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Mental Health and Related Laws

This chapter discusses acts of the 1998 General Assembly affecting mental health, developmental disabilities, and substance abuse services. Particular attention is given to legislation affecting area mental health, developmental disabilities, and substance abuse authorities (area authorities), the local governmental entities responsible for providing services.

In 1998 the General Assembly expanded funding for developmental disability services, authorized a comprehensive study of the public mental health system, and strengthened the state's oversight and control of community-based services. The legislature also established a civil cause of action for psychotherapy clients who are sexually exploited by their psychotherapists and, less than one year after enacting legislation to provide for an advance instruction for mental health treatment, amended the law at the urging of health care facilities. Provisions amending the powers and duties of area authorities and the disclosure of information relating to area authority clients appear in the Juvenile Justice Reform Act, which revises the Juvenile Code and other provisions of law relating to the state's juvenile justice system.

Appropriations

Current Operations

The 1998 Appropriations Act, S.L. 1998-212 (S 1366), 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) \$564,277,887 for 1998-99. Funding changes include the elimination of \$650,000 for legal services related to the Thomas S. and Willie M. programs. Court oversight of these programs ended in early 1998, when the two lawsuits forcing the state to establish these programs were dismissed. This reduction, combined with \$14.3 million in new funding, provides a net increase of \$13,655,001 over the \$550,619,886 appropriated for 1998-99 in the 1997 Appropriations Act, S.L. 1997-443. This represents an increase of approximately \$35.7 million over the appropriation for 1997-98. Appropriations for the past five fiscal years were \$528.5 million (1997-98), \$465.6 million (1996-97), \$473.6 million (1995-96), \$475.9 million (1994-95), and \$440.6 million (1993-94).

Section 12.34 of S.L. 1998-212 targets the largest increase in funding, \$6 million in recurring funds, to family support services for developmentally disabled individuals who are currently wait-listed for services and not eligible for the Medicaid Community Alternative Program for Mentally Retarded/Developmentally Disabled (CAP-MR/DD). The remaining increase in appropriations (all nonrecurring) is allocated as follows:

- \$750,000 to study the current public system for delivering inpatient psychiatric services and to assess the appropriate roles of the state psychiatric hospitals and area authorities in providing those services (these funds are transferred from MH/DD/SAS to the State Auditor);
- \$400,000 for the construction and expansion of a mental health center in Tyrell County;
- \$300,000 to provide matching funds to expand residential services for the mentally ill;
- \$5,353,003 to continue services to violent and assaultive children who were formerly class members in the Willie M. lawsuit;
- \$1,326,998 for atypical antipsychotic drugs at state-operated psychiatric hospitals (sec. 12.33 of S.L. 1998-212 changes the eligibility level for people in the Atypical Antipsychotic Medication Program from 100 percent to 115 percent of the federally determined poverty level);
- \$100,000 as a grant-in-aid to the Day-By-Day Treatment Center in Johnston County for the purpose of providing substance abuse services statewide;
- \$75,000 to purchase computer software or printed materials for training curricula that promote cultural diversity and competencies in services to children, families, and communities.

In addition to the appropriations to MH/DD/SAS in the 1998 Appropriations Act, Section 7 of S.L. 1998-166 (H 900) appropriates from the General Fund to the Office of the Controller in the Department of Health and Human Services (DHHS) \$38 million for 1998–99 (recurring) for state matching funds for Medicaid services provided by area authorities.

Capital Appropriations

Section 29 of S.L. 1998-212 (S 1366) appropriates from the General Fund to DHHS \$2 million in nonrecurring funds for 1998–99 to plan and design a new Dorothea Dix Hospital and to compare the cost of constructing and operating new facilities with the cost of redesigning and operating other existing state psychiatric hospitals. This activity must be coordinated with the State Auditor's study of state psychiatric hospitals and area mental health programs, and the design of any new Dorothea Dix Hospital is subject to the State Auditor's study. The 1998 Appropriations Act also appropriates \$250,000 to DHHS to plan and design a facility to replace Whitaker School, a reeducation facility for behaviorally and emotionally disturbed youth. The replacement facility must have not less than a thirty-three-bed capacity. DHHS must report the progress in planning these facilities to the House and Senate Human Resources Appropriations Committees by May 1, 1999.

Other capital appropriations to DHHS for 1998–99 include \$5,000,000 to replace a child and adolescent facility at Cherry Hospital in Goldsboro that no longer meets federal standards; \$1,040,000 for the construction of an independent living complex at the Eastern School for the Deaf in Wilson; and \$300,000 to purchase a building for the expansion of the Traumatic Brain Injured program at the Eastern Vocational Rehabilitation Facility in Goldsboro. Finally, Section 2 of S.L. 1998-212 makes a \$400,000 nonrecurring appropriation from the General Fund to MH/DD/SAS for the construction and expansion of a mental health center in Tyrell County.

