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## Mental Health

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This chapter discusses acts of the General Assembly affecting mental health, developmental disabilities, and substance abuse services, with particular attention given to legislation affecting publicly funded services. Although these services are administered on the state level by the Department of Health and Human Services' (DHHS) Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, they are delivered primarily at the community level through a service network managed by local governments or units of local government called area mental health, developmental disabilities, and substance abuse authorities (area authorities) or county mental health, developmental disabilities, and substance abuse programs (county programs). These entities are also referred to as "local management entities," a term not defined in statute but used colloquially and in some of the legislation discussed in this chapter, denoting a shift in the function of area authorities and county programs from service provider to manager of service providers resulting from changes mandated by S.L. 2001-437.

Among the 2005 legislative enactments are laws requiring area authorities and county programs to establish a crisis response system for psychiatric and substance abuse crises, permitting disclosure of medical records to employers and insurers paying medical compensation under the Workers' Compensation Act, and providing for the credentialing of criminal justice addictions professionals. The General Assembly also made changes to the laws governing the licensure and inspection of residential treatment facilities and enacted several provisions governing children's services, aimed at inducing greater coordination and collaboration among the several state agencies that administer services and programs for children at risk of institutionalization or other out-of-home placement.

### **Appropriations**

#### **General Fund Appropriations**

The Current Operations and Capital Improvements Appropriations Act of 2005, S.L. 2005-276 (S 622), appropriates \$603,315,155 from the General Fund to the Division of Mental Health, Developmental Disabilities, and Substance Abuse (MH/DD/SA) Services for fiscal year 2005-06 and \$602,556,655 for 2006-07, both more than the \$574.4 million appropriated for 2004-05 but less than the \$630.4 million appropriated for 2000-01, the high-water mark in recent years for public mental

health services funding. Other annual appropriations for the past six years were \$577.3 million (2003–04), \$573.3 million (2002–03), \$581.4 million (2001–02), \$630.4 million (2000–01), and \$614.3 million (1999–2000).

The 2005 appropriations act cuts funding to the Division of MH/DD/SA Services by \$3,050,000 for each fiscal year of the 2005–07 biennium by continuing two reductions from last year: \$500,000 for the Division of MH/DD/SA Service’s central office operations and \$2,550,000 in funding to state-operated institutions. The central office funding reduction is based on historical reversions and the state institution reduction is offset by budgeting over-realized receipts.

S.L. 2005-276 provides a net increase in MH/DD/SA services funding after balancing the reductions with over \$10 million in expansion funding, including the following recurring funding:

- \$2 million for start-up and continuing funding for crisis services
- \$2 million for implementing and continuing community-based “system of care” child and family teams
- \$258,000 for the mental health treatment courts in judicial districts 15B and 26 (serving Orange/Chatham and Mecklenburg counties respectively)
- \$1.25 million for intensive substance abuse services for children
- \$750,000 for adult substance abuse services
- \$427,747 for the UNC TEACCH Division in the School of Medicine
- \$1.5 million for long-term vocational support services for clients in supported employment

In addition to the recurring expansion funds, nonrecurring increases in funding for MH/DD/SA services include a number of relatively small grants-in-aid for specific programs as well as \$1.95 million to address a lack of sufficient funding for the administration of local management entities.

Increases in recurring funding to the DHHS Division of Facility Services (DFS) that could impact the quality of MH/DD/SA services include \$936,000 for 2005–06 and \$1,560,724 for 2006–07 to add twenty-three new personnel positions in the division’s Mental Health Licensure and Certification Section and to create two new regional offices. Thirty-one new personnel positions and two new regional offices are added to the Adult Care Licensure Section of DFS through approximately \$3 million in expansion funding over the 2005–07 biennium.

### **Mental Health Trust Fund**

In 2001 the General Assembly established the Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services and Bridge Funding Needs as a nonreverting special trust fund in the Office of State Budget and Management. G.S. 143-15.3D provides that the fund must be used solely to meet the mental health, developmental disabilities, and substance abuse services needs of the state and must supplement, not supplant, existing state and local funding for these services. Specifically, the fund must be used only for the following:

1. To provide start-up and operating funding for community-based treatment alternatives for individuals residing in state-operated institutions
2. To facilitate compliance with the U. S. Supreme Court’s *Olmstead*<sup>1</sup> decision
3. To expand services to reduce waiting lists
4. To provide bridge funding to maintain client services during transitional periods of facility closings and departmental restructuring
5. To construct, repair, and renovate state mental health, developmental disabilities, and substance abuse facilities

In 2005 the General Assembly allocated \$10 million in nonrecurring funds to the trust fund for fiscal year 2005–06, following trust fund appropriations of \$10 million in 2004–05 and \$12.5 million in 2003–04.

