

# Mental Health and Related Laws

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This chapter discusses acts of the 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 1999 the General Assembly expanded funding for community-based mental health, developmental disabilities, and substance abuse services while cutting appropriations to the Willie M. and Thomas S. programs. The legislature amended the certification and licensure laws for social workers and substance abuse professionals, enacted legislation authorizing the creation and maintenance of medical records in an electronic format, and called for a study of North Carolina's involuntary commitment laws that would address the roles and responsibilities of state and local agencies while examining the service systems and patient disabilities that contribute to patient noncompliance with recommended treatment.

## **Area Authorities**

### **County Funding**

In 1996 the General Assembly, at the recommendation of the Mental Health Study Commission, amended G.S. 122C-115 to prohibit counties from supplanting county appropriations to area authorities with other area authority revenues. For the most part S.L. 1996-749 merely codified existing provisions of the 1995 Session Laws, which prohibited counties from reducing county appropriations and expenditures for area authorities "because of the availability of State-allocated funds, fees, or capitation amounts to area authorities." The 1996 act changed the law, however, to add fund balances to the list of revenue sources that could not be used by counties as a basis for reducing area authority appropriations and expenditures. In its report to the 1996 General Assembly the commission explained that, under the recommended nonsupplant provision, coun-

ties would retain discretion to determine the amount of county funding to area authorities as long as reductions in funding were not made for the reasons prohibited by G.S. 122C-115.

Subsequent to the enactment of S.L. 1996-749, confusion and disagreement arose over the question of whether counties have any permissible grounds to reduce area authority appropriations or expenditures from one fiscal year to the next. As a result the General Assembly enacted S.L. 1999-202 (S 1122) to amend G.S. 122C-115(d) to clarify that counties are prohibited from using the listed revenue sources as a basis for reducing appropriations and expenditures “for current operations and ongoing programs and services of area authorities,” but that counties “may reduce county appropriations by the amount previously appropriated by the county for one-time, nonrecurring special needs of the area authority.”

### **Reimbursement of Area Authority Funds**

S.L. 1999-237 (H 168) enacts new G.S. 122C-123A to provide that any funds of an area authority that are transferred by the authority to any other entity, including a firm, partnership, corporation, company, association, joint stock association, agency, or nonprofit private foundation, are subject to reimbursement by the area authority to the state when area authority expenditures are disallowed pursuant to a state or federal audit.

## **Appropriations**

### **Current Operations**

The 1999 Appropriations Act, S.L. 1999-237, 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) \$614,290,187 for fiscal year 1999–2000 and \$607,658,021 for fiscal year 2000–2001. Appropriations for the past five fiscal years were \$564.3 million (1998–99), \$528.5 million (1997–98), \$465.6 million (1996–97), \$473.6 million (1995–96), and \$475.9 million (1994–95).

Two significant funding changes—both recurring—are a \$3.9 million reduction in appropriations for Thomas S. services and \$6 million in new funding for community-based mental health, developmental disabilities, and substance abuse services for individuals waiting for services. Other reductions in funding include the elimination of \$500,000 in area authority capital reserves—originally appropriated in 1994—and a cut of \$650,000 for 1999–2000 and \$960,000 for 2000–2001 in appropriations for state-operated residential treatment programs for children and adolescents. The latter funding cut, made in anticipation of increased Medicaid revenues, affects the Wright and Whitaker Schools for the Emotionally Disturbed and the residential treatment programs in Wilson and Butner for violent and assaultive children. In anticipation of increased patient revenues, the General Assembly further reduced state appropriations to MH/DD/SAS by \$1.3 million in 1999–2000 and \$2.5 million in 2000–2001.