Federal Block Grant Allocations

Section 5 of S.L. 1998-212 allocates federal block grant funds for fiscal year 1998–99. The act includes appropriations for community-based services provided in accordance with three of the state's long-range plans for services to specific age and disability populations. From the

Mental Health Services Block Grant, the General Assembly allocates \$3,794,179 (the same amount allocated for the past five fiscal years) for services provided in accordance with the comprehensive plan for services for persons with severe and persistent mental illness. From the same block grant, the legislature appropriates \$1,819,931 (the same as in 1997–98) for services provided under the child mental health plan.

Allocations from the Substance Abuse Prevention and Treatment Block Grant include \$5,964,093 for services provided in accordance with the child and adolescent alcohol and other drug abuse plan and approximately \$11.5 million for other substance abuse services provided by community-based and state-operated treatment centers. (The latter includes an unspecified amount for tuberculosis services.) From the Social Services Block Grant, which funds several DHHS divisions, the General Assembly made not only the usual \$4,764,124 appropriation to MH/DD/SAS, but also allocated an additional \$6 million to provide services to individuals who are on the state’s waiting list for developmental disabilities services but are not eligible for services under the CAP-MR/DD Medicaid Program.

From the Temporary Assistance to Needy Families (TANF) Block Grant, MH/DD/SAS receives six allocations: \$75,000 for a Work First substance abuse coordinator position in MH/DD/SAS; \$150,000 to develop a “Next Step” substance abuse program that meets the specialized substance abuse services needs of TANF children and their families; \$2 million for Work First substance abuse treatment and testing services (\$1 million less than the allocation in 1997–98); \$2.3 million for screening, diagnostic, and counseling services related to substance abuse treatment for Work First participants; \$1,182,280 for substance abuse services for juveniles; and \$1 million to implement the Enhanced Employee Assistance Program, a grant program of financial incentives for private businesses employing former and current Work First recipients.

Civil Commitment

Commitment of Insanity Acquittees

G.S. 15A-1321 requires the automatic civil commitment of criminal defendants who are found not guilty by reason of insanity. Upon a pretrial determination of insanity or a jury verdict of not guilty by reason of insanity, the presiding judge must enter an order committing the defendant to a state-operated twenty-four-hour facility. The defendant’s inpatient commitment at a twenty-four-hour facility continues until the defendant can prove, in accordance with G.S. Chapter 122C, that he or she no longer has a mental illness or is no longer dangerous to others.

Section 12.35B of S.L. 1998-212 (S 1366) amends G.S. 15A-1321 to create a new subsection dealing with insanity acquittees who are acquitted of crimes involving allegations that the defendant inflicted or attempted to inflict serious physical injury or death. For this class of insanity acquittees, the presiding judge must enter an order committing the defendant to the forensic unit at Dorothea Dix Hospital, a new unit established when the 1997 General Assembly authorized expenditures to create a program for individuals who are found mentally incompetent to stand trial or not guilty by reason of insanity and are considered at risk for escape or violent behavior. Under the amended law, unless released in accordance with G.S. Ch. 122C, the defendant must remain at this particular unit of Dorothea Dix Hospital and cannot be placed at any other state-operated facility.

Voluntary Admission of Family Unit to Substance Abuse Facility

Pursuant to G.S. 112C-211, any individual in need of treatment for mental illness or substance abuse may seek voluntary admission to any facility, including a twenty-four-hour

facility, that treats mental illness or substance abuse. The facility may admit the individual if he or she is in need of and can benefit from treatment or is in need of further evaluation.

S.L. 1998-47 (S 962), enacted July 16, 1998, amends G.S. 122C-211 to permit the voluntary admission of a "family unit" (defined as a parent and the parent's dependent children under the age of three years) to a twenty-four-hour substance abuse facility that is able to provide, directly or by contract, treatment services that specifically address the family unit's needs. Services provided in the facility must include assessment, well-child care, and early intervention services for the child as well as gender-specific substance abuse treatment, habilitation, or rehabilitation for the parent. A facility may not accept a family unit for admission if the facility determines that the family unit does not need or cannot benefit from the care available at the facility. A facility that denies admission to a family unit must give the parent seeking admission a referral to another facility that may be able to provide treatment.

Area Mental Health Authorities

Accountability

DHHS Rule-Making Authority. Both DHHS and the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services have the authority to promulgate rules governing area facilities (area authorities and their contract agencies), but the legislature has allocated separate and specific areas of rule making to each. G.S. 122C-191 requires DHHS to develop a process for reviewing area facilities for compliance with these rules, and pursuant to this authority, DHHS has developed an accreditation review process that examines area authorities for compliance with both state rules and "applicable standards of practice." Applicable standards of practice do not necessarily appear in or relate to promulgated rules but refer to accepted and prevailing standards of practice for mental health professionals and related disciplines. As DHHS proceeded to review area facilities for compliance with applicable standards of practice, questions arose as to whether DHHS was exceeding its rule-making authority and setting standards in areas that were under the exclusive purview of the commission. In an apparent attempt to resolve this recent controversy, Section 12.35C of S.L. 1998-212 (S 1366) amends G.S. 122C-191(d) to state that DHHS rules setting forth the process for area facility review may provide that DHSS "has the authority to determine whether applicable standards of practice have been met."

