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Rhetoric or Reform?: The Future of Mental Health in North Carolina is an analysis of the issues of program effectiveness, reform, reorganization, and privatization opportunities in the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse and community-based mental health care.

The author is Dr. N.N. “Nat” Fullwood, senior research fellow and director of Health and Human Services Policy for the Locke Foundation. Fullwood formerly served as chief of Vocational Rehabilitation Services, chief of Independent Living Services, and senior policy advisor to Gov. Jim Hunt for Higher Education. In addition, he was assistant vice chancellor for Academic Planning and Support Programs at Elizabeth City State University, and held administrative posts at Benedict College and Allen University. He is a graduate of the Governor Morehead School and Shaw University, and received his Ph.D. in administration from Ohio State University.

This report represents the John Locke Foundation’s continued commitment to examine North Carolina’s most challenging public policy issues. As usual, we welcome any comments regarding the analysis or recommendations found in this report.

Rhetoric or Reform?

The Future of Mental Health in North Carolina

North Carolina has reached a crossroads in the delivery of mental health services. After decades of escalating budgets and haphazard growth, years of costly and controversial study, and promises to act that have yet failed to materialize, the state's mental health system continues to suffer from a host of systemic problems. Only fundamental change in the structure and funding of the system will improve outcomes for patients and taxpayers.

Overview of the Mental Health System

The public-sector of the mental health system comprises more than 20 services, delivered by four state psychiatric hospitals, one specialized nursing facility, and 41 area mental health authorities that either purchase or provide community-based services to the mentally ill. The four hospitals serve a declining, but still large and expensive, caseload of institutionalized patients. Mental health services are housed within the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, a unit of the N.C. Department of Health and Human Services that in FY 1997-98 spent nearly \$1 billion, employed about 12,000 state workers, and served some 273,000 North Carolinians.

Other sectors of North Carolina's mental health system include the psychiatric beds of general hospitals, which make up about a third of total mental hospital capacity in the state, and freestanding private psychiatric hospitals, which contain 13 percent of the state's capacity. For a variety of reasons, these sectors have been underutilized in recent years, with an occupancy rate of 56 percent compared to more than 80 percent in the state hospitals.

Attempts at Reform

After the founding of Dorothea Dix hospital in Raleigh in 1856, the mental health system developed over time to include a number of institutions and programs. A Mental Health Study Commission recommended the establishment of area mental health authorities in the 1970s, during the period of "deinstitutionalization" in which state mental hospitals were emptied of most of their patients in favor of community-based care. Beginning in 1983, the commission attempted to develop long-range plans for reforming the system, and in 1989 state officials tried unsuccessfully to further downsize mental hospitals and decentralize service responsibilities.

Beginning in 1993, lawmakers have commissioned studies recommending significant changes in the mental hospitals, such as reduced capacity and replacement with new, state-of-the-art buildings designed to be cheaper to operate. One study of these proposals by MGT of America estimated savings to taxpayers over 10 years to be \$1.4 billion. But this study looked only at the hospital side of the ledger and did not estimate the cost of increased community-based care, upkeep of former hospital buildings as state offices, and costs to society from continuing to deinstitutionalize mental patients without adequate resources in community care to ensure they are not a threat to the public.

In the past few years, state officials have also learned to use the rhetoric of privatization — without creating a true culture of privatization to encourage the contracting out of both clinical and support services. Nor has privatization been extended to encourage sufficient competition among providers, particularly hospitals.

A Different Direction for Reform

Rather than continuing to study, debate, and delay, state policymakers should take immediate actions to create a new, community-based, market-driven mental health system for the 21st Century. The major feature of this plan would invite all nonpublic mental health entities in the state to join in a single purchase-of-service plan under the oversight of state officials and funded by state, federal, local, and private dollars.

This option means (a) getting the state out of the business of operating psychiatric hospitals by transferring ownership of current facilities to area mental health authorities, selling them to private or nonprofit operators, or closing them; (b) reforming the funding process to route more patients needing institutional care into private or nonprofit hospitals and patients needing community-based care into an appropriate setting; and (c) empowering area mental health authorities to act as informed purchasers of services, comparing cost and service quality among an array of providers, on behalf of those severely ill patients who cannot (or their families cannot) make such decisions themselves.

The oversight of mental health disabilities should also change. Consistent with the John Locke Foundation's Disability Policy Report titled *Enabling the Disabled*, the state of North Carolina should create a Division of Disability Services. This entity would supervise the administration and management of all programs and services for persons with disabilities, both mental and physical. Organizing such a Division would permit greater efficiencies and quality effectiveness of service delivery.

Accomplishing the radical reform of mental health in North Carolina in the manner outlined above would bring about great benefits for those with mental disabilities as well as for taxpayers. Revisiting disability reform will be an opportunity for North Carolina to get its mental health house in order.

Introduction

A Preliminary Exploration of a Critical Issue

What does the future hold for North Carolina's mental health system — for both the patients and family members who rely on it for treatment and the public who expects it to promote independence and societal tranquility? The system's leaders seem unsure as to what course of action to take in caring effectively for this special needs population, while at the same time protecting North Carolinians from increasing incidents of violence from mentally ill persons who are not in control of their mental faculties. Ambivalence and ambiguity persist regarding the future of mental health care; even after state leaders have commissioned a number of landmark studies and spent hundreds of thousands of dollars on research in 1998 alone.¹

The final report on North Carolina's psychiatric hospitals, commissioned by the N.C. Department of Health and Human Services and conducted by MGT of America, was published in March 1998. Along with a follow-up study by PCG, this research raises a number of important policy questions. Where do we build new replacement psychiatric hospitals when 53,000 of the state's 100,000 disabled mentally ill are not being treated under the current state psychiatric hospital system?² Do we perpetuate a bricks and mortar building program at the state level when the modern-day service trends clearly demonstrate a move to community-based mental health care? Do we redefine commitment policies to mean giving structure to the controlled and supervised administration of effective modern-day antipsychotic medicines to mental patients in their local area? Do we move assertively and decisively to reform and rebuild the mental health program in a systemic manner recognizing the best features of what has evolved over the past 140 years?

This paper is a limited report which primarily addresses the state of psychiatric care provided through state psychiatric hospitals in North Carolina; it is a concept treatment of the future of mental health care in the 21st Century. The subject of the developmentally disabled and substance abuse, area programs, and nonpublic mental health resources will only be touched on in a peripheral manner relating to agency and budget management, modern-day treatment practices, and the future systemic reform of mental health service delivery in North Carolina. The report discusses North Carolina's experience in mental health and the strategies necessary to build a new comprehensive, community-based mental health care system for the new millennium.

The mental health system in North Carolina has evolved into a kaleidoscope of positives and negatives. Its shifting colors reflect a number of fledgling problems. Too many studies, read by too few, and too much rhetoric regarding the mentally ill have resulted in what some characterize as a sense of timidity towards, and benign neglect of, mental health issues in general.