In addition to the \$6 million expansion funding for community-based services, MH/DD/SAS received the following increases in appropriations:

- \$200,000 (nonrecurring) to construct Union House, a psychosocial treatment facility for seriously and persistently mentally ill individuals;
- \$471,000 (nonrecurring) to the Autism Society to complete Camp Royall, a camp for autistic children and adults;
- \$158,000 (recurring) to the Blue Ridge Area Authority for allocation to First Step Farm of Western North Carolina, Inc., to increase contracted bed utilization;
- \$800,000 (recurring) to complete the merger of the Cleveland County Area Authority and the Gaston-Lincoln Area Authority;



tuberculosis services.) From the Social Services Block Grant, which funds several DHHS divisions, the General Assembly made the usual \$4,764,124 appropriation to MH/DD/SAS and allocated another \$5 million (\$1 million less than in 1998–99) 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 Medicaid Community Alternative Program for Mentally Retarded/Developmentally Disabled (CAP–MR/DD).

From the Temporary Assistance to Needy Families (TANF) Block Grant, MH/DD/SAS receives three allocations: \$3.5 million for substance abuse screening, diagnosis, treatment, and testing of Work First participants; \$1,182,280 for substance abuse services for juveniles; and \$1 million for the Enhanced Employee Assistance Program, a grant program of financial incentives for private businesses employing former and current Work First recipients.

## State Government Reorganization

Section 11.4 of the 1999 Appropriations Act, S.L. 1999-237, directs DHHS to create a Division of Education Services to manage the Governor Morehead School and the three residential schools for the deaf. The act authorizes DHHS to include within this new division any or all of the schools and educational programs currently managed by MH/DD/SAS, provided that any goals and plans for the new division are consistent with the recommendations proposed by DHHS in its April 14, 1999, report “Program Review of Disability Services.”

## Licensed Professionals

### Social Workers

**Certification and Licensure Act.** With certain exceptions, the Social Worker Certification and Licensure Act (G.S. Chapter 90B) has required the certification of social workers who engage in the practice of clinical social work. S.L. 1999-313 (H 1069, S 1157) amends G.S. Chapter 90B to require the licensure rather than certification of clinical social workers without changing the qualifications required to practice clinical social work. S.L. 1999-313 does revise, however, the academic requirements for becoming a “certified social worker” by requiring a bachelor’s degree from an accredited social work program. A bachelor’s degree in a human services–related subject with eighteen semester hours from an accredited social work program no longer suffices.

S.L. 1999-313 raises the maximum fees that may be assessed for applications for, and renewals of, certification and licensure and amends the provisions for certification and licensure of social workers certified, licensed, or registered in other jurisdictions. For example, the North Carolina Social Work Certification and Licensure Board may grant a certificate or license without examination to persons certified, licensed, or registered in other jurisdictions only if the applicant has passed an examination in the other jurisdiction that is equivalent to the examination required under North Carolina law. In addition the board may grant a temporary license to a nonresident clinical social worker who is certified, registered, or licensed in another jurisdiction whose standards, at the time of the person’s certification, registration, or licensure, were substantially equivalent to or higher than the requirements under G.S. Chapter 90B. Persons with temporary licenses must comply with the act’s supervision requirements.

S.L. 1999-313 also expands the disciplinary remedies that may be imposed by the board. In lieu of denying, suspending, or revoking certification or licensure when an applicant, certificate holder, or licensee has engaged in conduct prohibited by the act, the board may (1) issue a reprimand or censure; (2) order probation with conditions; (3) require examination, remediation, or rehabilitation, including care, counseling, or treatment by a professional designated or approved by the board; (4) require supervision by a certified or licensed social worker designated or approved by the board; or (5) limit or circumscribe the extent, nature, or location of the

applicant's, certificate holder's, or licensee's social work practice. In considering whether an applicant, certificate holder, or licensee is mentally or physically capable of practicing social work with reasonable skill and safety, the board may require the social worker to submit to a mental or physical examination by a mental health or health professional designated by the board.

