

Mental Health

This chapter discusses acts of the General Assembly affecting mental health, developmental disabilities, and substance abuse services. Particular attention is given to legislation affecting the public-sector system of services, including area mental health, developmental disabilities, and substance abuse authorities (area authorities), the local governmental entities responsible for providing and contracting for services.

The most important piece of legislation affecting the administration and delivery of services is S.L. 2001-437 (H 381), an Act to Phase In Implementation of Mental Health System Reform at the State and Local Level. With this legislation the General Assembly changes the way area authorities do business, modifies the relationship between area authorities and county government, and creates two new methods for governing and administering services on the local level. In addition, the act directs the Secretary of the Department of Health and Human Services to oversee the consolidation of local programs and to develop a state plan that, among other things, targets services to specific populations.

Perhaps the other legislative enactment with the most significant impact on services is the Appropriations Act. The Department of Health and Human Services' Division of Mental Health, Developmental Disabilities, and Substance Abuse Services lost 89.5 personnel positions and sustained an 8 percent cut—almost \$50 million—in General Fund appropriations for mental health, developmental disabilities, and substance abuse services. At the same time, the legislature established a \$47 million trust fund to be used, among other things, to enhance community-based services and implement the mental health system reform legislation.

Other legislation includes the creation of a central registry for advance health care directives, changes in the requirements for criminal records checks of employment applicants, amendments to the Substance Abuse Professional Certification Act, and a prohibition on the execution of criminal offenders who are mentally retarded.

Mental Health System Reform

The North Carolina General Assembly has taken an increasingly active role in the public system for mental health, developmental disabilities, and substance abuse services. In 1998 and 1999, the General Assembly directed the Office of the State Auditor to coordinate a comprehensive study of the state psychiatric hospitals, area authorities, and other components of

the public system. (Sec. 12.35A of S.L. 1998-212, sec. 11.36 of S.L. 1999-237.) On April 1, 2000, the State Auditor released the “Study of State Psychiatric Hospitals and Area Mental Health Programs,” which reported numerous findings and recommendations related to the governance, financing, organizational structure, and service delivery systems of area authorities and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. In response the General Assembly established the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services and charged it with developing a Plan for Mental Health System Reform that would provide for systematic, phased-in implementation of changes to the mental health system (S.L. 2000-83). After much study and deliberation by its subcommittees, the Oversight Committee introduced a mental health reform bill intended to address, among other things, such issues as the governance of local service systems, the quality of services, and consumer and family involvement in oversight of the system.

The bill ultimately adopted by the General Assembly, S.L. 2001-437, requires numerous changes to be made to the public system of mental health services. Among its key features, the act requires the Secretary of the Department of Health and Human Services (DHHS) to develop a “catchment area consolidation plan” that reduces the total number of local mental health programs from the current thirty-nine area authorities to twenty programs by January 1, 2007. Further, the secretary must develop and implement a State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services by December 1, 2001, that, among other things, redesigns the service system to target resources to the most needy in the most integrated community settings possible and moves area authorities away from the role of direct service providers toward the role of “local management entit[ies]” responsible for developing, managing, and monitoring networks of service providers.

By October 1, 2002, all counties must submit a “letter of intent” to DHHS designating one of the following four governmental units through which they will provide services as part of the revamped mental health system: (1) a single-county area authority, (2) a multicounty area authority, (3) a county program, or (4) a multicounty program. The first two methods for administering mental health services, the area authorities, are currently provided for by statute and have been, until now, the exclusive means by which counties could provide these services. The third and fourth entities, both referred to in the new legislation as “county programs,” are new options available to counties for purposes of service administration and delivery. In addition to selecting one of these four models, S.L. 2001-437 requires every county, through an area authority or county program, to develop, review, and approve a “business plan” for the management and delivery of mental health, developmental disabilities, and substance abuse services. The business plan must demonstrate, to the secretary’s satisfaction, the area authority’s or county program’s capacity to operate as a local management entity, capable of providing quality services in an efficient manner in its respective geographic service area. Business plans must be submitted to the secretary by January 1, 2003.

State Plan for Services

S.L. 2001-437 requires state and local government, within available resources,¹ to ensure the availability of “core services” to anyone who needs them. Core services include (1) screening, assessment, and referral; (2) emergency services; (3) service coordination; and (4) at the community level, indirect services such as consultation, prevention, and education. The act further defines *core services* as services “necessary for the basic foundation of any service delivery system” and, in order to improve consumer access to services at the local level, requires the secretary’s State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services (State Plan) to describe the core services available to all individuals. The act also requires the state, within available resources, to provide funding for services beyond the core services to

1. The act defines *available resources* to mean “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.”

“targeted populations.”² While the act defines *targeted populations* simply as “those individuals who are given service priority under the State Plan,” the intent of the Oversight Committee that introduced the legislation is that the redesigned system would focus on providing services and support to individuals with the most severe disabilities. In addition to requiring the secretary to develop criteria for identifying targeted populations, the State Plan must provide for or include the following:

- the vision and mission of the state service system;
- the organizational structure of DHHS and its divisions;
- the protection of client rights and consumer involvement in the planning and management of service systems;
- compliance with federal mandates in establishing service priorities;
- service standards;
- implementation of a “uniform portal process,” a set of standardized processes and procedures to ensure that people throughout the state will be able to enter and leave publicly funded services and supports in the same way;
- strategies and schedules for implementing the State Plan that include intersystem collaboration, best practices, technical assistance, outcome-based monitoring, evaluation, and consultation on Medicaid policy with area and county programs, qualified providers, and others designated by the secretary;
- a plan for coordinating the State Plan with the Medicaid State Plan and North Carolina Health Choice;
- a business plan to demonstrate efficient and effective resource management within the service system, including strategies for ensuring accountability for non-Medicaid and Medicaid services; and
- strategies and schedules for implementing a phased-in plan to eliminate disparities in the allocation of state funding among area authorities and county programs by January 1, 2007, including methods for identifying service gaps and ensuring equitable use of state funds to fill those gaps.