Monitoring of Fiscal and Administrative Practices. Section 12.35C of S.L. 1998-212 also amends G.S. 122C-112(a) to require the Secretary of DHHS to monitor the fiscal and administrative practices of area authorities to ensure that federal and state funds allocated for mental health, developmental disabilities, and substance abuse services are managed and used according to applicable state and federal rules and professionally accepted accounting and management principles. Specifically, DHHS must ensure that an area authority's rate-setting methodologies, reimbursement and billing procedures, record keeping, documentation, procedures for contracting with other providers of services, and other matters pertaining to financial management and fiscal accountability are sufficient to ensure maximum accountability for the use of federal and state funds. The Secretary of DHHS may adopt temporary rules to implement this oversight authority.

Area Authority's Failure to Provide Adequate Services. By amending G.S. 122C-112(b), Section 12.35C of S.L. 1998-212 authorizes DHHS to contract with one or more private or public agencies to provide services to clients of an area authority and to reallocate area authority funds to pay for these services if DHHS finds that

1. the area authority refuses or has failed to provide services to clients in its service area in a manner that is at least adequate;

2. clients within the area authority's service area will either not be served or will suffer unreasonable hardship if they are required to obtain the services from another area authority; and
3. there is at least one private or public agency within the area authority's service area willing and able to provide services under contract.

Section 12.35C of S.L. 1998-212 also permits DHHS to contract with one or more private or public agencies to serve clients from *more than one* area authority and reallocate funds of the applicable area authorities to pay for these services if DHHS finds that

1. there is no area authority available to act as the administrative entity under contract with the provider *or* the administering area authority refuses or has failed to properly manage and administer the contract with the contract provider, and
2. clients will either not be served or will suffer unreasonable hardship if services are not provided under the contract.

Before contracting with a private provider pursuant to these new provisions, DHHS must provide the area board written notice of its intent to contract and an opportunity to be heard on the matter.

Report. No later than March 1, 1999, DHHS must submit a report to the Joint Legislative Health Care Oversight Committee and the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services that includes

- any temporary rules adopted pursuant to new G.S. 122C-112(a)(16) and methods for ensuring area authority compliance with such rules;
- methods for ensuring area authority compliance with applicable standards of practice and laws, rules, and regulations governing clinical practices;
- methods for assisting area authorities in complying with applicable standards of practice and laws, rules, and regulations governing clinical practices;
- any recommendations, including proposed legislation, the Secretary of DHHS may have to enhance accountability of area authorities.

Psychotherapy Sexual Exploitation Act

S.L. 1998-213 (H 581) adds a new Article 1F to G.S. Chapter 90 to permit a client of psychotherapy to sue his or her psychotherapist for damages if the psychotherapist engages in sexual exploitation of the client during or following the psychotherapeutic relationship. For purposes of this act, a person who seeks or obtains psychotherapy is a "client," whether or not that person is charged for the service.

Psychotherapists subject to the act include psychiatrists, psychologists, licensed professional counselors, substance abuse professionals, social workers engaged in clinical social work practice, fee-based pastoral counselors, licensed marriage and family therapists, and mental health professionals who perform or purport to perform psychotherapy. "Psychotherapy" is defined as the "professional treatment or professional counseling of a mental or emotional condition that includes revelation by the client of intimate details of thoughts and emotions of a very personal nature to assist the client in modifying behavior, thoughts and emotions that are maladjustive or that contribute to difficulties in living."

The act provides a cause of action for sexual exploitation that occurs during the period of time the client is receiving psychotherapy (measured from the beginning of the first date of psychotherapy to the end of the last date of psychotherapy) or within three years after termination of the psychotherapy. It also applies to sexual exploitation that occurs at any time as a result of a "therapeutic deception," which means a "representation by a psychotherapist that sexual contact with the psychotherapist is consistent with or part of the client's treatment."

"Sexual exploitation," whether or not it occurs with the consent of the client or during any treatment, consultation, evaluation, interview, or examination, means "any act done or statement made" by the psychotherapist for the purpose of sexual stimulation or gratification of the client or psychotherapist that includes any of the following actions:

- making statements containing sexual innuendo, sexual threats, or sexual suggestions regarding the relationship between the psychotherapist and the client;
- relating to the client the psychotherapist's own sexual fantasies or the details of the psychotherapist's own sexual life;
- uncovering or displaying breasts or genitals of the psychotherapist to the client;
- showing sexually graphic pictures to the client for purposes other than diagnosis or treatment.