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1. *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 segregation 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.

Section 10.24 of S.L. 2005-276 directs that money may not be transferred from the trust fund until the Secretary of DHHS consults with the Joint Legislative Oversight Committee on MH/DD/SA Services and with the chairs of the Senate Appropriations Committee on Health and Human Services and the House of Representatives Appropriations Subcommittee on Health and Human Services. Further, DHHS must use at least 50 percent of the trust fund money for fiscal year 2005–06 for nonrecurring start-up funds for community-based services, which may include funding for transferring the provision of services from area authorities and county programs to the private sector or other public agencies. Trust funds may be used to expand recurring community services only if DHHS can identify sufficient recurring funds within its current budget for the continued support of these services.

### **Federal Block Grant Allocations**

Section 5.1 of S.L. 2005-276 allocates federal block grant funds for fiscal year 2005–06. The Mental Health Services (MHS) Block Grant provides federal financial assistance to states to subsidize community-based services for people with mental illnesses. This year the General Assembly allocated \$6,983,202 (up from \$6,307,035 in 2004–05) from the MHS Block Grant for community-based services for adults with severe and persistent mental illness, including crisis stabilization and other services designed to prevent institutionalization of individuals when possible. From the same block grant the legislature appropriated \$3,921,991 (the same amount as in 2004–05) for community-based mental health services for children, including school-based programs, family preservation programs, group homes, specialized foster care, therapeutic homes, and special initiatives for serving children and families of children having serious emotional disturbances. As it did last year, the General Assembly allocated \$1.5 million of the MHS Block Grant funds for the Comprehensive Treatment Services Program for Children (CTSP), which provides residential treatment alternatives for children who are at risk of institutionalization or other out-of-home placement.

The Substance Abuse Prevention and Treatment (SAPT) Block Grant provides federal funding to states for substance abuse prevention and treatment services for children and adults. This year's SAPT Block Grant funding matched the funding levels of 2004–05. The General Assembly allocated \$20,441,082 for the state-operated alcohol and drug abuse treatment centers, community-based alcohol and drug abuse services, and tuberculosis services. Other allocations include \$4,940,500 for services for children and adolescents (for example, prevention, high-risk intervention, outpatient, and regional residential services), \$5,835,701 for child substance abuse prevention, and \$8,069,524 for services for pregnant women and women with dependent children. The budget act also appropriates \$4,816,378 from the SAPT Block Grant for substance abuse services for treatment of intravenous drug abusers and others at risk of HIV disease and \$851,156 for prevention and treatment services for children affected by parental addiction.

From the Social Services Block Grant (SSBG), which funds several DHHS divisions, S.L. 2005-276 allocates \$3,234,601 to the Division of MH/DD/SA Services for unspecified purposes and another \$5 million to assist individuals on the state's developmental disabilities services waiting list. From the same block grant, the General Assembly allocated \$205,668 (down from \$213,128 in 2004–05) to the DHHS DFS for mental health licensure purposes and \$422,003 for the CTSP for Children. Both of the CTSP block grant allocations, from the MHS and SSBG block grants, must be used in accordance with Section 10.25 of the budget act, discussed below in the section entitled "Comprehensive Treatment Services Program for Children."

## **Area Authorities and County Programs**

### **Crisis Services**

S.L. 2005-371 (H 1112) amends the statutory powers and duties of area authorities by requiring them to maintain, twenty-four hours a day, seven days a week, a service system for responding to psychiatric and substance abuse crises. New G.S. 122C-117(a)(14) requires area authorities to establish

both telephonic and face-to-face capabilities, clarifying that area authorities' crisis response systems must go beyond providing telephonic triage and referral to other providers to include crisis prevention, intervention, and resolution services as well. These services must be provided in the least restrictive setting possible consistent with patient and family needs and community safety. Crisis services do not require prior authorization. DHHS must report to the Joint Legislative Commission on Governmental Operations and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on the status and compliance of area authorities' crisis services by March 1, 2006.