In conformity with the act’s other provisions, and to enhance the secretary’s authority over the local service systems, S.L. 2001-437 amends the powers and duties of the secretary to require him or her to:

- Establish a process for the submission, review, and approval or disapproval of business plans submitted by area authorities and county programs.
- Adopt rules specifying the content and format of the business plans.
- Establish comprehensive, cohesive oversight and monitoring procedures and processes that utilize performance measures and report cards to ensure continuous compliance by area authorities, county programs, and all providers of public services with state and federal policy, law, and standards.
- Monitor the compliance of area authorities, county programs, and all providers of public services with their respective business plans; oversee their core administrative functions and fiscal and administrative practices; and monitor outcome measures, consumer satisfaction, client rights complaints, and adherence to best practices.
- Make findings and recommendations based on information collected pursuant to the monitoring and oversight activities and submit them to the applicable area authority board, county program director, board of county commissioners, providers of public services, and Local Consumer Advocacy Offices.
- Adopt rules for the implementation of the uniform portal process.
- Provide counties technical assistance, including conflict resolution services, in the development and implementation of area authority and county program business plans and for other matters, as requested by the county.

2. While the state is responsible for providing funding for services to targeted populations, the act clarifies that both the state and counties must provide matching funds for entitlement program services as required by law.

- Develop accounting methods for calculating county resources expended on public services. These methods should take into account cash and in-kind contributions.
- Adopt rules establishing program evaluation procedures and methods for the management of services.
- Adopt rules regarding federal government requirements for grants-in-aid to area authorities, county programs, or the state.
- Adopt rules for determining “minimally adequate services,” the threshold local programs must meet to avoid enforcement action by the secretary.
- Establish a process for approving area authorities and county programs to provide services directly.
- Sponsor training opportunities in the fields of mental health, developmental disabilities, and substance abuse.
- Enforce and adopt rules for the enforcement of the rights of clients served by state facilities, area authorities, county programs, and providers of public services.
- Prior to any request for approval of the Governor and Council of State to close a state facility, present a plan to the legislature that addresses the impact of the closing.
- Ensure that the State Plan is coordinated with the Medicaid State Plan and North Carolina Health Choice.

Service Provision

Section 1.15 of S.L. 2001-437 limits the authority of county programs and area authorities to provide services directly to clients, requiring these entities to provide services primarily by contracting with other qualified public or private providers. A “qualified public or private provider” is a provider that meets the provider qualifications as defined by rules adopted by the Secretary of DHHS. Only upon approval of the secretary may area authorities and county programs provide services directly. Before approving the direct provision of services, the secretary must take into account the availability of qualified public or private providers as well as the importance of consumer choice, consumer access to services, and fair competition.

In its business plan, each area authority and county program must demonstrate how it will direct the development, maintenance, and oversight of a network of qualified providers of services sufficient to address the needs of the area authority’s or county program’s target populations. The business plan must set forth how gaps in services will be minimized during the transition to the new system, particularly in areas where the current provider network is insufficient.

Local Governance and Administration

In addition to creating two new structures for the governance and administration of local mental health, developmental disabilities, and substance abuse services (the county program and the multicounty program), the mental health reform legislation also modifies the relationship between the area authority and county government in such a way as to increase the county’s role in area authority affairs. To understand these changes, it is necessary first to review the primary features of the present system.

Currently, counties must provide services through an area authority. There are thirty-nine area authorities, fifteen single-county area authorities and twenty-four multicounty area authorities, each serving a designated geographic portion of the state called a “catchment area.” Catchment areas vary widely in geographic size and population. Some cover relatively small populations spread over large rural areas of the state, while others serve large urban populations concentrated in smaller geographic areas. (Because S.L. 2001-437 requires the secretary’s catchment area consolidation plan to reduce the total number of local programs to twenty by January 1, 2007, several of the existing programs will have to merge or otherwise reconfigure their catchment areas in a manner that produces fewer programs with larger catchment areas.)

Each area authority is governed by an area board that exercises specific powers and duties enumerated in the North Carolina General Statutes. These powers and duties include setting service priorities, appointing an area director, establishing a salary plan for area employees,

developing and maintaining an annual budget, preparing fee schedules for services, and entering into contracts necessary for the operation of the area authority.³ The area director appoints and supervises area authority employees, implements area board programs and policies, and administers services in compliance with state law.

Area boards must have between fifteen and twenty-five members, with the size determined by the boards of county commissioners of the counties served by the area authority. In a single-county area, the board of county commissioners appoints the members of the area board. In a multicounty area, each board of county commissioners within the catchment area must appoint one commissioner to the area board; these commissioner members then appoint the remaining area board members. A member may be removed, with or without cause, by the group authorized to make the initial appointment. Area board membership must include statutorily specified representatives, including a person representing the interests of individuals with mental illness, a person representing the interests of individuals with developmental disabilities, a client representing the interests of individuals suffering from alcoholism or other drug abuse, a family member of a client with mental illness, a family member of a client with developmental disabilities, and a family member of a client suffering from alcoholism or other drug abuse.

Like all other local governments and local public authorities, the area authority's budgeting and fiscal management must be administered according to the Local Government Budget and Fiscal Control Act, which prescribes a general system for adopting and administering a budget. Although both single-county and multicounty area authorities are local political subdivisions of the state with the power to exercise independent governing authority on many matters, for purposes of budget and fiscal control a single-county area authority is considered a department of the county in which it is located. Thus, the single-county area authority must present its budget for approval by the county commissioners in the manner requested by the county budget officer, and the area authority's financial operations must follow the budget set by the county commissioners in the county's budget ordinance. By contrast, the multicounty area authority is not a part of the budgeting and accounting system of any county but is responsible for its own budgeting, disbursing, accounting, and financial management, under the direction of a budget officer and a finance officer appointed by the area board.

