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A NEW AGENDA FOR MENTAL HEALTH REFORM

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With the historic passage of mental health parity, the stirrings of change in North Carolina's mental health policy can be detected. The appointment of a new Secretary of Health and Human Services offers an opportunity to reflect on North Carolina's public mental health system. There is general agreement that the effort to "reform" mental health by privatizing the provision of public mental health services has resulted in a broken system with an inadequate safety net for many with mental illness.

Recent suggestions for improvement have focused on governance and organization. In her August 17 letter to legislators, former Secretary Odom calls for consolidating local management entities (LME) – the local offices that oversee the provision of mental health services. Alice Lin's report to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDAS) also focuses on governance, viewing mental health reform in NC as a case study in failed implementation.

We suggest that the crucial next steps in reforming mental health in North Carolina should be based on simple people-centered principles. The basic features of a decent mental health system are simple to identify and provide.

All North Carolinians deserve access to a well-trained professional for treatment in a timely, easy-to-negotiate manner. We deserve treatment that is evidence-based, treatments that are proven to work. We deserve care that is integrated and continuous, with doctors and other care providers who talk to each other and stay in the job long enough to get to know us and our illness.

Fixing the complicated mess that the mental health system in North Carolina has become will not be easy. Our proposals focus on the people to be served and the people who serve them.

- 1) Each LME should be required to fund at least one basic one-stop safety-net mental health clinic. Privatization has resulted in a fragmented system with an inadequate safety net, where patients often fail to receive timely psychiatric care. LME's should restore these core clinical homes, providing stable support for a core team of psychiatrists, case managers and other mental health professionals. In these clinical homes, analogous to primary care clinics, patients would be assessed and treated, with referral for other specialized and privatized services only as needed.

2) To begin to restore the shattered professional public sector workforce, especially affecting psychiatrists, North Carolina should fully fund these safety net mental health clinical homes with a critical emphasis on developing and sustaining a revitalized public psychiatrist workforce. This will also assure that training needs of these staff can be addressed, as training has often been inadequate in privatized agencies; we should also address teaching the next generation of clinicians, by returning to the use of the LME clinical homes as training sites.

3) Priority must be given to creating effective substance abuse treatment units throughout the state, with medical detoxification capabilities. Substance abuse treatment (an essential part of preventing criminal recidivism) is woefully underfunded in North Carolina, and this must be remedied.

4) A quasi-governmental mental health policy institute, analogous to the NC Institute of Medicine, should be established with the staff and data capabilities to assess whether people in need are being appropriately served, state funds are appropriately spent, and clinical workforce needs are addressed. This organization would be a credible and fit partner to the legislature, to clients and families, to counties and LMEs, to clinicians and private provider agencies as North Carolina moves forward.

5) DMHDDSAS needs more staff. It was severely downsized before mental health “reform” began and has been unable to effectively manage reform with its current staffing. In addition, with the leadership of the Secretary, it must forge a new power-sharing partnership with the Division of Medical Assistance so that policy and financing are meaningfully aligned.

These proposals are not cheap – but the status quo is very expensive in human suffering and lost productivity. With these proposals as a starting point, North Carolina can begin to bring about what we need and deserve – a public mental health system in which accountable clinical care comes first.

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