMD exclusion was designed to avoid having the federal government assume the costs of long-term custodial care for psychiatric patients.²²⁴

*An unintended consequence of the exclusion, however, was that states changed their policies and began shifting tens of thousands of elderly patients with mental disorders from state mental hospitals to nursing homes so that they would be eligible for matching Medicaid funds.*²²⁵ As previously noted, this shifting of populations mimicked the way in which communities in states that had passed state care acts (which did not include North Carolina) had responded a half century earlier by moving significant portions of the local populations from almshouses to state hospitals.²²⁶ Within a decade, between 1962 and 1972, the number of patients in public mental hospitals who were 65 or older had declined from 153,000 to 78,000.²²⁷ By contrast, between 1963 and 1969, elderly mental patients in nursing homes increased from 188,000 to 368,000.²²⁸ By 1985, more than 600,000 individuals diagnosed with mental illnesses resided in nursing homes at a cost of \$10.5 billion paid in large part by Medicaid.²²⁹ This shift, which was often accompanied by increases in death rates, was motivated

²¹⁸ Richard G. Frank, "The Creation of Medicare and Medicaid: The Emergence of Insurance and Markets for Mental Health Services," *Psychiatric Services*, Vol. 51, No. 4, April 2000, p. 465.

²¹⁹ *Ibid.*

²²⁰ *Ibid.*, p. 466.

²²¹ *Ibid.*

²²² *Ibid.*; see also on the Internet at <http://www.psychlaws.org/GeneralResources/fact12.htm>.

²²³ On the Internet at <http://www.psychlaws.org/GeneralResources/fact12.htm> (quoting 42 U.S.C. §1396d(i)).

²²⁴ Frank, note 218 above, p. 466.

²²⁵ Frank, note 218 above, p. 467; Grob, note 3 above, pp. 491-92; Mechanic and Rochefort, note 137 above, p. 305.

²²⁶ Grob, note 3 above, p. 491.

²²⁷ *Ibid.*, p. 492.

²²⁸ *Ibid.*

²²⁹ Grob, note 44 above.

entirely by economics rather than a belief that the elderly mentally ill would be best served in nursing facilities, many of which provided no psychiatric care and whose overall quality of care ranged widely.²³⁰

Although advocates of the community movement sought deinstitutionalization and the eventual end of state hospitals, what occurred in large part was “transinstitutionalization”—at least with respect to elderly mentally ill patients.²³¹ In addition, rather than extinction, *the state mental institutions began to serve a different function—more short and intermediate term care and treatment for the severely mentally ill.*²³² The total number of resident patients in state hospitals began to fall between 1955 and 1965, and the decline accelerated after 1965. However, the total number of admissions was steadily increasing during this period from 178,003 in 1955 to 316,664 in 1965 to 384,511 in 1970.²³³ Although the state institutions still fulfilled the role of the institution of last resort for chronic patients who had nowhere else to go, the overall decline in the long-term chronic population from state institutions had the unintended benefit of improving the quality of acute care and treatment in state mental hospitals.²³⁴ Thus, while the 1960s marked a break in the pattern of more than a century of no federal involvement in mental health policy, the result of the community-based initiatives and Social Security Amendments had long-lasting and in many instances unforeseen and not necessarily compatible consequences.²³⁵

In addition, the Medicare and Medicaid entitlement programs established the themes for many of the most significant public debates about mental health and economic policy for the next 35 years, including “privatization of mental health care, the division of responsibility between state and federal governments, and parity for mental health and general medical services under insurance programs.”²³⁶ For example, Medicare encouraged certain types of care such as general hospital psychiatric care over specialty psychiatric hospitals, and thus “private nonprofit hospitals, the dominant form of general hospital, were preferred over public psychiatric hospitals. This shift in setting was one of several steps toward privatization of psychiatric inpatient care.”²³⁷

In terms of Medicaid’s impact, not only were elderly people with mental disorders shifted from state psychiatric hospitals to private for-profit nursing homes, but Medicaid’s generous matching provisions also encouraged “states to reduce their role as direct providers of specialty mental health care and to expand their functions as payer and regulator.”²³⁸ In addition, many of the same arguments made today against parity in benefit design under private insurance for mental illnesses—“the difficulty in defining mental illness, the lack of evidence on effective treatments, the high cost of covering mental health care, and the uncertainty in making actuarial estimates of costs”—were first raised in 1965 in the Medicare debates.²³⁹

²³⁰ *Ibid.*

²³¹ Although the most common term used to describe the effect of the community-based movement on state mental institution is “deinstitutionalization,” some scholars contend that other terminology is more accurate. For example, the term “transinstitutionalization” was coined by Dr. John Talbott at the end of the 1970s to describe what he viewed as the phenomenon of “the chronic mentally ill patient [having] his locus of living and care transferred from a single lousy institution to multiple wretched ones.” Geller, note 139 above, p. 42. Other scholars prefer the term “dehospitalization” for describing the phenomenon of transferring patients from state hospitals to other locations because “it implies no judgment about whether where they went could be considered an institution.” *Ibid.*

²³² Grob, note 44 above.

²³³ *Ibid.*

²³⁴ Grob, note 3 above, p. 492.

²³⁵ *Ibid.*; see also Frank, note 218 above, p. 467.

²³⁶ Frank, note 218 above, p. 465.

²³⁷ *Ibid.*, p. 467.

²³⁸ *Ibid.*

²³⁹ *Ibid.*, pp. 467-68.

SHIFTING POLITICAL WINDS: THE 1970s AND 1980s

Federal Actions

As the 1960s came to an end, federal legislators began to focus away from mental health issues, which they believed had been largely addressed by prior legislation, and towards substance abuse issues, including misuse of drugs and alcohol which was deemed a major threat to public health.²⁴⁰ Through separate legislative enactments in 1970 and 1972, Congress established the National Institute of Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse—both within the NIMH.²⁴¹ In 1974, all three Institutes became part of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) within the U.S. Department of Health, Education and Welfare (DHEW).²⁴² In 1968 and 1975, Congress enacted legislation that expanded the role of the Community Mental Health Centers (CMHCs) to include services for substance abusers as well as children and the elderly.²⁴³ Congress's reassessment of the CMHC program, however, never considered "the fundamental issue of providing for the basic human and medical needs of persons with severe mental illnesses."²⁴⁴ Thus, the needs of these individuals languished in the background of mental health policy.

In 1977, emphasis shifted back to the chronically mentally ill and other underserved groups when President Jimmy Carter created the President's Commission on Mental Health.²⁴⁵ This Commission's final report, which offered a variety of diverse and, in part, conflicting recommendations, advocated the creation of a national health insurance program that would include coverage for mental health care as the best means of assuring that the mentally disabled would have access to necessary services.²⁴⁶ A month before the 1980 presidential election, Congress finally passed the Mental Health Systems Act, which created a comprehensive federal-state system that would ensure care and treatment in community settings for the mentally ill, including previously underserved groups such as the chronically ill, children, and the elderly.²⁴⁷

The national system envisioned by the Mental Health Systems Act, however, never took effect because the election of President Ronald Reagan resulted in "an immediate reversal of policy."²⁴⁸ At Reagan's urging, in 1981, Congress passed the Omnibus Budget Reconciliation Act (OBRA) which provided, with few restrictions and no policy guidelines, a block grant to States for mental health and substance abuse services.²⁴⁹ In addition to a substantial reduction in federal funding for mental health, the OBRA reversed nearly 30 years of federal leadership and participation in mental

²⁴⁰ Grob, note 44 above.

²⁴¹ On the Internet at <http://www.nih.gov/about/almanac/archive/1999/organization/nimh/history.html>.

²⁴² *Ibid.*

²⁴³ Grob, note 44 above; see also Geller, note 139 above, p. 44.

²⁴⁴ Grob, note 44 above.

²⁴⁵ Geller, note 139 above, p. 44.

²⁴⁶ *Ibid.*

²⁴⁷ *Ibid.*; Grob, note 44 above.

²⁴⁸ Grob, note 44 above; see also Geller, note 139 above, p. 44 (The OBRA "eviscerates the Mental Health System Act and lumps together all remaining categorical mental health programs into a huge block grant.").

²⁴⁹ Grob, note 44 above.

health policy and shifted the focus back to and increased the fiscal burden of the states and their local communities.²⁵⁰

The impact of these changes, however, was blunted in part by the separate federal entitlement and disability programs which shared some of the same goals of the community-based movement but evolved on a separate track with no direct relationship to mental health policy. In addition to Medicare and Medicaid, Congress had previously amended the Social Security Act in 1956 to enable eligible persons age 50 and older to receive disability benefits.²⁵¹ The Social Security Disability Insurance (SSDI) program later was amended to include the mentally disabled.²⁵² In addition, in 1972 Congress again amended the Social Security Act to provide income support for individuals whose age or disability made them incapable of holding a job.²⁵³ The expansion of disability insurance enhanced the ability of patients to return to their families with adequate income to contribute to their support.²⁵⁴ Supplemental Security Income for the Aged, the Disabled, and the Blind (SSI), SSDI, Medicaid and Medicare, as well as public housing programs and food stamps, all inadvertently encouraged states to discharge the severely mentally ill from state mental hospitals because *presumably* the federal entitlement and disability programs would provide adequate means for these individuals to live in the community.²⁵⁵ In sum, since the 1970s, the severely mentally disabled “have come under the jurisdiction of two quite distinct systems—entitlements and mental health—that often lacked any formal programmatic or institutional linkages,” says Gerald Grob, a professor at Rutgers University.²⁵⁶

North Carolina’s Actions During the 1970s and 1980s

North Carolina’s actions during the 1970s and 1980s reflected the national trends to a certain extent. In 1973, four years prior to the Carter Administration’s efforts, the General Assembly established its own Mental Health Study Commission and charged the North Carolina Legislative Oversight Committee (LOC) with oversight of the delivery of mental health, mental retardation, and substance abuse services.²⁵⁷ Between 1973 and 1992, under the leadership of Senator Kenneth C. Royall, Jr., who was Chair and then Co-Chair of the Commission, the N.C. Division of Mental Health, Development Disabilities and Substance Abuse Services (hereafter DMH/DD/SAS) received significant budget increases, began seeking Medicaid funds; and developed a series of long-range plans.²⁵⁸

In the early 1970s, in response to the national community mental health centers legislation, the 100 North Carolina counties were clustered into area Mental Health/Developmental Disabilities/Substance Abuse Services Authorities.²⁵⁹ Although the more populated counties, such as Mecklenburg, Guilford, Durham and Wake, had single-county area authorities, most North Carolina area programs “were organized on a multi-county basis (to meet federal catchment area population requirements) and then chartered as private nonprofit 501(c)(3) corporations.”²⁶⁰ In accordance with

²⁵⁰ *Ibid.*

²⁵¹ Grob, note 3 above, p. 493; see also Grob, note 44 above, Chapter 2.

²⁵² Grob, note 3, above, p. 493; see also Grob, note 44 above, Chapter 2.

²⁵³ *Ibid.*

²⁵⁴ Mechanic and Rochefort, note 137 above, p. 305.

²⁵⁵ Grob, note 3 above, p. 493.; see also Grob, note 44 above, Chapter 2.

²⁵⁶ Grob, note 44 above, Chapter 2.

²⁵⁷ Human Services Research Institute, “Today’s Choice: Tomorrow’s Path, An Evaluation of the System for People with Developmental Disabilities in North Carolina,” Nov. 23, 2001, p. 2.

²⁵⁸ *Ibid.*

²⁵⁹ Martin Swartz and Joseph Morrissey, “Mental Health Care in North Carolina: Challenges on the Road to Reform,” *NC Medical Journal*, Vol. 64, No. 5, Sept./Oct. 2003, p. 206; see also Mark F. Botts, “2001 Legislation Affecting Mental Health, Developmental Disabilities, and Substance Abuse Services,” *Institute of Government Bulletin, Mental Health Law*, No. 7, March 2002, p. 4.

²⁶⁰ Swartz and Morrissey, note 259 above, p. 207.

the community-based philosophy, accountability in the area authority model rested with local citizen advisory/area governing boards.²⁶¹ Although the single-county area authorities were considered a department of the county for budgeting and fiscal control purposes, the more numerous multi-county area authorities were not part of the budgeting and accounting system of any county.²⁶² Rather, the area boards appointed a budget officer and finance officer who were responsible for budgeting, disbursing, accounting, and financial management.²⁶³

Although in many jurisdictions the state mental hospitals provided acute as well as long-term care services for area authorities, the four mental hospitals operated completely independently of the area authorities with respect to budgetary and management functions.²⁶⁴ In addition, there was no clear or overt arrangement for ensuring that area authorities were accountable for the number of patients admitted to the hospitals.²⁶⁵

With respect to federal entitlement programs, North Carolina submitted and received federal approval for its Medicaid State Plan in 1969 and began the North Carolina Medicaid Program in January 1970 under the direction of the North Carolina Division of Social Services.²⁶⁶ The North Carolina Medicaid program is currently under the N.C. Department of Health and Human Services (DHHS), which was previously the Department of Human Resources.²⁶⁷

In 1972, Medicaid services were expanded to include, among others, inpatient mental health services for individuals over 65 and mental health centers.²⁶⁸ The following year, service coverage was again expanded to include mental hospital inpatient services for individuals under age 21.²⁶⁹ In 1979, "Medicaid served 340,000 recipients at a total cost of \$379,769,848 through over 10,000 private providers, 150 in-state hospitals, 250 nursing homes, mental health clinics, county health departments and 7 State mental facilities and 4 specialty hospitals."²⁷⁰ Between 1978 and 2006, the yearly number of individuals eligible for Medicaid increased from 456,000 to 1,602,645 and Medicaid expenditures increased from approximately \$307 million to \$8.6 billion.²⁷¹

In the early 1980s, a major focus of the Division of Medical Assistance, which now had authority over North Carolina's Medicaid program, was shifting individuals who needed long-term care from institutional settings to presumably more cost-effective home-based and outpatient settings.²⁷² In 1982 and 1983, North Carolina completed the planning phase for development of home and community-based services to assist individuals in avoiding long term institutional care.²⁷³ The state initiated the program in various counties on a pilot basis.²⁷⁴ Initial efforts in this area, however, were focused more on home-based programs for disabled adults and those with developmental disabilities rather than individuals suffering from mental illness.²⁷⁵

²⁶¹ *Ibid.*

²⁶² Botts, note 259 above, p. 5.

²⁶³ *Ibid.*

²⁶⁴ Swartz and Morrissey, note 259 above, p. 207.

²⁶⁵ *Ibid.*

²⁶⁶ "History of North Carolina Medicaid Program State Fiscal Years 1970 to 2006," p. 1. On the Internet at <http://www.ncdhhs.gov/dma/historyofmedicaid.pdf>. Chapter 108A of the North Carolina General Statutes implemented Title XIX of the Social Security Act in North Carolina. *Ibid.* North Carolina Administrative Code, Title 10, Chapters 26 and 50 further defined the state's Medicaid policy apart from state law and federal law and regulations. *Ibid.*

²⁶⁷ *Ibid.*, p. 1.

²⁶⁸ *Ibid.*, p. 23. The scope of this discussion is limited to changes to the program directly related to mental health issues.

²⁶⁹ *Ibid.*, p. 3.

²⁷⁰ *Ibid.*, p. 5.

²⁷¹ *Ibid.*, p. 1.

²⁷² *Ibid.*, p. 5.

²⁷³ *Ibid.*, p. 6.

²⁷⁴ *Ibid.*

²⁷⁵ *Ibid.*

Following passage of the Omnibus Budget Reconciliation Act of 1981, which reduced the federal matching rate for Medicaid expenditures, the North Carolina General Assembly held a special legislative session in October 1981 to address the loss of federal funds in all areas of state government.²⁷⁶ The legislature imposed restrictions on certain Medicaid services, including restricting visits to mental health centers to 18 visits per year.²⁷⁷

In 1986, Congress enacted the State Comprehensive Mental Health Services Plan Act which required states “to develop and implement comprehensive plans for community-based services for people with severe mental illness.”²⁷⁸ In 1988, Medicaid expanded coverage for case management of chronically mentally ill individuals, which allowed the North Carolina “Division of Mental Health, Mental Retardation, and Substance Abuse Services to provide better access to comprehensive mental health services for this vulnerable population.”²⁷⁹

²⁷⁶ *Ibid.*, p. 5.

²⁷⁷ *Ibid.*

²⁷⁸ Geller, note 139 above, p. 45.

²⁷⁹ History, note 266 above, p. 10.

The Four Sectors of the Mental Health System

“The four sectors of the system are the specialty mental health sector, the general medical/primary care sector, the human services sector, and the voluntary support network sector. **Specialty mental health services** include services provided by specialized mental health professionals (e.g., psychologists, psychiatric nurses, psychiatrists, and psychiatric social workers) and the specialized offices, facilities, and agencies in which they work. Specialty services were designed expressly for the provision of mental health services. The **general medical/primary care** sector consists of health care professionals (e.g., family physicians, nurse practitioners, internists, pediatricians, etc.) and the settings (i.e., offices, clinics, and hospitals) in which they work. These settings were designed for the full range of health care services, including but not specialized for the delivery of mental health services. The **human services** sector consists of social welfare, criminal justice, educational, religious, and charitable services. The **voluntary support network** refers to self-help groups and organizations. These are groups devoted to education, communication, and support, all of which extend beyond formal treatment.”