Changes to the area authority. Currently, the county role in mental health services is limited to a few matters. Specifically, county commissioners appoint and may serve on the area board, appropriate funds for area authority services, possess the authority to purchase and hold title to real property used for providing services, and manage the budget and finances of the single-county area authority. Except for these matters, and depending on how active the commissioner members of the area board are, county government involvement with and attention to mental health services and clients can be minimal. To generate greater county involvement in area authority business, S.L. 2001-437 amends provisions of G.S. Chapter 122C related to personnel and finance. Specifically, the act makes the appointment of the area director subject to the approval of the boards of county commissioners of each county participating in the area authority and requires a county manager and county commissioner to sit on the area director search committee (which must also include a consumer member of the area board and may include a member appointed by the Secretary of DHHS). In matters of budget and fiscal control, the act requires the area authority to submit to the participating board or boards of county commissioners, in a format prescribed by the participating county or counties:

3. In the case of a county with at least 425,000 people, the board of county commissioners may choose a governing body different from the area board. Under G.S. 153A-77, there are two alternatives. The board of county commissioners, by a resolution adopted after a public hearing, may become the governing body for the area authority, in which case the powers and duties of the area board become the responsibility of the board of county commissioners. Mecklenburg County has exercised this option. The second alternative, applicable to counties that operate under the county-manager form of government, allows the board of county commissioners to consolidate the administration and delivery of health services, social services, and area authority services under the control of the county manager and a consolidated human services board. Wake County operates a consolidated human services agency.

- quarterly financial reports;
- quarterly service delivery reports that assess the quality and availability of services within the area authority's catchment area, including the types of services delivered, number of clients served, and services requested but not delivered due to staffing, financial, or other constraints;
- an annual progress report assessing the progress in implementing local service plans, goals, and outcomes; and
- ad hoc reports as requested by the participating boards of commissioners.

In addition to these reports, area authorities must recommend to counties the creation of new services, and multicounty area authorities must provide the area authority's budget and annual audit to the board of county commissioners of each county participating in the area authority. The audit findings must be presented in a format prescribed by the county and read into the minutes of the meeting at which the findings are presented.

Under S.L. 2001-437 boards of county commissioners retain the authority to appoint and remove area board members, and the method of appointment does not change, but the act permits the boards of county commissioners within a multicounty area authority to adopt a resolution setting forth a different method of appointment or allocation of appointment authority. The act also limits the terms of noncommissioner members to two consecutive terms, lowers the minimum number of board members from 15 to 11, and reduces the time permitted for filling vacancies from 120 to 90 days. The requirements for constituent and professional group representation on the area board change only minimally, with one exception: the board of county commissioners may elect to appoint an area board member to fill concurrently more than one category of membership if the member has the qualifications and attributes of all the categories under consideration. Otherwise, when making appointments, counties must take into account sufficient citizen participation, equitable representation of the disability groups, and equitable representation of participating counties. Individuals appointed to the area board must include an individual with financial expertise or a county finance officer, an individual with expertise in management or business, and an individual representing the interests of children. In addition, at least 50 percent of the area board membership must be composed of the following:

- a physician licensed to practice medicine in North Carolina who, when possible, is certified as having completed a residency in psychiatry;
- a clinical professional from the fields of mental health, developmental disabilities, or substance abuse;
- a family member, or an individual from a citizens' organization composed primarily of consumers or their family members, representing the interests of individuals with mental illness;
- a family member, or an individual from a citizens' organization composed primarily of consumers or their family members, representing the interests of individuals in recovery from addiction;
- a family member, or an individual from a citizens' organization composed primarily of consumers or their family members, representing the interests of individuals with developmental disabilities; and
- three openly declared consumers, one with mental illness, one with developmental disabilities, and one in recovery from addiction.

The member of the area board who is the county finance officer or individual with financial expertise must serve on the area board finance committee, and any other finance officers of participating counties in a multicounty area authority may serve on the committee as well.

S.L. 2001-437 grants counties the authority to dissolve, or withdraw from, an area authority upon the determination that the area authority is not operating in the best interests of consumers. No county may withdraw from, however, nor may counties dissolve, an area authority without first demonstrating that continuity of services will be assured and without prior approval of the Secretary of DHHS. Dissolution requires the board of county commissioners of each county constituting the area authority to direct that the area authority be dissolved. Prior to dissolution, the area authority must hold a public hearing with notice published in every participating county at least ten days before the hearing. For a county to withdraw from an area authority, the board of commissioners of the county seeking withdrawal must hold a public hearing with at least ten days

notice. Dissolution or withdrawal can be effective only at the end of the fiscal year in which the action to dissolve or withdraw is taken.

Any budgetary surplus available to an area authority at the time of its dissolution must be distributed to the counties comprising the area authority on the same pro rata basis that the counties appropriated and contributed funds to the area authority's budget during the current fiscal year. The same method of distribution applies when one or more counties decide to withdraw from an area authority. Distribution must be based upon an audit of the area authority's financial records performed in accordance with G.S. 159-34 and conducted by a certified public accountant or an accountant certified by the Local Government Commission to conduct the audit. Funds distributed to a county as a result of withdrawal or dissolution must be placed in the fund balance of the county program or area authority subsequently established or joined by the county. Any liabilities at the time of the dissolution of an area authority must be paid from unobligated surplus funds available to the authority. If these funds are insufficient to satisfy the total indebtedness of the area authority, then the remaining unsatisfied indebtedness will be apportioned to counties on the same pro rata basis that the counties appropriated and contributed funds to the area authority's budget for the current fiscal year.

The county program. In addition to the single-county and multicounty area authority, S.L. 2001-437 permits counties to operate a "county program" for mental health, developmental disabilities, and substance abuse services. Before establishing a county program, the board(s) of county commissioners for the county or counties planning to operate the program must hold a public hearing with notice published at least ten days before the hearing.

Like the area authority, the county program model has both a single-county and a multicounty option. A single-county program is considered a department of the county for all purposes, with a county program director appointed by the county manager. Unlike the single-county area authority, the single-county program is governed by the board of county commissioners, but S.L. 2001-437 requires the board of county commissioners to appoint an advisory committee whose membership must represent many of the same constituent and professional groups represented on the area authority board.

Counties may operate a multicounty program by entering into an interlocal agreement with one or more other counties pursuant to Article 20 of G.S. Chapter 160A. Any interlocal agreement must:

- provide for the adoption and administration of the program budget in accordance with G.S. Chapter 159;
- provide for the appointment of a program director to carry out relevant provisions of G.S. Chapter 122C and duties and responsibilities delegated by the county;
- be designed to serve a targeted minimum population of 200,000 or a targeted minimum number of five counties served by the program;
- comply with the provisions of G.S. Chapter 122C and rules of the Secretary of DHHS and the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services;
- provide for written notification to the Secretary of DHHS prior to its termination;
- provide for the appointment of an advisory committee whose membership conforms to the same requirements for single-county program advisory committees;
- designate a county manager to whom the advisory committee must report; and
- designate the entities authorized to appoint the advisory committee.

