1999-2000

HOUSE
MENTAL HEALTH
COMMITTEE

MINUTES

HOUSE COMMITTEE ON MENTAL HEALTH

1999 – 2000 SESSION

CO-CHAIRMEN

Representative Jim Crawford
Representative Wayne Goodwin

STAFF

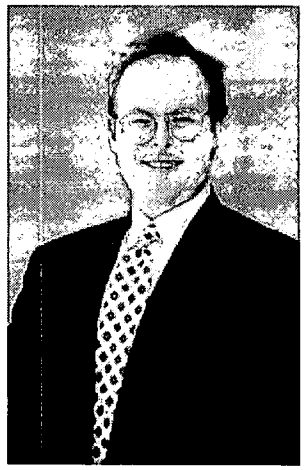
Linda Attarian
Kory Goldsmith

COMMITTEE ASSISTANTS

Linda Winstead
Kristen Younts

MENTAL HEALTH COMMITTEE
1999 - 2000

Rep. Jim Crawford, Chair



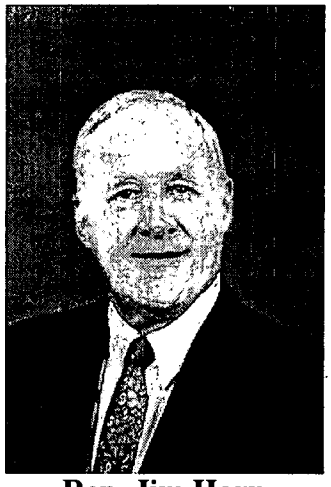
Rep. Wayne Goodwin, Chair

Rep. Cherie Berry

Rep. Lanier Cansler

Rep. Theresa Esposito

Rep. Charlotte Gardner



Rep. Jim Horn

Rep. Verla Insko

Rep. Mary McAllister

Rep. Edd Nye

Rep. Pete Oldham

Rep. Nurham Warwick

Ex-Officio Members

Rep. Phil Baddour

Rep. Pete Cunningham

Rep. Andy Dedmon

Rep. Beverly Earle

Rep. Joe Hackney

MENTAL HEALTH COMMITTEE
1999-00

Member/Clerk	Telephone	Room
James W. **Crawford**, Chair Linda Winstead	3-5824	1301
Rep. Wayne **Goodwin**, Chair Kristen Younts	3-4838	502
Rep. Cherie **Berry** Betty Smith	3-5602	1426
Rep. Lanier **Cansler** Barbara Cansler	3-5605	1209
Rep. Theresa **Esposito** Judy Lowe	5-3012	418A
Rep. Charlotte **Gardner** Barbara Hocutt	3-5802	604
Rep. Jim **Horn** Alice Sharpe	3-5849	503
Rep. Verla **Insko** Pat Baker	3-5775	1323
Rep. Mary **McAllister** Annecia Norwood	3-5959	638
Rep. Edd **Nye** Jo Bobbitt	3-5477	639
Rep. Pete **Oldham** Delta Prince	5-3026	403
Rep. Nurham **Warwick** Carolyn Honeycutt	5-3003	419C
Staff		
Linda Attarian Kory Goldsmith	3-2578	545

NORTH CAROLINA GENERAL ASSEMBLY

COMMITTEE SUMMARY REPORT

1999-2000 Biennium HOUSE: MENTAL HEALTH Valid Through 14-JUL-1999

BILL	INTRODUCER	SHORT TITLE	LATEST ACTION ON BILL	IN DATE	OUT DATE
H 298	HACKNEY	STUDY CONDITIONAL RELEASE	*H -RE-REF COM ON RULES	03-04-99	04-15-99
H 972=	INSKO	TRANSP. COSTS/INVOL. COMMITMENT	*R -CH. SL 99-0201	04-12-99	04-20-99
H1142	BUCHANAN	PHYSICAL RESTRAINT RESTRICTIONS	H -REF TO COM ON MNTLHLTH	04-15-99	
H1156	CRAWFORD	AMEND PSYCHOLOGY PRACTICE ACT	*H -RE-REF COM ON MNTLHLTH	04-23-99	04-28-99
H1156	CRAWFORD	AMEND PSYCHOLOGY PRACTICE ACT	*H -RE-REF COM ON MNTLHLTH	05-13-99	
S1122	MOORE K	AREA MENTAL HEALTH/COUNTY APPROP	*R -CH. SL 99-0202	04-29-99	05-26-99

NOTES- = AFTER BILL NUMBER SHOWS THAT BILL IS IDENTICAL, AS INTRODUCED, TO ANOTHER BILL.
* AFTER NUMBERS INDICATES THAT TEXT OF BILL WAS ALTERED BY ACTION ON THE BILL.
BOLDED LINE INDICATES BILL INDEXED AS AFFECTING APPROPRIATIONS.