Excerpted from U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General*, Rockville, MD, 1999, Chapter 2, § 7, on the Internet at <http://www.surgeongeneral.gov/library/mentalhealth/pdfs/c2.pdf>.

OVERVIEW OF THE CONSEQUENCES OF THE COMMUNITY-BASED MOVEMENT OVER THE LAST HALF OF THE 20th CENTURY

“The emphasis must be moved away from programs and places toward the patients themselves.’ We remain entrenched in our concerns about locus of care, confusing it with the humaneness, effectiveness, and quality of care.”

—Jeffrey L. Geller, MD, MPH
(quoting L.L. Bachrach)

“The most enduring change in the post World War II period has been the deinstitutionalization of persons with mental illness.”

—David Mechanic, Ph.D.

Unquestionably, there were many positive consequences of the community-based movement and subsequent deinstitutionalization, or more accurately “dehospitalization,” for a number of individuals with varying types and degrees of mental illness.²⁸⁰ Indeed, “the evidence is overwhelming that most clients are immeasurably better off in the deinstitutionalized care system than they ever could be in mental hospitals,” writes David Mechanic, the director of the Institute of Health, Health Care Policy, and Aging Research at Rutgers University.²⁸¹

Even for those individuals with severe mental illness, the community-based approach was successful as long as comprehensive services to fit the individual patient’s needs were provided. For example, the Vermont Longitudinal Research Project, which began in the mid-1950s, demonstrated that severely mentally ill individuals “who were provided with a range of comprehensive services could live in the community.”²⁸² Data from this research project indicated that “two-thirds ‘could be maintained in the community if sufficient transitional facilities and adequate aftercare was provided.’”²⁸³ Other longitudinal studies both in the United States and Europe reached similar conclusions.²⁸⁴ In addition,

a variety of other mental health service demonstration projects supported by private foundations and Federal agencies (e.g., the Robert Wood Johnson Foundation, NIMH, the Agency for Health Care Research and Quality, and CMHS) have confirmed the effectiveness of a system that provides employment opportunities, supportive housing, social supports, treatment of individuals with both mental illness and substance abuse diagnosis, and the diversion of persons with mental illnesses from jails into integrated treatment facilities. That individuals with severe mental disorders prefer and do better in community settings is clear; access to

²⁸⁰ Grob, note 44 above, Chapter 2.

²⁸¹ Mechanic, note 2 above, Chapter 7.

²⁸² Grob, note 44 above, Chapter 2.

²⁸³ *Ibid.*

²⁸⁴ *Ibid.*

economic resources (particularly vocational rehabilitation) and empowerment provide a feeling of mastery rather than a sense of dependency.²⁸⁵

Other studies comparing hospital treatment to various alternative care arrangements also concluded that alternative care is “more effective than hospitalization across a wide range of patient populations and treatment strategies.”²⁸⁶

However, as discussed below, in many instances determining that a particular pattern of care was effective often was not matched with the equally important development of “financial and organizational arrangements assuring that such care could be made available to a widely dispersed population.”²⁸⁷ The continuing provision of comprehensive services was not always the norm and the community-based movement resulted in a number of long-term negative consequences, especially for those individuals who were chronically and severely mentally ill. As one scholar has noted, the focus of the last half of the 20th century was one of “moving patients out of state hospitals and *putting* them someplace else” with emphasis too often on the location of the care and treatment rather than what services individual patients actually needed.²⁸⁸

Inherent Problems in the Community-Based Approach

One overriding reason that the community-based approach resulted in a number of problems in care is that the rhetoric of the movement often was not based on hard data or the realities of the existing mental health system that proponents of the movement sought to change.²⁸⁹ As evident from the passage of the Community Mental Health Centers Act, political leaders and the mental health community in general had accepted the underlying theory that a community-based approach would overcome the problems presented by the old system of mental hospitals.²⁹⁰ However, in reality, many of the criticisms of the “warehousing functions” of the state hospital system were unfounded and data suggested that any policy had to consider that patient populations were diverse with different mental disorders and different prognoses.²⁹¹

Equally, if not more, significant was the fact that the community-based concept rested on unrealistic assumptions.²⁹² Specifically, the new policy was based on the following expectations:

that patients would have a home to return to; that a sympathetic family or other person would assume responsibility for providing care of the released patient; that the organization of the household would not impede rehabilitation; and that the patient’s presence would not cause undue hardships for other family members. In 1960, however, 48 percent of the mental hospital population were unmarried, 12 percent widowed, and 13 percent either divorced or separated. The assumption that patients would be able to reside in the community with their families while undergoing rehabilitation was hardly supported by these data.²⁹³

An additional assumption involved the permanence of community-based services and related funding. In reality, however, many of the enabling factors that made sig-

²⁸⁵ Grob, note 44 above, Chapter 2.

²⁸⁶ Mechanic and Rochefort, note 137 above, p. 318.

²⁸⁷ *Ibid.*

²⁸⁸ Geller, note 139 above, p. 58.

²⁸⁹ Grob, note 3 above, p. 487.

²⁹⁰ *Ibid.*

²⁹¹ *Ibid.*

²⁹² *Ibid.*, pp. 487-88.

²⁹³ *Ibid.*

nificant movement from state institutions to community programs possible—including Medicaid, SSI and SSDI, housing programs, and food stamps—were reduced or their rate of growth cut back.²⁹⁴ Such measures, especially in the 1980s, impacted the seriously mentally ill most significantly with particular impact on the younger sub-population of this patient group because the Social Security Administration was more interested in excising from disability rolls younger persons who could draw benefits for years rather than their older counterparts.²⁹⁵ The mentally ill also typically lacked the bureaucratic skills to gain eligibility for public housing, facing housing administrators who had little appreciation for their special needs.²⁹⁶

The Diminution of State Involvement in Mental Health Policies and Its Impact on the Severely Mentally Ill

The community-based ideology also had major unforeseen and, in many instances, negative implications for the entire structure of intergovernmental relations relating to mental health care.²⁹⁷ As previously discussed, prior to World War II, state and local governments had sole authority over mental health policy. After the war, the federal government began to play a more significant role in health policy but still almost never provided direct mental health services.²⁹⁸ The 1963 CMHC Act differed from prior legislation in that it created more direct relations between the federal government and local communities with the resulting diminution of state government authority over policy and the increased power of professional and federal officials who, in large part, had no direct knowledge or contacts with state mental hospitals.²⁹⁹

The regulations governing the community centers, which were drafted by the National Institute of Mental Health (NIMH), further diminished state authority by excluding from the five defined essential services any reference to state mental hospitals.³⁰⁰ This absence of any mandated links between the existing mental hospital system which provided care and treatment for the country's most severely and chronically mentally ill patients, and the new community centers, which were supposed to provide comprehensive services and continuity of care, resulted in the "development of an independent system of centers that ultimately catered to a quite different clientele."³⁰¹ In contrast to the severely mentally ill population that state institutions primarily addressed, the community mental health centers tended to focus on clients with personal difficulties such as marital and family difficulties, children and delinquency, and substance abuse.³⁰²

The new community centered system, in effect, "ignored the needs of the mentally ill who were most in need of services."³⁰³ This occurred not only because of the fracture between the state system and local autonomy over community centers, but also because fewer constituents at the community-based level had severe mental illnesses.

²⁹⁴ Mechanic and Rochefort, note 137 above, p. 316.

²⁹⁵ *Ibid.*, pp. 316-17.

²⁹⁶ *Ibid.*, p. 317.

²⁹⁷ Grob, note 3 above, p. 488.

²⁹⁸ *Ibid.*

²⁹⁹ *Ibid.*

³⁰⁰ *Ibid.*, p. 489.

³⁰¹ *Ibid.*; see also Mechanic and Rochefort, note 137 above, p. 305.

³⁰² Grob, note 3 above, p. 489; Grob, note 98 above, p. 440. The CEO of Crossroads Behavioral Healthcare, David Swann says, "A variety of initiatives to ensure a continuum of local services were developed to address the priority needs of persons with severe and persistent mental illness (SPMI). In many rural areas of North Carolina, community programs developed services for the SPMI population because the distances to the state hospitals were significant. Services such as partial hospitalization, psychosocial rehabilitation, and day programs, along with medications available at the time, were all targeted at priority populations."

³⁰³ Grob, note 3 above, p. 489.

And, the needs of the severely mentally ill—including housing, food, clothing, and support systems for medication—were much harder to adequately address at the community level.³⁰⁴ Community-based practitioners were much less likely to interact with psychotic patients—the traditional clientele of the state institutions.³⁰⁵ “Psychiatric involvement with non-psychotic patients was rationalized on the grounds that early treatment would prevent future progression along the continuum that separated health from disease.”³⁰⁶

State officials in a 1966 conference convened by the NIMH raised concerns about (1) the absence of coordinating mechanisms between state and local officials; (2) the growing divisions among state hospitals and community mental health centers; and (3) the lack of any plans by local authorities for accepting responsibility for severely and chronically ill patients.³⁰⁷ Although they proposed a single system of services that would require the state and local systems to plan and coordinate with each other, this proposal made no headway since the CMHC Act and its implementing regulations had diminished the state mental health officials’ regulatory authority.³⁰⁸

Ultimately, however, the CMHC Act’s effort to shift the emphasis from state hospitals to community mental health centers through construction and staffing subsidies did not succeed to the extent originally envisioned because the fiscal restraints created by the Vietnam War led to large-scale cutbacks in funding for such efforts.³⁰⁹ Thus, although mental health policy had shifted to community care and treatment, by the end of the 1960s the federal commitment to funding this policy had left far fewer centers actually being built than originally projected. And, the community treatment centers that had been built typically did not provide comprehensive services but tended to ignore the severely and chronically mentally ill.³¹⁰ “Their presence continued to represent a challenge to the visions and policies of a postwar generation dedicated to the proposition that community treatment, prevention, and social activism in non-traditional settings would resolve once and for all the problems posed by the mental illnesses.”³¹¹

The Effect of the Community-Based Movement on State Mental Institutions: “Dehospitalization”

The Progressive Depopulation of State and County Mental Institutions

Between 1950 and 1996, the number of state and county hospitals declined from 322 to 232.³¹² The trend of dehospitalization hastened by the expansion of federal entitlement programs is further reflected in a comparison of inpatient populations between 1955 and 1986 which reflects a decline from 559,000 to 119,000 with the sharpest drop occurring in the 1970s and 1980s.³¹³ One author, Maxwell Jones, described the situation of state hospitals during the 1970s as follows:

I’m very worried about state hospitals, which I visit in many parts of the country. They are all demoralized and feel forgotten. The interest

³⁰⁴ *Ibid.*, pp. 489-90; see also Mechanic and Rochefort, note 137 above, p. 314 (“The strategic task of integrating these functions outside of institutions is a formidable one, and there is persistent evidence of failure in meeting these needs in even the most rudimentary ways.”).

³⁰⁵ Grob, note 98 above, p. 421.

³⁰⁶ *Ibid.*, p. 421.

³⁰⁷ Grob, note 3 above, p. 490.

³⁰⁸ *Ibid.*

³⁰⁹ *Ibid.*, pp. 490-91.

³¹⁰ *Ibid.*, p. 491.

³¹¹ Grob, note 98 above, p. 446.

³¹² Geller, note 139 above, pp. 45-46.

³¹³ Grob, note 3 above, p. 494; see also Grob, note 44 above; Geller, note 139 above, pp. 45-46; Mechanic and Rochefort, note 137 above, p. 307.

(and money) has moved to the new community programs, which are not supplying the answer to chronic mental patients.³¹⁴

Although the closing of state institutions received a great deal of attention, also important was the lowered national, state, and county patient population, attributable mostly to shortening lengths of stay and the movement of patients out of each of the state hospitals. Each hospital decreased in capacity.³¹⁵ In the 1990s, the number of inpatient beds in state and county mental health institutions dropped below 100,000 with an inpatient population in 1996 of 61,722.³¹⁶ Thus, the decline in the number of state hospitals was accompanied by a reduction in the number of inpatient beds at remaining hospitals, which is even more noteworthy given the nation's population growth during the same period.³¹⁷

State hospitals, however, never become obsolete, as originally envisioned by the community-based movement. In theory, the federal entitlement programs and the availability of alternate psychiatric services apart from state hospitals should have resulted in greater state financial support for community programs.³¹⁸ "The presumption was that a successful community policy would eventually permit the consolidation of some mental hospitals and closure of others, thus facilitating the transfer of State funds from institutional to community programs."³¹⁹ In reality, however, the state hospitals proved resistant to change due to several factors including (1) continuing support from community residents and hospital employees; and (2) the existence of a "seemingly irreducible group of individuals who were so disabled that institutional care appeared to be a necessity."³²⁰ Thus, despite dehospitalization, state hospitals remain "the largest provider of total inpatient days of psychiatric care." In their common role as the system of last resort, their patients come disproportionately from the ranks of the uninsured; treatment-resistant; the most difficult, troubled, and violence-prone; and those most difficult to relocate to alternative settings.³²¹

The Increase in Other Institutional Settings

In addition, the depopulation of state mental hospitals corresponded to an increase in other *institutional* providers including general hospitals.³²² Throughout the last half of the 20th century, treatment of psychiatric patients in general hospitals flourished in large part due to the growth in health insurance covering mental health benefits.³²³ In the early 1960s, 1,005 general hospitals were treating mentally ill patients and admitting one and a half times as many patients as the state-run facilities.³²⁴ This number had increased by 1978 to 2,244 general hospitals, including 1,100 which had separate psychiatric units.³²⁵ By that time, some were voicing concerns that the general hospital units should be on guard against morphing into miniature state hospitals.³²⁶ Five years later, in 1983, the number of general hospitals with separate psychiatric units had grown to 1,259.³²⁷ At that time, debates focused on whether involuntarily committed patients should be admitted to general hospitals and what effect "dehospitalization" of

³¹⁴ Geller, note 139 above, p. 46.

³¹⁵ Geller, note 139 above, pp. 45-46; see also Mechanic and Rochefort, note 137 above, p. 308.

³¹⁶ Grob, note 44 above; see also Geller, note 139 above, p. 46; Mechanic, note 2 above, Chapter 7.

³¹⁷ Mechanic and Rochefort, note 137 above, p. 308.

³¹⁸ Grob, note 44 above.

³¹⁹ *Ibid.*

³²⁰ *Ibid.*

³²¹ *Ibid.*; see also Grob, note 3 above, p. 494; Mechanic and Rochefort, note 137 above, p. 313.

³²² Mechanic and Rochefort, note 137 above, p. 311.

³²³ Geller, note 139 above, p. 53; see also Mechanic and Rochefort, note 137 above, p. 313.

³²⁴ Geller, note 139 above, p. 53.

³²⁵ *Ibid.*

³²⁶ *Ibid.*

³²⁷ *Ibid.*

state institutions was having on general hospitals.³²⁸ By the 1990s, the general hospital was integrally involved “in the system of care for those with chronic mental illness, and inquiry now focused on what determined where a patient would be directed for care and treatment.”³²⁹ The substitution of general hospital care for chronic patients, spurred on by Medicaid as a major source of payment for inpatient psychiatric care, contributed to a “pattern of episodic hospital care characterized by short lengths of stay with little community follow-up.”³³⁰

As previously discussed, many elderly patients of state mental institutions were transferred in the 1960s and 1970s to nursing homes. As of 1989, of the approximately 1.5 million individuals in nursing homes, anywhere between 30 and 75 percent, depending on how mental disorder was defined, had a serious psychiatric disorder or dementia.³³¹ Often these institutions were unprepared to address the special needs of these patients.

The Rise of a New Generation of Mentally Ill Different From Institutionalized Patients

The community-based movement also resulted in the creation of a new and different generation of mentally ill whose behavior was vastly different from the earlier generation of mentally ill individuals who had spent some significant part or time of their lives in institutional settings.³³² The early stages of dehospitalization after 1965 involved patients who had been institutionalized for either long periods or had been first admitted later in their lives.³³³ Because most of these individuals had internalized the behavioral norms of a hospital community, they did not appear to pose a threat to others, and the initial phase of dehospitalization was neither controversial nor overly difficult.³³⁴ Many of these individuals made a fairly successful transition into the community as a result of federal disability and entitlement programs.³³⁵

After 1970, however, a different patient population arose, consisting of young adults who had reached adulthood within the community and had been rarely confined for any length of time in psychiatric hospitals.³³⁶ These individuals, whose mental disorders were fundamentally the same as the prior generations, nevertheless behaved in very different ways than those who had been confined for long periods in state hospitals.³³⁷ The new generation of young-adult patients with severe mental disorders (1) tended to be more aggressive, volatile, and noncompliant; (2) typically lacked functional and adaptive skills; and (3) generally had high rates of alcoholism and substance abuse which heightened the more negative aspects of their behavior and complicated their treatment.³³⁸

Homelessness and Incarceration

As noted by historian Gerald Grob, these younger and more aggressive mentally ill individuals often ended up on the streets or in the criminal justice system:

³²⁸ *Ibid.*

³²⁹ *Ibid.*

³³⁰ Mechanic and Rochefort, note 137 above, p. 314.