The board must provide the opportunity for a contested case hearing (G.S. 150B, Article 3A) to (1) any applicant whose certification or licensure was denied; (2) any applicant whose certification or licensure was granted subject to restrictions, probation, or other limitations; and (3) any certificate holder or licensee before revoking, suspending, or restricting his or her certificate or license. No person is entitled to a hearing for failing to pass a qualifying examination.

S.L. 1999-313 also addresses the board's authority to access and protect client information and what information acquired or generated by the board is public record. The board may order the production of records concerning the practice of social work that are relevant to a complaint received by the board or to an inquiry or investigation conducted by the board. Records and other documents containing information compiled by or on behalf of the board through an investigation, inquiry, or interview conducted in connection with a certification, licensure, or disciplinary matter are not public records within the meaning of G.S. Chapter 132. Notices of charges, notices of hearings, and decisions rendered in connection with a hearing are public records, but information that identifies a client of social work services must be deleted from the public record unless the client consents to disclosure. In any proceeding before the board, the board may withhold from public disclosure the identity of any client of social work services, and if necessary for the protection of the client and the full presentation of relevant evidence, the board may close a hearing to the public for purposes of receiving evidence related to social work services.

The provisions of G.S. 90B-10(b)(3)a, which exempted from the act's certification and licensure requirements clinical social workers employed by the state, political subdivisions of the state, or local governments (including clinical social workers employed by area authorities), expired on January 1, 1999. Employees of state or local governments who are engaged in clinical social work practice, therefore, must be licensed under G.S. Chapter 90B unless they are otherwise exempt from licensure under that chapter.

**Health Services Corporation.** G.S. Chapter 55B regulates corporations formed to render certain personal or professional services, including health services. G.S. 55B-14(c) lists the types of professionals who may form a professional corporation and the professional services they may render. In particular the statute permits a licensed clinical social worker to form a professional corporation with a physician practicing psychiatry or a psychologist for the purpose of providing psychotherapeutic and related services. S.L. 1999-136 (S 620) amends G.S. Chapter 55B to permit licensed clinical social workers to incorporate with any type of physician.

## Psychologists

S.L. 1999-292 (S 793) amends the Psychology Practice Act to define the *practice of psychology* to include the diagnosis and treatment of neuropsychological aspects of physical illness, accident, injury, or disability. The act defines *neuropsychological* as “[p]ertaining to the study of brain-behavior relationships, including the diagnosis, including etiology and prognosis, and treatment of the emotional, behavioral, and cognitive effects of cerebral dysfunction through psychological and behavioral techniques and methods.”

Legislation (H 1156) that would have exempted certain licensed psychological associates from the act's supervision requirements failed to pass the House in the 1999 legislative session and is, therefore, not eligible for consideration during the regular 2000 legislative session.

## Substance Abuse Professionals

**Certification Act.** S.L. 1999-164 (S 1062) makes several amendments to the statutory provisions for certification of substance abuse professionals. The act creates an intermediary designation, clinical supervisor intern, for substance abuse counselors or addictions specialists who wish to become certified clinical supervisors. To be designated a clinical supervisor intern,

the applicant must have a master's degree in a human services field with a clinical application from a regionally accredited college or university (the same educational background now required to become a certified clinical supervisor) and have completed at least 50 percent of the supervision-specific training required of certified clinical supervisors.

S.L. 1999-164 amends the certification requirements for certified clinical addictions specialists, adding 300 hours of supervised practical training to one of the four alternative certification classes, and revises certification requirements for certified residential facility directors to permit both substance abuse counselors and certified addictions specialists to apply.

Until January 1, 2001, certified clinical supervisors or persons who function, according to their job descriptions, as certified clinical supervisors are qualified to supervise applicants for certified clinical supervisor. Between January 1, 2001, and January 1, 2003, only a person certified both as a clinical supervisor and as a clinical addictions specialist may supervise applicants for certified clinical addictions specialist. During the same period either a certified clinical supervisor or a certified clinical addictions specialist may supervise applicants for certified substance abuse counselor. Effective January 1, 2003, only a person certified as a clinical supervisor or a clinical supervisor intern may supervise applicants for certification as clinical supervisors, substance abuse counselors, or clinical addictions specialists.