ATTENDANCE

MENTAL HEALTH

(Name of Committee)

DATES	3/2	3/23	3/30	4/6	4/13	4/20	4/27	5/4	5/11	5/18	5/25	6/1	6/8	6/22	
CRAWFORD, Jim, Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
GOODWIN, Wayne, Chair	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓			
BERRY, Cherie							✓								
CANSLER, Lanier	✓	✓		✓			✓			✓	✓		✓	✓	
ESPOSITO, Theresa	✓	✓	✓	✓		✓	✓		✓	✓	✓			✓	
GARDNER, Charlotte			✓	✓	✓						✓			✓	
HORN, Jim	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	
INSKO, Verla						✓		✓			✓				
MCALLISTER, Mary				✓		✓				✓			✓		
NYE, Edd				✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	
OLDHAM, Pete			✓	✓		✓		✓	✓		✓		✓		
WARWICK, Nurham				✓		✓			✓	✓	✓				
Ex-Officio															
BADDOUR, Phil															
CUNNINGHAM, Pete															
DEDMON, Andy															
EARLE, Beverly															
HACKNEY, Joe															

HOUSE COMMITTEE ON MENTAL HEALTH

MARCH 2, 1999
10:00 a.m.
Room 415

AGENDA

Chair: Rep. Wayne Goodwin

Introductions

Current Issues in State Mental Health Services

Dr. Terry Stelle, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

Overview of Substantive Legislative Proposals

Michele Cotton, Legislative Liaison

Overview of Catchment Areas of the Area Mental Health Authorities

Carolina Alternatives – What Happened and What's Next

MINUTES
HOUSE COMMITTEE ON MENTAL HEALTH
MARCH 2, 1999
RM. 415 LOB

The house Committee on Mental Health met on Tuesday, March 2, 1999 in Room 415 of the Legislative Office Building at 10:00 AM. The following members were present: Chairs- Representatives Crawford and Goodwin (Presiding), Representatives Cansler, Esposito, and Horn. Also attending, staff members, Kory Goldsmith and Linda Attarian. A visitor registration list is attached and made part of these minutes.

Representative Goodwin introduced the pages for the day, also, the staff and committee assistants. Committee members introduced themselves. Dr. Terry Stelle, from the Division of Mental Health spoke on the indictments of Dr. Lou Stein and others in the Division. He states that department attorneys believe there is no culpability for the State of NC in these cases. He briefly explained Carolina Alternatives, a Medicaid waiver program before turning the program over to Tara Larson, Chief of Management Support Services.

Ms. Larson explained that the application to the federal government had been withdrawn because of concerns with compliance, cost-effectiveness, consumer rights, and plan choice for consumers. Carolina Alternatives will be terminated on June 30, 1999. Rep. Cansler asked several questions of Ms. Larson. Ms. Michelle Cotton, Legislative Liason, was asked to return at a later time to give her presentation.

Rep. Goodwin adjourned the meeting at 10:50AM.

Respectfully submitted,

Rep. Wayne Goodwin
Chairman

Kristen Younts
Committee Assistant

VISITOR REGISTRATION SHEET

MENTAL HEALTH ~~House Ways and Means Committee~~ — MARCH 2, 1999 ~~February 24, 1999~~

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tara Larson	DMH/DD/SAS
Bob Hedrick	CNC
[illegible] Simonean	NC Council of Community Programs
[illegible] Tate	MHA/NC
Heather [illegible]	OSA
Dave Richard	Arc/NC
Allen [illegible]	NC Council of Comm Programs
HUGH TILSON	NCHA
Tommy Worth	CHS
[illegible] Bain	NCMS
Steve Keene	NCMS
[illegible] Williams	OSBM
Jim Edgerton	DHHS
DAVE BRUTON	DHHS
MICHELLE COTTON	DMH/DD/SAS
A Dennis McBride	DHHS
Adam Searing	NCHAC
[illegible] H[illegible]	NTO
Lisa Appatomarco	DHHS BR+A
Joyce Peters	JP Assoc/MAM ST
Katherine Miller	Harry Kaplan
Karen [illegible]	NC Dept of Health & Human Svcs [illegible]

Handout # 1
3-2

North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

325 North Salisbury Street • Raleigh, North Carolina 27603 • Courier # 56-20-24

James B. Hunt, Jr., Governor
H. David Bruton, MD, Secretary

John F. Baggett, Ph. D., Director
(919) 733-7011

MEMORANDUM

TO: The Honorable Representative Jim Crawford, Chair and House Committee Members
House Committee on Mental Health

FROM: Michelle Cotton

RE: DMH/DD/SAS Legislative Proposals

DATE: March 2, 1999

The following is a summary of the proposals that the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services is pursuing during this legislative session of the North Carolina General Assembly.