There is a lack of a clear vision of the system's future and related private mental health resources. Given the substantial taxpayer investment in the Division of Mental Health, Development Disabilities, and Substance Abuse Services as a whole (more than \$1 billion in the current fiscal year) there is not enough substantive effect in quality modern-day service and treatment in the deinstitutionalized mental health care system, resulting in an eclectic array of services, underutilization of psychiatric resources, and case management practices that are sometimes incongruent with modern casework practice.

Leaders have yet to grapple with the real results of the deinstitutionalization movement of the 1970s, which unwittingly unleashed mental illness onto the public streets, schools, work place, and our communities as "normal" daily encounters.³ Deinstitutionalization without effective community treatment is not a coherent policy.

FIGURE A: FISCAL TRENDS IN THE DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES

Fiscal Year	State Appropriations	Federal/Other Receipts	Total Appropriations
1990-91	\$372,939,535	\$274,152,328	\$647,091,863
1991-92	\$384,084,358	\$283,176,569	\$667,260,927
1992-93	\$392,110,958	\$322,530,951	\$714,641,909
1993-94	\$419,306,572	\$311,575,423	\$730,881,995
1994-95	\$487,588,293	\$363,926,424	\$851,514,717
1995-96	\$488,745,585	\$360,676,477	\$849,422,062
1996-97	\$478,213,980	\$403,395,706	\$881,609,686
1997-98	\$520,350,090	\$392,017,922	\$912,368,012
1998-99	\$583,747,119	\$457,082,777	\$1,040,829,896
1999-00	\$604,985,869	\$436,119,470	\$1,041,105,339
Total Percent Change	62.2%	59.1%	60.9%
Avg. Annual Change	5.7%	5.6%	5.6%
Avg. CPI (Adjusted)	1.9%	1.9%	1.9%

SOURCES: North Carolina State Budget, 1989-91 through 1999-2001 bienniums

These problems point to one major question among many mental health issues: whether there is a need for the state to construct new replacement and/or modernize existing psychiatric hospitals as a stand-alone, independent state mental health system when it appears that deinstitutionalization, community-based service-delivery, and excess capacity in private hospitals might further lessen the need for a traditional brick-and-mortar approach at the state level. Even as far back as 1992, the Government Performance Audit Committee (GPAC) study unveiled the utilization gap that existed in that period when available mental health resources showed something less than full utilization (the average resident population was 2,347, average occupancy rate in 1992 was 81.2%).⁴ Simply put, GPAC found that state hospitals were somewhat underutilized, while private and local hospitals providing care to psychiatric patients were significantly underutilized. State leaders should have taken notice.

Part One: Perspectives

Getting the Mental Health Policy Lay of the Land

In our state, as is the case across the nation, the mental health system is now operationally defined by major components including mental illness, developmental disabilities, and alcohol and substance abuse. Mental illness is defined by several recognizable behavioral concepts such as: 1) schizophrenia (hallucination, suspicion, delusion, and drastic changes in behavior and personality); 2) adjustment disorders (children with problems adapting to social, school, and other stressful events and resulting physical symptoms); 3) bipolar disorder (manic depression); 4) major depression (majority of suicides are blamed on major depression); 5) schizo-affective disorder (hallucination, delusions, mood swings); and 6) psychosis (mental illness and out of touch with reality). These conditions are treated with modern atypical antipsychotic drugs such as clozapine, risperidone, and olanzapine. These are 1990s medicines developed to treat and control hallucination, delusion, apathy, and isolation.⁵

The public mental health service-delivery system in North Carolina comprises more than 20 services. These services are provided through four state hospitals, one specialized nursing facility, and 41 area programs for the mentally ill. The mental hospitals served approximately 16,530 in 1998 (down from 22,802 clients in 1992) excluding outpatients and visiting patients. The 41 area mental health program authorities across the state served 296,724 clients, 112,101 admissions, and 80,802 terminations, with 46% of admissions being for mental illness in 1998.⁶ Additionally, there are five mental retardation centers, three residential and outpatient alcohol and drug abuse centers, and three special care centers in the Division (see below).

FIGURE B: MENTAL HEALTH, DEV. DISABILITY & SUBSTANCE ABUSE SERVICES AT A GLANCE (FY 1997-98)

Unit or Program	State Approp.	Total Approp.	FTE Positions	Persons Served	Avg. Daily Pop.
Mental Health					
State Psychiatric Hospitals	\$161,963,880	\$232,634,434		16,598	2,228
Other Institutions	\$2,803,249	\$15,809,917		351	222
Community Mental Health	\$74,454,919	\$129,113,964		164,028	
Willie M. Services	\$53,472,520	\$60,488,833		1,624	1,447
SUBTOTAL	\$292,694,568	\$438,047,148	5,678	182,601	
Developmental Disabilities					
State Institutions	\$9,618,925	\$205,966,272		2,838	2,557
Community DD Services	\$82,987,584	\$93,009,512		9,989	
Thomas S. Services	\$87,901,986	\$89,162,778		1,682	
SUBTOTAL	\$180,508,495	\$388,138,562	5,832	14,509	
Substance Abuse					
State Institutions	\$9,933,631	\$11,814,149		3,537	224
Community SA Services	\$30,984,470	\$59,190,813		72,022	
SUBTOTAL	\$40,918,101	\$71,004,962	245	75,559	
Administration	\$6,328,926	\$15,182,970	140		
TOTAL	\$520,450,090	\$912,373,642	11,895	272,669	

SOURCES: North Carolina State Budget, 1997-99 and 1999-2001 bienniums

Another tier of mental health services are the psychiatric beds located on the sites of general hospital wards apart from state owned and operated hospitals. This component of the system contained a 1,889 psychiatric bed capacity (or 34.7% of total mental health bed capacity) spread across 42 different general hospital sites according to the 1992 Government Performance Audit Commission study conducted by KPMG Peat Marwick.⁶

Finally, one cannot consider the North Carolina mental health system without recognizing the relatively large presence of private psychiatric care. Mental health care in the private sector is significant. It includes 15 private psychiatric hospitals with a capacity of 690 freestanding beds (or 12.7% of the total psychiatric beds available in North Carolina). The most recent statistics provided by the Division of Facility Services shows 704 freestanding beds in private psychiatric hospitals in 1999.

The occupancy rate in North Carolina's private sector psychiatric hospitals is only 56%. Full occupancy is considered to be 85% or 2,192 beds. Private mental health hospitals have an excess capacity of 748 beds according to the Certificate of Need Office. This difference in referrals was due to the area programs referring people to state facilities rather than private ones.

What we have come to know as the "mental health system" in North Carolina is now an array of services, a larger and very diverse client population, and a multiple port-of-entry, dual-funding structure conglomerate. Yet some view it as one of the best mental health systems among large states in the nation.