### **Fiscal and Administrative Policy Review**

Section 10.31 of S.L. 2005-276 requires the DHHS Division of MH/DD/SA Services, in cooperation with area authorities and county programs, to identify and eliminate administrative and fiscal barriers created by state and local policies to the delivery of area authority and county program services, including services delivered to multiply-diagnosed adults and services provided through the CTSP. The special provision further directs DHHS to implement changes in policies and procedures to accomplish the following:

1. Create a system for allocating state and federal funds to area authorities and county programs based on projected needs rather than on historical allocation practices and spending patterns
2. Provide services to adults and children defined as priority or targeted populations in the State Plan for MH/DD/SA Services
3. Provide services to children not deemed eligible for the CTSP but who would otherwise need medically necessary treatment services to prevent out-of-home placement
4. Provide community-based services to adults who should be moved to less restrictive settings in accordance with *Olmstead v. L.C.* but who remain or are being placed in state-operated institutions

### **Private Agency Uniform Cost-Finding Requirement**

Section 10.30 of S.L. 2005-276 duplicates a provision in the 2001 and 2003 appropriations acts authorizing the Division of MH/DD/SA Services to require private agencies providing services under a contract with an area authority or county program to complete an agencywide uniform cost finding. This year, however, the legislative language is codified in G.S. 122C-147.2 and clarifies that it does not apply to hospital services having an established Medicaid rate. The cost finding is intended to ensure uniformity in rates charged to area authorities and county programs for services paid for with state-allocated funds. DHHS may suspend all funding and payment to a private agency if the agency fails to timely and accurately complete the required agencywide uniform cost finding in a manner acceptable to the DHHS controller's office. Funding may remain suspended until an acceptable cost finding has been completed by the private agency and approved by the DHHS controller's office.

### **Involuntary Commitment**

North Carolina's involuntary commitment statutes provide that anyone with knowledge of an individual meeting the criteria for court-ordered psychiatric treatment may initiate proceedings for involuntary commitment by filing a petition with a magistrate or clerk of court. Petitioners must appear personally before the magistrate or clerk, except a physician or psychologist who has examined the individual may avoid personal appearance if the petition is executed before any official authorized to administer oaths. The petition must then be hand delivered to the clerk or magistrate, although some judicial districts have permitted physician or psychologist petitioners to send a copy of the petition by facsimile transmission.

S.L. 2005-135 (H 1199) clarifies that facsimile transmission is permissible by amending G.S. 122C-261(d) to provide that, when the petitioner is a physician or psychologist, the petition may

be filed with the clerk or magistrate by delivering the original petition or transmitting a paper copy through facsimile transmission. If the petition is filed through facsimile transmission, the petitioner must mail the original petition to the clerk or magistrate no later than five days after the facsimile transmission. The law then requires the clerk or magistrate to file the original petition with the facsimile copy.

In related legislation (S.L. 2005-371), the General Assembly directed the Division of MH/DD/SA Services to develop a central listing of the mental health facilities designated by DHHS for the placement of individuals to be involuntarily committed. Intended to help law enforcement officers providing custody and transportation of individuals subject to the commitment process, the list was required to be accessible on the Internet by October 1, 2005.

## **Identity Theft Protection Act and Use of Social Security Numbers**

S.L. 2005-414 (S 1048) creates requirements, applicable to private and public providers of MH/DD/SA services, concerning the collection, use, and dissemination of Social Security numbers. For a description of the obligations imposed on both private businesses and government agencies, see Chapter 12, "Health."

## **Workers' Compensation Act—Access to Medical Information**

Section 6.1 of S.L. 2005-448 (H 99) amends Article 1 of Chapter 97 of the General Statutes to provide that, notwithstanding the physician-patient privilege or other laws concerning the privacy of medical information, an employer or insurer paying medical compensation under the Workers' Compensation Act to a treatment provider may obtain "records of the treatment" without the express authorization of the employee.

This provision, set forth in new G.S. 97-25.6, also permits an employer or insurer paying compensation for a claim to communicate with an employee's medical provider in writing to determine, among other information, the diagnosis for the employee's condition, the reasonable and necessary treatment, the anticipated time the employee will be out of work, the relationship of the employee's condition to the employment, the restrictions resulting from the condition, the kind of work for which the employee may be eligible, the anticipated time that the employee will be restricted, and the permanent impairment, if any, resulting from the condition. This communication is limited to specific questions promulgated by the North Carolina Industrial Commission, and the employer or insurer must provide a copy of the written communication to the employee at the same time it is made to the provider. Other forms of communication with a medical provider may be authorized by the voluntary written consent of the employee, by agreement of the parties, or by order of the commission.