Sexual exploitation also includes "sexual contact," whether or not it occurs with the consent of the client or during any treatment, consultation, evaluation, interview, or examination. "Sexual contact" covered by the act includes any of the following actions:

- sexual intercourse, cunnilingus, fellatio, anal intercourse, or any intrusion, however slight, into the oral, genital, or anal openings of the client's body by any part of the psychotherapist's body or by any object used by the psychotherapist for the purpose of sexual stimulation or gratification of either the psychotherapist or client; or any intrusion, however slight, into the oral, genital, or anal openings of the psychotherapist's body by any part of the client's body or by any object used by the client for the purpose of sexual stimulation or gratification of either the psychotherapist or client, if agreed to, or not resisted by the psychotherapist;
- kissing of, or the intentional touching by the psychotherapist of, the client's lips, genital area, groin, inner thigh, buttocks, or breast, or of the clothing covering any of these body parts, for the purpose of sexual stimulation or gratification of either the psychotherapist or the client, or kissing of, or the intentional touching by the client of, the psychotherapist's lips, genital area, groin, inner thigh, buttocks, or breast, or of the clothing covering any of these body parts, if agreed to or not resisted by the psychotherapist, for the purpose of sexual stimulation or gratification to either the psychotherapist or the client.

A cause of action for sexual exploitation must be commenced within three years after the last act of the psychotherapist giving rise to the cause of action, or within three years of the time the client discovers or should reasonably discover that sexual exploitation occurred, whichever is later. No cause of action, however, may be commenced more than ten years after the last act of the psychotherapist giving rise to the cause of action. With limited exceptions specified in the act, a client's sexual history is not subject to discovery before trial or admissible as evidence at trial.

A client who prevails on a claim of sexual exploitation may recover from the psychotherapist actual or nominal damages, attorney fees, and punitive damages. In the event that a psychotherapist settles a claim of sexual exploitation, the settlement agreement cannot prohibit the client from filing or pursuing a complaint before the regulatory entity responsible for licensing or regulating the conduct of the psychotherapist.

The act is effective January 1, 1999, and applies to conduct occurring on or after that date.

Juvenile Justice Reform

In response to a report issued by the Governor's Commission on Juvenile Crime and Justice, the General Assembly revised and recodified the Juvenile Code and other provisions of law relating to the state's juvenile justice system. The Juvenile Justice Reform Act, S.L. 1998-202 (S 1260), is discussed in detail in Chapter 13 (Juvenile Law). This chapter discusses only those provisions of the law that relate to or may affect the Division of MH/DD/SAS and area authorities.

Treatment Programs for Juvenile Delinquents

Effective January 1, 1999, S.L. 1998-202 abolishes the Juvenile Services Division of the Administrative Office of the Courts and the Division of Youth Services of DHHS and transfers the functions and duties of those divisions to a new Office of Juvenile Justice (OJJ) in the Office

of the Governor. Among other powers and duties, the OJJ is authorized to adopt rules applicable to local human services agencies that provide juvenile court and delinquency prevention services; establish procedures for the drug testing of juveniles adjudicated delinquent for substance abuse offenses; develop and coordinate services and programs for delinquency prevention, early intervention, and the rehabilitation of juveniles; and fund programs that are determined to be effective in preventing delinquency and reducing recidivism.

Section 1(b) of the act, effective January 1, 1999, requires the OJJ to develop a comprehensive juvenile delinquency and substance abuse prevention plan that identifies community-based programs and activities that can prevent delinquent behavior or be used as alternatives to training schools. G.S. 147-33.47. Implementation of the plan must be coordinated with county juvenile crime prevention councils, appointed by the boards of county commissioners, whose members must include, where possible, a substance abuse professional and the director of the area authority or the director's designee. Section 31 of the act requires the OJJ, in cooperation with DHHS, to study the funding process for the juvenile delinquency and substance abuse prevention programs.

G.S. 7B-2506, part of the new Juvenile Code that is effective July 1, 1999, retains many of the dispositional alternatives available to a court in delinquency cases under the former law and adds new alternatives, including some relating to substance abuse treatment. For example, the court may order the juvenile to cooperate with an intensive substance abuse program. In addition, every juvenile who is committed to the OJJ for placement in a training school must be tested for the use of controlled substances or alcohol. ("Training school" means a secure residential facility authorized to provide long-term treatment, education, and rehabilitative services for delinquent juveniles.) Results of these initial tests must be incorporated into a plan of care prepared by OJJ and used only for evaluation and treatment purposes.

Section 4(t) of S.L. 1998-202 (S 1260) amends G.S. 122C-117(a) to require the area authority to provide services to juveniles committed to the custody of OJJ and to coordinate the provision of services with the OJJ. Section 4(s) of the act amends G.S. 122C-113(b1) to add the OJJ to the list of state agencies that DHHS must cooperate with when coordinating adolescent substance abuse programs. Both of these sections are effective January 1, 1999.

Interagency Exchange of Confidential Information

New G.S. 7B-3100, effective July 1, 1999, directs the OJJ, after consultation with the Conference of Chief District Court Judges, to adopt rules designating local agencies that are required to share certain information. Former G.S. 7A-675(h), much of which is retained under the new statute, directed the chief district court judge in each district to designate these agencies by administrative or "standing" order. In addition, the former statute applied only to abuse, neglect, and dependency cases, whereas the new statute requires designated agencies, upon request of another designated agency, to share information in their possession that is relevant to any case in which a petition has been filed alleging that a juvenile is undisciplined, delinquent, abused, neglected, or dependent. Information shared under former G.S. 7A-675(h) could be used only for the protection of the juvenile. Information shared pursuant to the new statute may be used for the protection of the juvenile and others or to improve the educational opportunities of the juvenile.