S.L. 1999-164 adds several provisions pertaining to records sought and compiled by the North Carolina Substance Abuse Professional Certification Board. The presiding officer of the board may subpoena witnesses and documents, including client records, concerning any matter to be heard before or inquired into by the board. Client records subpoenaed by the board must be produced, notwithstanding the application of any law that provides a "counselor-client or physician-patient privilege." (In spite of this provision, no information protected by the federal drug and alcohol confidentiality law, 42 C.F.R. pt. 2, should be disclosed except as authorized by those regulations.) Upon written request, the board must revoke the subpoena if, upon hearing, it finds the evidence sought does not relate to a matter in issue, the subpoena does not describe the evidence with sufficient particularity, or the subpoena is invalid.

Generally records and other documents containing information collected and compiled by the board as a result of an investigation, inquiry, or interview conducted in connection with a certification or disciplinary matter are not public records within the meaning of G.S. Chapter 132. Any notice of charges, any notice of hearing, and any documents received and admitted into evidence in any hearing before the board are public records. However, any information in a board proceeding, hearing record, or notice of charges that identifies or tends to identify a client of substance abuse services must be withheld from public disclosure unless the client or the client's representative expressly consents to the disclosure. The new law authorizes the board to receive evidence in a closed session when necessary for the full presentation of relevant evidence and the protection of the substance abuse client or accused substance abuse professional.

**Reimbursement for Services.** S.L. 1999-199 (H 714) amends articles 50 and 65 of G.S. Chapter 58, and G.S. 135-40.7B(c1), to provide for direct payment to substance abuse professionals for services covered by health insurance policies and plans. Any person certified by the North Carolina Substance Abuse Professional Certification Board is covered by the act.

## **Mental Health Records**

### **Electronic Medical Records**

S.L. 1999-247 (H 957) authorizes any health care provider or facility licensed, certified, or registered under North Carolina law, as well as any unit of state or local government (including area authorities), to create and maintain medical records in an electronic format. A separate paper copy of the electronic medical record is not required. When a consent to treatment or release of records is contained in a paper writing, however, the writing must be preserved in a durable

medium, and its existence and location must be noted in the electronic record. Electronic medical records must be maintained in a legible and retrievable form, including adequate data backup. The act further provides that laws pertaining to the security, confidentiality, accuracy, integrity, access to, and disclosure of records embodied in paper or other media also apply to electronic records.

Facilities and agencies covered by the act (new G.S. 90-412) may authorize individuals to authenticate orders and other medical record entries by written signature or by electronic or digital signature in lieu of signature in ink. Medical record entries must be authenticated by the individual who made or authorized the entry. The act defines *authentication* to mean the identification of the author of an entry by that author and confirmation that the contents of the entry are what the author intended.

### **Guardian Ad Litem Access to Records**

G.S. 7B-601 provides for the court appointment of guardians ad litem to represent children alleged to be abused, neglected, or dependent in juvenile court proceedings. S.L. 1999-432 (S 25) amends G.S. 7B-601 to give the guardian ad litem the authority to obtain any information or reports (except those protected by the attorney-client privilege), whether or not confidential, that may in the guardian ad litem's opinion be relevant to the case. Previously the guardian ad litem had this authority only if the court specifically granted it in the order appointing the guardian ad litem. (Like the former statute, the amended statute does not authorize or compel the disclosure of information protected under the federal drug and alcohol confidentiality statute and implementing regulations at 42 C.F.R. pt. 2.)

Under the amended statute the guardian ad litem's appointment terminates when a permanent plan has been achieved for the juvenile and approved by the court. The act also adds to the guardian ad litem's responsibilities the duties (1) to conduct follow-up investigations to insure that court orders are being properly executed and (2) to report to the court when the needs of the juvenile are not being met.