Origins of North Carolina Mental Health Care

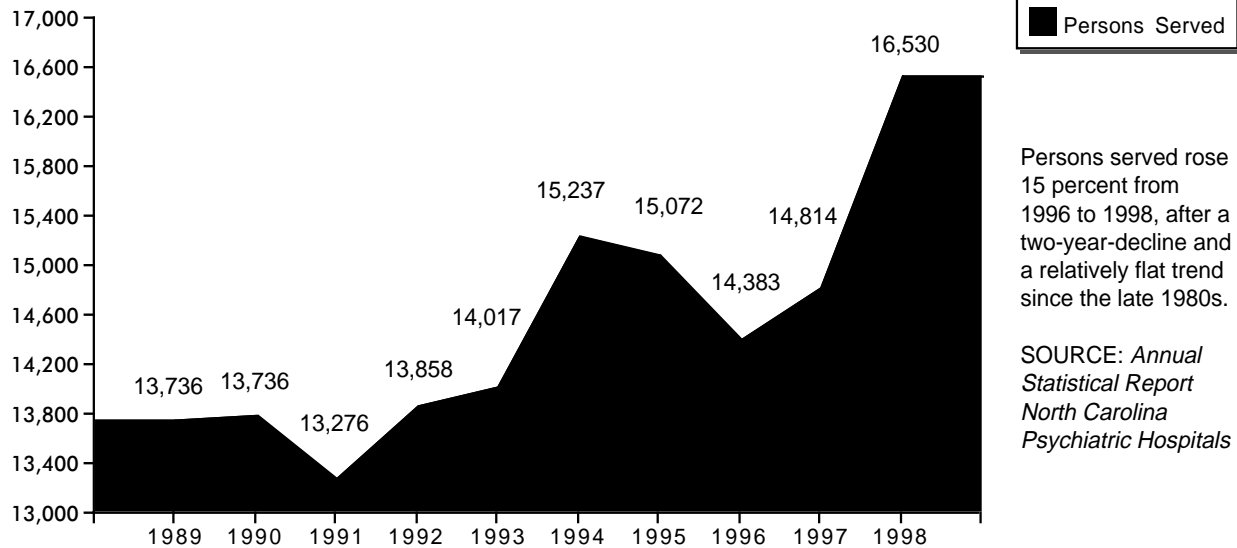
Creation of a state mental health service-delivery systems began in earnest in North Carolina with the opening of Dorothea Dix mental hospital in 1856. Institutionalizing persons with mental illness was a new phenomenon in the early 19th century. Caregiving before then was left to the family and "people-of-faith" to help such individuals within their local confines. The jail was, in many instances, the treatment facility of choice. Providing asylum-based mental health care remained the predominant mental health care of choice of public policymakers for another century during which time three additional mental hospitals were opened in the state: Cherry in Goldsboro in 1880, Broughton in Morganton in 1882, and John Umstead in Butner in 1947.⁷

In fact, mental health as we knew it prior to the 1960s not only has changed significantly in function, it has become a vast bureaucratic structure of psychiatric hospitals and local programs known as Area Mental Health Authorities that operate or contract for services.

FIGURE C: PERSONS SERVED IN AREA MENTAL HEALTH PROGRAMS, 97-98

AREA PROGRAM	PERSONS SERVED
Western Region	
Smoky Mountain	14,748
Blue Ridge	8,901
New River	5,199
Trend	4,313
Foothills	10,318
Rutherford-Polk	3,622
Cleveland	3,224
Gaston-Lincoln	7,103
Catawba	4,896
Mecklenburg	25,631
Tri-County	4,671
Piedmont	8,450
N.C. Region	
Surry-Yadkin	7,090
Forsyth-Stokes	12,018
Rockingham	4,287
Guilford	16,971
Alamance-Caswell	6,559
O-P-C	7,978
Durham	7,978
V-G-F-W	6,727
S.C. Region	
Davidson	5,932
Sandhills	6,491
Southeastern Reg.	10,859
Cumberland	8,082
Lee-Harnett	5,093
Johnston	4,115
Wake	10,339
Randolph	6,890
Eastern Region	
Southeastern	8,336
Onslow	5,131
Wayne	6,381
Wilson-Greene	4,475
Edgecombe-Nash	6,241
Halifax	3,868
Neuse	5,278
Lenoir	4,083
Pitt	6,122
Roanoke-Chowan	4,832
Tideland	6,183
Albemarle	4,632
Duplin-Sampson	3,811
STATE TOTAL	296,724

SOURCE: North Carolina Area Programs Annual Statistical Report

FIGURE D: N.C. PSYCHIATRIC HOSPITAL PERSONS SERVED FY 1989 THRU FY 1998

Here is a timeline for the development of the mental health system:

1856: Responding to a national call for more humane treatment of the insane, North Carolina builds its first “asylum”—Dorothea Dix Hospital in Raleigh.

1950s: The push to free patients begins as new drugs, including Thorazine, help ease some symptoms.

1970s: The discharge pace accelerates after courts demand greater respect for patient rights. The state toughens commitment laws, requiring that a patient be dangerous to self or others. The system of community mental health agencies is created.

1982: State officials and mental health advocates battle over state plan to close much of Dix and use more community services. Advocates say patients will be dumped on streets because the needed services aren’t available outside.

1988: Carolina Legal Assistance wins a federal class-action suit on behalf of mentally retarded adults who were wrongly confined to psychiatric hospitals, where they were unnecessarily medicated and restrained while denied training. The Thomas S. ruling mandated improved services in the community, with 1,700 people now enrolled at a cost of \$90 million a year.

1989: Legislature orders mental health officials to study how to consolidate funding of hospitals and regional-mental health centers to force badly needed improvements in community services. The following year, Secretary of Human Resources David Flaherty recommends committing people to regional centers rather than hospitals and giving community agencies greater control of funding. Never enacted.