Employees appointed by the single-county program director are employees of the county (whereas employees under the direct supervision of an area authority director are employees of the area director). In a multicounty program, employment of county program staff will be as agreed upon in the interlocal agreement.

Some legislative requirements apply equally to county programs and area authorities. Both area authority directors and county program directors must have a master's degree, management experience, and other related experience, unless these qualifications are specifically waived by the Secretary of DHHS. Similarly, county programs must submit to the participating board or boards of county commissioners the same reports (quarterly financial and service delivery reports and an annual progress report) that area authorities are now required to submit.

Implementation of Local System Reform

S.L. 2001-437 provides specific mechanisms for implementing the reform legislation. As discussed above, every county, through an area authority or county program, must develop, review, and approve a business plan for the management and delivery of mental health, developmental disabilities, and substance abuse services. The business plan must include detailed information on how the area authority or county program will meet state standards and abide by the laws and rules for ensuring the quality of services and on the outcome measures to be used for evaluating program effectiveness. The plan must describe how the following core administrative functions will be carried out:

- service planning that, among other things, targets resources to individuals with the most severe disabilities in accordance with the State Plan;
- provider network development;
- service management, including utilization management, case management, and quality management;
- service monitoring and oversight;
- evaluation based on statewide outcome standards and participation in independent evaluation studies;
- financial management and accountability;
- collaboration with other local service agencies, other area authorities and county programs, and the state; and
- facilitation of access to services.

In addition, S.L. 2001-437 requires the business plan to describe :

- how reasonable administrative costs calculated according to state criteria will be achieved;
- how costs or savings anticipated from consolidation will be handled;
- how reinvestment of savings toward services might be achieved;
- how compliance with the secretary's catchment area consolidation plan will be achieved;
- the population base of the catchment area to be served;
- a method to be used to calculate county resources that will reflect cash and in-kind contributions;
- how financial and services accountability and oversight in accordance with the State Plan will be achieved;
- the composition, appointment, and selection process for area boards;
- how local funds will be used for the alteration, improvement, or rehabilitation of real property; and
- other matters as determined by the secretary.

Once the business plan is approved by the board or boards of county commissioners who intend to participate in the area authority or county program, and on or before January 1, 2003, the area authority or county program must submit the plan to the Secretary of DHHS for review and certification. Counties participating in a multicounty area authority or a multicounty program (an interlocal agreement) must jointly submit one plan.

The secretary must review the business plan within thirty days of its receipt. If the plan meets all of the requirements of state law and the standards adopted by the secretary, then the secretary must certify the area authority or county program as a single-county area authority, a multicounty area authority, a single-county program, or a multicounty program. If the secretary determines that changes to the plan are necessary, then he or she must notify the submitting county program or area authority and the applicable participating boards of county commissioners of the changes that need to be made before the proposed program can be certified. The submitting county program or area authority has thirty days from receipt of the secretary's notice to make the necessary changes and resubmit the amended plan to the secretary for review. The secretary must provide any assistance necessary to resolve outstanding issues, and amendments to the business plan must be approved by the participating board or boards of commissioners. Implementation of the business plan must begin within thirty days of certification, and the plan must remain in effect for at least three fiscal years. Each year, in accordance with procedures established by the secretary, each area authority and county program must enter into a memorandum of agreement with the secretary for

the purpose of ensuring that state funds are used in accordance with the priorities expressed in the business plan.

The secretary must complete certification of one-third of the area authorities and county programs by July 1, 2003, another third by January 1, 2004, and the remaining third by July 1, 2004.

Consumer Advocacy Program

As an additional component of reform, Section 2 of S.L. 2001-437 establishes 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. (*Consumer* is defined to mean an individual who is a client or potential client of public services provided by an area or state facility.) This section is effective July 1, 2002, only if the 2001 General Assembly appropriates funds for that purpose during the 2002 regular session.

The Mental Health, Developmental Disabilities, and Substance Abuse Consumer Advocacy Program is to be established by the Secretary of DHHS, who will also appoint a state consumer advocate as its head. The state consumer advocate, in turn, must establish a Local Consumer Advocacy Program in locations designated by the secretary and appoint a local consumer advocate to administer each of the local advocacy programs. The state consumer advocate must also:

- train and certify local consumer advocates,
- establish procedures for processing consumer complaints,
- coordinate these procedures with local human rights committees and the state protection and advocacy agency,
- establish procedures for advocate access to client records,
- monitor the development and implementation of laws and policies relating to consumers,
- monitor data relating to complaints or concerns about services, and
- identify significant systemic problems and opportunities for improvement and advise the secretary accordingly.

Further, the state advocate must submit an annual report to the General Assembly on the types of problems experienced and complaints reported and include recommendations to resolve identified issues and improve the administration of services.

Section 2 of S.L. 2001-437 authorizes the state advocate and local advocates to receive and resolve consumer complaints, and if complaints cannot be resolved informally, to refer them to the appropriate licensing agency. The local consumer advocate, under the supervision of the state advocacy office, must also:

- assist consumers and their families in obtaining services by providing information, referral, and advocacy;
- assist consumers and their families in understanding their rights in, and remedies available from, the public service system;
- serve as a liaison between consumers and facility staff;
- promote consumer and citizen involvement in addressing issues relating to the public service system;
- visit state, area authority, and county program facilities to review and evaluate the quality of care provided to consumers and then submit these findings to the state consumer advocate;
- report regularly to area authorities, county programs, and boards of county commissioners concerning his or her activities and findings;
- provide training and technical assistance to counties, area boards, and providers on how to respond to consumers and evaluate quality of care and availability and access to services;
- coordinate his or her activities with local human rights committees;
- provide information to the public on mental health, developmental disabilities, and substance abuse issues; and
- perform any other related duties as directed by the state consumer advocate.