### **Peer Review Information**

S.L. 1999-222 (H 190) provides that peer review information that is confidential pursuant to G.S. 122C-191(e)(2) and medical review information that is confidential under G.S. 131E-95(b) may be released to a professional standards review organization that performs accreditation or certification functions. In the case of peer review information governed by G.S. 122C-191, only accrediting organizations that perform reviews pursuant to a contract with a federal or state agency may have access to the information. Peer review and medical review information released to an accrediting organization must be limited to that which is reasonably necessary and relevant to the organization's determination to grant or continue accreditation or certification. The released information retains its confidentiality and must be protected from disclosure by the accrediting organization.

### **Information Obtained by Health Maintenance Organizations and Provider Sponsored Organizations**

S.L. 1999-272 (H 958) amends G.S. 58-67-180 and G.S. 131E-310 to clarify that confidential medical information obtained by health maintenance organizations (HMOs) and provider sponsored organizations (PSOs) may be disclosed pursuant to a court order for the production or discovery of evidence.

### **Records of Alleged Abusers of Juveniles**

S.L. 1999-318 (H 1159) requires the county department of social services, whenever a juvenile is removed from the home due to physical abuse, to review any mental health records of the alleged abuser and petition the court for a mental health evaluation of the alleged abuser if the

review reveals a history of violent behavior. The section of the act relating to the department's access to mental health records is summarized here, while the provisions providing for court-ordered mental health evaluations are described below, in the section "Abused, Neglected, and Dependent Juveniles."

The act amends G.S. 7B-302 to require the director to conduct a thorough review of the background of the alleged abuser(s) whenever, due to physical abuse, a juvenile is removed from the home of a parent, guardian, custodian, stepparent, or adult relative entrusted with the juvenile's care. The review must include a check of the person's criminal history and a review of any "available" mental health records.

In obtaining the access to mental health records, social services directors may rely on existing wording in G.S. 7B-302(e), which gives the director broad authority to obtain information he or she needs in the performance of "any duties" related to the investigation of abuse, neglect, or dependency reports or to the provision of or arrangement for protective services. Under that subsection, the director may make a written demand for any information or reports, whether or not confidential, that the director believes may be relevant to the investigation or to the provision of protective services. A person or agency receiving such a request must give the director access to and copies of the requested information or reports

- to the extent permitted by federal law and regulations,
- unless they are protected by the attorney-client privilege, and
- subject to the right of a custodian of criminal investigative information or records to seek a court order to prevent disclosure, based on a belief that disclosure would jeopardize the state's right to prosecute a defendant or the defendant's right to receive a fair trial.

## **Transportation Costs for Involuntary Commitment**

Generally, under the proceedings for involuntary commitment in North Carolina, a city has the duty to provide transportation in the case of a respondent who resides in or can be taken into custody within city limits. A county has the duty to provide transportation for a respondent who resides in or can be taken into custody in the county outside of city limits. Under some circumstances a county or city may have a duty to transport a respondent who resides in another county. Further, cities and counties may alter their statutory duty to transport by contracting with each other to provide transportation.

Regardless of who provides transportation, G.S. 122C-251(h) provides that the cost and expense of transporting a respondent to or from a twenty-four-hour facility is the responsibility of the county of residence of the respondent. Until amended, the statute further provided that a city or county was entitled to recover transportation costs from (1) respondents who have sufficient financial resources to pay or (2) the county of residence of an indigent respondent. S.L. 1999-201 (H 972) amends the reimbursement provision to provide that a county or city may recover from the respondent's county of residence the cost of transporting any respondent, whether or not indigent, and that the county of residence must reimburse the other county or city for the reasonable transportation costs incurred. Further, the ability of a respondent's county to seek transportation costs directly from the respondent is now limited to costs incurred as a result of the county of residence reimbursing another county or city for transportation.