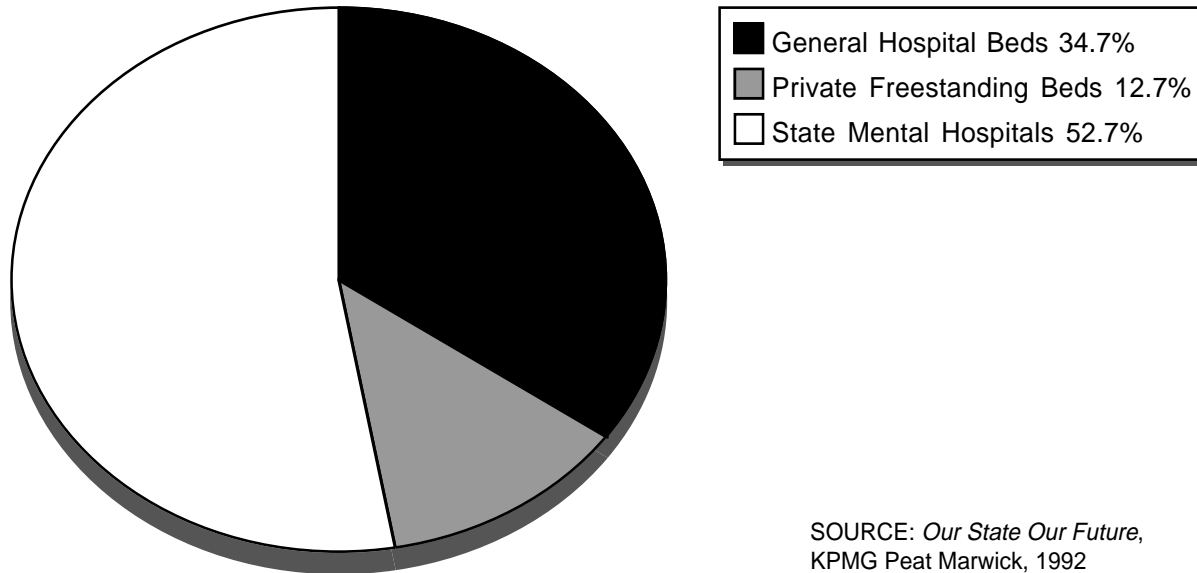
1993 — State Senate bill proposes replacing the four hospitals with more modern facilities operated by a non-profit group. Patient advocates, still fearful of inadequate community services, fight the plan. Never enacted.

1995 — Looking to improve the system in stages, mental health officials propose forcing regional centers to build better community services by making them pay when their patients get admitted to a state hospital. The officials find that up to 40% of long-term hospital patients don't belong but stay because of inadequate services back home. Plan never implemented.

1998 — Study commissioned by legislature concludes that all four hospitals are outdated and recommends that they be replaced with smaller institutions. It faults them for keeping people —including the aged, very young and violent drug and alcohol addicts — who would be better served in community-based programs.⁸

The move from state psychiatric hospitals to community-based service and treatment has been fraught with slowdowns. Much of the problem can be attributed to the struggle by decisionmakers and advocates to define a community-based service policy that would be practicable. The evolving area mental health authorities developed over the past four decades as a “work in progress.” Here are some of the authorities' major mile markers:

- 1963: Local mental health authorities are formed.
- 1973: State legislature forms Mental Health Study Commission.
- 1973-77: Mental Health Study Commission orders a comprehensive review of the regional mental health system and establishes 41 regional mental health authorities.
- 1980: A Federal lawsuit is settled on behalf of mentally and emotionally disabled children not treated by the state mental health system. The Willie M. program is established, which now costs \$60 million.
- 1983-91: Mental Health Study Commission develops long-range plans for how the state should care for children, adults, prison inmates, substance abusers, and those with developmental disabilities.
- 1991: Responding to a severe budget crisis, legislators slash programs and raise taxes. Mental health division loses one-third of its staff.
- 1994: State starts developing a managed care system called Carolina Alternatives to better coordinate care for all mental health clients, starting with children in 10 regional centers.
- 1996: Responding to complaints, federal authorities urge state Medicaid officials to start investigating how Medicaid mental health funding is managed in North Carolina.
- 1997: Governor's Advocacy Council for Persons with Disabilities completes a survey of regional mental health centers that finds deficiencies in handling of patient grievances and slowness to create clients-rights committees. It has these results:
 1. Extensive mismanagement of Medicaid dollars is found. State is expected to owe the federal government at least \$37.5 million.
 2. State mental health director John Baggett moves to assert greater control over the authorities. He begins accrediting them and threatens to cut off money to those that don't improve.
 3. Legislators negotiating the budget wrestle with ways to improve the system. Under discussion: \$38 million to continue providing care for the indigent; \$2 million to redesign Dorothea Dix Hospital; \$750,000 to study the regional mental health centers; \$1.3 million to pay for antipsychotic drugs; up to \$12 million in federal and state money to reduce waiting list for the developmentally disabled.⁹

FIGURE E: NUMBER OF MENTAL HEALTH BEDS, BY TYPE

SOURCE: *Our State Our Future*,
KPMG Peat Marwick, 1992

Similar Systems in Other States

The mental health industry is organized in ways that are very similar from state to state. The similarities are due much in part to federal funding and program administration guidelines and regulations. There isn't much room for creativity and independent thinking regarding the states' unique mental health needs. The majority of states now operate a combined mental health agency containing mental illness, developmentally disabled, and substance abuse services. Most states operate a state psychiatric hospital system and a series of community-based mental health agencies in the public sector. General hospitals — private, private nonprofit, and public — provide psychiatric care on specially-designated wards for the mentally ill.

The funding apparatus is much the same as state agencies finance mental health care through an array of federal grant and indigent care schemes via Medicaid, Medicare, and other public assistance programs.

North Carolina's mental health system is close to being identical to the organizational and service functions of neighboring states and other regions of the country. However, budgets are somewhat dissimilar among the southeast region, because each state budget is driven by the number of clients served, and clients served is driven by the population of the state.

Commitment Considerations

In this state, commitment policies permit families and physicians to seek orders to have a mentally ill person evaluated for treatment. Commitment policies and procedures being proposed by state mental health leaders have extended the effects of traditional commitment procedures. These measures propose that physicians be given the legal authority to require six months of supervised treatment following hospital discharge. Health care

power-of-attorney statutes providing for advanced authority for treatment of the mentally ill further confirms the intensified efforts to protect the public while ensuring treatment of deinstitutionalized mentally ill patients.¹⁰

Modern-day commitment laws seek to recognize the deinstitutionalization of the bricks and mortar asylums and providing treatment in community-based settings. The most interesting feature of this movement is the forced realization that “commitment” in the asylum without walls simply means that society must authorize “supervised” follow-along medical treatment of discharged clients who will then become the predominant “outpatient” population of the mental health care system in North Carolina.¹¹

With the introduction of highly effective antipsychotic medications three decades ago, it was thought that patients could be effectively treated in the community as outpatients. This wholly reasoned and laudable idea gave rise to a policy of deinstitutionalization in which large numbers of patients who had responded to treatment were discharged from hospitals with the expectation that they continue their treatment as outpatients. The irresistible appeal of this policy, both humanitarian and economic, resulted in a massive reduction in the number of state mental hospital inpatients. About 90% of such inpatients since 1960 have been deinstitutionalized. Obviously, the policy brought about major subsequent problems. The authors of the deinstitutionalization policy assumed that discharged patients would maintain their treatment plans without supervision. The result has been that nearly half of those homeless people on the streets are individuals with mental illness. The most resounding effect of deinstitutionalization is that the number of beds occupied by mentally ill patients is drastically down. There have been so few beds needed that psychiatric hospitals operated by the state have been converted to state government office buildings.¹²