³³¹ *Ibid.*, p. 311.

³³² Grob, note 44.

³³³ *Ibid.*

³³⁴ *Ibid.*; see also Mechanic and Rochefort, note 137, pp. 315-16.

³³⁵ Grob, note 44 above.

³³⁶ *Ibid.*

³³⁷ *Ibid.*; see also Mechanic and Rochefort, note 137 above, p. 316.

³³⁸ Grob, note 44 above; see also Mechanic and Rochefort, note 137 above, p. 316.

Virtually every community experienced the presence of these young adult individuals on their streets, in emergency medical facilities, and in correctional institutions. Recent estimates have suggested that perhaps a quarter to a third of the single adult homeless population have a severe mental disorder. Many have a dual diagnosis of severe mental illness and substance abuse and were often caught up in the criminal justice system. . . . The mobility of such individuals, the absence of a family support system, and programmatic shortcomings complicated their access to such basic necessities as adequate housing and social support networks. The dearth of many basic necessities of life further exacerbated their severe mental disorders. Ironically, at the very time that unified, coordinated, and integrated medical and social services were needed to deal with a new patient population, the policy of decentralization had created a decentralized system that often lacked any clear focus and diffused responsibility and authority.³³⁹

The homeless mentally ill emerged as a particular concern in the 1980s and remains of concern to date. As described by one author in 1983: “The homeless have become a major urban crisis. The streets, the train and bus stations, and the shelters of the city have become the state hospital of yesterday.”³⁴⁰ Other articles from the 1990s portrayed situations in homeless shelters reminiscent of conditions in almshouses in the 1800s prior to the asylum movement and in some state hospitals during their worst period.³⁴¹ Studies during the late 1980s suggested that one-fourth to one-half of the homeless at that time had significant psychiatric symptoms.³⁴²

Although there is much debate about whether dehospitalization is the primary cause of homelessness, or simply one of many interacting causes, what is clear is that “homelessness and inappropriate housing options pose extraordinary problems for the effective administration of mental health services.”³⁴³ The lack of suitable housing, which many public health authorities view as the most serious programmatic shortcoming, impedes effective care, results in episodic hospitalizations, and remains a major impediment in the release from state hospitals of those patients who are legally and clinically ready for discharge.³⁴⁴

Another significant problem intertwined with dehospitalization is the “criminalization” of persons with mental illness. Although the extent of such criminalization is hard to determine because psychiatric categories have expanded to include deviant behavior, including substance abuse and antisocial behavior, there is little question that jail and prison populations have expanded and include numerous inmates with defined mental disorders.³⁴⁵ “The freedom of community life, the fragmentation of service systems, easy availability and use of substances, and the unavailability of hospital beds for other than short-term acute care makes it inevitable that many person with serious mental illness in the community will, at some time, face arrest.”³⁴⁶

The extent of the problem was revealed in a 1998 Justice Department study that estimated that more than 280,000 individuals with mental illness were in jails and prisons and more than 500,000 additional persons with mental illness were on probation.³⁴⁷ Although a number of individuals with mental illness require secure detention

³³⁹ Grob, note 44 above.

³⁴⁰ Geller, note 139 above, p. 49 (quoting F.R. Lipton *et al.*, “Down and Out in the City: The Homeless Mentally Ill,” *Hospital & Community Psychiatry*, Vol. 34, Sept. 1983, pp. 817-21).

³⁴¹ Geller, note 139 above, p. 50.

³⁴² Mechanic and Rochefort, note 137 above, p. 317.

³⁴³ *Ibid.*, p. 318.

³⁴⁴ *Ibid.*

³⁴⁵ Grob, note 44 above.

³⁴⁶ Mechanic, note 2 above, Chapter 7.

³⁴⁷ *Ibid.*

as a result of serious and violent criminal behavior, others are being “compassionately” arrested for nuisance offenses to get them temporarily off the streets when they have nowhere else to go.³⁴⁸ Such arrests often reinforce “stigmatization that is already a barrier to community support and care, and complicates relationships with family, caretakers, and the community.”³⁴⁹ In Raleigh, North Carolina, *The News & Observer* reported in 2002 that “the Wake County sheriff estimated that 80 percent of the inmates in his jail had mental health problems often in conjunction with addictions and substance abuse. That, in effect, made the Wake County jail the largest mental institution in the state.”³⁵⁰

³⁴⁸ *Ibid.*

³⁴⁹ *Ibid.*

³⁵⁰ William K. Atkinson, II, Ph.D., “North Carolina’s Community Hospitals and Mental Health Reform,” *NC Medical Journal*, Vol. 64, No. 5, Sept./Oct. 2003, p. 233.

THE 1990s: LEGISLATIVE AND JUDICIAL DECISIONS AND THE EMERGENCE OF INITIATIVES DESIGNED TO ADDRESS THE FRAGMENTATION OF RESPONSIBILITY AND FINANCING IN THE MENTAL HEALTH SYSTEM

“Since we can no longer assume any single historical event, no matter how recent, to be common knowledge, I must treat events dating back only a few years as if they were a thousand years old.”

—Milan Kundera, *The Book of Laughter and Forgetting*

The Americans with Disabilities Act of 1990 and the *Olmstead* Decision

Despite the problems described above, the community-based movement gained further strength in the 1990s due to significant legislation at the beginning of the decade and a decision by the U.S. Supreme Court at the end. In 1990, Congress enacted the Americans with Disabilities Act (ADA) to eliminate discrimination against those with disabilities. Title II of the ADA provides that “No qualified individual with a disability, shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.”³⁵¹ The ADA applies to all public entities and the use of public funds; therefore, it has implications for publicly-funded Medicaid services to people with mental and other disabilities.³⁵²

Nine years after the enactment of the ADA, the Supreme Court held in *Olmstead v. L.C.*, a case involving plaintiffs with both mental illness and mental retardation, that the ADA requires states to provide placement in communities for individuals with disabilities if the state’s treatment professionals have determined that such community-based placement is appropriate, if the individuals affected do not oppose such placement, and if such placement can reasonably be provided considering the state’s resources and the need of others with disabilities.³⁵³ The decision challenged all levels of government to create “additional opportunities for individuals with disabilities through more accessible systems of cost-effective community-based services.”³⁵⁴ States risked litigation if they failed to develop a comprehensive plan at a reasonable pace for transferring qualified individuals with mental disabilities from institutions to less restrictive settings.³⁵⁵ In short, the ADA and *Olmstead* provided another means

³⁵¹ Public Law 101-336, codified as 42 U.S.C. § 12132.

³⁵² Martin Kitchener *et al.*, “Home and Community-Based Services: Introduction to *Olmstead* Lawsuits and *Olmstead* Plans,” UCSF National Center for Personal Assistance Services, 4th Rev., Oct. 2006. On the Internet at <http://www.pascenter.org/olmstead/olmsteadcases.php?print=yes>.

³⁵³ *Olmstead v. L.C.*, 527 U.S. 581, 119 S. Ct. 2176, 144 L.Ed.2d 540 (1999).

³⁵⁴ Sue Estroff, “The Unhealthy State of Our Mental Health,” *The Journal of Common Sense*, Vol. 6, No. 3, Winter 2000/2001, on the Internet at <http://www.common-sense.org/journal/courage.html>.

³⁵⁵ Botts, note 259 above, p. 10.

through which the mentally ill and their advocates could challenge arrangements and treatments that limit opportunities for fuller community participation.³⁵⁶

Outpatient Commitment

Although the ADA and *Olmstead* decision focused on increasing the rights of the mentally ill and reducing coercive controls involved in institutionalization, a separate and contrasting legal trend, involuntary outpatient commitment (IOC) also gained some traction in the 1990s.³⁵⁷ The concept, which dates back to the mid-1960s, sought to support deinstitutionalization by *imposing* certain controls on living in the community.³⁵⁸ The concept uses the threat of hospitalization to induce community-based patients to maintain contact with treatment programs and to take their medications.³⁵⁹ Failure to do so can result in involuntary re-hospitalization.³⁶⁰ The legal basis for and efficacy of IOC is controversial.³⁶¹ And, a 1999 study in New York showed that reductions in subsequent hospital readmissions resulted less from the legal intervention itself and more from the fact that the use of IOC was linked to providing more and higher quality services to clients.³⁶² Similarly, a 2001 report on IOC in North Carolina found that IOC can improve treatment outcomes when the court order is sustained over time and combined with relatively intensive community treatment.³⁶³

Evolving Approaches to Financing and Organizational Issues in the Mental Health System

The last decade of the 20th century also was noteworthy for the emergence and/or strengthening of approaches that addressed many of the financing and organizational issues that were an outgrowth of the community-based movement. The three main initiatives were (1) case management; (2) financing based on capitation; and (3) the development of public mental health authorities.³⁶⁴

In brief, case management typically “refers to a process of integrating the elements of a client’s total care, filling in gaps by either providing services directly or arranging for necessary services, and insuring that the client receives essential entitlements.”³⁶⁵ Beyond that basic definition, however, there is little consistency in terms of conception or implementation, with case management roles varying from purely therapeutic care to more administrative functions focused on obtaining entitlements and coordination.³⁶⁶

Capitation, the second initiative, “is a predetermined payment for a specified set of services for individuals over a defined period of time.”³⁶⁷ In the United States, this system has been used extensively by health maintenance organizations (HMOs). In

³⁵⁶ Mechanic, note 2 above, Chapter 7.

³⁵⁷ *Ibid.*; see also Geller, note 139 above, p. 53.

³⁵⁸ Mechanic, note 2 above, Chapter 7; see also Geller, note 139 above, p. 53.

³⁵⁹ *Ibid.*

³⁶⁰ *Ibid.*

³⁶¹ See, e.g., Judge David L. Bazelon Center for Mental Health Law, “Studies of Outpatient Commitment Are Misused,” rev. July 3, 2001. On the Internet at <http://www.bazelon.org/issues/commitment/more-resources/studies.htm>.

³⁶² Mechanic, note 2 above, Chapter 7.

³⁶³ Marvin S. Swartz *et al.*, “Outpatient Commitment: A Randomized Controlled Trial of Outpatient Commitment in North Carolina,” *Psychiatric Services*, Vol. 52, No. 3, March 2001, pp. 325-29.

³⁶⁴ Mechanic and Rochefort, note 137 above, p. 318.

³⁶⁵ *Ibid.*, p. 319.

³⁶⁶ *Ibid.*

³⁶⁷ *Ibid.*, p. 320.

the mental health context, capitation has been applied both by mainstreaming the mentally ill into HMOs or by developing mental health HMOs.³⁶⁸

The third initiative, the mental health authority, also seeks “to focus authority, capacity, and responsibility in caring for the chronic mental patient in the community.”³⁶⁹ The idea behind this approach is that, in order to address the fragmentation between community mental health and welfare agencies, a new public or nonprofit entity would be created and given responsibility. It would have the “authority and resources to direct care for public patients by developing its own services or by contracting with other community entities. Authorities would receive federal, state, and local funds for mental health services and have more discretion in their use than is characteristic of many existing categorical programs.”³⁷⁰

³⁶⁸ *Ibid.*

³⁶⁹ Mechanic and Rochefort, note 137 above, p. 321.

³⁷⁰ *Ibid.*

“Great wits are sure to madness near allied,

And thin partitions do their bounds divide.”

—John Dryden

CONSEQUENCES OF THE COMMUNITY-BASED MOVEMENT ON NORTH CAROLINA'S MENTAL HEALTH SYSTEM DURING THE DECADES BRIDGING THE NEW Millennium

Overview of Flaws in North Carolina's Mental Health System Prior to Reform

Because the individual state mental health systems developed for the majority of their histories independently from the standardizing influence of national mental health policies and federal entitlement programs, wide variations existed in terms of how they responded to the community movement and dehospitalization.³⁷¹ Although North Carolina adopted core aspects of both the asylum and community-based movements, the state was not in the forefront of the major trends that transformed public mental health system beginning in the 1970s, such as dehospitalization, Medicaid expansion, and managed care.³⁷²

For example, with respect to dehospitalization, none of the four North Carolina psychiatric hospitals closed during the last half of the 20th century; and the rate of decline in state hospital inpatient figures was below the national numbers. According to a State Auditor's report released in April 2000, among a peer group of nine states, North Carolina's bed capacity (32.3 beds per 100,000 persons in the general population) was 23 percent higher than the average and the rate of adult admissions (243 per 100,000) was second highest among peer group states.³⁷³ This is not to say, however, that North Carolina by-passed the dehospitalization movement. To the contrary, a comparison of "beds per 100,000 population" between 1955 and 2004-2005 demonstrates that North Carolina's bed count fell from 232.4 in 1955 to 17.1 in 2004-2005—or 7.4 percent of the 1955 figures.³⁷⁴ However, the hospital closure rate and changes in beds per population in a number of other states were more pronounced.³⁷⁵

The absence of a rush to close or substantially empty state hospitals, or rely more heavily on Medicaid or managed care (efforts to deliver health care services in a way

³⁷¹ Mechanic and Rochefort, note 137 above, p. 310.

³⁷² Swartz and Morrissey, note 259 above, p. 206. North Carolina also lagged behind the national movement toward self determination for individuals with developmental disabilities. Services for this population centered around large intermediate care facilities and regional centers. See "Study of State Psychiatric Hospitals and Area Mental Health Programs," N.C. Office of the State Auditor, Raleigh, NC, Apr. 1, 2000, p. 1. On the Internet at <http://www.ncauditor.net/EPWeb/Reports/Performance/PER-0184.pdf>.

³⁷³ See April 2000 N.C. State Auditor's Report, note 372 above, § I, p. 9. The nine states in the peer group were Illinois, Kentucky, Massachusetts, Michigan, Missouri, Ohio, Pennsylvania, South Carolina, and Virginia.

³⁷⁴ E. Fuller Torrey, *et al.*, "The Shortage of Hospital Beds for Mentally Ill Persons," A Report by the Treatment Advocacy Center, Table 1: Degree of Deinstitutionalization: Public Psychiatric Beds Per Population, 1955 and 2004-2005. On the Internet at http://www.treatmentadvocacycenter.org/documents/Table1--PublicPsychBedsperpop1955and2004-2005_5_.pdf. These figures also show a fairly significant drop between 2000 and 2004—i.e., 32.3 beds in 2000 to 17.1 in 2004. *Ibid.* As a result of this post-reform decrease, North Carolina went from what the authors of the study term a "serious" bed shortage to a "severe" bed shortage, using the assumption that the minimum needed was 50 public psychiatric beds per 100,000 population for hospitalization for individuals with serious psychiatric disorders. *Ibid.* at "The Magnitude of Psychiatric Bed Shortage," on the Internet at <http://www.treatmentadvocacycenter.org/reportbedshortage.htm>.

³⁷⁵ Thirty-three states had more dramatic declines than North Carolina. *Ibid.* For example, South Carolina declined from 264.7 beds per 100,000 population in 1955 to 10.6 beds per population in 2004-2005—or 4.0 percent of the 1955 beds. *Ibid.*, Table 1.

that reduces costs and improves quality by having a manager for each patient who is responsible for providing personal attention and individualized care) meant that North Carolina avoided some of the negative consequences of the community-based movement suffered by other states in the late 1980s and 1990s who hurried to implement policies without adequate management and alternative community-based services infrastructure in place.³⁷⁶ However, North Carolina's three-tiered mental health system did not escape unscathed because existing organizational and financing problems "were allowed to intensify and reinforce each other until the system itself became dysfunctional," according to Marvin Swartz, a doctor at Duke University's School of Medicine, and Joseph Morrissey, a professor at the UNC School of Medicine.³⁷⁷

During the last decade of the 20th century, North Carolina's public mental health system consisted of: (1) state-operated services under the supervision of the N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services including the four psychiatric hospitals (built between the 1850s and the 1940s), developmental disability centers, and alcohol and drug rehabilitation centers; (2) 39 multiple or single-county semi-autonomous governmental area mental health programs created in the 1970s that provided direct services; and (3) private, nonprofit and for-profit providers who offered services through purchase-of-service contracts with area programs.³⁷⁸ This system's dysfunction became painfully evident in the 1990s.