The act also provides that, with written notice to the employee, the employer or insurer may obtain from a medical provider "medical records of evaluation or treatment restricted to a current injury or condition" for which the employee is claiming compensation from that employer under the act. To the extent that any such records are in the possession of an employee seeking compensation, the employee must furnish the records to the employer if the employer makes a written request for the records.

The provision authorizes the commission, upon motion of an employee or medical provider or upon its own motion, to enter any order that justice requires to protect an employee or other person from unreasonable annoyance, embarrassment, or oppression, or undue burden or expense. G.S. 97-25.6 became effective September 29, 2005, and applies to claims pending or filed on or after that date.

## Licensed Professionals

### Substance Abuse Professionals

Article 5C of G.S. Chapter 90 establishes standards for the credentialing of substance abuse professionals practicing in North Carolina. Professionals credentialed under this law include substance abuse counselors, substance abuse prevention consultants, clinical supervisors, clinical addictions specialists, and substance abuse residential facility directors. The law also sets standards for and recognizes professionals under interim status such as registrants, substance abuse counselor interns, and clinical addictions specialist interns. S.L. 2005-431 (S 705) amends Article 5C, now called the North Carolina Substance Abuse Professional Practice Act, to add “certified criminal justice addictions professional” to the list of recognized and credentialed substance abuse professionals, to change the credential issued to a clinical addictions specialist, and to provide for criminal history record checks of applicants seeking credentialing under the act.

S.L. 2005-431 changes the credentialed status of clinical addictions specialists from “certification” to “licensure” without substantially changing the qualifications for credentialing. The act also more specifically defines in new G.S. 90-113.31B the scope of practice for each category of substance abuse professional and incorporates into the defined scopes of practice the principles, methods, and procedures of performance domains prescribed by the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Incorporated (ICRC/AODA).

The 2005 law defines *certified criminal justice addictions professional* (CCJP) as a person certified by the North Carolina Substance Abuse Professional Practice Board to practice as a CCJP and who, under supervision, provides direct services to clients or offenders exhibiting substance abuse disorders in a program determined by the board to be in a criminal justice setting. According to the act, the CCJP’s scope of practice is based on knowledge in the domains of dynamics of addiction in criminal behavior; legal, ethical, and professional responsibility; the criminal justice system and processes; screening, intake, and assessment; case management; monitoring; and client supervision and counseling to treat, and prevent or reduce the risk of, addictive disorder or disease.

To become certified as a CCJP, an applicant must have

- 270 hours of board-approved education or training, except that 180 hours is sufficient if the applicant has a minimum of a master’s degree with a clinical application and a substance abuse specialty from a regionally accredited college or university;
- 300 hours of board-approved supervised practical training;
- a certain number of hours of supervised work experience providing direct services to clients or offenders involved in the criminal justice system (the required number of hours varies depending on the applicant’s level of education); and
- passed the certified criminal justice addictions professional written examination of the ICRC/AODA.

Section 4 of S.L. 2005-431 provides that, within ninety days after the time the act became effective (September 22, 2005) and the ICRC/AODA approves the CCJP credential, the board may certify a person as a certified criminal justice addictions specialist under a set of alternative qualifying criteria that recognize longer periods of supervised work experience in lieu of other requirements.

All applicants for credentialing as a substance abuse professional must submit to a complete criminal history record check, and the board must provide the North Carolina Department of Justice (DOJ) with all materials necessary for processing the record check with the state and national repositories of criminal histories, including the applicant’s fingerprints and written consent to the check. The act amends G.S. 114-19.11A to authorize the DOJ and the State Bureau of Investigation to process the criminal record checks for the board. If an applicant’s criminal history record check reveals one or more of several types of convictions specified in the act, the board must review the criminal history in light of factors enumerated in G.S. 90-113.46A to determine whether to deny registration, certification, or licensure of the applicant. A conviction does not automatically bar issuance of a credential by the board.

Among other changes to the practice act, S.L. 2005-431 does the following:

- Defines “dual relationship” and recognizes as a ground for disciplinary action dual relationships that impair professional judgment or increase the risk of exploitation of a client or supervisee
- Modifies the continuing education requirements for renewal of credentials and the number of hours of supervised experience required for obtaining certification as a substance abuse counselor or substance abuse prevention consultant
- Changes the term of office for board members from three to four years and authorizes the board to employ legal counsel

### **Social Work Certification and Licensure Board**

S.L. 2005-129 (H 1262) amends G.S. 90B-6 to authorize the North Carolina Social Work Certification and Licensure Board to employ or retain professional personnel, including legal counsel or clerical or other special personnel, as necessary to carry out the provisions of the Social Work Certification and Licensure Act.