North Carolina has seemingly decided to both preserve asylum-based care and turn its attention to outpatient commitment via voluntary and involuntary treatment policies. This dichotomous focus is being driven as much by notions of protecting the public from the violent behavior of deinstitutionalized patients as it is by the legal requirement to treat and prevent the ravages of mental illness. More than half (53,000) of North Carolina’s 100,000 persons with seriously disabling mental illness are not receiving treatment or receiving services from psychiatric facilities or community-based mental health programs. Coming up with controlled medical treatment strategies in the community could make all the difference in resolving this self-inflicted dilemma of community care and perpetuating outdated asylum-based mental health.¹³

John Baggett of the Division of Mental Health, Developmental Disabilities, and Substance Abuse views this new commitment policy as the key to accomplishing effective community-based care. It addresses concerns about both patient care and public safety. In-place outpatient commitment must assure patient compliance with their medical plan. The technology, expertise, and assertive client treatment, contends Baggett, will provide wraparound care functions including prevention, productive activity, and long-term stability in the community. “Conditional Release” legislation provides statutory authority to local psychiatric providers to deinstitutionalize patients under compliance with a six-month medical plan; noncompliance with such a plan could return patients to psychiatric hospitals. And of course, if the mental health system placed small, widely dispersed hospitals throughout the state as a part of area programs, this conditional release policy would work better for everyone involved.

Privatizing: The Real Thing

Health and human service programs have a lousy track record in the genuine privatization of mental health care. What has been touted the loudest in mental health agencies is the contracting-out of some professional services, such as those of physicians in private or university practice, or support services such as maintaining office equipment. Unfortunately, North Carolina’s mental health officials have learned to use the jargon, but have yet to create a culture of privatization. The evidence unequivocally shows potential cost savings, as demonstrated by

FIGURE F: OUTSOURCING OPPORTUNITIES FOR DOROTHEA DIX HOSPITAL

Current	Potential
• maintenance of various laboratory, medical, and office equipment	• EEG technician
• professional services such as ultrasound, anesthesia, cardiology, dermatology, gastrology, etc.	• furniture refinishing
• residents program and medical staff with University of North Carolina	• grounds maintenance
• interpreter services	• housekeeping and extermination of DHHS buildings
• laundry - contracted with Cherry Hospital	• renovations in excess of \$3,000
• solid waste disposal and recycling	

Source: MGT of America, 1998

services; that it has a privatization system in place. Privatization, in reality, has to facilitate inclusion of private for-profit mental health programs and facilities as “equals” to the local and state owned and operated systems. Public and private entities must be able to compete, on a level playing field, in such factors as cost and service delivery. Obvious cost savings could and would accrue from the elimination of duplicative or marginal positions, facilities, and support services.

Privatization means contracting-out of those services and activities that affect direct patient service delivery and direct program infrastructure delivery. Finally, privatizing ultimately means contracting and outsourcing so that the state mental health headquarters is left with accountability responsibilities for centralized functions such as planning, policymaking, evaluation and monitoring, research and statistics, training, quality assurance, budgeting, and contract administration. Privatization, in this instance, means nothing more or less than creating a competitive marketplace for mental health services, purchased by informed consumers — either patients and families themselves, or area mental health agencies on their behalf.

Contradiction in Terms

Deinstitutionalization is a mental health policy concept with a lofty intention. Unknown to its crafters, however, are the serious contradictions brought on by the premature implementation of deinstitutionalization. The public mental health care system, as a follow-up to this federal policy, was simply unprepared structurally to give meaning to the function and practice of deinstitutionalization. There are five concepts that constitute a contradiction in terms with regard to deinstitutionalization as a casework or public policy practice:

First, severely and seriously mentally ill people are not capable of being effective participants in the labor market. For all practical purposes, the severely mentally disabled are “wards of the state.” The flawed assump-

the MGT of America and other studies. Some human service agencies show savings in the 40% range for some support services such as maintenance and janitorial, house keeping, physical therapy, vehicle maintenance, barber shop, extermination, EEG technician, furniture repair, renovations, construction, and food preparation. Figure F provides both current (1997) and potential outsourcing opportunities existing at Dorothea Dix Hospital in Raleigh. Similar opportunities exist at the remaining three state hospitals (Cherry, Broughton, and Umstead).¹⁴

The professional services side of things is quite misleading to the layperson. The impression conveyed in most instances is that the state is engaged in an active privatization of professional ser-

tion is that such persons are economically and socially independent; they are not. The mentally disabled cannot be expected to execute a medical treatment plan, hold a competitive job, be in control of their faculties and behavior, and perform independent living functions. This population is inherently “dependent” and it is the state’s responsibility to provide for their care and hence the safety and security of society.

Some advocates of limited government, and regular readers of Locke Foundation research, might be surprised at the proposition that the severely mentally ill should be the responsibility of state taxpayers. But the journey from A (a limited government) to B (a government-funded and regulated mental health system) is not a long one. As long as municipalities and counties (creatures of the state) own and operate public streets, many of those without the mental faculties to care for themselves will end up on these streets — inhibiting the ability of such public infrastructure to fulfill its intended tasks of facilitating transportation and commerce. In the past, such individuals might have been confined to jails for “vagrancy.” Surely a mental-health intervention by the state is preferable to this; the question is merely how best to treat these individuals effectively.

Second, there is a problem with the concept of “normality” when it is used to define the object of intervention. Deinstitutionalization, discharge, and release suggest that a state of normality has been achieved or can be maintained through the administration of modern-day antipsychotic medicines. Such normality cannot be achieved or maintained if seriously mentally ill people will not remain under medication and proper care unless they are institutionalized in some setting.

Third, the multi-stream funding structure of the public mental health system in our state is currently in sync with the multi-port of entry organizational structure of the state and local mental health system. So, the call for a single funding stream without radically reforming the statewide mental health system is contradictory and inconsistent. Form follows function whether in service-delivery public policy or organizational public policy.

Fourth, efficiency and effectiveness are not necessarily one and the same; performing efficiently does not inherently mean that service delivery is effective. Concentrating the state’s mental health consulting resources on the study of management performance, cost-benefit analysis, decision strategies, and organizational design doesn’t speak to the relevant issue of how well programs and services improve and strengthen the plight and conditions of the mentally ill. Efficiency studies alone are not enough; the goal of care must be defined and programs (public or private) judged by their effectiveness in reaching the goal.

Fifth, privatization and outsourcing of professional services as practiced in the mental health system cannot be considered as one and the same. To equate the concepts would undermine one of the key principles of “radical reform” of the mental health system in the new millennium. It is disingenuous not only because in-house capacity to deliver professional services doesn’t exist, but because it prevents the building of the critical enabling privatization infrastructure. Building-blocks such as political sanctioning, legislation, bid solicitation, nonpublic system participation, and community/advocacy contracting must flourish with a strong statement of privatization in public policy and enactments.