First, Carolina Alternatives, which was the state's first endeavor at Medicaid-managed health care, was terminated in 1999 due to the failure to demonstrate the cost-neutrality of the program to Medicaid.³⁷⁹ This program, which the state implemented in 1994 as a coordinated care system for the delivery of child mental health and substance abuse services by area authorities to children from birth to age 18,³⁸⁰ was the only Medicaid waiver in the country ever to be revoked by the federal government.³⁸¹

In addition, audits of area programs demonstrated a lack of proper documentation. Area programs also showed signs of fiscal distress, in some cases quite severe, due to increased demands for services and continual reductions in state reimbursement rates. And, there were other problems with the area programs, including the cost of administrative overhead, their independence from the state, failure to provide evidence-based services because of outdated service definitions, and a reluctance to refer clients to the private sector. The state also faced a \$42 million payback to the federal government because the state failed to provide the required state matching dollars for Medicaid.³⁸²

Similar to the area programs, the state hospital system also faced substantial difficulties. For example, Dorothea Dix Hospital's certification and Medicaid reimbursement status were threatened in light of numerous staffing and record-keeping complaints.³⁸³ In addition, the physical condition of the state hospitals, all of which were more than 50 years old and in some cases more than a century old, had deteriorated and were deemed incompatible with modern life-safety standards and patient

³⁷⁶ Swartz and Morrissey, note 259 above, p. 206.

³⁷⁷ *Ibid.*

³⁷⁸ *Ibid.*; see also Mental Health Association—NC, "Mental Health, Developmental Disabilities, and Substance Abuse Services System Reform in North Carolina," May 2006. On the Internet at www.mha-nc.org/reform.pdf.

³⁷⁹ Swartz and Morrissey, note 259 above, p. 206; see also History, note 266 above, p. 20.

³⁸⁰ History, note 266 above, p. 17.

³⁸¹ Verla C. Insko, N.C. Representative, "Achieving Mental Health Reform: A Legislator's Perspective," *N.C. Medical Journal*, Vol. 64, No. 5, Sept./Oct. 2003, p. 214. "The Social Security Act authorizes multiple waiver and demonstration authorities to allow states flexibility in operating Medicaid programs." On the Internet at <http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGL/>.

³⁸² Swartz and Morrissey, note 257 above, p. 206; see also April 2000 N.C. State Auditor's Report, note 372 above, § I, p. 1.

³⁸³ Swartz and Morrissey, note 259 above, p. 206; see also April 2000 N.C. State Auditor's Report, note 372 above, § I, p. 1.

care requirements.³⁸⁴ Replacement of the facilities would require several hundred million dollars.³⁸⁵ That reality also ran up against the *Olmstead* decision’s mandate for community care for many of the disabled patients served by the state hospitals, “raising the prospects of additional dollars for community care and sizeable financial penalties to the state for noncompliance.”³⁸⁶ Thus, the state was placed between the proverbial rock and a hard place in terms of where to focus its efforts and money since both the state hospitals and community alternatives served important purposes in the state’s overall mental health system.

The state’s troubles continued into the new millennium with an investigation in 2001 by the U.S. Department of Justice concerning allegations of violations of patients’ civil rights at all four state hospitals.³⁸⁷ In a throwback to the exposes from the 1940s, *The News & Observer* in Raleigh and *The Charlotte Observer* ran stories depicting “a system badly out of control and in need of major reform.”³⁸⁸ This would not be the last time that the system came under such searing newspaper scrutiny.

Steps Toward Reform

In an attempt to address the allegations of fraud, mismanagement, and other system shortcomings, the North Carolina General Assembly instructed “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.”³⁸⁹ In a final report issued in April 2000, the State Auditor—in conjunction with health care experts from Public Consulting Group—highlighted two major overriding issues: (1) the over-reliance on state institutions; and (2) the lack of accountability among the local area programs.³⁹⁰

With respect to the first issue, the State Auditor recommended: (1) closing one of the four state psychiatric hospitals, (2) downsizing and replacing with new facilities the remaining three outdated hospitals at a construction cost of \$580 million; and (3) transferring at least \$38 million to local entities to pay for new community-based services.³⁹¹ Dorothea Dix Hospital, the oldest North Carolina state hospital, was targeted as the facility to be closed and its functions transferred to John Umstead Hospital, the newest of the state hospitals, until the three new facilities could be constructed.³⁹² A prior study of the State’s psychiatric hospitals by MGT of America in April 1998 had also recommended dramatic reductions in the number of beds by moving some hospital services to the community programs and an extensive renovation or complete rebuilding of the hospitals.³⁹³ Although the Auditor’s Report envisioned that “most of the resources necessary for the system’s transformation should be achieved through

³⁸⁴ Swartz and Morrissey, note 259 above, p. 206.

³⁸⁵ *Ibid.*

³⁸⁶ *Ibid.*

³⁸⁷ *Ibid.*

³⁸⁸ *Ibid.*

³⁸⁹ *Ibid.* The Secretary of the N.C. Department of Health and Human Services subsequently asked the State Auditor to include an analysis of the related issue of whether developmental disabilities services should be a separate division, or reorganized within the existing Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. See March 31, 2000 Letter of Transmittal from State Auditor to The Honorable James B. Hunt, Jr., Governor (transmitting the April 1, 2000 State Auditor’s Report). The State Auditor recommended the establishment of a separate developmental disabilities (DD) division but noted that prior and during implementation, the state would have to assess how DD services would be managed in the newly proposed county program structure and the final design and implementation of a new DD structure.

³⁹⁰ Insko, note 381 above, p. 214.

³⁹¹ *Ibid.*, p. 215; see also Swartz and Morrissey, note 259 above, p. 206; April 2000 N.C. State Auditor’s Report, note 372 above, p. 7.

³⁹² Swartz and Morrissey, note 259 above, p. 206.

³⁹³ April 2000 N.C. State Auditor’s Report, note 372 above, p. iii (“Events Leading Up to This Study”).

State hospital savings and through the reconfiguration of current services, financial operations and administrations costs” of a new governing system,³⁹⁴ it recognized that a “mental health transfer account” would be needed to provide “bridge funding and handle cash flow as community services were established and beds were closed at the state level.”³⁹⁵

With respect to the second issue, the report recommended a radical reorganization of the entire system including “the 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.”³⁹⁶ Specifically, the State Auditor recommended that the area programs should be replaced by a new *county-operated* system consisting of county mental health, developmental disabilities, and substance abuse services programs (county programs) which, acting under long-term contracts with the state to manage services, would “coordinate all mental health, developmental disabilities and substance abuse services in community networks.”³⁹⁷ Unlike the existing area programs, which provided services directly to individuals and also billed the State, Medicaid, and insurance companies for such services, the county programs would not provide any direct treatment or rehabilitative services as long as qualified private services were available to provide such services.³⁹⁸ Limiting the service aspect of the county programs, which would be patterned after similar systems that had been adopted in the 1970s and 1980s by a handful of states—including California, Ohio, Michigan, and Pennsylvania—was advocated as a means of avoiding what some saw as a conflict of interest when area programs both funded and provided services.³⁹⁹ The report also noted that, if certain counties declined this new role, the state would manage local services directly but charge counties a fee for such management services.⁴⁰⁰

Just as the asylum and community-based movements had struggled with finding the right governing structure, be it federal, state, or local entities, or some combination thereof, the State Auditor’s Report, at its core, also concerned proper governance and accountability. North Carolina’s existing 1970s-era area program model placed accountability with local citizen boards in conformance with the Community Mental Health Act legislation signed by President John F. Kennedy and further strengthened by President Lyndon Johnson in the 1960s.⁴⁰¹ As previously noted, this system was designed to by-pass the states and made no effort to integrate the state hospitals under a single system of care since the belief was that state hospitals would become obsolete and those funds would be diverted to the community programs. However, state hospitals did not become obsolete and federal funds were decreased and rerouted through the states during President Reagan’s administration.

Even though in North Carolina, the area programs, like counties, were subdivisions of the state, they operated independently of counties and of the North Carolina Department of Health and Human Services.⁴⁰² The state, however, provided the funding. The absence of formal connecting mechanisms resulted in the various components

³⁹⁴ *Ibid.*, § I, p. 2. But see Christina Thompson, Ph.D., “Long-Range Plan for Meeting Mental Health, Developmental Disabilities & Substance Abuse Service Needs for the State of North Carolina,” Dec. 12, 2006, on the Internet at <http://www.ncdhhs.gov/mhdsas/statpublications/reports/long-range-plan-12-20-06.pdf>, for later estimates of total funding needed.

³⁹⁵ Insko, note 381 above, p. 215; see also N.C. State Auditor’s Report, note 372 above, § I, p. 2.

³⁹⁶ Swartz and Morrissey, note 259 above, p. 206.

³⁹⁷ April 2000 N.C. State Auditor’s Report, note 372 above, § I, pp. 2 and 6.

³⁹⁸ Swartz and Morrissey, note 259 above, p. 206; see also Mental Health Association—NC, note 378 above.

³⁹⁹ Swartz and Morrissey, note 259 above, p. 206.

⁴⁰⁰ April 2000 N.C. State Auditor’s Report, note 372 above, § II, p. 20.

⁴⁰¹ Swartz and Morrissey, note 259 above, p. 207.

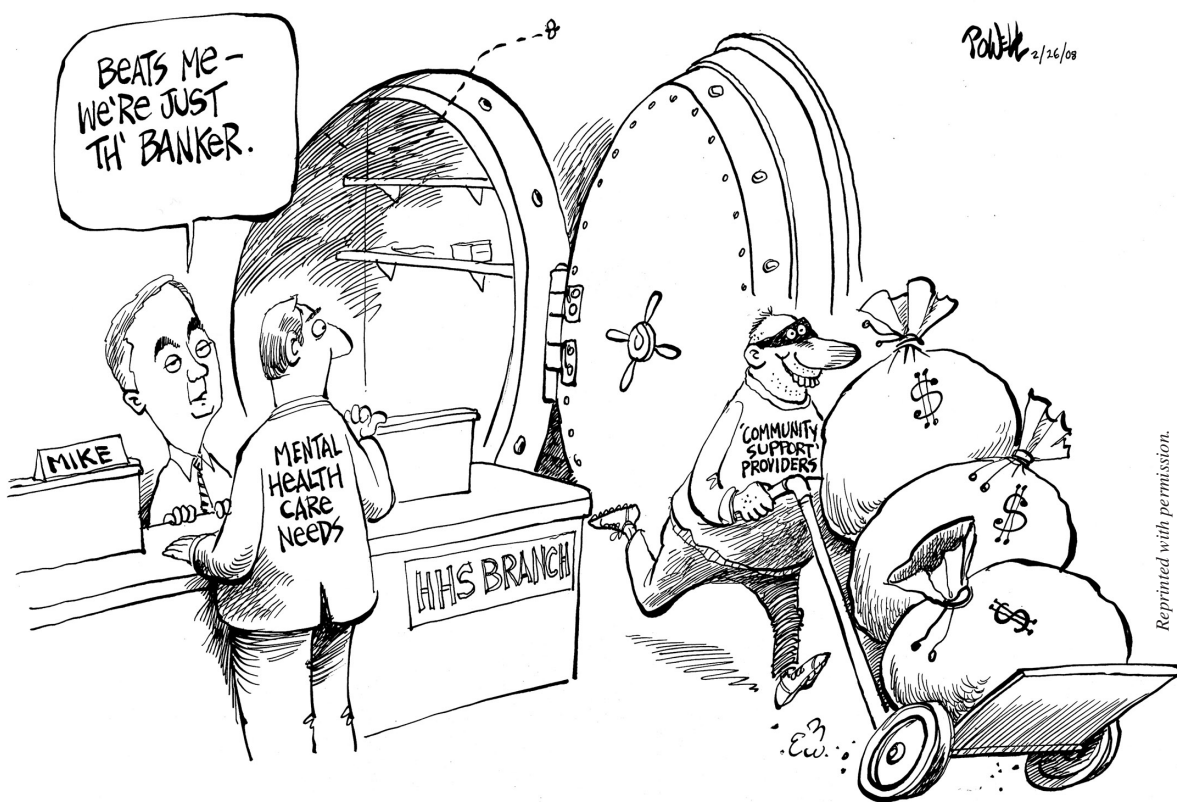
⁴⁰² Insko, note 381 above, p. 214.

of the system acting independently and increasingly in opposition to each other.⁴⁰³ As noted by Drs. Marvin Swartz and Joseph Morrissey in an article on North Carolina's recent reform history in the *North Carolina Medical Journal*,

Tellingly, although the federal-local partnership had changed [during the Reagan era], the [community] 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. . . . When the complexities associated with managing and financing an ever-growing caseload intensified with Medicaid expansion⁴⁰⁴ 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. . . . The fear in many quarters was that Area programs had used the hospitals as safety valves, transferring

⁴⁰³ *Ibid.*

⁴⁰⁴ For example, in 1992 and 1993, Medicaid coverage was expanded to include case management services for seriously emotionally disturbed children and psychological services provided by local education agencies. History, note 266 above, p. 16.



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difficult to manage patients to the hospitals in times of fiscal shortfalls in their outpatient and case management rolls.⁴⁰⁵

The Auditor's Report attempted to address the issues of governance and accountability at the local level by calling for a unified state-local service system where the new county programs would have budgetary control over the proposed three new and downsized hospitals.⁴⁰⁶ This system would allow the county programs to determine how the new state institutions would fit within the local continuum of care with options including continued use of the proposed new hospitals or diversion of local funds to general hospital inpatient care.⁴⁰⁷ As previously noted, the use of general hospitals for psychiatric care reflected a national trend that had gained increasing acceptance yet posed its own set of problems in the last half of the 20th century.

Although most of the State Auditor's findings and recommendations concerned the over-reliance on state hospitals and the problems in governance and accountability under the area program system, a third area of concern involved federal entitlements, which, as previously discussed, were a major factor in the evolution of mental health policy nationwide and in North Carolina. The State Auditor recommended that the Department of Health and Human Services, which had legal responsibility for managing the state's Medicaid program, "restructure and unify Medicaid policy and operations across the three agencies responsible for services to persons affected by this report" including (1) the Division of Medical Assistance (DMA), and (2) the proposed new separate Division of Developmental Disabilities (DDD), and the newly-circumscribed Division of Mental Health and Substance Abuse Services.⁴⁰⁸ As the State Auditor noted,

The split in service provision, rate setting and policy making and the lack of clear roles and coordination at the State level have contributed to organization instability and financial and service crises in the local and State systems. Resolving structural issues in Area Programs without improving State-level policy coordination and management would not resolve the system's current crisis of confidence and performance.⁴⁰⁹

At the time of the report, DMA managed all Medicaid funding, which was approximately 25 percent, and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services managed the remaining state funding, which was approximately 52 percent.⁴¹⁰ The remaining 33 percent derived from paying patients, third party insurance, and county contributions.⁴¹¹

⁴⁰⁵ Swartz and Morrissey, note 259 above, p. 207.

⁴⁰⁶ *Ibid.*

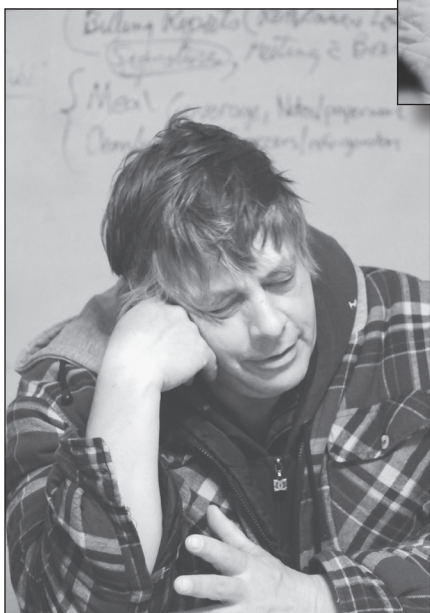
⁴⁰⁷ *Ibid.*

⁴⁰⁸ April 2000 N.C. State Auditor's Report, note 372 above, § I, p. 2. The recommendation to integrate DMA and DMH/DD/SAS was echoed in Governor Beverly Perdue's transition report on mental health. See Governor-Elect Perdue Transition Advisory Group Sessions, Session Summary 11 on Mental Health, Developmental Disabilities, and Abuse Services, p. 13.

⁴⁰⁹ *Ibid.*, § I, p. 5.

⁴¹⁰ *Ibid.*, § III, p. 14.

⁴¹¹ *Ibid.*



Members of Club Nova
 Founded in 1987 to address the needs of Orange County citizens living with mental illness, Club Nova provides a holistic, caring environment designed to promote rehabilitation and reintegration into the community.



MENTAL HEALTH POLICY IN THE NEW MILLENNIUM

“One of the reasons why history repeats itself is because every generation refuses to read the minutes of the last meeting.”

—Anonymous

“All too often, psychiatric services continue to be built on wishes for outcomes rather than data. And we remain trapped between the dialectic of the legalistic goal of minimizing restrictions on liberty and the clinical goal of maximizing clinical outcomes through optimal treatment interventions.”

“In every decade of the last five, questions about who would pay for care and treatment were raised. In no decade did there appear to be any widespread endorsement of a major intervention that will cost more and be the right thing to do.”

—Jeffrey L. Geller, M.D., M.P.H.