Finally, the Secretary of DHHS must establish criteria and operational procedures for the Consumer Advocacy Program and report these to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services by March 1, 2002.

Appropriations

General Fund Appropriations

The Current Operations and Capital Improvements Appropriations Act of 2001, S.L. 2001-424 (S 1005), appropriates from the General Fund to the Department of Health and Human Services' Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS) \$581,394,627 for fiscal year 2001–2002 and \$581,068,627 for fiscal year 2002–2003. Appropriations for the past five fiscal years were \$630.4 million (2000–2001), \$614.3 million (1999–2000), \$564.3 million (1998–1999), \$528.5 million (1997–1998), and \$465.6 million (1996–1997).

Cuts in funding, all recurring, include:

- \$1.5 million to area authorities;
- \$2.9 million to the five state-operated mental retardation centers in accordance with the state's plan to downsize those facilities;
- \$1,326,036 in personnel costs by eliminating 89.5 positions;
- \$571,526 by eliminating the planned neurobehavioral treatment unit for persons with traumatic brain injury at Black Mountain Center;
- \$1,079,242 by transferring responsibility for the Cherry Hospital laundry operations to the Department of Correction Enterprise Industries;
- \$420,982 for the medical/surgical unit at Dorothea Dix Hospital; and
- \$600,055 through the elimination of state appropriations to the Oakview Program, an apartment program for adolescents.

The General Assembly continued the trend of reducing appropriations to the state-operated residential treatment programs for children and adolescents while expanding funding for residential treatment alternatives for children at risk of institutionalization or other out-of-home placement. Specifically, the legislature reduced appropriations for child and adolescent beds in the state psychiatric hospitals and for adolescent beds in the state's Eastern Adolescent Treatment Program in Wilson by a combined \$1,809,118. Increased funding for children's services includes \$4,353,000 (recurring) for direct services to seriously disturbed children and \$326,000 (nonrecurring) for residential services to autistic children. Other expansion funding includes \$1 million (recurring) for housing support and placements for the mentally ill and \$3.5 million in recurring funds to area authorities to be allocated as follows:

- \$200,000 for assertive community treatment teams for non-Medicaid clients;
- \$300,000 for family support activities;
- \$1 million for substance abuse services to special populations; and
- \$2 million to expand detoxification, residential, and outpatient services.

The state budget includes a \$15 million appropriation to a reserve to implement the Health Insurance Portability and Accountability Act (HIPAA), a federal law that—among other things—requires health plans, health information clearinghouses, and health care providers to standardize their electronic transactions of health information and to protect the privacy and security of the information. S.L. 2001-424 establishes the reserve in the Office of State Budget and Management and directs that office, in consultation with the state Chief Information Officer and the Secretary of DHHS, to develop a strategic plan to implement HIPAA within the state's agencies.

Mental Health Trust Fund

Section 21.58 of S.L. 2001-424 amends G.S. Chapter 143 to establish the Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services and Bridge Funding

Needs. The General Assembly appropriates \$47,525,675 (nonrecurring) to the trust fund, an interest-bearing, nonreverting fund in the Office of State Management and Budget. The State Treasurer will be the custodian of the trust fund, and investment earnings credited to the assets of the trust fund must become part of the fund. Moneys in the trust fund must be used solely to meet the service needs of the state and to supplement, not supplant, existing state and local funding. Specifically, the trust fund must be used only to:

- Provide start-up funds and operating support for programs and services that provide more appropriate and cost-effective community treatment alternatives for individuals currently residing in state-operated institutions.
- Facilitate the state's compliance with the United States Supreme Court decision in *Olmstead v. L.C.*, 527 U.S. 581, 119 S. Ct. 2176, 144 L. Ed. 2d 540 (1999). (In *Olmstead*, the Court held that the unnecessary placement of individuals with mental disabilities in institutions may constitute discrimination based on disability, in violation of the Americans with Disabilities Act. As a result of the ruling, states risk litigation if they do not develop a comprehensive plan for moving qualified persons with mental disabilities from institutions to less restrictive settings at a reasonable pace.) Money in the Mental Health, Developmental Disabilities, and Substance Abuse Services Reserve for System Reform and *Olmstead*, established last year, is to be transferred to the trust fund.
- Expand and enhance treatment and prevention services so that waiting lists can be eliminated and appropriate and safe services can be provided to clients.
- Provide bridge funding to maintain appropriate client services during transitional periods resulting from facility closings and departmental restructuring.
- Construct, repair, or renovate state mental health, developmental disabilities, and substance abuse facilities.

After consultation with advocacy groups and affected state and local agencies and programs, DHHS must develop a plan for using the moneys from the trust fund. This plan must be consistent with the State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services. Moneys in the trust fund may be used to establish or expand community-based services only if sufficient recurring funds for this purpose can be identified within DHHS from funds currently budgeted for mental health, developmental disabilities, and substance abuse services.

Funds may not be transferred from the trust fund until the Secretary of DHHS has consulted with the Joint Legislative Commission on Governmental Operations, the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and the chairs of the Senate Appropriations Committee on Health and Human Services and the House of Representatives Appropriations Subcommittee on Health and Human Services.

Federal Block Grant Allocations

Section 5.1 of S.L. 2001-424 allocates federal block grant funds for fiscal year 2001–2002. From the Mental Health Services Block Grant, the General Assembly allocated \$5,192,826 (compared to \$4,301,361 in 2000–2001 and \$3,895,179 in 1999–2000) for community-based services provided in accordance with the state's comprehensive plan for services for persons with severe and persistent mental illness. From the same block grant, the legislature appropriated \$2,378,540 for community-based services to children (\$1,898,520 was allocated in 2000–2001) and \$1.5 million for the Child Residential Treatment Services Program, the same amount appropriated in 2000–2001, the first year of the program.

Allocations from the Substance Abuse Prevention and Treatment Block Grant include \$6,839,190 for services for children and adolescents (compared to \$7,216,992 in 2000–2001) and \$14,501,711 (\$542,130 less than in 2000–2001) for alcohol and drug abuse services provided by community-based and state-operated treatment centers. (The latter includes an unspecified amount for tuberculosis services.) To the Child Residential Treatment Services Program, the General Assembly allocates \$700,000 from this block grant, \$300,000 less than the amount allocated in 2000–2001.