Children with Special Needs

In a special legislative session, the General Assembly established a health insurance program for children that includes coverage for children who, due to mental illness, developmental disabilities, or other chronic illnesses, require extensive medical intervention. This legislation also establishes a commission to study the health care needs of these children and make recommendations for meeting these needs. These features of the legislation are discussed below.

A more comprehensive discussion of the new children's health insurance program is included in Chapter 11 (Health).

Health Insurance Program for Children

Section 1 of S.L. 1998-1 (Ex. Sess.) (S 2) establishes a comprehensive health insurance program for uninsured low-income children who are ineligible for Medicaid, Medicare, or other federal government-sponsored health insurance. The act authorizes DHHS, the state agency charged with administering the program, to enroll children whose families meet the residency, income, and fee requirements of the act.

Children with special needs who are enrolled in the program are eligible for services to meet those needs. As defined in new G.S. 108A-70.23, "children with special needs" or "special needs children" means children who have been diagnosed as having one or more of the following conditions, which in the opinion of the diagnosing physician, is likely to continue indefinitely, interferes with daily routine, and requires extensive medical intervention and extensive family management:

- Birth defect, including a genetic, congenital, or acquired disorder.
- Developmental disability as defined in G.S. 122C-3.
- Mental or behavioral disorder.
- Chronic and complex illnesses.

Benefits under the health insurance program are subject to the availability of federal and state funds appropriated for this purpose.

Commission on Children with Special Needs

Section 3 of S.L. 1998-1 (Ex. Sess.) establishes the Commission on Children with Special Health Care Needs to study the health care needs of children with special needs, to evaluate the availability and provision of health services to these children, and to make recommendations to DHHS and the Commission for Health Services on how to improve these services. This commission also must monitor and evaluate services provided to special needs children under the health insurance program for children, and DHHS must consider the recommendations of the commission when implementing the special needs service provisions of the health insurance program for children. The commission will consist of eight members appointed by the Governor:

1. a parent of a chronically ill child;
2. a parent of a child with a developmental disability or behavioral disorder;
3. a licensed psychiatrist recommended by the North Carolina Psychiatric Association;
4. a licensed psychologist recommended by the North Carolina Psychological Association;
5. a licensed pediatrician whose practice includes services for special needs children, recommended by the Pediatric Society of North Carolina;
6. a representative of one of the children's hospitals in the state, recommended by the Pediatric Society of North Carolina;
7. a local public health director recommended by the Association of Local Health Directors; and
8. an educator providing education services to special needs children, recommended by the North Carolina Council of Administrators of Special Education.

Advance Directive for Mental Health Treatment

Within one year of enacting an advance directive statute that applies specifically to mental health treatment, an action now taken by only ten state legislatures, the General Assembly amended the law at the urging of health care facilities and physicians whose activities are

covered by the law. The new advance directive law, S.L. 1998-198 (S 1287), was effective November 1, 1998. S.L. 1998-217 (S 1279), sec. 53.

S.L. 1998-198 preserves the primary features of the 1997 legislation but adds provisions to provide greater protection from liability for health professionals who provide treatment pursuant to an advance directive and transfers some of the mental health advance directive provisions to another statute governing health care powers of attorney.

To understand the 1998 legislation, it is necessary to describe briefly the law that it amends. The 1997 legislation (S.L. 1997-442) added provisions to Article 3 of G.S. Ch. 122C to permit an individual to plan for a time in the future when the individual needs mental health treatment but lacks the capacity to make and communicate treatment decisions. Two nonexclusive methods of advanced planning were established. Using a written instrument called an “advance instruction,” an adult of sound mind could instruct his or her health care provider on the kinds of treatments to be provided in the event the “principal” (the person making the advance instruction) loses the capacity to give or withhold consent to treatment. Alternatively, or in addition to instructing the health care provider, the principal could use the advance directive to designate a friend or relative to make mental health treatment decisions on behalf of the principal when the principal lacks the capacity to make or communicate treatment decisions. The 1997 law referred to this proxy or surrogate decision-maker as an “attorney-in-fact.”

The 1998 legislation deletes from G.S. Ch. 122C all provisions relating to the appointment of an attorney-in-fact and amends Article 3 of G.S. Ch. 32A to clarify that an individual may instead use a “health care power of attorney” to appoint a surrogate decision maker. G.S. Ch. 122C still permits an individual to use an advance instruction form to instruct health care providers on the treatment to administer when the individual needs treatment but lacks decision-making capacity. The 1998 legislation also amends G.S. Ch. 122C to clarify that an attending physician or other mental health treatment provider *must* provide treatment in accordance with the advance instruction when the principal lacks the capacity to make treatment decisions. It also clarifies that authorizations for treatment expressed in an advance instruction function as informed consent to treatment. The advance instruction for mental health treatment and the health care power of attorney are not exclusive of each other, and one may be combined with the other.