### **School Social Worker Liability Insurance**

S.L. 2005-355 (H 1491) amends G.S. 115C-317.1, effective October 1, 2005, to provide that a school social worker cannot be required to transport students under that provision without the existence of a written job description or local school board policy imposing the requirement. The act also amends G.S. 115C-47 to provide that, unless a local school board otherwise provides for liability insurance coverage of a school social worker who is required to transport students under G.S. 115C-317.1, the board may require a school social worker to increase liability protection on the employee’s personal automobile liability insurance policy for the purpose of transporting students within the course of the employee’s work only if the board reimburses the employee for the additional premium charged for the increased protection.

### **Criminal Record Checks**

Over the past few years, the General Assembly has sought ways to expand the state’s laws on criminal history record checks while meeting federal requirements affecting the distribution of national criminal history check information. (See Section 2.1A of S.L. 2002-180 and Sections 10.19 and 10.1 of S.L. 2004-124.) Until S.L. 2005-4 (S 41) became law, on March 23, 2005, laws requiring criminal record checks for applicants for employment with area authorities, adult care homes, nursing homes, home care agencies, and contract agencies of these entities required the North Carolina Department of Justice (DOJ) to forward the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the DHHS DFS, which would forward the results to the agency requesting the check. To conform the record check process to federal law, S.L. 2005-4 now requires DOJ to forward these record check results to the DHHS Criminal Records Check Unit, which in turn must notify the requesting entity, without sharing the results of the national criminal history record check, whether the information received may affect the employability of the applicant.

In light of the fact that many providers of mental health, developmental disabilities, and substance abuse services no longer have to contract with area authorities to receive Medicaid reimbursement or to have area authority clients referred to them, S.L. 2005-4 amends G.S. 122C-80—the statute requiring state and national criminal history checks of applicants for employment with area authorities

and their contract agencies—to expand the statute’s applicability to any MH/DD/SA service provider licensed under G.S. Chapter 122C. The act also clarifies that G.S. 122C-80 is applicable to county MH/DD/SA programs.

In related enactments, S.L. 2005-358 (S 737) amends G.S. 114-19.14 to authorize a county and the DOJ to conduct state and national criminal history record checks on applicants for county employment, and S.L. 2005-114 (H 451) amends G.S. 114-19.6(a)(1) to expand the types of individuals subject to criminal records checks by DHHS to include independent contractors providing services to DHHS, employees of these contractors, and individuals approved to perform volunteer services for DHHS.

## **Substance Abuse Services for Persons Convicted of Driving While Impaired**

A person whose driver’s license is revoked as a result of a conviction of driving while impaired must obtain a certificate of completion before having his or her license restored by the Division of Motor Vehicles. To obtain a certificate of completion, the person must have a substance abuse assessment and, depending on assessment results, complete either an alcohol and drug education traffic (ADET) school or a substance abuse treatment program. In 2004 the General Assembly amended G.S. 122C-142.1, effective October 1, 2005, to specify the professionals authorized to conduct substance abuse assessments and to require the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services to study the certification requirements for persons conducting ADET schools (S.L. 2004-197). In response to this study, the legislature enacted S.L. 2005-312 (H 35), amending G.S. 122C-142.1 again, to specify the professionals qualified to provide ADET school instruction. By January 9, 2009, these instructors must be either certified substance abuse counselors, certified clinical addiction specialists, or certified substance abuse prevention consultants, as defined by the Commission for MH/DD/SA Services.

The 2004 law also required the Oversight Committee to study the adequacy of fees paid by clients to treatment facilities and ADET schools. In response to recommendations of the Oversight Committee, S.L. 2005-312 changes from \$75 to \$160 the fee to be paid to an ADET school, while maintaining the fee paid to a treatment facility at \$75. The 2005 law also increases from 5 to 10 percent the amount of each fee that must be remitted from an ADET school to DHHS for ADET school administration.

S.L. 2005-312 directs the Commission for MH/DD/SA Services to revise its rules regarding the number of instructional program hours and class size for ADET schools and sets a minimum of sixteen program hours and a maximum class size of twenty participants. In addition, DHHS must establish an outcomes evaluation study on the effectiveness of substance abuse services provided to persons obtaining a certificate of completion under G.S. 20-17.6 as a condition for driver’s license restoration and report the study’s findings every two years to the Joint Legislative Commission on Governmental Operations, with the initial report to be submitted by December 31, 2007.