From the Social Services Block Grant, which funds several DHHS divisions, the General Assembly allocates \$3,234,601 to MH/DD/SAS and another \$5 million to individuals who are on

the state's waiting list for developmental disability services. These allocations mirror the allocations made in 2000–2001.

From the Temporary Assistance to Needy Families (TANF) Block Grant, MH/DD/SAS receives three allocations: \$3.5 million for substance abuse screening, diagnosis, treatment, and testing of Work First participants; \$1,182,280 for substance abuse services for juveniles; and \$4.5 million to provide regional residential substance abuse treatment and services for TANF women with children.

State Government

Section 21.14 of S.L. 2001-424 directs DHHS to establish an Office of Policy and Planning within the Office of the Secretary to:

- coordinate the development of departmental policies, plans, and rules, in consultation with the divisions of the department;
- create a departmental process for the development and implementation of new policies, plans, and rules;
- develop a departmental process for the review of existing policies, plans, and rules to ensure that they are relevant;
- coordinate and review all departmental policies before dissemination to ensure that they are well coordinated within and across all programs;
- implement ongoing strategic planning that integrates budget, personnel, and resources with the mission and operational goals of the department; and
- review, disseminate, monitor, and evaluate best practice models.

The Director of the Office of Policy and Planning will have the authority to require divisions, offices, and programs within DHHS to conduct periodic reviews of policies, plans, and rules and to recommend to the secretary the repeal, modification, or amendment of those policies, plans, and rules.

Several other special provisions of the budget act require DHHS to consolidate, centralize, or coordinate activities or programs. These provisions:

- Require DHHS to consolidate its regional, district, field, and satellite offices by June 30, 2002, and to report to the General Assembly the anticipated cost savings and efficiencies in service delivery resulting from the consolidation.
- Require DHHS to implement a centralized contracts system including policies and procedures for the development and execution of contracts.
- Establish the Intervention Services Unit within the Office of the Secretary of DHHS. This unit will be responsible for the planning, research, monitoring, and data analysis necessary to enhance coordination among programs and activities related to intervention services. Services to be coordinated include MH/DD/SA services, social services, public health services, preschool education services, and Smart Start services.

S.L. 2001-424 also authorizes DHHS to establish special time-limited positions in the Division of Information Research Management for an information technology project to prepare for and implement the privacy provisions of HIPAA. These positions expire June 30, 2003.

Licensed Professionals

Certified Substance Abuse Professionals

S.L. 2001-370 (S 1062) amends the Substance Abuse Professional Certification Act to add “registrant” to the list of professionals regulated by the North Carolina Substance Abuse Professional Certification Board. *Registrant* is defined, at G.S. 90-113.31(6a), as a “person who has initiated a certification process to become a certified substance abuse counselor or a certified clinical addictions specialist pursuant to this Article and is authorized to provide DWI assessments

pursuant to G.S. 122C-142.1.” Effective April 1, 2002, the licensing board must designate as a registrant an applicant who (1) completes a registration application form and pays the required fee; (2) provides documentation that he or she has received a high school diploma, or the equivalent, and evidence of any baccalaureate or advanced degree he or she has received; (3) provides documentation of three hours of educational training in ethics; (4) signs a form attesting to his or her commitment to adhere to the ethical standards adopted by the board; and (5) signs a supervision contract provided by the board that documents the proposed supervision procedures to be implemented by an approved supervisor.

Registrant status may be maintained for a period of up to five years while the registrant is in the process of completing certification requirements. If at the end of the five-year period a registrant has not obtained certification, he or she may apply to renew the registration for an additional five-year period.

The act also designates as follows the persons qualified to supervise individuals applying for registration or certification as a substance abuse professional:

- A certified clinical supervisor must supervise a clinical supervisor intern.
- A certified clinical supervisor or a clinical supervisor intern must supervise a residential facility director applicant, a clinical addictions specialist applicant, or a substance abuse counselor applicant.
- A certified clinical supervisor, a clinical supervisor intern, a certified clinical addictions specialist, or a certified substance abuse counselor must supervise a registrant who provides DWI assessments.
- A certified prevention consultant with a minimum of three years of professional experience, a certified clinical supervisor, or a clinical supervisor intern must supervise a registrant applying for certification as a prevention consultant.

The foregoing supervision requirements do not apply to persons applying for certification as a certified clinical addictions specialist under G.S. 90-113.41A.

S.L. 2001-370 amends the disciplinary provisions of the certification act to provide that a Class A-E felony conviction must result in immediate suspension of certification or registration for a minimum of one year. The act also sets the maximum fees that may be assessed for applications for, and renewals of, registration and raises the maximum fees that may be charged for certification and renewals of certification.

G.S. 90-113.41B currently provides that a treatment recommendation for persons convicted of driving while impaired must be reviewed and signed by a certified substance abuse counselor, a physician certified by the American Society of Addiction Medicine, or a certified alcoholism, drug abuse, or substance abuse counselor as defined by the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services. The act amends this statute to require that the signature on the recommendation be the personal signature of the individual authorized to review the recommendation and not the signature of his or her agent. Further, the signature must reflect that the authorized individual has personally reviewed and approved the recommended treatment.

Licensed Professional Counselors

S.L. 2001-297 (H 593) amends Articles 50 and 65 of G.S. Chapter 58 to provide for direct payment to licensed professional counselors for services covered by health insurance policies and plans. Any person licensed by the North Carolina Board of Licensed Professional Counselors and providing services within the scope of practice of a duly licensed professional counselor is covered by the act.

Physicians

In S.L. 2001-27 (S 118), the legislature amended G.S. 90-18 to clarify that any person who uses the Internet, a toll-free telephone number, or other electronic means to prescribe medication or otherwise practice medicine in North Carolina must be licensed by the North Carolina Medical Board. The law provides an exception for physicians in other states or foreign countries who are contacted by a regular patient for treatment while the patient is temporarily in North Carolina.