To reflect these and other changes discussed below, the new law amends the statutory forms for advance instructions for mental health treatment (G.S. 122C-77) and health care powers of attorney (G.S. 32A-25). Any advance instruction document executed before January 1, 1999, is not invalidated because of S.L. 1998-198. In covering the remaining aspects of S.L. 1998-198, health care powers of attorney and advance instructions for mental health treatment are discussed separately.

Health Care Power of Attorney

Using a document called a “health care power of attorney,” any adult having the understanding and capacity to make and communicate health care decisions may appoint a “health care agent” to make “health care” decisions on behalf of the individual when he or she is incapable of making those decisions. S.L. 1998-198 amends G.S. Ch. 32A, Article 3, to provide that “health care” includes “mental health treatment,” which means “the process of providing for the physical, emotional, psychological, and social needs of the principal for the principal’s mental illness.”

When acting on behalf of the principal, the health care agent has the authority to make treatment decisions to the same extent that the principal could make those decisions if the principal did not lack decisional capacity, unless the principal set forth specific limitations or restrictions in the health care power of attorney. This means that, unless the principal expressly limits the health care agent’s authority, the agent will have the authority to make both health and mental health treatment decisions. S.L. 1998-198 amends G.S. 32A-25, however, to enable the principal to limit the health care agent’s authority to mental health treatment decisions only. When making mental health treatment decisions for the principal, the 1998 legislation grants to the health care agent the power to authorize the administration of psychotropic medications or

electroconvulsive treatment (ECT) and admission to a psychiatric hospital. The principal may limit or direct this authority, however, by including special provisions instructing the agent to consent to or refuse any specific types of treatments. The principal, however, does not have the power to prevent his or her custody or treatment in accordance with the statutory provisions for involuntary commitment.

As before, a health care power of attorney becomes effective when and if the physician or physicians designated by the principal determines in writing that the principal lacks sufficient understanding or capacity to make or communicate health care decisions. Under the new law, when the principal's capacity to make *mental health* treatment decisions is at issue, the determination of decisional capacity may be made by the physician *or psychologist* designated by the principal. [The psychologist must be an "eligible psychologist," as defined in G.S. 122C-3(13d).] The determination must be made by the principal's *attending* physician or psychologist if the physician or psychologist designated by the principal is unavailable, unable, or unwilling to make the determination or if the principal failed to designate a physician or psychologist. The principal may revoke the health care power of attorney at any time, except when the principal lacks decisional capacity, by communicating an intent to revoke to the health care agent or agents named in the power of attorney and to the principal's attending physician or psychologist.

A health care power of attorney may incorporate or be combined with an advance instruction for mental health treatment executed in accordance with G.S. Ch. 122C. The health care agent's mental health treatment decisions must be consistent with any statements expressed by the principal in an advance instruction for mental health treatment or, if none exists, with what the agent believes in good faith to be the manner in which the principal would act if the principal did not lack decisional capacity. The health care agent is not subject to criminal prosecution, civil liability, or professional disciplinary action for any action taken in good faith pursuant to an advance instruction for mental health treatment.

The definition of "legally responsible person" [G.S. 122C-3(20)] is amended to include, when applied to an adult who lacks decisional capacity and who has not been adjudicated incompetent, a health care agent named pursuant to a valid health care power of attorney. This means that a health care agent may have access to, and consent to the disclosure of, confidential information relating to the principal during the period of time that the principal lacks decisional capacity.

Advance Instruction for Mental Health Treatment

G.S. 122C-73 continues to allow an "adult of sound mind" to make an advance instruction regarding mental health treatment, but a number of changes were made to clarify the scope and effect of an advance instruction. For example, S.L. 1998-198 clarifies that a principal may grant or withhold authority to use psychotropic medication, ECT, or admission to a twenty-four-hour psychiatric facility when the principal needs treatment but is "incapable" (lacks sufficient understanding or capacity to make and communicate mental health treatment decisions). S.L. 1998-198 also clarifies that, when the principal is capable of providing informed consent or refusal, the attending physician or other mental health treatment provider must continue to obtain the principal's informed consent to all mental health treatment decisions in accordance with G.S. 122C-57. Unless the principal is deemed "incapable" by the attending physician or eligible psychologist, the instructions of the principal at the time of treatment supersede any declarations expressed in the principal's advance instruction. The fact that a principal has executed an advance instruction may not be considered an indication of the principal's capacity to make or communicate mental health treatment decisions when treatment decisions are required.

The advance instruction law now requires the principal, in the company of two qualified witnesses, to appear before a notary public to affirm under oath that the principal understands that the document is an advance instruction for mental health treatment and that he or she willingly and voluntarily executes it. In addition, the witnesses must affirm to the notary public that they witnessed the principal's signature, believe the principal to be of sound mind and not acting under duress, and are "qualified witnesses" as that term is defined in G.S. 122C-72(6). The definition of "qualified witness" is amended to exclude employees of physicians and mental

health treatment providers and persons related within the third degree to the principal or to the principal's spouse.