For the respondent's county of residence to recover transportation costs paid to a county or city that provided transportation, the respondent or other individual liable for the respondent's support must be provided reasonable notice and opportunity to object to the recovery. Reimbursement may be sought from any respondent who is not indigent, any person or entity that is legally liable for the respondent's support and maintenance and who has sufficient property to pay the cost, any person or entity that is contractually responsible for the cost, or any person or entity otherwise liable for the cost under federal, state, or local law.

## **Health Care Personnel Registry**

G.S. 131E-256 requires DHHS to maintain a registry containing the names of persons who may have neglected or abused residents of health care facilities. Specifically the registry must contain 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. In 1998 the General Assembly expanded the list of facilities covered by the law by adding state-operated facilities and certain facilities licensed under Article 2 of G.S. Chapter 122C. S.L. 1999-159 (H 1258) amends G.S. 131E-256 to clarify that, with respect to facilities providing mental health, developmental disabilities, and substance abuse services, the law applies to “state facilities,” “24-hour facilities,” and “residential facilities,” as those terms are defined in G.S. 122C-3(14). (*State facility* means a facility operated by the Secretary of Health and Human Services; *24-hour facility* means a facility that provides a structured living environment and services for a period of twenty-four consecutive hours or more and includes hospitals providing mental health, developmental disabilities, or substance abuse services; and *residential facility* means a twenty-four hour facility that is not a hospital, including a group home.)

In addition S.L. 1999-159 amends the health care personnel registry statute to require that facilities covered by the law, before hiring health care personnel into a facility or service, access the health care personnel registry and note each incident of access in the appropriate business files.

## **Insurance**

### **Substance Abuse Services**

S.L. 1999-116 (H 715) amends G.S. Chapter 58 to require insurers, when determining whether a patient needs to be placed in a substance abuse treatment program (for purposes of deciding whether to pay for services covered by the patient’s insurance plan), to use either (1) criteria adopted by the American Society of Addiction Medicine or (2) clinical review criteria adopted by the insurer or its utilization review organization.

### **Health Insurance Program for Uninsured Children**

Legislation affecting North Carolina’s “Health Choice for Children” program for uninsured children is discussed in Chapter 11 (Health).

## **Medicaid**

Legislation affecting Medicaid and other public assistance programs, including acts relating to Medicaid eligibility for the disabled, special assistance for adult care home residents, and foster care and adoption assistance, are discussed in Chapter 23 (Social Services).

## **Abused, Neglected, and Dependent Juveniles**

### **Children in Institutions**

Section 1 of S.L. 1999-190 (H 262) amends the Juvenile Code’s definition of *caretaker* in G.S. 7B-101(3) to specify that a “person responsible for a juvenile’s health and welfare [in a

residential setting]” includes “any employee or volunteer of a division, institution, or school operated by the Department of Health and Human Services.”

Section 2 of the act amends G.S. 7B-302(b) to address the responsibility of a county department of social services when it receives a report of suspected abuse, neglect, dependency, or death from maltreatment relating to a juvenile in an institutional setting, such as a residential child care or educational facility. In those cases the department must ascertain immediately whether other juveniles remain in the facility subject to the alleged perpetrator’s care or supervision and, if they do, assess the circumstances of those juveniles to determine whether they require protective services or whether their immediate removal from the facility is necessary for their protection.

### **Petition and Order for Mental Health Evaluation**

S.L. 1999-318 requires county social services directors, whenever a juvenile is removed from the home due to physical abuse, to review any mental health records of the alleged abuser. Under new G.S. 7B-302(d1), if the director’s review reveals that the alleged abuser has a history of violent behavior against people, the director must petition the court to order the alleged abuser to submit to a complete mental health evaluation by a licensed psychologist or psychiatrist. The act amends G.S. 7B-503 to require the court to rule on the petition before returning the child to a home where the alleged abuser is or has been present. If the court finds that the alleged abuser has a history of violent behavior against people, the court must order the alleged abuser to submit to a complete mental health evaluation and may order the alleged abuser to pay the cost of the evaluation. An amendment to G.S. 7B-506 requires the court, in determining whether the juvenile’s continued nonsecure custody is warranted, to consider the opinion of the mental health professional who performed the evaluation.