Part Two: Systemic Problems

Too Much Study and Too Little Vision or Action in Mental Health

Repercussions from the effects of deinstitutionalization on the mental health system in North Carolina have been noticeable from within the halls of the legislature and other venues. The result has been the commissioning of a major cost-efficiency study of North Carolina's four psychiatric hospitals conducted by MGT of America. It is important to recognize that this study idea emanated from the concerns of Rep. Lanier Cansler (R-Buncombe) regarding the fragmented and piecemeal state of the psychiatric hospital system in North Carolina. The study did not address comprehensively the entire mental health system; the focus was placed upon adult mentally ill. Children and the aged mentally ill at the local level were not addressed in detail in the study. Additionally, psychiatric services in general hospitals along with private and private nonprofit facilities and services were not included. Earlier studies conducted by KPMG Peat Marwick in 1992 and later in 1997 focused on management and efficiency issues. The PCG follow-up project authorized in the Fall of 1998 objective is to provide implementation analysis on the findings and recommendations of the 1997 MGT of America study. However, the purposes of the ensuing study focused on the following:

- identify specific areas for improved operations and efficiency;
- identify potential areas for achieving greater cost efficiencies by contracting with private providers;
- identify the need for specific physical plant renovations, replacements, or new construction for improved operations and efficiencies;
- determine the impact of any proposed changes on all potential revenue sources and the need for state appropriations.¹⁵

Too Many Studies Read By Too Few

Now, what seems clear to me is that these studies had to do more with efficiency of operations and less to do with the need to reform the fabric and the function of how this state will more effectively provide services and treatment to the mentally ill within their local communities. This is a particularly troublesome point since the deinstitutionalization and mainstreaming policies have been the driving force behind all that has come to be known as community-based service delivery.

Without a clear focus and constituency for reform, studies just stir up more feeding frenzies and add more opportunities for more rhetoric and very little resilient action on the part of state leaders in both the executive and legislative branches of government. The following story from 1998 illustrates the barriers to implementation that surround continued study:

A Buncombe County Republican proposed Wednesday that the state spend nearly \$3 million for more study of the state's four psychiatric hospitals. Rep. Lanier Cansler, co-chairman of the House Human Resources Committee, said lawmakers should appropriate \$2.9 million to continue recent efficiency studies of the Dorothea Dix, Cherry, Broughton and Umstead hospitals and to begin assessing the state's 40 area mental health authorities — the local centers North Carolinians turn to for mental health treatment. Lawmakers in the House and Senate have introduced bills to study the hospitals and begin a redesign of

Dorothea Dix. “We have a segmented approach to care with respect to mental illnesses,” Cansler told reporters at a morning press conference. “We want to create a new focus on more efficient operations and providing more quality of care for these folks.”

“As long as we have very large, very old facilities it will be difficult to effect change,” said Don Willis, chief of the state mental health division. The aged hospitals need frequent repairs, Willis said. Their old-fashioned ward design require more staffing than at more modern hospitals. And they lack the space to provide therapy to patients. But the division’s backing doesn’t mean thousands of severely ill patients will move to better quarters anytime soon. State leaders — including Health and Human Services Secretary David Bruton, Gov. Jim Hunt and members of the General Assembly — must decide whether to endorse the plan. If they give their blessing, the new hospitals would take four to five years to plan and build, Willis said.¹⁶

Studies of the North Carolina mental health system extend back to the days of the establishment of area mental health authorities. The debate continues regarding the state’s position on future use of facilities or community mental health programs. In the final analysis, no substantive actions have taken place in either direction — while the talk goes on. Additional information may be useful during the reform process, but there already exists adequate research to chart a course for reform.

Lack of Vision

The absence of a vision of the future where the mental health system is concerned means uncertainty and instability. Studies seem to further confuse the issue, bringing on multiple points of view as to what the system should be both structurally and functionally. Agreement by stakeholders on some basic terminology would be the most important first steps in getting decisionmakers reading, writing, and planning on the same page. Terms such as deinstitutionalization, commitment, appropriate treatment, the mental health care system are but a few “make it or break it” concepts which must be fleshed out.

A couple of examples of this: John Baggett, the director of the Division, views deinstitutionalization as a two-pronged concept encompassing (a) inpatient service and treatment inside of modern-day asylums we refer to as psychiatric hospitals and (b) providing care in community-based service and treatment centers we refer to as area mental health authorities. Does this definition of deinstitutionalization leave the state of North Carolina with a static mental health system? It could mean preserving the status quo and leaving little or no room for systemic reform, but rather continuing opportunities for more management and efficiency studies. Baggett’s concept, when viewed another way, could mean new construction of psychiatric hospitals. Such new construction would take place as a part of the area mental health authority’s charge to provide care in the least restrictive environment to patients in the local community.

Deinstitutionalization has had an operational impact on mental health in our state even during the 1990s. The most prominent operational influence has been the increased underutilization of inpatient psychiatric beds as shown by KPMG Peat Marwick’s GPAC study entitled *Our State Our Future*. Not only were public psychiatric hospitals impacted but so were the private psychiatric hospitals and mental health wards of general hospitals.

Don Willis, chief of the mental health section, takes issue with the veracity and accuracy of these GPAC data even though the study was authorized and paid for by the state legislature. It is difficult to analyze actuarial management and treatment effects from one time frame to another when state leaders themselves don’t trust or

have confidence in the information generated by experts in the state's employ. The apparent message here is, if the studies are not sanctioned or performed by the Division of Mental Health, it is of no value in the management decisionmaking process.

The lack of a vision of the mental health care system creates yet another barrier for decisionmakers and advocates to surmount: confusion and uncertainty about the importance of mental health needs and the needs of other competing state initiatives. John Baggett believes that mental health does not rank as a high state priority because mental disability is stigmatized and the program does not receive the political and executive support as other state programs. The evidence strongly suggests to the contrary that this is a problem more akin to no vision than it is to stigma or prejudice against mental disability.

Big Bucks and Little Bang

Some question whether the state has gone far enough in effecting substantive change in mental health care. It isn't for lack of funds, however. As the figure below shows, even if you look only at the mental health component of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the growth in spending since 1992-93 is remarkable — particularly in the non-institutional, community services, and administrative areas. These dollars may not have been wisely spent, but it is hard to argue that they were paltry.

The bad news, though, is that in order to genuinely “fix” the array of available mental health resources in the state, North Carolina will have to spend more in the short run to spend less with greater quality outcomes in the community over the long haul, according to the recent study by MGT of America. Specifically, MGT concluded in its final report that the state's four psychiatric hospitals were badly out-of-date and needed to be replaced. The cost of constructing four new state-of-the-art hospitals was estimated to be \$154 million. MGT recommended that the construction be financed by federal “disproportionate share hospital” receipts over two years.