## **Licensable Facilities**

Section 10.40A of S.L. 2005-276 amends the statutory provisions governing licensable mental health facilities, adult care homes, home care services, and hospital facilities. “Licensable mental health facilities” means facilities licensable as mental health, developmental disabilities, or substance abuse facilities under G.S. Chapter 122C, which includes facilities providing outpatient services, day services offered to the same individual for three or more hours during a twenty-four-hour period, and residential services for twenty-four consecutive hours or more. With respect to these facilities, Section 10.40A amends G.S. 122C-23(e) to shorten the period of time a license issued under G.S. Chapter 122C is valid. Initial licenses, previously valid for a two-year period, will be valid for no more than fifteen months. Thereafter, licenses must be renewed annually and will expire at the end of the

calendar year. Licenses for facilities that have not served any clients in the previous twelve months are not eligible for renewal.

G.S. 122C-23(d) requires the Secretary of DHHS to issue a license to a person who complies with the licensure provisions of G.S. 122C and with applicable regulatory standards. G.S. Chapter 122C-23(e) grants the Secretary the authority to issue a provisional six-month license to a person temporarily unable to comply with a rule. Section 10.40A qualifies that provision by adding that the noncompliance must not present an immediate threat to the health or safety of individuals served in the licensable facility. The act also adds that a provisional six-month license may be granted to a person obtaining the initial license for a facility, but it does not define the basis for issuing such a license or otherwise provide any guidance on when these licenses may be issued. Before being issued a full license, the licensee operating under an initial six-month license must demonstrate substantial compliance. Similarly, Section 10.40A amends G.S. 131-2 to require all initial licenses for adult care homes, previously valid for one year, to be issued on a six-month basis, with licenses for the balance of the calendar year issued after the licensee demonstrates substantial compliance with applicable statutes and rules.

Section 10.40A of S.L. 2005-276 requires licensable facilities to be inspected every two years for compliance with physical plant and life-safety requirements. In addition, it amends the penalty provisions of the licensure statutes to double the penalties for a Type A violation (a rule violation that results in, or creates a substantial risk of, death or serious physical harm) and for failure to correct violations.

### **Residential Treatment Facilities**

Section 10.40 of S.L. 2005-276 applies to *residential facilities* as defined in G.S. 122C-3(14): twenty-four-hour facilities, including group homes and excluding hospitals, whose primary purpose is to provide mental health, developmental disabilities, or substance abuses services in structured living environments. Section 10.40 amends Article 2 of G.S. Chapter 122C to require applicants for licensure of residential facilities to submit to DHHS with the application a letter of support obtained from the area authority or county program in whose catchment area the facility will be located. The letter of support must be submitted to both DFS and the Division of MH/DD/SA Services, specify the number of existing beds for the same type of facility in the catchment area, and specify the projected need for additional beds of the same type of facility. The provision excludes residential facilities subject to Certificate of Need requirements under Article 9 of G.S. Chapter 131E and applies to license applications pending or submitted on or after August 13, 2005.

In a separate provision, Section 10.40A of S.L. 2005-276 amends G.S. Chapter 122C to require all residential facilities to be inspected annually by DHHS and to post conspicuously in a public area of the facility the DFS complaint hotline number. The same requirements are made applicable to adult care homes in G.S. 131D-2.

### **Accreditation Study**

Section 10.35A of S.L. 2005-276 requires DHHS to study the feasibility of establishing accreditation requirements for residential treatment facilities and to report its findings and recommendations to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division by March 1, 2006.

### **Temporary Rule Making**

Section 10.35B of S.L. 2005-276 authorizes DHHS to adopt as temporary rules those rules governing residential treatment for children and adolescents that were both approved for adoption or revision on May 18, 2005, by the Commission on MH/DD/SA Services and approved by the Rules Review Commission.