Advance Health Care Directive Registry

S.L. 2001-455 (H 1362) amends G.S. Chapter 130A, effective January 1, 2002, to require the Secretary of State to establish and maintain a statewide, on-line, central registry for advance health care directives. The act authorizes persons who execute an advance directive to submit the directive, and any subsequent revocation of the directive, to the secretary for filing in the registry. The failure to register an advance directive with the secretary does not affect the directive's validity, and the failure to notify the secretary of the revocation of a document filed with the registry will not affect the validity of a revocation that meets the statutory requirements for revocation. Documents that may be submitted to the registry include:

- an advance instruction for mental health treatment executed pursuant to Article 3 of G.S. Chapter 122C,
- a health care power of attorney executed pursuant to Article 3 of G.S. Chapter 32A,
- a declaration of a desire for a natural death executed pursuant to Article 23 of G.S. Chapter 90, and
- a declaration of an anatomical gift executed pursuant to Article 16 of G.S. Chapter 130A.

S.L. 2001-455 amends the laws regarding these documents to permit physicians and health care providers to rely upon a copy of a document obtained from the registry to the same extent that they may rely upon the original document.

Documents submitted for registration must be notarized and accompanied by a return address and any required fee. Upon receiving the document the secretary must create a digital reproduction of the document for entry into the registry database, assign a unique file number and password to the document, return the original document to the person who submitted it, and give him or her a wallet-size card with the electronic document's file number and password printed thereon. Upon receiving a revocation of a document that is filed with the registry and that document's file number and password, the secretary must delete the document from the registry database. The fee for filing a document is \$10, except no fee may be charged for filing a revocation.

The secretary is not required to review a document to ensure that it complies with the statutory requirements applicable to it. Entry of a document into the registry does not:

- affect the validity of the document in whole or in part;
- relate to the accuracy or information in the document; or
- create presumption regarding the validity of the document concerning either the accuracy of the information contained in the document or whether the statutory requirements for the document have been met.

Further, the secretary, any agent or person employed by the secretary, and the State of North Carolina are immune from liability for any claims arising out of the administration or operation of the registry, excluding claims for acts of gross negligence, willful misconduct, or intentional wrongdoing.

The registry will be accessible only over the Internet, and a document in the registry must only be accessible if the person attempting to obtain access enters both the file number and password for the document. Documents filed in the registry, file numbers, passwords, and any other information maintained by the secretary pursuant to operating the registry are exempt from the public records law.

Criminal Record Checks

DHHS

Section 21.2 of S.L. 2001-424 requires DHHS to centralize all activities throughout the department relating to the coordination and processing of criminal record checks required by law. The centralization must include the transfer of positions and corresponding funds. The department must report its progress in this effort to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division by January 1, 2002.

Area Authorities

Two bills were enacted that affect criminal record checks conducted on behalf of area authorities. G.S. 122C-80, enacted in 2000, requires area authorities and their contract agencies to condition an offer of employment, if the position applied for does not require the applicant to have an occupational license, on the applicant's consent to a state and national criminal history check when the applicant has been a North Carolina resident for less than five years. When the applicant has been a state resident for five or more years, only a state criminal history check is required. Within five business days of making a conditional offer of employment, the agency must submit to the Department of Justice (DOJ) a request for a criminal history record check with a form signed by the job applicant that demonstrates the applicant's consent to the check and to the use of fingerprints where applicable. G.S. 114-19.10 authorizes DOJ to provide criminal histories from both the state and national repositories of criminal histories and outlines the procedures for agencies to use when requesting a criminal history check.

S.L. 2001-155 (H 857) amends G.S. 122C-80 to permit an area authority to submit its request for a criminal history record check to a county rather than DOJ. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct a state criminal history record check on behalf of an area authority without the area authority having to submit a request to DOJ. In this case the county must commence the record check within five business days of the conditional offer of employment by the area authority.

The second enactment results from a change in federal law. The federal budget act of 1999 (Pub. L. No. 105-277) provided in 28 U.S.C. § 534 that a nursing facility or home health care agency could request the U.S. Attorney General to conduct a criminal history check of job applicants if the job involved direct patient care. In light of this provision, S.L. 2001-465 (S 826) suspends until January 1, 2003, those North Carolina provisions purportedly authorizing greater access to national criminal history information. Effective November 16, 2001, the act provides that, notwithstanding G.S. 131E-265, nursing homes and home care agencies are not required to conduct national criminal history checks for jobs other than those involving direct patient care; and notwithstanding G.S. 131E-265(a1), 131D-40, and 122C-80, contract agencies of nursing homes and home care agencies, adult care homes and their contract agencies, and area mental health authorities are not required to conduct national criminal history checks. The act also directs the Legislative Research Commission to study how federal law affects access to national criminal history information for these entities.

Health Insurance and Related Laws

Patients' Bill of Rights

This session legislation denominated a "Patients' Bill of Rights" by its supporters was approved and made significant changes in the laws affecting health insurers and managed care plans. Among other things, S.L. 2001-446 (S 199) establishes that managed care entities may be held liable for harm to insureds proximately caused by the entity's failure to exercise ordinary care when making the determination not to pay for a health care service because it does not meet the

health plan's requirements for medical necessity, appropriateness, health care setting, or level of care or effectiveness. The legislation also requires insurers to establish a binding procedure for independent review of coverage decisions that are adverse to insured persons and creates a new program to assist patients in exercising their rights under the law. For a detailed discussion of the Patients' Bill of Rights and other laws affecting the obligations of health insurers, see Chapter 11, "Health."

Health Choice (State Children's Health Insurance Program)

North Carolina Health Choice is the state's program that provides health insurance for children who would otherwise be uninsured because their family incomes are too high to qualify the children for Medicaid but too low for the family to afford private insurance. Early in 2001, enrollment in Health Choice was frozen because of an anticipated shortfall in funding for the program. The budget act expands the funding for Health Choice by \$8 million in fiscal year 2001–2002 and \$12.5 million in fiscal year 2002–2003. In addition, a special provision in the budget law eliminates the waiting period for the Health Choice program. Previous law required that a child be uninsured for at least sixty days before applying for Health Choice.