North Carolina’s Reform Legislation: Key Provisions

In July 2000, the North Carolina General Assembly enacted legislation establishing the Legislative Oversight Committee for Mental Health, Developmental Disabilities, and Substance Abuse Services to develop a plan implementing the State Auditor’s recommendations.⁴¹² The legislative committee drafted enabling legislation and guidelines for the new mental health care system for a five-year period from 2001 to 2006, and in 2001, the General Assembly enacted the reform legislation, “An Act to Phase in Implementation of Mental Health System Reform at the State and Local Level.”⁴¹³

The draft bill incorporated the State Auditor’s recommendation that governance should be transferred from area programs to the counties.⁴¹⁴ However, after the bill was introduced, several area programs and their board members objected to counties subsuming the area program. County commissioners also opposed this feature, concerned that they would be saddled with funding responsibility.⁴¹⁵ The bill ultimately adopted by the General Assembly opted for a compromise position.

Under the new legislation, the Secretary of Health and Human Services was required to “develop and implement a State Plan for MH/DD/SAS by December 1, 2001, that among other things, redesigned the service system to target resources to the most needy in the most integrated community settings possible and moved area programs away from the role of direct service providers toward the role of ‘local management enti[ties]’ (LMEs) responsible for developing, managing, and monitoring networks of service providers.”⁴¹⁶ The new LMEs could take one of four forms: (1) single county area authority; (2) multi-county area authority; (3) county program; or

⁴¹² N.C. Session Law 2000-83 (H.B. 1519); see also Swartz and Morrissey, note 259 above, p. 207.

⁴¹³ N.C. Session Law 2001-437 (H.B. 381); see also Swartz and Morrissey, note 259 above, p. 207, and Insko, note 381 above, p. 215.

⁴¹⁴ Insko, note 381 above, p. 215.

⁴¹⁵ *Ibid.*

⁴¹⁶ Botts, note 259 above, p. 2; see also Insko, note 381 above, p. 215. The term “LME” was not part of the 2001 reform legislation. First codified in 2006, LME is defined as “an area authority, county program, or consolidated human services agency. It is a collective term that refers to functional responsibilities rather than governance structure.” N.C. Session Law 2006-143 § 4(a) (H.B. 2077); see also N.C. Gen. Stat. § 122C-3 (20b).

(4) multi-county program.⁴¹⁷ The first two options retained the former structure but with changes designed to give counties greater government involvement over personnel and finance decisions.⁴¹⁸ The last two options were new structures for governing and administering local MH/DD/SAS.⁴¹⁹ The single county program would be considered a department of the county for all purposes and would be governed by the board of county commissioners.⁴²⁰ The multi-county programs would operate under inter-local agreements between the counties involved in the respective catchment areas⁴²¹—a term used to describe the area and population for which a government needs to provide a service. A single LME was required to have a minimum population of 250,000, or be at a minimum a five-county region in order to address economies of scale.⁴²²

The legislation required the counties to (1) submit a “letter of intent” to the Department of Health and Human Services by October 1, 2002, designating their LME choice; and (2) through the chosen LME, develop, review, and approve a “business plan” for the management and delivery of services which demonstrates to the Secretary’s satisfaction, the chosen area authority’s or county program’s ability to operate as an LME “capable of providing quality services in an efficient manner, in its respective geographic service area.”⁴²³ The act required the plans to be submitted to the Secretary by January 1, 2003. The new legislation also required the Secretary of DHHS “to develop a ‘catchment area consolidation plan’ that would reduce the total number of local mental health programs from the existing 39 area programs to twenty programs by January 1, 2007.”⁴²⁴

In sum, a central outcome of North Carolina’s reform legislation was (1) the transfer, over a multi-year period, of management and oversight functions of mental health, developmental disability, and substance abuse programs from the existing quasi-independent local area authorities to fully governmentally accountable LMEs; and (2) privatization of mental health services by transferring clinical services from public area authorities to private nonprofit and for-profit provider groups.⁴²⁵ LMEs would purchase, fund, and oversee the provision of services from private providers and vendors which, in theory, would increase administrative efficiency, allow decentralization of administrative functions through regional contracting, and “buffer clinical services from the constraints of governmental personnel policies.”⁴²⁶

⁴¹⁷ Botts, note 259 above, p. 2. Marks Botts at the UNC School of Government says, “Interestingly, though the county program governance structure was placed in the act as an option for counties, only one county, Pitt County, opted for that model, which it has since abandoned. The Orange-Person-Chatham area authority considered and planned to implement that model, but abandoned it” for budgetary and other reasons.

⁴¹⁸ *Ibid.*, p. 5. Specifically, if the county elected to retain the area authority system, the appointment of the area director would be subject to the approval of the board of county commissioners of each participating county and a county commissioner and county manager would have to sit on the area director search committee. *Ibid.* In addition, the area authority would be required to submit to the participating board or boards of county commissioners (1) quarterly financial reports; (2) quarterly service delivery reports assessing the quality and availability of services within the relevant catchment area; (3) an annual progress report; and (4) any other reports requested by the participating boards of commissioners. *Ibid.*

⁴¹⁹ *Ibid.*, p. 4. If the county elected to adopt the new single county and multi-county programs, such programs would be required to submit the same quarterly and annual reports as the area authorities. *Ibid.*, p. 7.

⁴²⁰ *Ibid.*, p. 4. Even prior to the reform legislation, Mecklenburg County adopted a resolution whereby the powers and duties of the area board became the responsibility of the board of county commissioners, and Wake County adopted a system whereby the administration and delivery of health services, social services and area authority services were placed under the control of the county manager and a consolidated human services board. *Ibid.*, p. 4 at n. 3.

⁴²¹ *Ibid.*, p. 7

⁴²² Mental Health Association—NC, note 378 above.

⁴²³ *Ibid.*, p. 2.

⁴²⁴ *Ibid.*, p. 2.

⁴²⁵ Swartz and Morrissey, note 259 above, pp. 207-08.

⁴²⁶ Swartz and Morrissey, note 259 above, p. 208.

In terms of services to be provided, the reform legislation required state and local government, within available resources,⁴²⁷ to (1) ensure the availability of “core services” (screening, assessment, and referral services; emergency services; service coordination; and community-level indirect services such as consultation, prevention, and education) to anyone who needed them; and (2) provide funding for services beyond core services to “targeted populations” which had been interpreted to mean individuals with the most severe disabilities.⁴²⁸

The reform legislation also established the “Mental Health, Developmental Disabilities, and Substance Abuse Consumer Advocacy Program to provide consumers, their families, and providers with the information and advocacy needed to locate services, resolve complaints, address common concerns, and promote community involvement.”⁴²⁹ This provision was contingent on the General Assembly appropriating funds for that purpose.⁴³⁰

Finally, the legislation established the Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services and Bridge Funding Needs and the General Assembly appropriated \$47,525,675 in 2001 for this purpose.⁴³¹ The use of the fund was limited to (1) providing start-up funds and operating support for community-based alternatives for individuals currently residing in state institutions; (2) facilitating compliance with the *Olmstead* decision; (3) expanding and enhancing treatment and prevention programs in order to eliminate waiting lists; (4) providing bridge funding during transitional periods resulting from the closure of state institutions and departmental restructuring; and (5) constructing, repairing, and renovating state MH/DD/SAS facilities.⁴³²

⁴²⁷ The act defines such resources as “State funds appropriated and non-State funds and other resources appropriated, allocated, or otherwise made available for mental health, developmental disabilities, and substance abuse services.” Botts, note 259 above, p. 2 at n.1.

⁴²⁸ Botts, note 259 above, pp. 2-3.

⁴²⁹ *Ibid.*, p. 8.

⁴³⁰ *Ibid.*

⁴³¹ *Ibid.*, p. 10.

⁴³² *Ibid.*

AN OVERVIEW OF THE CURRENT STATE OF NORTH CAROLINA'S REFORM EFFORTS

“Past roles and functions, as well as the culture of practices, cast a long shadow on the public system; some old habits do not disappear. A large scale system change needs to be accompanied by necessary cultural change.”

—Alice P. Lin, Ph.D.

Like the asylum movement and federal community-based initiative, North Carolina's 2001 mental health reform has resulted in both successes and failures and continues to be a work in progress with the threads of both prior movements still playing significant roles. As a general matter, it was clear that system transformation would not be an overnight process and community capacity to provide services would require “adequate funding, time and support for development and a qualified workforce.”⁴³³ Three years after issuance of the State Auditor's Report, Ralph Campbell, Jr., the State Auditor at the time, noted that “We had no illusions when the report was released that its recommendations would, or could be quickly implemented or that the mental health system would be reformed overnight. We anticipated it would take years to create the system the report envisioned.”⁴³⁴

The legislation's vision is to provide: (1) community-based rather than institutional services and support; (2) a system that is participant-driven, prevention-focused, outcome-oriented, reflective of best practices, cost-effective, community-integrated, with resource equity and fairness throughout the state; (3) screening, triage, and referral to everyone in need; and (4) other services and support to those most in need, including the most seriously mentally ill or disabled, racial/ethnic minorities, and individuals with more than one disorder.⁴³⁵ However, from the beginning, individuals involved in the reform effort have expressed *concerns about how the vision would be implemented*. As stated by Drs. Marvin Swartz and Joseph Morrissey, “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.”⁴³⁶

The Impact of Reform on Consumers

Prior to reform, there was no consensus on how public resources should be used. Area programs thus became all things to all people, resulting in the severely mentally ill being underserved and a lack of sufficient services for substance abusers.⁴³⁷ The reform legislation set forth “how public resources should be prioritized by defining targeted populations and identifying core services to be provided to all

⁴³³ Mental Health Association—NC, note 378 above.

⁴³⁴ Ralph Campbell, Jr., “Mental Health Reform: Where Are We Three Years Later?,” *NC Medical Journal*, Vol. 64, No. 5, Sept./Oct. 2003, p. 217. Campbell was the N.C. State Auditor from 1993 to 2005.

⁴³⁵ Mental Health Association—NC, note 378 above.

⁴³⁶ Swartz and Morrissey, note 259 above, p. 209.

⁴³⁷ Alice P. Lin, *The Implementation of Local Management Entities in North Carolina*, Aug. 2007, final draft, p. 12. On the Internet at [http://www.naminc.org/dihoff_documents/Alice%20Lin_LMERreview\(Final\).report.doc](http://www.naminc.org/dihoff_documents/Alice%20Lin_LMERreview(Final).report.doc). In reviewing the rationale for reform, Lin writes:

“In 2000, problems cited as symptoms of system failure were numerous:

consumers with state and local resources.”⁴³⁸ Dr. Drew Bridges, who began work in the area program of Vance, Granville, Warren and Franklin counties in 1978, says that although questions remain regarding “who deserves to be included and what are the appropriate mechanisms of denying care to others, . . . it is intelligent and appropriate for the public dollar to be spent within a framework of conscious choice about who will benefit. Rationing by design rather than default is overdue.”⁴³⁹

Despite such intentions and mandates, however, “the most serious shortcoming of the implementation is that in the rush to complete structural changes, the public partners have jointly lost sight of the most important beneficiary of the reform: the consumers.”⁴⁴⁰ Adult consumers with severe and persistent mental illness in particular continue to have significant problems in obtaining services.⁴⁴¹ Although the system is serving many new consumers, it appears that many of these individuals are not the state’s priority populations and, while these consumers seem satisfied with the services, the system is likely denying services to those with more complex needs.⁴⁴² In addition, a 2008 study of consumers “identified service gaps in supported housing, supported employment, psychiatric services, and crisis interventions that can help to avoid out-of-home placement for children and hospitalization for adults, including such services as in-home crisis stabilization, emergency respite, mobile crisis teams, and 24/7 availability of crisis response.”⁴⁴³

There also is concern that “many providers have chosen not to serve IPRS [Integrated Payment and Reporting System]-funded consumers, or only a small portion of them, in order to have Medicaid business.”⁴⁴⁴ The likely rationale is that Medicaid benefits are more lucrative than IPRS benefits and the authorization process is less arduous. This phenomenon also can affect access to services by those who may need them the most. Alice Lin, a long-time consultant to the Division of Mental Health,

*Loss of public credibility with the system, evidenced by the removal of the State’s Medicaid waiver program North Carolina Alternatives, issues with consumers falling into cracks, especially the indigent consumers and those with substance abuse problems

*Fragmentation and disconnection between hospital/institution-based and community-based services; area programs had no incentive to divert hospital admissions when there was no local financial penalty for using state hospitals or institutions, nor incentive for managing the utilization well

*Lack of articulation of a rational use of public resources; area programs were asked to be everything to everyone, resulting in underserving those with serious mental illnesses and lack of services for individuals with substance abuse problems

*Weak linkage between area programs and counties and state, lack of accountability and consumer involvement at the local and State levels

*With the area programs functioning as providers, monitoring and oversight over the delivery system is weak

*Relationships were contentious and adversarial; lack of trust permeated stakeholders, including consumers, providers, area program, counties, and the state government”

Ibid., pp. 11-12.

⁴³⁸ *Ibid.*, pp. 13-14.

⁴³⁹ Drew Bridges, M.D., “Living the Reform for Twenty-Five Years,” *NC Medical Journal*, Vol. 64, No. 5, Sept./Oct. 2003, p. 224.

⁴⁴⁰ Lin, note 437 above, p. 77.

⁴⁴¹ Alice P. Lin, “Consumer and Provider Feedback at the Local Level,” Feb. 2008, draft, p. 2. On the Internet at <http://www.dhhs.state.nc.us/MHDDSA/statspublications/reports/consumerproviderfeedback-02-08-report.pdf>

⁴⁴² *Ibid.*, p. 63. Lin writes, “It is now commonly understood that the reform has created a large provider network and attendant service capacity. The number of consumers served in the network has increased exponentially. Many new consumers have entered the system, and some new services, such as crisis services and ACT [assertive community treatment], have benefited consumers in need.... This is a necessary phase of correction. In one respect, what this series of on-site reviews showed is unsettling: many new consumers entering the public system could not be considered the state’s priority populations, and that while the services seemed to be well received by the users, it is also possible that other consumers with more complex needs may have been denied services.”

⁴⁴³ *Ibid.*, p. 2.

⁴⁴⁴ *Ibid.*, p. 64. In 2002, North Carolina began implementing the Integrated Payment and Reporting System (IPRS) to replace three existing non-integrated claims systems that had been used for claims processing. On the Internet at <http://www.ncdhhs.gov/mhddsas/iprsmenu/index.htm>.

Developmental Disabilities, and Substance Abuse Services and the Joint Legislative Oversight Committee, writes, “[T]he public system needs to question both the trend and the practice”⁴⁴⁵

In addition, there remain concerns about how to address the needs of those individuals who do not fall within the reform legislation’s definition of a target or priority population and who would no longer be eligible for state funding and services.⁴⁴⁶ As Dr. William Atkinson noted,

It is unrealistic to expect that charitable organizations or private clinicians will be able to serve all of those who do not qualify for state funding. This will have major effects on emergency services, inpatient hospital care, jails and law enforcement agencies and, most importantly, human beings in North Carolina.⁴⁴⁷

Such concerns were legitimately raised in light of the many unintended consequences of the federal community-based initiative previously outlined.

As summarized by Alice Lin:

It is commonly known that since 2001 there has been a dramatic growth in the provider network and an increased number of consumers served,⁴⁴⁸ but the jury is still out on whether such growth has advanced the objectives of the reform. It also seems that the state’s targeted populations are competing with other consumers with Medicaid eligibility for access to enhanced services, and there are barriers to obtaining Medicaid eligibility for the state’s targeted populations, especially consumers with severe and persistent mental illnesses.⁴⁴⁹

The Impact of Reform on the Availability of a Qualified Work Force

*One theme evident in the biennial reports published prior to WWII was the shortage of trained workers. This same concern is present more than 60 years later in the context of the 2001 reforms. A 2007 joint initiative by the North Carolina Commission on MH/DD/SAS and Division of MH/DD/SAS regarding work force development noted that such concerns have increased due to the ongoing transformations created by the 2001 reform legislation and the *Olmstead* decision—both of which called for an increase in community-based services and*

*changes to state-operated facilities.*⁴⁵⁰ Several prior national and North Carolina studies also documented significant shortages of mental health professionals with particularly acute shortages in North Carolina for child and geriatric psychiatrists.⁴⁵¹

⁴⁴⁵ Lin, note 441 above, p. 64.

⁴⁴⁶ William K. Atkinson, Ph.D., *NC Medical Journal*, Vol. 64, No. 5, Sept./Oct. 2003, p. 233.

⁴⁴⁷ *Ibid.*

⁴⁴⁸ In state fiscal year 2006, the NC MH/DD/SAS system “served 17,298 more consumers than were served in state fiscal year 2001. In FY 2006, services reached 326,671 people.” NCDHHS, “Milestones and Accomplishments: Mental Health, Developmental Disabilities, and Substance Abuse Services in North Carolina,” March 2007, p. 3. On the Internet at <http://www.ncdhhs.gov/mhddsas/statpublications/reports/milestones3-07final.pdf>.