## **Comprehensive Treatment Services Program for Children**

Section 10.25 of S.L. 2005-276 directs DHHS to continue the Comprehensive Treatment Services Program for Children (CTSP) and establishes both an interagency children's services workgroup and a study commission on children's services. The purpose of CTSP is to provide appropriate and medically necessary residential and nonresidential treatment alternatives for children at risk for institutionalization or other out-of-home placement. Program funds must be targeted to non-Medicaid eligible children and may be used to expand statewide a "system-of-care" approach to children's services. The children's program must include the following:

1. Behavioral health screening for all children at risk of institutionalization or other out-of-home placement
2. Appropriate and medically necessary residential and nonresidential services for deaf children, sexually aggressive youth, children with serious emotional disturbances, and youth needing substance abuse treatment services
3. Multidisciplinary case management services
4. A system of utilization review specific to the nature and design of the program
5. Mechanisms to ensure children are not placed in department of social services custody for the purpose of obtaining mental health residential treatment services
6. Mechanisms to maximize current state and local funds and to expand the use of Medicaid funds to accomplish the intent of the program
7. A system to identify and track children placed outside of the family unit in group homes, therapeutic foster home settings, and other out-of-home placements

S.L. 2005-276 requires DHHS to establish from funds appropriated for CTSP a 3 percent reserve to ensure the availability of funding for children with specialized needs and complex problems. In addition, the act authorizes DHHS to enter into contracts with residential service providers. The Division of MH/DD/SA Services is charged with implementing utilization review of services, limiting services to those that are medically necessary, providing services in accordance with guidelines enumerated in the act, and implementing cost-reduction strategies, including the preauthorization of all services except emergency services.

## **Interagency Memoranda of Agreement for Children's Services**

Section 10.25 of S.L. 2005-276 prohibits the allocation of funds appropriated for CTSP until a memorandum of agreement has been executed between DHHS, the Department of Public Instruction (DPI), and other affected state agencies. The memorandum of agreement must address the specific roles and responsibilities of various departmental divisions and state agencies involved in the administration, financing, care, and placement of children at risk for institutionalization or other out-of-home placement. Although the Department of Juvenile Justice and Delinquency Prevention (DJJDP) is not specifically listed as a participant in the state agency memorandum of agreement, it presumably should be, as it is included in other provisions of the act requiring it to consult, collaborate, and report on the program with DHHS and DPI.

S.L. 2005-276 also requires local government agencies to be parties to memoranda of agreement with each other and certain state agencies. DHHS must not allocate CTSP funds until memoranda of agreement are executed between local departments of social services, area mental health programs, local education agencies, the Administrative Office of the Courts, and DJJDP, as appropriate to effectuate the program. These memoranda of agreement must address issues pertinent to local implementation of the program, including the availability of student records to a local school administrative unit that receives a child placed in a residential setting outside of the child's home county.

DHHS, in conjunction with DJJDP and DPI, must report specified program data to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, the Joint Legislative Oversight Committee on MH/DD/SA Services, and the Fiscal Research Division on April 1, 2006, and April 1, 2007.

## **Children's Services Work Group**

Expressing the need for greater collaboration and coordination among the state agencies responsible for developing and implementing policy pertaining to children's services, Section 10.25 of S.L. 2005-276 establishes a state-level children's services work group. The Secretaries of DHHS and DJJDP, the Chair of the State Board of Education, the Superintendent of Public Instruction, and the Chief Justice of the North Carolina Supreme Court must each designate at least one representative to serve on the work group from among the programs, divisions, or departments under their respective control that provide services to children and youth. Each of these administrators must also appoint at least one parent of a child or youth who has been or is at risk for behavioral, social, health, or safety problems or academic failure; at least one member of a local collaborative body; and at least one private sector service provider. The work group must meet at least monthly to do the following:

1. Identify common outcome and preventative measures for child-serving agencies that can be used for monitoring the safety, health, and well-being of North Carolina's children, youth, and families
2. Identify strategies for funding flexibility between state and local agencies, including shared funding streams and the removal of financial and bureaucratic barriers
3. Develop an appropriate common service terminology to be used across child-serving agencies that will assist collaboration and coordination
4. Make recommendations regarding the creation of a shared database to track population and program outcomes information while protecting individual confidentiality
5. Develop mechanisms to allow agencies to share information about individual children receiving multiple services in a manner that would meet legal requirements for confidentiality, be voluntary on the part of the party receiving services, and be time-limited
6. Examine state and local training needs for implementing increased coordination and collaboration
7. Study other issues the work group determines would improve coordination and collaboration between child-serving agencies

The work group must submit its findings and recommendations, specifying those recommendations that require statutory changes and those that do not, to the Coordination of Children's Services Study Commission (discussed below) by December 15, 2005, and April 15, 2006.