S.L. 1998-198 modifies the grounds for not following an advance instruction. When the principal is deemed incapable, physicians and other mental health treatment providers must provide treatment in accordance with an advance instruction unless

1. compliance, in the opinion of an attending physician or other mental health treatment provider, is not consistent with "generally accepted community practice standards of treatment to benefit the principal;"
2. compliance, in the opinion of an attending physician or other mental health treatment provider, is not consistent with appropriate treatment in case of an emergency endangering life or health;
3. compliance is not consistent with applicable law;
4. the treatment requested by the principal is not available; or
5. the principal is committed to a twenty-four-hour facility pursuant to the statutory provisions for involuntary commitment and treatment is provided in accordance with G.S. 122C-57.

S.L. 1998-198 adds several provisions intended to protect health care providers from liability for actions taken in accordance with the advance directive law.

1. A physician or other mental health treatment provider may presume that a person who executes an advance instruction was of sound mind and acted voluntarily when he or she executed the document.
2. An attending physician or eligible psychologist who in good faith determines that the principal is or is not incapable for the purpose of deciding whether to proceed according to an advance instruction is not subject to criminal prosecution, civil liability, or professional disciplinary action for making and acting upon that determination.
3. In the absence of actual knowledge of the revocation of an advance instruction, an attending physician or other mental health treatment provider is not subject to criminal prosecution or civil liability and will not be deemed to have engaged in unprofessional conduct as a result of the provision of treatment to a principal in accordance with an advance instruction, unless the absence of actual knowledge resulted from the negligence of the attending physician or mental health treatment provider.
4. An attending physician or mental health treatment provider who administers or does not administer mental health treatment according to, and in good faith reliance upon, the validity of an advance instruction is not subject to criminal prosecution, civil liability, or professional disciplinary action resulting from a subsequent finding of an advance instruction's invalidity.
5. An attending physician or mental health treatment provider who administers or does not administer treatment under authorization obtained pursuant to an advance instruction may not be held liable with respect to any legal claim to the extent that the claim is based on lack of informed consent or authorization for this action.

S.L. 1998-198 amends G.S. 122C-57(d) to provide that a responsible professional may disclose an advance instruction or confidential information from an advance instruction to a physician, psychologist, or other qualified professional when the responsible professional determines that disclosure is necessary to give effect to or provide treatment in accordance with the advance instruction.

Under the 1997 legislation, advance instructions automatically expired after two years and principals could revoke the advance instruction in whole or in part. Because of the potential confusion and increased administrative burden that might arise from a series of partial revocations, as well as the burden on principals to renew their advance instructions, S.L. 1998-198 deletes these provisions. Now an advance directive is effective until revoked, and principals who want to make changes to an advance instruction should simply revoke the instruction and execute a new one. Advance instructions may be revoked at any time the principal is not incapable by communicating, in any manner the principal is able, an intent to revoke to the treating physician or other mental health treatment provider.

Under the 1997 law, if a court appointed a guardian of the person or a general guardian for the principal following the principal's execution of an advance instruction, then the advance instruction remained in effect and was superior to the powers and duties of the guardian with respect to mental health treatment covered by the advance instruction. S.L. 1998-198 replaces this provision with one that requires the principal's guardian to follow the principal's advance mental health instruction to the extent that doing so is consistent with G.S. 35A-1201(a)(5), which provides that guardianship should preserve for the ward the opportunity to exercise rights within his or her comprehension and judgment and to participate in decisions to the full extent of his or her capabilities.

Medicaid

Section 12.12D of S.L. 1998-212 (S 1366), effective January 1, 1999, extends Medicaid coverage to all elderly and disabled people who have incomes equal to or less than 100 percent of the federal poverty guidelines. Section 12.7 of S.L. 1998-212 makes Medicaid enrollment of categorically needy families with children continuous for one year without regard to changes in income or assets. Section 12.26A of S.L. 1998-212 amends G.S. 108A-25.1 to require fingerprinting of all Medicaid recipients, applicants, and payees, other than institutionalized adults, minors (unless they are minor parents applying for or receiving assistance), and individuals who must be excluded according to federal law or regulation. Changes in the Medicaid program are discussed in more detail in Chapter 24 (Social Services).

Health Care Personnel Registry

Section 12.16E of S.L. 1998-212, effective January 1, 1999, amends G.S. 131E-256 to expand the list of health care facilities covered by the health care personnel registry maintained by DHHS. This registry contains the names of health care personnel working in health care facilities who have been alleged or found to have neglected or abused a resident of a health care facility, misappropriated property of a resident or facility, diverted drugs belonging to a patient or facility, or committed fraud against a health care facility or patient for whom the employee was providing services. S.L. 1998-212 extends the provisions of G.S. 131E-256 to facilities providing mental health, developmental disabilities, and substance abuse services that are operated by the state or licensed under Article 2 of G.S. Chapter 122C.