MGT also recommended a dramatic reduction in capacity in these hospitals, from 2,236 down to 1,287, reflecting the transfer of children, adolescents, elderly patients no longer responsive to psychiatric treatment, and substance abusers to more appropriate (and lower-cost) community treatment. Overall, MGT estimated that the

FIGURE G: TOTAL SPENDING FOR MENTAL HEALTH, 92-93 TO 99-00

Fiscal Year	State Institutions	Community Services/Other	Total Expenditures
1992-93	\$215,416,884	\$137,765,965	\$353,182,849
1993-94	\$230,302,251	\$135,602,900	\$365,905,151
1994-95	\$235,185,512	\$182,768,022	\$417,953,534
1995-96	\$239,503,941	\$181,228,467	\$420,732,408
1996-97	\$248,896,337	\$191,176,051	\$440,072,388
1997-98	\$248,444,351	\$192,530,867	\$440,975,218
1998-99	\$269,332,448	\$212,858,529	\$482,190,977
1999-00	\$274,908,456	\$207,177,633	\$482,086,089
Total Percent Change	27.6%	50.4%	36.5%
Avg. Annual Change	3.6%	6.6%	4.7%
Avg. CPI (Adjusted)	1.7%	1.7%	1.7%

SOURCES: North Carolina State Budget, 1989-91 through 1999-2001 bienniums

FIGURE H: MGT RECOMMENDATION FOR DOWNSIZING, REPLACING HOSPITALS OVER 10 YEARS

State Hospital	No. Beds	Operating Costs	Capital Costs	Total Costs	Cost/Bed/Day
<i>Current Buildings, Beds</i>					
Dorothea Dix	429	\$594,902,733	\$71,653,333	\$666,556,066	\$426
Broughton	632	\$561,431,540	\$10,895,600	\$572,327,140	\$248
Umstead	513	\$567,667,740	\$5,823,333	\$573,491,073	\$306
Cherry	661	\$562,539,045	\$18,473,167	\$581,012,212	\$241
TOTAL	2,235	\$2,286,541,058	\$106,845,433	\$2,393,386,491	\$293
<i>Downsize, Keep Buildings</i>					
Dorothea Dix	247	\$355,176,477	\$71,653,333	\$426,829,810	\$473
Broughton	423	\$386,288,850	\$10,175,025	\$396,463,875	\$257
Umstead	256	\$269,266,290	\$3,070,000	\$272,336,290	\$291
Cherry	361	\$317,726,114	\$17,842,583	\$335,568,697	\$255
TOTAL	1,287	\$1,328,457,731	\$102,740,941	\$1,431,198,672	\$305
<i>Downsize, Replace Bldgs.</i>					
Dorothea Dix	247	\$197,394,202	\$12,800,000	\$210,194,202	\$426
Broughton	423	\$313,858,670	\$16,533,333	\$330,392,003	\$248
Umstead	256	\$188,936,051	\$11,000,000	\$199,936,051	\$306
Cherry	361	\$294,957,162	\$11,000,000	\$305,957,162	\$241
TOTAL	1,287	\$995,146,085	\$51,333,333	\$1,046,479,418	\$293

SOURCE: MGT of America, Final Report on State Psychiatric Hospitals, 1998

cost of operating the four state hospitals without change over the next 10 years would approach \$2.4 billion. Alternatively, the consultants estimated that downsizing the capacity of the current hospitals would cost \$1.4 billion over the same period, saving taxpayers nearly \$1 billion over the 10 years. Finally, MGT estimated that both downsizing and replacing the buildings with smaller, more modern hospitals would cost only \$1 billion. This MGT estimate of cost savings included a cost of \$51 million to build the new buildings, representing the first 10 years of a 30-year amortization of the up-front \$154 million price tag.

There may be some reason to question the MGT of America forecast of decreases in mental health operating costs during the next decade if the “replace and downsize” recommendation is adopted.¹⁷ The forecast assumes continued state ownership and operation of psychiatric hospitals. Therefore, even given possible savings from downsizing and redesign, it is possible that the overall cost savings may not materialize for the following reasons: 1) the cognitive disability population in our state may well continue to grow, 2) existing or new psychiatric hospitals may incur additional unforeseen state capital expense, 3) patient care demands of the chronic and severe mentally ill from area mental health authorities will persist with referrals to the state, and 4) referral of the most severe cases from the private and local hospitals to the state ones will continue.

Perhaps the most significant problem with the savings estimate is that it does not represent a net savings to taxpayers, only a savings in one segment of the mental health services budget that will be somewhat or largely offset by higher costs elsewhere. Obviously, for example, routing nearly 1,000 patients from the hospitals to community-based care will bring significant costs in the latter category, which the study does not estimate. Similarly, part of MGT’s recommendation appears to be to convert unneeded Dorothea Dix space from hospital to office uses, yet the high capital-replacement cost for Dix facilities, estimated by MGT at more than \$70 million over 10 years, doesn’t simply disappear; much of it moves to other DHHS budget codes. Finally, if

further deinstitutionalization is pursued without adequate treatment options and oversight in community-based care, society as a whole may bear greater costs in the areas of homelessness, violence, and law enforcement. Past experience argues for caution here.

Perhaps given no other options, and certainly if community-based treatment alternatives will be available in a competitive and effective manner, the recommendation may make sense. But MGT failed to ask more fundamental questions. Why should all four state hospitals be replaced at state expense given significant available capacity in local or private hospitals? Why should the state make a direct capital investment in four facilities, rather than simply paying the full cost of treatment and letting providers make capital investment decisions themselves as business enterprises?

Threat to the Public

A significant systemic problem today is the conditions inside psychiatric facilities that lead to escapes by psychiatric patients to the streets of our communities. Elements of this problem include violent inmates who have beaten the rap with insanity pleas, inactive patients with bipolar and disorders, severe schizophrenics who become prey for violent patients, and those who appear to be only a danger to themselves just walk away to “freedom” for themselves and potential violence for society.¹⁸

Escapes, discharges, or deinstitutionalization have caused society to be selfishly, but rightfully, concerned with this problem of the severely mentally ill sharing the streets and community. The argument is for doing what is required to protect the public and the mentally ill. Does it really make any difference whether a relative or friend is murdered by a mentally ill patient who has escaped, been discharged, or deinstitutionalized; or whether a criminal committed the horrible act?

Conclusion and Recommendations

State Should Exit the Hospital Business and Oversee Purchase of Services

North Carolina has an opportunity of a lifetime; it is at the crossroads and has to take decisive action as to the direction it will go with its mental health system. Two major operational milestones have been exhausted in their times: the state owned and operated brick and mortar psychiatric hospital system and the area mental health authorities. Two other mental health resource components (private for-profit and private nonprofit psychiatric care) outside the purview of the state have arrived at the point where their viability, in the total scheme of mental health, is dependent upon the choice of direction of the state mental health policymakers.