## **Children's Services Study Commission**

S.L. 2005-276 creates the Coordination of Children's Services Study Commission to study and recommend changes to improve collaboration and coordination among agencies providing services to children, youth, and families with multiple service needs. As part of its charge, the commission must do the following:

- Recommend consolidation, reorganization, or elimination of existing state, regional, and local collaborative bodies charged with serving, protecting, or improving the well-being of children, youth, and families
- Study agencies currently implementing a "system of care" platform of practices and recommend whether to adopt those practices in child-serving agencies statewide
- Examine the principles associated with a system of care platform and determine whether to recommend the adoption of a state policy reflecting these principles
- Determine whether system of care principles articulate measurable goals and, if not, whether they can be modified to reflect measurable goals
- Receive and study the recommendations of the children's services work group and determine whether to recommend any of that group's statutory proposals

The commission must consist of eighteen members, nine appointed by the Speaker of the House of Representatives (five members of the House and four members of the public) and nine appointed by the President Pro Tempore of the Senate (five members of the Senate and four members of the public). The study commission must report annually on April 1 to the House of Representatives Appropriations

Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, the Joint Legislative Oversight Committee on MH/DD/SA Services, and the Fiscal Research Division.

## **Consumer Advocacy Program**

In 2001 the General Assembly enacted legislation to establish the Mental Health, Developmental Disabilities, and Substance Abuse Consumer Advocacy Program (Section 2 of S.L. 2001-437). The program is to furnish 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 as a client or potential client of public services provided by an area or state MH/DD/SA services facility.) The 2001 legislation contained a provision, however, making it effective only if the 2001 General Assembly appropriated funds for the program in the 2002 regular session. When funds were not appropriated in 2002 or thereafter, the legislature simply inserted a special provision in the budget act for each succeeding legislative session amending S.L. 2001-437 to permit the program to become effective if funds were appropriated in the legislative session following the enactment of the special provision. As an acknowledgement that funds are unlikely to be available for the program next year, Section 10.27 of S.L. 2005-276 amends S.L. 2001-437 deleting the reference to a particular year and providing that the consumer advocacy program provisions of that law will become effective the year funds are appropriated by the General Assembly.

## **Rule-Making Commission**

Sections 10.33 and 10.35 of S.L. 2005-276 amend the powers and duties of the Commission for MH/DD/SA Services. New G.S. 122C-26(5)e directs the commission to adopt rules requiring personnel of licensable facilities who refer clients to other provider agencies to disclose any pecuniary interest the referring person has in the provider agency or any other interest that may create the appearance of impropriety. New G.S. 143B-147(a)(9) directs the commission to establish a process for non-Medicaid-eligible clients of area authorities and county programs to appeal to the Division of MH/DD/SA Services decisions affecting the client made by the area authority or county program. The new provision is not to be construed to create an entitlement to MH/DD/SA services.

## **Studies**

### **Long-Range Plan for MH/DD/SA Services**

Section 10.24 of S.L. 2005-276 directs DHHS, in consultation with advocacy groups and affected state and local agencies, to develop a long-range plan for addressing the mental health, developmental disabilities, and substance abuse services needs of the state. The plan must be consistent with the State Plan for MH/DD/SA Services developed pursuant to G.S. 122C-102 and must address the following:

1. The services needed at the community level within each local management entity (LME) to ensure an adequate level of services to the average number of persons needing services based on population projections
2. The full continuum of services needed for each disability group within an LME, including the following:
  - Which services could be based regionally or in a multi-LME area
  - What percentage of the population each LME would expect to use state-level facilities
  - An inventory of existing services and service gaps within each LME for each disability

3. Projected growth in services for each disability group within each LME or region that can reasonably be managed over the next five years
4. Projected start-up costs and total funding needed from the Trust Fund for MH/DD/SA Services and Bridge Funding Needs to implement the long-range plan

DHHS must report on the implementation of the long-range planning initiative 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 March 1, 2006.

### **DHHS Monitoring and Oversight of Services**

Section 10.34 of S.L. 2005-276 directs the Legislative Oversight Committee on MH/DD/SA Services to study the oversight and monitoring roles and activities of the DHHS Divisions of Social Services, Facility Services, Medical Assistance, and MH/DD/SA Services and how those activities benefit consumers of MH/DD/SA services in residential settings. The committee must report its findings and recommendations to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, the Joint Legislative Oversight Committee on MH/DD/SA Services, and the Fiscal Research Division no later than April 1, 2006.

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