The results of the mental health evaluation must be included in the evaluation the social services director prepares pursuant to G.S. 7B-304 for presentation to the court following adjudication. In addition, at disposition under G.S. 7B-903 or G.S. 7B-1003 (disposition pending appeal), if the court has found that the juvenile suffered physical abuse and that the responsible individual has a history of violent behavior against people, the court must consider the opinion of the mental health professional who performed the evaluation before returning the juvenile to that person’s custody.

### **Court-Ordered Psychiatric or Psychological Treatment of Parents and Others**

G.S. 7B-904 describes the court’s authority, at a dispositional or subsequent hearing in an abuse, neglect, or dependency proceeding, to require parents to do specified things. S.L. 1999-318 rewrites the section to give the court most of the same authority in relation to the juvenile’s guardian, custodian, or stepparent; an adult member of the juvenile’s household; or an adult relative entrusted with the juvenile’s care. Under the new law the court may order those persons, as well as the juvenile’s parents, to

- participate in the juvenile’s medical, psychiatric, psychological, or other treatment;
- undergo psychiatric, psychological, or other treatment or counseling designed to remedy behaviors or conditions that led or contributed to the juvenile’s adjudication or removal from that person’s custody (this may be a direct order or a condition of the person’s having custody of the juvenile);
- pay, if able to do so, for treatment the court orders the person to undergo. (If the person is not able to pay, the court may order the county to pay the cost of the treatment.)

## **Other Legislation Relating to Child Welfare**

Other legislation relating to child welfare and changes in Juvenile Code provisions relating to abuse, neglect, and dependency is discussed in chapters 4 (Children and Families) and 23 (Social Services).

## **Adult Protective Services**

Section 1.10 of S.L. 1999-334 (S 10) amends G.S. 108A-103 to establish new time frames for county social services department investigations of certain reports involving the abuse or neglect of disabled adults.

- A report alleging a life-threatening situation must be investigated immediately.
- Investigation of a report alleging the abuse of a resident of an adult care home must be initiated within twenty-four hours of receipt of the report.
- Investigation of a report alleging the neglect of a resident of an adult care home must be initiated within forty-eight hours.
- All other investigations must be initiated within two weeks of the date the report is received.

The county social services department must complete all adult protective services investigations within thirty days.

## **Camp Butner Reservation**

Under Article 6 of G.S. Chapter 122C the residential areas and state and federal facilities at Camp Butner Reservation in Durham and Granville Counties are administered by North Carolina through the Office of the Secretary of Health and Human Services. Under this administrative system Camp Butner residents generally have not had elected representation with respect to public services that normally would be under the control of an elected city council or board of county commissioners. In 1996 the General Assembly amended Article 6 to create the Butner Advisory Council, consisting of seven members elected by the residents of Camp Butner, to advise the Secretary of Health and Human Services on the administration of Camp Butner and to act, upon appointment of the secretary, as the planning agency for the reservation. S.L. 1996-667 (H 1144). In the 1997 session the General Assembly amended Article 6 to delete provisions requiring the election of council members, providing instead for their appointment by the Secretary of Health and Human Services. S.L. 1997-59 (S 428). The General Assembly revisited the issue in 1999 and enacted S.L. 1999-140 (H 105), which restores provisions for the election of council members by Camp Butner Residents. The council may advise the secretary on the operations of Camp Butner through resolutions adopted by the council, and the secretary may approve or disapprove any council recommendations.