The intersection between the outmoded and the underutilized elements of the system is where state policymakers should focus their attention. These are the possible directions to take:

1. Go backwards. The state could retain its existing mental health structure and functions by (a) continuing to operate outdated psychiatric facilities, (b) retaining the state-controlled and operated mental health care system, (c) retaining the separateness of public, private, and private nonprofit mental health resources in the state, (d) retaining the multi-stream funding apparatus in the state, and (e) minimizing privatization and competitive contracting opportunities of both direct patient and management support services.
2. Inch forward. This would keep the state in a maintenance mode with only a few changes, such as renovating current state psychiatric facilities, while continuing to study mental health issues over time.
3. Leap forward. This option would retain the overall mental health framework but invest significant new dollars and other resources into (a) replacing current state psychiatric facilities with new ones, (b) reducing the overall bed demands for mental health care at the state level, and (c) continuing to “deinstitutionalize” mental patients without significant attention to their subsequent care in community programs and the possible threats to public safety and security.
4. Change direction entirely. Rather than maintaining the current approach, transform the role of the state from provider of mental health services to an oversight and funding function. This option means (a) getting the state out of the business of operating psychiatric hospitals by transferring ownership of current facilities to area mental health authorities, selling them to private or nonprofit operators, or closing them; (b) reforming the funding process to route more patients needing institutional care into private or nonprofit hospitals and patients needing community-based care into an appropriate setting; and (c) empowering area mental health authorities to act as informed purchasers of services, comparing cost and service quality among an array of providers, on behalf of those severely ill patients who cannot (or their families cannot) make such decisions themselves.

This last approach reflects several important points. First, the state has to get control of deinstitutionalization; it is masked with the label of success when in fact it has been a gigantic failure to the mentally ill and society. Unless treatment and casework practices are able to keep pace with deinstitutionalization, increasing numbers of ill people will be discharged and released onto the streets. Finally, deinstitutionalization generates a perception of physical and social integration into society; such discharged “outpatients” are viewed as “normal” people on the street who are homeless. Deinstitutionalization of the mentally ill is society’s Trojan horse. Hence, society will be increasingly victimized by this policy and the mentally ill will become criminalized.

Second, judging the effectiveness of service-delivery performance by outside evaluators and analysts is practically impossible in the state mental health system. Statistical data and performance jargon are nothing more than a form of rhetoric that prevents objective scrutiny and evaluation of mental health care performance. There is very little chance of substantive improvement and change if the language itself is a communications barrier and no one understands or knows what is being reported in these statistically heavy-laden annual reports.

Third, the state should focus not just on efficiency but on effectiveness. We should go forward with mental health agents of change who will cast off the rhetoric in exchange for radical mental health reform.

Finally, when public psychiatric hospital utilization is above 80%, nonpublic and private psychiatric hospital utilization is around 50%, and nearly half of the seriously mentally ill are going untreated and homeless, the message is unequivocal: we have to embrace fundamental change. We are spending too much and getting too little in return.

Radical Reform

The solution to the problems discussed in this report lie in the will of policymakers to undertake not another study but a comprehensive plan to tear down the existing public mental health system and build a 21st century community-based mental health care service in North Carolina. The major feature of this plan would invite all nonpublic mental health entities operating resources available in the state to join in a single purchase-of-service/delivery-of-service mental health care superstructure under the statutory auspices of the North Carolina Department of Health and Human Services.

Such a bold undertaking must not only address the physical construction of appropriate psychiatric facilities and patient care service delivery, but must also reflect an all-encompassing philosophy fashioned to accomplish a functional community-based mental health infrastructure of facilities and service treatment. The philosophical and operational premise is a simple one: all mental health resources in the state must be utilized as a systemic whole regardless of whether they are (or started out as) state psychiatric hospitals, general hospital psychiatric wards, private psychiatric facilities and services, or private nonprofit psychiatric services and facilities.

This philosophical premise must contain the following basic tenets: (a) community-based service and treatment with proximity to the home as the main feature; (b) systemic deinstitutionalization that accommodates a variety of mental conditions via the application of modern-day clinical casework practice; (c) use of legal policy linkages between “commitment” and “conditional release” requirements; (d) a unified mental health superstructure; (e) establishment of an efficiency-based operating system which has as its foundation a promulgated privatization policy for both management support products and services, and, professional medical and related services and treatments; and (f) a single funding stream for the unified mental health superstructure.

The methodology for accomplishing this unified psychiatric system is one that John Baggett espouses: (a) a “purchase of service” mechanism exercised and controlled under the legal authority of the state where the money would follow the patient and (b) free market competition in an enterprise system where existing psychiatric hospitals (perhaps under different ownership) would compete for sale of facility services and treatment. Lines of distinction between these mental health domains would disappear and all mental health vendors would have the opportunity to engage in business on a level playing field. The mental health superstructure would eliminate the nagging problem of multiple funding streams for mental health entities where service and treatment are concerned. Under this approach, all patient case service monies would come through the state mental health division for disbursement via a patient reimbursement process. Brick and mortar and other mental health capital requirements would be the responsibility of administrators of local participating political subdivisions (such as area mental health agencies) and private organizations.

The state mental health division would exercise responsibility for planning, evaluation, training, program development, budget administration, policy and rulemaking, purchase-of-service, and performance contracting.

It is difficult to understand what is so magical about the four state psychiatric hospital since none of them are held to any proportional service population requirement. So, in building smaller versions of 19th-century psychiatric asylums, why not do the job right: allow local or private providers to build them where they are needed to accommodate full service community mental health care. State control of existing or newly constructed facilities would shift to an enterprise system allowing hospitals to compete for business and earn their keep.

Administrative Reorganization

Mental illness and mental retardation are by definition disabilities. Under the Americans with Disabilities Act of 1990, those persons who are alcohol and substance abusers are also considered to have a disability. Consistent with the John Locke Foundation's Disability Policy Report titled *Enabling the Disabled*, the state of North Carolina should create a Division of Disability Services. This entity would supervise the administration and management of all programs and services for persons with disabilities, both mental and physical. Organizing such a Division would permit greater efficiencies and quality effectiveness of service delivery.

Further, service and treatment practices can be improved with uniquely applicable casework practice where each disability population is concerned through a rigorous cross-training staff development program. The current mental health system is burdened at the state level with the mixing of disabilities resulting in territorial disputes and competition for more and more financial resources.

Accomplishing the radical reform of mental health in North Carolina in the manner outlined above would bring about great benefits for those with mental disabilities. Revisiting disability reform will be an opportunity for North Carolina to get its mental health house in order so the general public and those with mental and physical disabilities can benefit.

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