⁴⁴⁹ Lin, note 441 above, p. 3.

⁴⁵⁰ NC Commission for MH/DD/SAS and the NC Division of MH/DD/SAS, “The Workforce Development Initiative,” April 15, 2008, pp. 8 and 10. On the Internet at <http://www.ncleg.net/documents/sites/committees/ILOCMH-DD-SAS/LOC%20Minutes%20and%20Handouts/Minutes%20for%202008/April%2017,%202008/Workforce%20Development%20Plan-%20-S.%20Hairston%20-%20Attach.%20No.%204d.pdf>.

⁴⁵¹ Thomas J. Bacon, Dr.P.H., and Karen D. Stallings, R.N., M.Ed., “Workforce Demands of Mental Health Reform,” *NC Medical Journal*, Vol. 64, No. 5, Sept./Oct. 2003, p. 231.

***The News and Observer* Sheds Light on North Carolina's Mental Health System**

In a series of five investigative articles published by *The News & Observer* of Raleigh in February and March 2008, the newspaper concluded:

- Funding for mental health services has more than doubled since 2001 to more than \$1.5 billion, but 90 percent of the new community spending was spent on community support, and only 4.9 percent was spent on the seven services more likely to reduce the need for hospitalization.
- The number of private for-profit companies providing community support totals 784, but 98 percent of the work force used by these private companies are high school graduates who were paid \$61/hour to take patients to such activities as swimming, to the mall, to a movie, or to eat—activities with little therapeutic value.
- The state has wasted \$400 million in this privatization effort. As a result, the N.C. Department of Health and Human Services demanded that providers repay \$59 million for medically unnecessary treatments.
- Of North Carolina's 100 counties, 25 counties have no practicing psychologist, and 15 counties have only one.
- Since December 2000, 537 patients have died in 14 state mental facilities—82 under suspicious circumstances, and 5 while in restraints.
- 192 state employees have been sanctioned for abuse, neglect, or stealing from patients.
- All four of North Carolina's state mental hospitals have been threatened with a cut-off of federal funds due to mistreatment of patients, and two, Broughton Hospital and Cherry Hospital, lost their federal funding.

After *The News & Observer* series, Mike Moseley, the Director of the State Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, retired on February 22, 2008.

THE NEWS & OBSERVER
newsobserver.com

Part 1:

Reform wastes millions, fails mentally ill

Mental-health changes aimed to improve community treatment, but providers took clients shopping, swimming and to movies for \$61 an hour

By Pat Stith and David Raynor, Staff Writers

[Comment on this story](#)

North Carolina's mental-health reform was supposed to improve treatment for the mentally ill and provide good value for taxpayers. It has done neither.

The work force initiative noted that the state's work force challenges arose in the context of a "national crisis in the training of the behavioral health workforce."⁴⁵² According to a study commissioned by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), the work force crisis has resulted because (1) education and training programs have not kept pace with changes in mental health care resulting from managed care and mental health reform efforts; (2) direct care staff with the most one-on-one contact with consumers often receive the least amount of education and training; and (3) consumers and families who continue to perform significant care-giving roles typically receive "no educational support, nor is their unique knowledge and experience used in the training of other members of the workforce."⁴⁵³

The initiative also found that, at the state level, a number of other factors affected the establishment of new community providers and the overall public mental health work force in North Carolina.⁴⁵⁴ For example, the delay in obtaining approval by the state from the federal Centers for Medicare and Medicaid Services of new services that would be reimbursed through Medicaid resulted in many pre-existing provider organizations adopting a "wait and see" approach before entering into contracts with LMEs.⁴⁵⁵ In addition, plans to downsize or replace the four existing state hospitals also had an impact.⁴⁵⁶ Although a number of LMEs successfully divested their in-house services and established successful private provider agencies between 2001 and 2007, some local management entities have either not fully divested or been less successful in such efforts.⁴⁵⁷

In the years immediately following the 2001 legislation, the shortage of qualified professionals raised related concerns as to (1) whether former area program providers would continue to provide services as new nonprofit provider groups; (2) whether private providers would link up with these previously public-sector employees to fill gaps in services; and (3) whether new provider groups if they materialized would extend their services to non-target indigent patients and complex patients for whom the existing system was the last resort.⁴⁵⁸ There also were concerns that former public sector psychiatrists might be much less willing to accept public patients since there will be more than enough work in private practice.⁴⁵⁹ In 2003, a number of North Carolina communities were already "seeing increasing numbers of psychiatrists refusing to see Medicaid patients due to low reimbursement levels."⁴⁶⁰

In addition, the overall shortage of trained professionals has been exacerbated by the reality that many area programs during the transition period lost staff necessary to make the transition period successful.⁴⁶¹ These clinical positions are very difficult to refill because they ultimately will be eliminated under the reform plans.⁴⁶² Thus, the staff flight has created "gaps in a public system that already experiences an extreme workforce shortage amplifying at an alarming rate, causing increased consumer and

⁴⁵² Workforce Initiative, note 450 above, p. 10.

⁴⁵³ *Ibid.* (citing The Annapolis Coalition on the Behavioral Health Workforce, "An Action Plan for Behavioral Health Workforce Development, A Framework for Discussion," Executive Summary, 2007, on the Internet at <http://www.cms.hhs.gov/>).

⁴⁵⁴ Workforce Initiative, note 450 above, p. 10.

⁴⁵⁵ *Ibid.*

⁴⁵⁶ *Ibid.*

⁴⁵⁷ Lin, note 437 above, p. 85.

⁴⁵⁸ Swartz and Morrissey, note 259 above, p. 210.

⁴⁵⁹ Bacon and Stallings, note 451 above, p. 231; see also Bridges, note 439 above, p. 224 ("[D]ivestiture and privatization strategies show a fundamental misunderstanding of the marketplace for professionals. The practice of psychiatry does not need the target populations to earn a living. There are easier and more prestigious jobs that pay more money.")

⁴⁶⁰ Bacon and Stallings, note 451 above, p. 231.

⁴⁶¹ Carol Duncan Clayton, Ph.D., "Terms of Engagement: Implementing a Change Process at the Local Level," *NC Medical Journal*, Vol. 64, No. 5, Sept./Oct. 2003, p. 222.

⁴⁶² *Ibid.*

advocacy dissatisfaction.”⁴⁶³ Although the exact fate of the clinical work force that was not retained by the LMEs as administrators or managers is not entirely clear, unquestionably “there was a loss of historical knowledge and staff experienced in working with the populations served.”⁴⁶⁴

The work force initiative identified a number of key issues warranting immediate attention including: (1) a statewide shortage of and poor distribution of psychiatric and other professional and direct support staff, especially in rural areas; (2) chronic vacancy rates among nurses, pharmacists, physical/occupational /recreational therapists, health care technicians, and substance abuse counselors in state facilities; (3) the lack of adequate numbers of supervisors within the system; and (4) a high turnover rate among direct care staff and difficulties in filling vacancies.⁴⁶⁵ The work force initiative also expressed concern over the long-term issue of projections of a growing and aging population that will outpace projections of the number of future providers and the mental health work force.⁴⁶⁶

Furthermore, although the reform legislation called for the use of evidence-based treatments and emerging “best practice” treatment paradigms, the legislation provided no guidance on how to finance and implement the training that would be required given existing work force shortages.⁴⁶⁷ Nor has the state fully defined and prioritized what precisely is called for by “evidence-based practice.”⁴⁶⁸ Rather, “Area programs are left to ‘read the literature’ and make their best decision for a new treatment paradigm.”⁴⁶⁹

Others are concerned that if private providers do not attend to the needs of the indigent and low-fee patients that general hospitals will be overwhelmed with patients who have no other option.⁴⁷⁰ As previously noted, this same concern had arisen in other states as the last half of the 20th century saw a dramatic increase in the treatment of psychiatric patients in general hospitals and in the growth of number of hospitals with psychiatric units.⁴⁷¹

The Impact of Reform on System Governance

Issues of proper governance and accountability with respect to the local governance structure and the state’s continuing role remain at the forefront in any review of mental health reform efforts. Prior to reform, the linkage between the area programs and the counties they served, as well as with the state, was weak.⁴⁷² In addition, there was a lack of accountability and consumer involvement at the local and state levels, and monitoring and oversight of the delivery system also was deficient.⁴⁷³

The intent of the 2001 reform was to separate management from provider functions for area programs and create local governance (LMEs) with strong ties to county government as well as oversight and assistance from the state.⁴⁷⁴ The original legislation also directed the Secretary of Department of Health and Human Services to develop

⁴⁶³ *Ibid.*

⁴⁶⁴ NC Commission Workforce Initiative, note 450 above, p. 10.

⁴⁶⁵ *Ibid.*, p. 5.

⁴⁶⁶ *Ibid.*; see also Mental Health Association—NC, note 378 above (noting acute need for qualified staff in rural parts of the state).

⁴⁶⁷ Swartz and Morrissey, note 259 above, p. 210.

⁴⁶⁸ Clayton, note 461 above, p. 221.

⁴⁶⁹ *Ibid.*

⁴⁷⁰ Swartz and Morrissey, note 259 above, p. 210.

⁴⁷¹ Mechanic and Rochefort, note 137 above, pp. 311-13; see also Geller, note 139 above, p. 53.

⁴⁷² Lin, note 437 above, p. 12.

⁴⁷³ *Ibid.*

⁴⁷⁴ *Ibid.*, p. 13. Mark Botts at the UNC School of Government says, “The separation of functions has by and large been achieved. The strong ties to county government have generally not been achieved (with a few exceptions). And, the assistance from the state agency generally has been small and insufficient, in

a plan to reduce the number of LMEs from 39 in 2001 to no more than 20 by January 2007.⁴⁷⁵ The reform legislation also intended to provide for increased consumer voice through the establishment of a state and local consumer structure.⁴⁷⁶ Subsequent 2006 legislation codified Consumer and Family Advisory Committees⁴⁷⁷ and further defined the functions and authority of the LMEs,⁴⁷⁸ while also continuing to ensure that the LMEs function in coordination with the state's authority.⁴⁷⁹

To date, reform has reduced the number of area programs. Effective July 2008, the number of LMEs will have been reduced from 40 to 24—not quite hitting the target but still a significant consolidation and restructuring effort in a fairly short period of time.⁴⁸⁰ In addition, although not funded by the original legislation, the DHHS created Consumer and Family Advisory Committees as part of its State Plan, and the LMEs have successfully established a viable consumer and family advisory structure.⁴⁸¹

Despite such progress, however, there still is a great deal of unevenness between LMEs in terms of developing the tools and expertise to be effective.⁴⁸² One of the main concerns at the beginning of the reform was how adept the single and multi-county LMEs would be at transforming themselves into “management entities that perform a wide range of administrative services; create and manage diverse provider contracts, [and] assure quality for the divested provider networks.”⁴⁸³ Although some counties had already developed such capabilities, reformers recognized that developing such a government/business infrastructure would be very challenging for other counties.⁴⁸⁴ This has proven to be the case, in part, due to a high learning curve in transitioning from being a provider of mental health services to being a management entity with responsibility over mental health, developmental, and substance abuse disabilities.⁴⁸⁵ Ambiguity regarding the LMEs' role in the Medicaid program also has hampered the effective functioning of some LMEs.⁴⁸⁶

spite of several legislative enactments since 2001 to require DHHS to give technical assistance to LMEs. DHHS and DMHDDAS have generally not had the capacity and resources to do so.”

⁴⁷⁵ Mark F. Botts, “2006 Legislation Affecting Mental Health, Developmental Disabilities, and Substance Abuse Services,” Institute of Government Bulletin, *Mental Health Law*, No. 10, Nov. 2006, p. 7.

⁴⁷⁶ Lin, note 437 above, p. 13.

⁴⁷⁷ N.C. Session Law 2006-142 (H.B. 2077).

⁴⁷⁸ For example, the 2006 legislation defined the functions of the LMEs to include:

*the implementation of a 24/7 screening, triage and referral process and a uniform portal of entry into care so that all citizens are provided better access to this core services covered by the 2001 reform legislation;

*the authority to remove a provider's endorsement if the provider does not (a) meet defined quality criteria or (b) provide required data to the LME;

*the authority to review and approve person-centered plans for (a) consumers who receive state-funded services; and (b) all consumers in the LME's catchment area who receive services funded by Medicaid; and

*the financial management and accountability for state and local fund use.

Ibid.

⁴⁷⁹ For example, (1) the DHHS has authority in “statewide planning, standard development and financing strategies, and technical assistance to LMEs;” (2) the DMHDDAS retains responsibility over state psychiatric hospitals and facilities, although the legislation requires “the state to develop strategies for LMEs to manage hospital/facilities bed days;” and (3) the DMA retains its role as the single Medicaid agency; however, “DHHS is responsible for ensuring inter-divisional collaboration and development of Medicaid policies for the MH/DD/SA service system.” Lin, note 437 above, p. 15; see generally Botts, note 475 above.

⁴⁸⁰ Mercer Government Human Services Consulting, “Independent Evaluation of the Performance of Local Management Entities: North Carolina Department of Health and Human Services/Division of Mental Health, Developmental Disabilities, and Substance Abuse Services,” April 2008, p. 4; see also Lin, note 437 above, p. 76; Botts, note 475 above, p. 7.

⁴⁸¹ Lin, note 437 above, p. 76.

⁴⁸² *Ibid.*, p. 78.

⁴⁸³ Swartz and Morrissey, note 259 above, p. 208.

⁴⁸⁴ *Ibid.*

⁴⁸⁵ Lin, note 437 above, p. 76.

⁴⁸⁶ *Ibid.*

An independent review of the LMEs conducted in 2007 and 2008 by Mercer Government Human Services Consulting found that most LMEs were performing at an average (13 LMEs) or above average (7 LMEs) level with respect to the following functions: (1) financial and business management, (2) information technology and claims management, and (3) clinical operations and governance.⁴⁸⁷ Mercer found that five were performing below average.⁴⁸⁸ Mercer also offered three options for improving functions, including: (1) the creation of three to five regional entities and converting the other existing LMEs into core service providers; (2) the creation of a central management entity for North Carolina which could be formed through a consortium of existing LMEs, with some LMEs converting back to core providers or core service agencies; and (3) the voluntary consolidation of LMEs to decrease their number to fewer than 20.⁴⁸⁹ It is unclear at this point whether the state will maintain or modify the current structure based on Mercer's recommendations.

Legislative Commitment to Funding Reform

Regardless of the underlying philosophy, as seen with the asylum and federal community mental health initiative, proper financing is always a critical component to the success of any reform effort. North Carolina's 2001 reforms are no different. As noted by former State Auditor Ralph Campbell, at a minimum, there has to be funding stability with respect to the basic services [required] by the legislation:

Those services, once offered, should not be taken away from needy patients. Private providers, who are a key to local management of mental health programs, must be assured of payment for the services they provide. Those services, and the payment for them, cannot expand and contract with the economic cycle.⁴⁹⁰

An initial concern was whether the legislature would provide such funding stability to ensure that the reforms succeeded and not use any savings for other programs or provide tax cuts rather than support community treatment capacity.⁴⁹¹ In the past, mental health programs had been chronically underfunded and were often the first to be cut during budget reductions and the last to be funded during positive economic times.⁴⁹²

Legislative commitment has not always been stable since passage of the reform legislation. Economic difficulties in the first two years—fiscal years 2001-02 and 2002-03—after reform made it problematic for North Carolina to undertake any sweeping changes.⁴⁹³ In addition, the tendency to target mental health programs for cuts did not change post-reform. When the state needed additional funds in 2003 to cover a revenue shortfall, mental health programs were the most severely cut—although subsequent lobbying efforts helped transfer some of the cuts to other areas.⁴⁹⁴

Despite such shortcomings, however, there has been some progress over the seven-year post-reform period of 2001-08. Overall, the General Assembly has appropriated more funds for the MH/DD/SAS system and has shown some commitment to ensuring

⁴⁸⁷ Mercer, note 480 above, p. 16.

⁴⁸⁸ *Ibid.*

⁴⁸⁹ *Ibid.*, pp. 52-54.

⁴⁹⁰ Campbell, note 434 above, p. 218.

⁴⁹¹ Insko, note 381 above, pp. 215-16.

⁴⁹² Campbell, note 434 above, p. 218; see also Lin, note 437 above, p. 75 (noting that both pre—and post-reform North Carolina ranks low in terms of per capita expenditure on the public MH/DD/SAS system.).

⁴⁹³ Campbell, note 434 above, p. 217.