## **Studies and Reports**

### **Conditional Release of Involuntary Commitment Respondents**

Section 5.2 of S.L. 1999-395 (H 163), the 1999 Studies Act, directs the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services to study whether and under what circumstances persons committed involuntarily to state psychiatric hospitals should be released under specific conditions. In conducting the study, the commission must consider the following:

1. the target population for whom conditional release may be appropriate and necessary to protect public safety and enhance patient stability;

2. the estimated number of persons who could qualify for conditional release;
3. criteria for conditional release that are clearly and narrowly defined to ensure that conditional release will apply only to the target population and will not be susceptible to application in an overinclusive manner;
4. costs of implementing conditional release, including the need for such additional resources at the area mental health authority level as medication, transportation, case management, and administrative start-up costs;
5. the roles, duties, and responsibilities of area mental health authorities, twenty-four-hour facilities, courts, and law enforcement agencies, sufficiently and clearly defined to ensure both efficient coordination and communication among these entities and continuity of care for respondents on conditional release;
6. the qualifications necessary for personnel monitoring and supervising conditional release and providing treatment to respondents on conditional release;
7. the mental health system issues and patient disabilities that currently contribute to patient noncompliance with recommended treatment and treatment approaches and systems designs that would enhance patient compliance, mental health, and quality of life; and
8. any other issues the commission deems appropriate for the study.

The commission must report its findings and recommendations, including any recommended legislation, to the 1999 General Assembly, regular session 2000, within one week of its convening.

### **Physical and Mechanical Restraints**

Section 5.3 of the Studies Act directs the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services to study the use of physical and mechanical restraints in facilities providing mental health, developmental disabilities, and substance abuse services and licensed under G.S. Ch. 122C and in child placing and child caring facilities. The commission must report its findings and recommendations, including any recommended legislation, to the 1999 General Assembly, regular session 2000, within one week of its convening.

### **Traumatic Brain Injury**

Section 11.2 of S.L. 1999-237 directs DHHS to study (1) the long-range costs of treating and caring for persons with traumatic brain injury and (2) the feasibility and cost to the state of obtaining a Home and Community-Based Medicaid Waiver to provide Medicaid services to one hundred individuals with traumatic brain injury. DHHS must report to the House Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Human Resources by May 1, 2000.

### **Mental Health Insurance Parity**

In 1997 a bill was introduced and passed in the Senate that would have required group health insurance plans covering five or more employees to provide mental health care benefits at least equal to the coverage provided for physical illness, unless the insurer demonstrated that compliance increased the cost of the policy by at least 2 percent. Under the bill (S 400), 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, co-payments, out-of-pocket limits, and other dollar limits or fees for covered services. Although eligible for consideration during the 1998 session, S 400 was not enacted. The Studies Act of 1999, S.L. 1999-395, authorizes the Legislative Research Commission to study the issue of requiring health insurance plans to provide mental health and chemical dependency benefits in parity with the benefits for physical illness. If the commission decides to study the issue, any findings and recommendations may be reported to the General Assembly in 2001 or 2000.

### **State Psychiatric Hospitals and Area Mental Health Programs**

In 1998 the General Assembly directed the State Auditor to coordinate with the Fiscal Research Division and DHHS a comprehensive study of area authorities and state psychiatric hospitals. Section 12.35A of S.L. 1998-212 (S 1366). The study must, among other things, (1) compare the costs of constructing and operating new facilities with the cost of redesigning and operating existing state psychiatric hospitals, taking into account patient access to quality care; (2) assess how many and what type of inpatient beds are needed statewide and how to provide adequate and efficient access to them; (3) assess the capacity and ability of area authorities to efficiently and effectively provide services now provided by state psychiatric hospitals; and (4) evaluate 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. Section 11.36 of 1999-237 reiterates that the State Auditor must make a final report on the study of state psychiatric hospitals to the Senate Appropriations Committee on Human Resources and the House Appropriations Subcommittee on Health and Human Services by December 1, 1999. A second interim report on the study of area authorities must be made by November 1, 1999, and a final report by April 1, 2000.

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