Medicaid

Medicaid is a state and federally funded entitlement program that provides payment for health care services for low-income people. It is an extremely significant component of the state budget, accounting for more than 10 percent of total state expenditures each fiscal year. Further, it accounts for more than one-third of all area authority revenues.

In this session's budget act, the legislature appropriates an additional \$460 million for the Medicaid program for fiscal year 2001–2002—a 30 percent increase over the 2000–2001 appropriation. The increase is not enough, however, to cover the program's anticipated costs, so the legislature also makes several cuts to the Medicaid budget. It reduces provider reimbursement rates and eliminates inflationary increases in those rates. It reduces anticipated expenses for prescription drugs by increasing co-payments, lowering dispensing fees, and requiring the use of generic drugs in most instances. It also requires the Division of Medical Assistance, the state agency that administers Medicaid, to contain costs by reducing the rate of growth of the Medicaid program—but not the rate of growth in the number of persons eligible for the program—to 8 percent or less of the total expenditures in fiscal year 2001–2002. These and other budget provisions affecting Medicaid, including provisions expanding Medicaid funding for certain services, are discussed in Chapter 11, "Health."

Group Homes for Developmentally Disabled Adults

Pursuant to S.L. 2001-209 (H 387), group homes for developmentally disabled adults licensed as adult care homes under Article 1 of G.S. Chapter 131D are now subject to licensure as supervised living facilities for developmentally disabled adults under Article 2 of G.S. 122C. A supervised living facility will be subject to adverse action on a license under G.S. 122C-24 and, at its option, must comply with either the categories of existing rules applicable to group homes for developmentally disabled adults adopted under Article 1 of G.S. Chapter 131D or the categories of existing rules applicable to residential facilities defined at G.S. 122C-3(14)e.

Several other enactments affect adult care homes and concern such matters as reporting requirements, patient notices, the application of the state's certificate of need law, and studies to be conducted by DHHS. These are discussed in Chapter 11, "Health."

No Death Penalty for the Mentally Retarded

New G.S. 15A-2005, enacted by S.L. 2001-346 (S 173), provides that “no defendant who is mentally retarded shall be sentenced to death.” The law places the burden of proving mental retardation on the defendant. He or she must show (1) significantly subaverage general intellectual functioning, defined as an IQ of 70 or less; (2) significant limitations in adaptive functioning in two or more adaptive skill areas, such as communication and self-care; and (3) the existence of both concurrently before the age of eighteen.

Bills prohibiting the execution of persons with mental retardation have come before the General Assembly previously and failed. The act’s passage this session was no doubt aided by the U.S. Supreme Court’s decision to review *McCarver v. North Carolina*, a case raising the constitutionality of executing mentally retarded people. After the act passed, the Court vacated its decision to review the case, but its concern about this issue remains. The same day the Court decided not to hear *McCarver*, it granted review of a Virginia case presenting the constitutionality of executing mentally retarded people. *See Atkins v. Virginia*, 122 S. Ct. 24 (2001).

For a detailed analysis of S.L. 2001-346, see Chapter 6 “Criminal Law and Procedure.”

Other Laws

Database of Children Receiving Psychotropic Medications

Concerned with the increased use of psychotropic medications in the treatment of children, the General Assembly directed DHHS and the Department of Juvenile Justice and Delinquency Prevention to review the feasibility of establishing and maintaining a statewide database containing information on the prescription and administration of psychotropic medications to children who receive state services while residing in state facilities administered by either department. S.L. 2001-124 (S 542) requires the departments, in conducting the review, to consider how the database can be maintained in a manner that protects medical records and other privacy interests as required by state and federal law. By January 1, 2002, the two departments must report their findings and recommendations, including the cost of establishing and maintaining the database in a manner that provides data for analyzing prescription medication usage by and effects on children, to the Joint Legislative Health Care Oversight Committee and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

Cherry Hospital and Dorothea Dix Hospital Security Force

S.L. 2001-125 (S 370) authorizes the Secretary of DHHS to establish security personnel at both Dorothea Dix Hospital and Cherry Hospital to enforce North Carolina laws and DHHS regulations on hospital territory. When acting within hospital territory, these special police officers have the same powers vested in sheriffs. In addition, upon notice of an escape or breach of conditional release from the hospital, these officers may take a patient into custody outside of hospital territory but only within the county in which the hospital is located. In addition, they may arrest a person outside hospital territory but within the county in which the hospital is located when (1) the person has committed an offense at the hospital for which the officer could have arrested the person and (2) the arrest is made during the person’s immediate and continuous flight from the hospital.

Public Official Conflict of Interest

S.L. 2001-409 (H 115) clarifies and updates several criminal statutes prohibiting public officials from benefiting from contracts with public agencies. The act repeals G.S. 14-236 and 14-237 and incorporates their essential provisions into revised G.S. 14-234. For a detailed discussion of these provisions, see Chapter 21, “Purchasing and Contracting.” A violation of the conflict-of-

interest provisions remains a Class 1 misdemeanor. The principal parts of the act apply to actions taken and offenses committed on or after July 1, 2002.

Domestic Violence Privilege

S.L. 2001-277 (H 643) creates a new evidentiary privilege for communications made to domestic violence shelter and rape crisis center personnel, effective for communications made on or after December 1, 2001. This act, described more fully in Chapter 6, "Criminal Law and Procedure," appears to have been adopted in response to efforts by those accused of domestic abuse to obtain information provided to such centers by their alleged victims.

Marital Counseling Privilege

G.S. 8-53.6 prevents physicians, licensed psychologists, and marital and family therapists from disclosing marital counseling information in alimony and divorce proceedings. S.L. 2001-152 (S 739) extends this coverage to licensed psychological associates and licensed clinical social workers.

Inpatient Substance Abuse Facilities Serving Prison Inmates

Section 25.19 of the budget act exempts from licensure under G.S. Chapter 122C, and from certificate-of-need requirements under G.S. Chapter 131E, inpatient chemical dependency or substance abuse facilities that provide services exclusively to inmates of the Department of Correction. If a facility serves both inmates and members of the general public, the portion of the facility that serves inmates is exempt from licensure. If a facility is built without a certificate of need, it may not admit anyone other than inmates until a certificate of need is obtained.

Mark F. Botts