⁴⁹⁴ *Ibid.*

future funding.⁴⁹⁵ For example, in 2003 and 2004, the General Assembly appropriated, in addition to other mental health appropriations, \$12.5 and \$10 million, respectively, in non-recurring funds to the Mental Health Trust Fund which was established for, among other things, bridge funding purposes and to facilitate compliance with the U.S. Supreme Court's *Olmstead* decision.⁴⁹⁶ In addition, the 2004 General Assembly enacted legislation providing, in part, that if excess funds are available after the LMEs have used appropriated funds to meet service needs, one-half of the excess funds shall be transferred to the Mental Health Trust Fund rather than revert to the General Fund.⁴⁹⁷ Many counties also have increased funding to fill the gaps or provide new and needed services.⁴⁹⁸ These are positive steps in terms of state and county commitment to funding mental health reforms.

The Quest for Integrated Funding

Another significant financing concern derives from the complex array of funding sources from the federal, state, and local levels that evolved during the course of prior reforms in mental health and federal entitlement programs.⁴⁹⁹ As explained by Drs. Swartz and Morrissey,

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 [*sic*] of a viable financing plan is the integration of funding streams combined with an overhaul of the state mental health Medicaid plan.⁵⁰⁰

Implementing such a system, however, has not been possible and the ramifications of an unclear financing plan over the course of the reform effort have extended down the line to (1) LMEs that cannot adequately plan for and implement reform if the payment mechanisms and rates are not clear; and (2) providers who may refrain from participating in the system until they know what rates will be provided for what services.⁵⁰¹

In addition, although “state hospital dollars can leverage far more community-based Medicaid services, [t]he unknown is whether this leveraging will create *viable alternatives* to state hospital care.”⁵⁰² As previously noted, a number of states failed in this regard by downsizing before adequate community alternatives had been established, resulting in unacceptable consequences for the most severely mentally ill and increased rates of homelessness and incarceration of the mentally ill. By 2003, the

⁴⁹⁵ Lin, note 437 above, p. 75.

⁴⁹⁶ Mark F. Botts, “2004 Legislation Affecting Mental Health, Developmental Disabilities, and Substance Abuse Services,” NC Institute of Government, Mental Health Bulletin, No. 9, Dec. 2004, pp. 2-3.

⁴⁹⁷ *Ibid.*, p. 4.

⁴⁹⁸ Lin, note 437 above, p. 77. Mark Botts at the UNC School of Government cautions, “While there is anecdotal evidence of some counties committing additional funds, funding statewide, as a percentage of LME revenues, has not changed. Generally, it is about 6 percent, with the larger counties—Mecklenburg and Wake, for example—lifting the average by contributing from 25-35 percent of LME revenue.”

⁴⁹⁹ Swartz and Morrissey, note 259 above, p. 209.

⁵⁰⁰ *Ibid.*; see also Campbell, note 434 above, p. 218 (noting that “greater efforts must be made to channel the confusing maze of mental financing programs into an integrated system that ensures the most efficient and effective use of every dollar that is available”).

⁵⁰¹ Swartz and Morrissey, note 259 above, p. 209; see also Clayton, note 461 above, p. 221 (Similar concerns have arisen with respect to lack of clarity regarding provider credentialing and certification and documentation and other regulatory requirements.).

⁵⁰² Swartz and Morrissey, note 259 above, p. 209; see also Campbell, note 434 above, p. 217.

availability of community hospital beds in North Carolina—especially for mentally ill children and child and adult substance abusers—was already an issue with the state having lost 500 general hospital psychiatry beds due to pressure from private sector managed care.⁵⁰³ Although the reform legislation provides for establishment of a Mental Health Trust Fund to help bridge the transition and develop community-based capacity, at times it has been used for other purposes, including “administrative and planning purposes” as well as being “raided during the budget crisis.”⁵⁰⁴

Implementation of the policy goal that state institution dollars will “follow the patient” to community programs also has been problematic. Specifically,

The state hospitals are to be a part of the continuum of service for the Area programs with Area programs determining admissions and discharges based on medical necessity. The Area authorities have been allocated “bed days”—a number of beds per catchment area. These beds are to serve the community and the Area program is to pay for additional beds out of their own budgets, if necessary. However, the dollars for the beds remain in the state hospital budget and the admitting physician at the hospital can admit a patient without penalty even if the Area program has other alternatives to serve the patient locally. The Area program, however, will be penalized if the number of bed days used exceeds the number allotted. This reverse incentive paradigm does not support the desire to move patients to community settings nor a strong community managing entity, which causes significant reliance on communication and relationships as the only means to determine best use of state hospital beds.⁵⁰⁵

In sum, North Carolina will effectively be operating dual systems—both state institutions and community centers—for anywhere from seven to 10 years, if not longer.⁵⁰⁶ This creates an added strain to the whole reform process not only because the institutions need to be updated but because institutional funding has built-in inflationary increases whereas community funding increases only through the expansion in the use of Medicaid.⁵⁰⁷ In addition, as of 2006, LMEs were serving twice the number of clients as in 1996 with only an 11 percent increase in state funding.⁵⁰⁸ And, although Medicaid pays for nearly 50 percent of mental health services delivered, only one in five patients qualifies for Medicaid.⁵⁰⁹

Notes Insko, “It is the intent of the General Assembly to have a unified system directed by the State with the day-to-day management of the system done by the LMEs. While the hospitals are managed by DHHS, they are part of a continuum of services and not a separate system. For those patients who are not long term residents at a state hospital, their treatment must be part of an overall treatment plan so that the stay in a state hospital will be consistent with the community-based treatment.”

Despite the complexity of these funding issues, the state has made some changes in an effort to streamline administration and financing. Specifically, the state (1) contracted Medicaid utilization management functions to a single statewide vendor to promote statewide uniformity; and (2) rewrote and received approval for new Medicaid

⁵⁰³ Swartz and Morrissey, note 259 above, p. 209.

⁵⁰⁴ Mental Health Association—NC, note 378 above.

⁵⁰⁵ Clayton, note 461 above, p. 222.

⁵⁰⁶ Mental Health Association—NC, note 378 above.

⁵⁰⁷ *Ibid.*

⁵⁰⁸ *Ibid.*

⁵⁰⁹ *Ibid.* Although overall only 20 percent of those provided with mental health services qualify for Medicaid, this percentage varies by population. For example, 60 percent of the developmentally disabled qualify, 50 percent of children qualify, 30 percent of mental health adults qualify, and between zero and 20 percent of substance abusers qualify.

service definitions providing additional services and supports in order to maximize the state’s use of Medicaid dollars, 63 percent of which comes from federal dollars.⁵¹⁰

The move to a single statewide vendor, Value Options, has been controversial. According to Verla Insko, this isn’t consistent with the General Assembly’s goal of integrated funding and a system managed by the LMEs. “Now we have two mental health systems. The Division of Medical Assistance (DMA) runs the Medicaid services; the LMEs, with oversight by the Division of Mental Health, Developmental Disabilities, and Substance Abuse, run the services funded by the state and local dollars for non-Medicaid patients. Providers like working with one Medicaid vendor for obvious reasons but that leads to their accepting only Medicaid patients and declining to serve state-funded or free patients—the very people who end up in local emergency departments and state institutions. If we had integrated funding managed by the LMEs, they could control cost, quality, appropriateness of services, and ensure access to more people. The role of the State would be to direct the system to ensure uniformity and consistency with CMS rules.”

Others question whether the statewide vendor for Medicaid counts as progress, given the loss of hundreds of millions in public funds, the disconnect between non-Medicaid and Medicaid funding creating a two-tiered service system, and the management of public funds without local government control. According to Mark Botts at the UNC School of Government, “DHHS and DMHDDSAS think this promotes uniformity. But many in local government believe there are ways to achieve uniformity without having one entity perform this function, such as establishing uniform standards.”

The Impact of Reform on State Hospitals

Prior to reform, there was fragmentation and disconnection between the services provided by the state institutions and those provided at the community level.⁵¹¹ The area programs had zero incentive to redirect hospital admissions to other resources because there was no local financial penalty for using the state hospital system nor any incentive for managing such utilization in a cost-effective and efficient manner.⁵¹² Under the 2001 reform, the state psychiatric hospital system was intended to be downsized and resources moved from that system to enhance community-based treatments. The state has made some progress in that direction. For example, within six years of the legislation, the state “permanently closed 539 state psychiatric hospital beds and transferred more than \$15.4 million in annual recurring savings from the hospitals’ budgets to the community to pay for community services.”⁵¹³ Insko cautions that many of these patients were older mentally ill patients who could no longer benefit from mental health services. She says, “They were moved to nursing homes or the state neurological medical centers, and the money went to these ‘community-based’ agencies—not to services managed by the LMEs. The money followed the patient.”

In addition, progress has been made in replacing the four aging state hospitals with three new facilities. The new Central Regional Hospital opened on July 21, 2008, when 200 patients from John Umstead Hospital in Butner moved into the new facility. It is designed to replace aging facilities at Dorothea Dix Hospital as well. However, the N.C. Department of Health and Human Services has entered into a court-approved agreement with Disability Rights North Carolina to “maintain the status quo and leave the patients at Dorothea Dix Hospital for the immediate future” until “known safety

⁵¹⁰ Mental Health Association—NC, note 378 above.

⁵¹¹ Lin, note 437 above, p. 11.

⁵¹² *Ibid.*, pp. 11-12.

⁵¹³ NCDHHS, “Milestones and Accomplishments,” note 448 above, p. 3.

concerns” are addressed. In the meantime, Central Regional Hospital was notified by the U.S. Centers for Medicare and Medicaid Services (CMS) that it would lose federal funding if it did not correct deficiencies by December 14, 2008. By December 19, 2008, Central Regional Hospital had been cleared by the CMS inspection agent. Then in early February, because of abuse and neglect of patients, the hospital was notified that it was under a notice of immediate jeopardy and termination of funding if it did not submit a plan of correction and pass re-inspection by February 20, 2009.

⁵¹⁴ Planning is in progress to replace Broughton Hospital in Morganton and Cherry Hospital in Goldsboro.

Nevertheless, overall, the reform legislation’s goal of closing the gap between the state psychiatric hospitals and community-based systems has not been met.⁵¹⁵ Rather, the state facilities, which constitute the final safety net for consumers, have been utilized in a haphazard manner with most admissions in recent years consisting of clients with substance abuse or short-term stabilization needs, short term stays (up to seven to eight days), and no continuity of care upon discharge.⁵¹⁶ In addition, consumers “continue to fall through the cracks at both ends, creating burdens on limited resources in law enforcement (for transportation and emergency room waiting) and state hospitals/facilities (for overcrowding and inability to admit).”⁵¹⁷

Mark Botts at the UNC School of Government provides this example of the impact of reform on state hospitals and the role of community providers:

So, it is not merely about incentives, but about resources. In some cases, there has been nowhere else to send these patients but the state hospitals. And, LMEs have not had sufficient resources to develop community inpatient beds (and generally have been proscribed from operating them themselves due to the 2001 legislative prohibition against LMEs running service programs). This is where a Wake or Mecklenburg LME can create, due to the array of medical facilities and professionals in their areas, a much different service environment than a predominantly rural LME.

When the rural Smoky Mountain LME was still seven counties in size, there were no inpatient psychiatric or substance abuse beds anywhere in its catchment area. The LME had to send consumers in need of inpatient services out of its catchment area to private hospitals in Hickory or Hendersonville or to the state hospital in Broughton. There were no private entities interested in operating inpatient beds in the catchment area, and the crisis services needed to prevent and reduce inpatient admissions did not exist. Through its community business planning initiative immediately following and required by the 2001 legislation, the Smoky Mountain stakeholders identified a facility-based crisis center with a 24-hour unit as the community’s top priority. The Balsam Center for Hope and Recovery was created in response.

While the Balsam Center was a direct byproduct of the business planning element of reform, it was bedeviled by another element, the requirement

⁵¹⁴ Disability Rights North Carolina, “TRO Stopping the Transfer of Dix Patients to Central Regional Hospital Extended Indefinitely,” Raleigh, NC, Oct. 2, 2008, p. 1; see also NCDHHS, “Milestones and Accomplishments,” note 448 above, p. 3; NCDHHS, “Dix patients to move to Central Regional Hospital starting Oct. 1,” Raleigh, NC, Sept. 18, 2008, pp. 1-2; NCDHHS, “DHHS Agrees to Postpone Hearing on Dix Transition,” Raleigh, NC, Oct. 2, 2008; NCDHHS, “CMS Surveyors Return to Central Regional Hospital for Follow-Up Survey,” Raleigh, NC, Dec. 2, 2008; NCDHHS, “Central Regional Hospital submits plan to preserve federal funding,” Raleigh, NC, Feb. 13, 2009. Website for Central Regional Hospital, on the Internet at <http://www.ncdhhs.gov/mhdsas/centralhospital/index.htm>.

⁵¹⁵ Lin, note 437 above, p. 83.

⁵¹⁶ *Ibid.*, pp. 83-84.

⁵¹⁷ *Ibid.*, p. 83.

that every six months it seek from the Secretary a waiver from the rule that says LMEs are not allowed to provide services. Nevertheless, the Balsam Center was permitted to stay open if it repeatedly made its case to do so, and it successfully diverted a significant number of admissions away from the state hospital in Broughton through its crisis stabilization services and referral to outpatient services, as well as through admissions to its own 24-hour adult unit.

Still, efforts like these were not sufficient to meet the demand for services across the state. In partial response, the 2006 General Assembly appropriated money to develop and purchase inpatient psychiatric care at community hospitals. The Smoky Mountain LME worked with Haywood Regional Medical Center to develop a 24-hour behavioral health unit. Unfortunately, the Balsam Center had to close so that its professionals would be available to staff the hospital unit, as there were insufficient qualified professionals in the area to staff both facilities. In time, the Balsam Center may reopen. But, the inability of communities to meet the demand for emergency and inpatient services and, therefore, have to rely on state hospitals, is not due to a lack of effort or incentive. It is due to the lack of resources—both money and professionals—necessary to create community services.

Privatization of Services

Privatization of clinical services—which gathered steam on the national level throughout the 1970s, 1980s, and 1990s—originally was not a central premise of North Carolina’s 2001 reform. The real impetus for reform was separating the management of services from the delivery of services. In fact, section 1.15 of House Bill 381, Mental Health System Reform, revised the existing state statute to provide that “The area authority or county program shall contract with other qualified *public or private providers* . . . for the provision of services.”

Prior to reform, private providers already were involved in delivering some services. However, “there were increasing concerns that with both public and private sectors actively involved in delivering services, there was no neutral entity to manage consumer access, quality of services, or effective use of public resources.”⁵¹⁸ This concern for public accountability, combined with a national trend of outsourcing public functions, led North Carolina to decide as a matter of policy not to outsource governance or accountability for locally-delivered services.⁵¹⁹ Instead, the state decided to preserve a public role through the development of the local management entities which is “a local governance model, not a private managed care model.”⁵²⁰ Says Representative Verla Insko, “It is true we wanted a firewall between the management of services and the delivery of services. Stop the ‘conflict of interest’ was the phrase of the day from providers. But it was only after House Bill 381, Mental Health System Reform, passed that private providers and LME staff began to say the goal was to privatize, so that became ‘the truth.’”

It is fairly clear that North Carolina’s modified version of privatization has not become a cure-all as advocates hoped. Whether this is due to the underlying concept,

⁵¹⁸ Lin, note 437 above, p. 11. Representative Verla Insko says, “The private providers were pushing to dismantle the public service system because they were effectively left out—because the area programs needed Medicaid funding in the form of the administrative peel-off to pay their bills and hire staff. To the private providers, the area programs had a conflict of interest. Medicaid services were supposed to be open to any willing and qualified provider, but they were not.”

⁵¹⁹ *Ibid.*, p. 11.

⁵²⁰ *Ibid.*

implementation, or both is unresolved, but even from the beginning there were questions whether privatization would result in more effective management of human services. Early concerns focused on whether the private sector could and would respond to the needs of the mentally ill and whether the profit motive would result in a reduction in the quality or quantity of services.⁵²¹

In theory, North Carolina's approach was supposed to (1) increase administrative efficiency by segregating management and oversight from the provision of services; (2) promote innovation and utilize new technologies; (3) enhance provider quality; and (4) stimulate competition among providers.⁵²² Attainment of such ideals, however, is dependent on numerous factors. For example, whether privatization results in innovation and change depends on whether the private sector providers are available and well-trained for their role in the mental health system.⁵²³ Many private providers do not have the specialized training required for working with complex mental health issues, and many rural counties have few private group integrated practices.⁵²⁴ It is also unclear how many nonprofit mental health agencies ultimately will step in and develop new provider practices.⁵²⁵ Innovation also may be dampened by the necessary public accountability requirements, including documentation requirements, for this type of purchase of service privatization approach.⁵²⁶

In addition, as noted above, many area programs have suffered attrition at the clinical staff level. For those who have not left, some area programs are "spinning" staff out to work in nonprofit agencies.⁵²⁷ According to Dr. Carol Duncan Clayton, former Executive Director of the N.C. Council of Community Programs, in an article on implementing reforms at the local level:

The transition of public service to private and nonprofit providers is one of the most sensitive areas of reform. The competing principles of choice versus sustainability, fragmentation of service versus one-stop shopping, manager versus provider play out in this transition and are difficult to balance and prioritize. Several issues further complicate the transition. First, requirements for provider credentialing/certification, rates for services, documentation or other regulatory requirements are not yet finalized. Without these key pieces of information, local managers have no information with which to attract, develop, negotiate, or contract with new or existing private or nonprofit providers.⁵²⁸

North Carolina's reform plan also is based on the concept that quality of services will be enhanced "by making providers compete on quality and value of services rather than price."⁵²⁹ Whether such an approach will actually work, however, largely depends on the ability of the LMEs to monitor numerous contracts effectively and determine which are high-quality providers.⁵³⁰ In addition, there are concerns that there will be little true competition within service categories—particularly for under-funded categories of patients.⁵³¹ On the other hand, there is a concern that if true competition leads to changes in providers, this will disrupt the goal of maintaining continuity of care to the mentally ill patient.⁵³² In a related vein, there also is concern that competi-

⁵²¹ Insko, note 381 above, pp. 215-16.