Studies and Reports

State Psychiatric Hospitals and Area Mental Health Programs

Section 12.35A of S.L. 1998-212 (S 1366) directs the State Auditor to coordinate with the Fiscal Research Division and DHHS a comprehensive study of area authorities and state psychiatric hospitals. The State Auditor must contract with independent consultants with expertise in the structure and administration of mental health programs and state psychiatric hospitals. The study must compare the costs of constructing and operating new facilities with the cost of redesigning and operating existing state psychiatric hospitals, taking into account both cost efficiencies and patient access to quality care. In addition the study must assess

- how many and what type of inpatient beds are needed statewide and how to provide adequate and efficient access to them;
- the capacity and ability of area authorities to efficiently and effectively provide services now provided by state psychiatric hospitals;

- the overall structure of the current system for delivering mental health services and whether changes should be made in the governance and administration of services and in the relationship between state and local mental health agencies;
- current policies and procedures governing administration and operations; and
- current funding streams.

The State Auditor must make the following reports to the Senate and House Appropriations Committees on Human Resources:

- An interim report on the study of the state psychiatric hospitals by May 1, 1999, and a final report by December 1, 1999.
- A progress report on the study of area authorities by March 15, 1999; a first interim report by May 1, 1999; a second interim report by November 1, 1999; and a final report by April 1, 2000.
- An interim report on funding streams and operational and administrative policies and procedures by March 15, 1999, and a final report by May 1, 1999.

Developmental Disability Services Review

Section 12.34 of S.L. 1998-212 (S 1366) requires DHHS to review and implement initiatives to provide and enhance person-centered and family support services to developmentally disabled individuals served by the public mental health services system. DHHS must

- determine why Medicaid-eligible individuals are waiting for services from area authorities;
- establish for the state and area authorities goals that require no more than a six-month wait for developmental disabilities services;
- collaborate with area authorities to use existing funds to increase services for developmentally disabled individuals not eligible for the CAP-MR/DD Medicaid Waiver Program;
- seek from the Health Care Financing Administration greater flexibility in the use of funding provided under the CAP-MR/DD Medicaid waiver;
- study the feasibility of providing new or additional services using the regular Medicaid program; and
- pursue additional Medicaid waivers that emphasize person-centered and family support services for the developmentally disabled.

DHHS must report the results of these activities to the Senate and House Human Resources Appropriations Committees by May 1, 1999. The report also must address the impact of the General Assembly's expansion funding on the waiting list for services for developmentally disabled individuals.

Residential Care for Persons with Mental Illness and Developmental Disabilities

Section 12.35D of S.L. 1998-212 (S 1366) directs DHHS to review the effectiveness of agency oversight of family care centers, foster homes, nursing homes, and adult care homes that provide care for persons with mental illness or developmental disabilities. The department must report on the enforcement of existing laws; whether clients, families, and staff in small residential settings feel free to speak to authorities who can resolve problems; and what can be done about problems in facilities that require immediate resolution but for which no enforcement remedies are immediately available. DHHS must report its findings and recommendations to the Joint Legislative Health Care Oversight Committee and the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services no later than April 1, 1999.

Failed Legislation

Mental Health Insurance Parity

Senate Bill 400 was introduced in 1997, passed the Senate, and remained eligible for consideration during the 1998 session. It would have required health insurance plans to provide mental health care benefits at least equal to the coverage for physical illness. Under this bill, benefits for the treatment of mental and physical illnesses would have been subject to the same annual and lifetime limits, deductibles, durational limits, coinsurance factors, copayments, out-of-pocket limits, and other dollar limits or fees for covered services. It would have applied only to group health insurance contracts covering five or more employees and would have exempted a policy if the insurer showed that compliance increased the cost of the policy by 2 percent or more on an annual basis.

Mental Health Center Funds

Senate Bill 1434, introduced in 1998, would have appropriated from the General Fund to DHHS \$1 million for 1998–99 to construct mental health centers in low-wealth and economically distressed counties.

Composition of Area Mental Health Boards

G.S. 122C-118 requires that all area boards include at least one individual representing the interests of persons with mental illness, one individual representing persons with developmental disabilities, and one client of substance abuse services, openly in recovery, representing the interests of individuals suffering from alcohol or other drug abuse. The area board also must include a family member of a person receiving services for mental illness, a family member of a person receiving developmental disabilities services, and a family member of a person receiving services for alcoholism or other drug abuse. House Bill 327 would have amended G.S. 122C-118(e) to allow the appointing entity, when a person openly in recovery for substance abuse cannot be found, to appoint an additional person from any of the other foregoing categories. Having passed the House in 1997, House Bill 327 was eligible for consideration in 1998, but was not acted upon by the Senate.

Health Care Information Privacy

Identical bills introduced during the 1998 session (Senate Bill 1288 and House Bill 1495) would have established a comprehensive health and mental health privacy law to give patients a right of access to health care and mental health care information and limit the disclosure and use of such information by those who obtain, create, maintain, or use it. The bills also addressed subpoenas, search warrants, requests for discovery, court orders, electronically stored information, electronic signatures, master indexes of patient information, and the responsibilities of medical records custodians. Neither bill was reported out of committee.

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