⁵²² Swartz and Morrissey, note 259 above, p. 208.

⁵²³ *Ibid.*

⁵²⁴ *Ibid.*

⁵²⁵ *Ibid.*

⁵²⁶ *Ibid.*

⁵²⁷ Clayton, note 461 above, pp. 221-22.

⁵²⁸ *Ibid.*, p. 221.

⁵²⁹ Swartz and Morrissey, note 259 above, p. 208.

⁵³⁰ *Ibid.*

⁵³¹ *Ibid.*

⁵³² *Ibid.*

tive contracting of individual services will fragment care.⁵³³ Although the reform plan proposed means of integrating services, “for some consumers, the loss of a ‘one-stop shop’ will be a difficult transition.”⁵³⁴

Another overriding concern is accountability under privatization, especially if consumer advocacy groups, who have typically served in a watchdog role over quality of care issues involving the public mental health system, expand their role to directly provide services.⁵³⁵ The potential conflicts of interest include, for example, conflicts in oversight of their own services as well as in their role of advising consumers as to the quality of care provided by other providers.⁵³⁶

To date, the reform has created a large provider network and corresponding service capacity.⁵³⁷ There is, however, a “lack of development of evidenced-based practices, which raises the question of competency and qualifications of providers in the system and what steps should be taken to nurture such development.”⁵³⁸ Following audits and endorsement reviews (both different types of quality assurance processes) of all providers, a “corrective phase” took place during which some providers incurred large fiscal penalties, others lost their endorsement, others went out of business, while still others became fully endorsed and proficient in the delivery of services.⁵³⁹ In addition, despite the overall increase in providers and service capacity in some treatment areas, the “apparent lack of crisis services and inadequate number of substance abuse providers have been identified by the public partners as serious service gaps.”⁵⁴⁰

Mark Botts at the UNC School of Government says, “The legislative requirement to separate service delivery from management and oversight does not preclude the public provision of services. It just precludes the LME from providing services. Some counties have created public entities that provide services by contracting with their local LME. They have done this partly out of a concern that there will be no private entities willing to step in and provide services to the more severely disabled. For example, the counties formerly in the New River area authority do this jointly. Also, Rockingham County operates a department that provides direct services to LME consumers. It, as well as the New River entity, has to be endorsed and meet the same qualifications as any other provider, public or private.” Insko points out that the statute allows LMEs to provide direct services with the Secretary’s approval.

Says Verla Insko, “As reform rolled out, no public providers emerged. It is only now that we are beginning to discuss the need for them. We now have two public provider agencies and many social services departments that provide and bill for mental health services. We do not have to change the law to have public providers.”

North Carolina’s *Olmstead* Plan

As previously noted, the *Olmstead* decision suggested that states demonstrate compliance with the ADA’s requirements by creating formal plans for increasing the integration of Medicaid-eligible persons from institutional settings into the community.⁵⁴¹ Independently of the reform legislation, North Carolina responded to the *Olmstead* decision in June 2000 by establishing “an 18-member steering committee consisting of advocates, consumers, family members, and professionals to oversee the development of a comprehensive *Olmstead* plan covering the

⁵³³ *Ibid.*

⁵³⁴ *Ibid.*

⁵³⁵ *Ibid.*

⁵³⁶ *Ibid.*, p. 209.

⁵³⁷ Lin, note 441 above, p. 63.

⁵³⁸ *Ibid.*, p. 3.

⁵³⁹ *Ibid.*, p. 63. Endorsement is a verification and quality assurance process using statewide criteria and procedures. It is required for providers of services reimbursed by Medicaid.

⁵⁴⁰ Lin, note 437 above, p. 84.

⁵⁴¹ Kitchener *et al.*, note 352 above.

institutions” operated by the North Carolina Division of MH/DD/SAS.⁵⁴² At the federal level, in June 2001, President Bush issued Executive Order 13217 promoting community-based alternatives for all individuals with mental and physical disabilities and directing key federal agencies to work closely with states to ensure full compliance with the *Olmstead* decision and the ADA.⁵⁴³ In 2001, the Centers for Medicare and Medicaid Services (CMS) issued guidance to states regarding compliance with the ADA’s mandate.⁵⁴⁴

Merely having a plan, however, does not guarantee full integration of Medicaid-eligible persons into the community. Rather, as with other reform efforts, numerous barriers exist, including “financial constraints on Medicaid, the lack of affordable and accessible housing, labor shortage of home care workers and political pressure of institutional care facilities.”⁵⁴⁵ North Carolina has made some progress in this area. Although North Carolina did not publish its final *Olmstead* plan until April 2003, *Olmstead* assessments began in the state hospitals in 2001.

In addition, in September 2007, the General Assembly passed Session Law 2007-323, which provides that:

In keeping with the United States Supreme Court decision in *Olmstead v. L.C. & E.W.* and State policy to provide appropriate services to clients in the least restrictive and most appropriate environment, the [N.C.]

⁵⁴² Estroff, note 354 above.

⁵⁴³ Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services, “Transforming Mental Health Care in America. The Federal Action Agenda: First Steps,” DHHS Pub. No. SMA-05-4060, Rockville, MD, 2005, p. 3.

⁵⁴⁴ Kitchener *et al.*, note 352 above.

⁵⁴⁵ *Ibid.*



Department of Health and Human Services shall continue to implement a plan for the transition of patients from State psychiatric hospitals to the community or to other long-term care facilities, as appropriate. The goal is to develop mechanisms and identify resources needed to enable patients and their families to receive the necessary services and supports based on the following guiding principles:

- (1) Individuals shall be provided acute psychiatric care in non-State facilities when appropriate.
- (2) Individuals shall be provided acute psychiatric care in State facilities only when non-State facilities are unavailable.
- (3) Individuals shall receive evidence-based psychiatric services and care that are cost-efficient.
- (4) The State shall minimize cost shifting to other State and local facilities or institutions.⁵⁴⁶

The legislation also called for (1) individual patient assessments and transition plans by the N.C. Department of Health and Human Services in consultation with the patient, the patient's family or other legal representative; and (2) the submission of reports to be submitted on December 1, 2007, and May 1, 2008, on the status of implementation of the legislations mandated assessments.⁵⁴⁷

The December 2007 report issued under this legislative mandate notes that *Olmstead* assessments are completed with individuals who have been receiving treatment in state hospitals for 60 or more days “with the goal of identifying the types of services and supports an individual will need when he/she transitions to the community.”⁵⁴⁸ According to the report, approximately 400 assessments are conducted annually.⁵⁴⁹ If an individual remains hospitalized, a reassessment is conducted annually.⁵⁵⁰ If an individual is clinically ready for discharge from the institution, then the treatment team, consisting of the patient and his or her family or guardian, the hospital treatment team, and an LME/provider representative, finalizes a discharge plan.⁵⁵¹ In 2007, reviews of recidivism—the repetition of undesirable behaviors—also were initiated at each state psychiatric hospital and LME so the state can identify problem areas and improve practices.⁵⁵²

⁵⁴⁶ N.C. Session Law 2007-323, § 10.49(u) (H.B. 1473).

⁵⁴⁷ *Ibid.*

⁵⁴⁸ “Report to the Joint Legislative Commission on Government Operations *et al.*, *Olmstead Report*,” Dec. 1, 2007, p. 1. On the Internet at <http://www.dhhs.state.nc.us/MHDDSAS/statspublications/reports/LOC/loc-olmstead12-07report.pdf>.

⁵⁴⁹ *Ibid.*

⁵⁵⁰ *Ibid.*

⁵⁵¹ *Ibid.*, p. 2.

⁵⁵² *Ibid.*

CONCLUSION

The current state of mental health reform in North Carolina cannot be viewed in a vacuum. Rather, the ghosts of past reforms continue to play a significant role from the continuing existence of state psychiatric hospitals to the creation of additional community options to the current funding patterns with interwoven threads of federal, state, and local dollars. An understanding of past policy decisions that have dramatically impacted the care and treatment of the mentally ill today should serve to guide future reform efforts which, as with past efforts, continue to focus on these central issues:

What is the role of the federal, state, and local governments in assisting the mentally ill?

Who among a vastly diverse population of the mentally ill should receive such help?

Where should such help be provided, who will provide it, and at what cost?

Going forward, reform has to be a state priority and not just on the front burner when there is a newspaper exposé or a leader committed to raising the profile of the issue. A system 200 years in the making cannot be reformed overnight. The success of reform efforts going forward will depend on leadership, funding, time and support for development, and a qualified work force. ☞☞

Mental Health Legislation in the 2007-08 N.C. General Assembly

Mental Health Parity in 2007—The most significant piece of mental health legislation passed in 2007 requires group health insurance plans to cover nine mental illnesses at the same level that they cover physical illnesses. This is called mental health parity. The nine mental illnesses covered are bipolar disorder, major depressive disorder, obsessive compulsive disorder, paranoid and other psychotic disorders, schizoaffective disorder, schizophrenia, post traumatic stress disorder, anorexia nervosa, and bulimia. Parity means that no durational limits can be set in insurance or managed care plans for these diagnoses.

For other mental illness diagnoses, deductibles, coinsurance, co-payments, and maximum out-of-pocket expenses must be the same as coverage limits for physical illnesses, but there may be durational limitations. Insurers must provide coverage for these other mental illnesses for at least 30 combined inpatient and outpatient days and 30 office visits a year.

Budget Changes Made by the 2008 Legislature—One way of describing what the General Assembly did in the 2008 short session is to say they added money with their right hand and cut with their left. For example, they added \$21 million for mental health services, such as increased staffing at psychiatric hospitals, mobile crisis intervention teams, and additional beds and staff at the Dorothea Dix Hospital overflow unit. But this extra \$21 million was offset by the \$86 million in cuts to mental health community support services (funded by Medicaid) which was criticized in *The News & Observer's* February/March 2008 investigative series on mental health reform. The real reform of mental health reform is left to Governor Beverly Perdue and the 2009-10 legislature.

Glossary of Mental Health Terms

Developmental Disability. According to federal law [42 U.S. Code Section 15002(8)], the definition of developmental disability is a severe, chronic disability of an individual that is attributable to a mental and/or physical impairment; manifests before age 22; is likely to continue indefinitely; and results in substantial functional limitations in three or more areas of major life activity, including self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, economic self-sufficiency; and reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

Intellectual Disability. Intellectual disability is a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. This disability originates before the age of 18. Intellectual functioning—also called intelligence—refers to general mental capacity, such as learning, reasoning, problem solving, and so on. One criterion to measure intellectual functioning is an IQ test. Generally, an IQ test score of 75 or below can indicate a limitation in intellectual functioning. Standardized tests can also determine limitations in adaptive behavior, which comprises three skill types: (1) conceptual skills—language and literacy; money, time, and number concepts; and self-direction; (2) social skills—interpersonal skills, social responsibility, self-esteem, gullibility, naïveté (i.e., wariness), social problem solving, and the ability to follow rules/obey laws and to avoid being victimized; and (3) practical skills—activities of daily living (personal care), occupational skills, healthcare, travel/transportation, schedules/routines, safety, use of money, use of the telephone. See the American Association of Intellectual and Developmental Disabilities, on the Internet at http://www.aaid.org/content_100.cfm?navID=21.

Mental Health. How people look at themselves, their lives, and the other people in their lives; evaluate their challenges and problems; and explore choices. This includes handling stress, relating to other people, and making decisions.

Mental Health Problems. Refers generally to mental illness, including depression, bipolar disorder (also referred to as manic depression), attention deficit and hyperactivity disorder, *anxiety disorders*, eating disorders, schizophrenia, and conduct disorder.

Mental Illness. General term applied to severe emotional problems or psychiatric disorders. This term is usually used to refer to severe mental health problems in adults.

Mental Retardation. An outdated term used to refer to intellectual disability.

Substance Abuse/Dependence. The misuse of alcohol or drugs.

Sources: Provided for information only, not as original research. These definitions are excerpted directly from these sources in most cases. See 42 U.S.C. § 15002 (8); American Association of Intellectual and Developmental Disabilities, on the Internet at http://www.aaid.org/content_100.cfm?navID=21; Glossary of Children's Mental Health Terms, 2008 Research and Training Center on Family Support and Children's Mental Health, Portland State University, Portland, OR, on the Internet at <http://www rtc.pdx.edu/pgGlossaryOfChildrensMH.shtml#M>; and Dr. Greg Mulhauser, Glossary of Terms Commonly Used in Mental Health, on the Internet at <http://counselling resource.com/types/glossary/index.html>. See also <http://www.nimh.nih.gov/>.

Glossary of Mental Health Treatment Options

Electroconvulsive therapy (ECT), “also known as electroshock therapy, is a well-established, albeit controversial *psychiatric* treatment in which *seizures* are electrically induced in anesthetized patients for therapeutic effect. Today, ECT is most often used as a treatment for severe *major depression* which has not responded to other treatment. It also is used in the treatment of *mania* (often in *bipolar disorder*), *catatonia*, *schizophrenia* and other disorders. It was first introduced in the 1930s and gained widespread use as a form of treatment in the 1940s and 1950s. Today, an estimated 1 million people worldwide receive ECT every year, usually in a course of 6-12 treatments administered 2 or 3 times a week.” Excerpted from “Electroconvulsive therapy,” in *Wikipedia, The Free Encyclopedia*, on the Internet at http://en.wikipedia.org/w/index.php?title=Electroconvulsive_therapy&oldid=272570393.

Insulin shock therapy or **Insulin coma therapy** was “a form of psychiatric treatment in which patients were repeatedly injected with large doses of *insulin* in order to produce daily *comas* over several weeks. It was introduced in 1933 by Polish *psychiatrist Manfred Sakel* and used extensively in the 1940s and 1950s, mainly for *schizophrenia*, before falling out of favor” and replaced by drug therapy. Excerpted from “Insulin shock therapy,” in *Wikipedia, The Free Encyclopedia*, on the Internet at http://en.wikipedia.org/w/index.php?title=Insulin_shock_therapy&oldid=269015653.

Psychosurgery is “a subset of *neurosurgery*—the *surgery* of the *brain*—intended to modulate the performance of the brain, and thus effect changes in cognition, with the intent to treat or alleviate severe *mental illness*. It was originally thought that by severing the nerves that give power to ideas you would achieve the desirable result of a loss of affect and an emotional flattening which would diminish creativity and imagination—the idea being that those are the human characteristics that are disturbed. The first systematic attempts at human psychosurgery occurred in 1935, when the neurosurgeon *Egas Moniz* teamed up with the surgeon *Almeida Lima* at the *University of Lisbon* to perform a series of prefrontal *lobotomies* — a procedure severing the connection between the *prefrontal cortex* and the rest of the *brain*.” This procedure is now rarely used because of less-invasive and less-objectionable methods of treatment such as *therapy* and modified *electroconvulsive therapy*. Excerpted from “Psychosurgery,” in *Wikipedia, The Free Encyclopedia*, on the Internet at <http://en.wikipedia.org/w/index.php?title=Psychosurgery&oldid=272419715>.

Psychotherapy is treatment through a therapeutic relationship with a practitioner. Multiple methods of psychotherapy exist including, but not limited to, psychoanalytic psychotherapy and cognitive-based therapy. **Psychoanalytic psychotherapy** developed from the field of **psychoanalysis**, a body of ideas developed by Austrian physician *Sigmund Freud* and his followers. It is devoted to the study of human psychological functioning and behavior. **Cognitive-based therapy** involves goal-directed and systemized practices utilizing the patient’s thoughts and actions to address difficult emotions and problem behaviors. See “Psychotherapy,” in *Wikipedia, The Free Encyclopedia*, on the Internet at <http://en.wikipedia.org/w/index.php?title=Psychotherapy&oldid=271607535>.

Source: Provided for information only, not as original research. See also <http://www.nimh.nih.gov/>.

Reforming Mental Health Reform: The History of Mental Health Reform in North Carolina.

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All photos of Club Nova by Karen Tam. Founded in 1987 to address the needs of Orange County citizens living with mental illness, Club Nova provides a holistic, caring environment designed to promote rehabilitation and reintegration into the community.