State Hospitals Share Peer Review (a proposed amendment to Section Number: 122C-191)

The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), which accredits the State psychiatric hospital, recently began requiring these facilities to submit the results of peer review investigations. This reporting requirement is a cause of concern as the hospitals will share sensitive investigative information regarding unexpected deaths and other unfavorable events that occur at the hospitals. The current peer review statute shields the results of these investigations from discovery in an effort to promote candor among reviewers.

Sharing peer review reports with the JCAHO could undermine the reports' current immunity from discovery, thus increasing the State's exposure to civil liability. Sharing these reports could also undermine the integrity of the peer review process. Because of concerns regarding confidentiality and the accompanying potential liability, the Division is not voluntarily complying with this requirement. However, continued resistance to compliance could jeopardize the hospital's accreditation and the receipts that accrue as the result of that accreditation. The suggested amendment to NC GS 122C - 191 will address these concerns by allowing the hospitals to share

peer review information with accrediting organizations, such as JCAHO, without waiving any of the privileges granted in the peer review statute.

Conditional Release of Mentally Ill Clients (a proposed amendment to G.S. 122-277)

This proposed legislation would amend North Carolina's conditional releases statue GS122-277 and give the State the authority to better protect the public welfare by allowing for immediate return to the hospital when the patient fails to comply with prescribed medication and treatment program. It would provide legal authority for close supervision of mentally ill persons released from psychiatric hospitals that are likely to become dangerous if they are not taking their medication. The bill would allow by legal authority for a client to be closely monitored by community mental health workers and returned immediately to the hospital without a hearing should they not remain stable in the community.

Improving the Effectiveness of DWI Offender Services

This proposal will provide mechanisms through which the Division may more directly impact upon the quality and effectiveness of services provided to the mandated DWI population toward reducing recidivism and thereby increasing public safety. The legislation would allow DHHS to establish a system to track DWI offenders (funded/supported by a portion of offender assessment fees) that links to a statewide database system, e.g. the Criminal Justice Information Network (managed under the direction of the Department of Crime Control and Public Safety).

Controlled Substance Prescription Accountability Act - Electronic Data

This legislation will provide new technological solutions to the problem of prevention and controlling the diversion and abuse of prescription drugs through the use of an electronic data transfer system (EDT) system.

Changes in Scheduling of Certain Controlled Substances

This legislation will make a technical change to existing statute (G.S. 90, Article 5) to accurately reflect the current scheduling of controlled substances as scheduled by the Drug Enforcement Administration.

Cc: John Baggett, Ph.D.
Terry Stelle, Ph.D.

HOUSE COMMITTEE ON MENTAL HEALTH

MARCH 23, 1999
10:00 a.m.
Room 415

AGENDA

Chair: Rep. Jim Crawford

Area Mental Health Authorities

Dr. Terry Stelle, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

Allen Spader, Executive Director
North Carolina Council of Community Programs

Mental Health Legislative Initiatives

Michele Cotton, Legislative Liaison

MINUTES
HOUSE COMMITTEE ON MENTAL HEALTH
MARCH 23, 1999

The House Committee on Mental Health met on Tuesday, March 23, 1999 in Room 415 of the Legislative Office Building at 10:00 a.m. The following members were present: Chairman Jim Crawford, Representatives Goodwin, Cansler, Esposito, and Horn. Kory Goldsmith, staff counselor, attended. A visitor registration list is attached and made part of these minutes.

Chairman Crawford introduced the pages for the day and Dr. Terry Stelle, Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. Dr. Stelle handed out a map showing a breakdown of regions and areas within. He discussed the trend of merging areas or collaborating efforts among areas. This should eliminate some of the difficulties that small areas have in meeting accreditation requirements, managing care, maintaining management information systems, etc. He added that there are some added costs to mergers that might have to be addressed in this committee.

Chairman Crawford introduced Allen Spader, Executive Director, NC Council of Community Programs. Mr. Spader gave statistics such as number of clients served, independent contract providers, local board makeup, and percentages of funding. He also provided information on current issues and changes with which area programs are dealing. He offered the following solutions needed to deal with those changes: performance-based accreditation and evaluation systems, new information-based management, and strengthening the community-based system through consolidation and restructuring.

Chairman Crawford adjourned the meeting at 10:40.

Respectfully submitted,

Representative Jim Crawford
Chairman

Linda S. Winstead
Committee Assistant

VISITOR REGISTRATION SHEET

MENTAL HEALTH — March 23, 1999

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

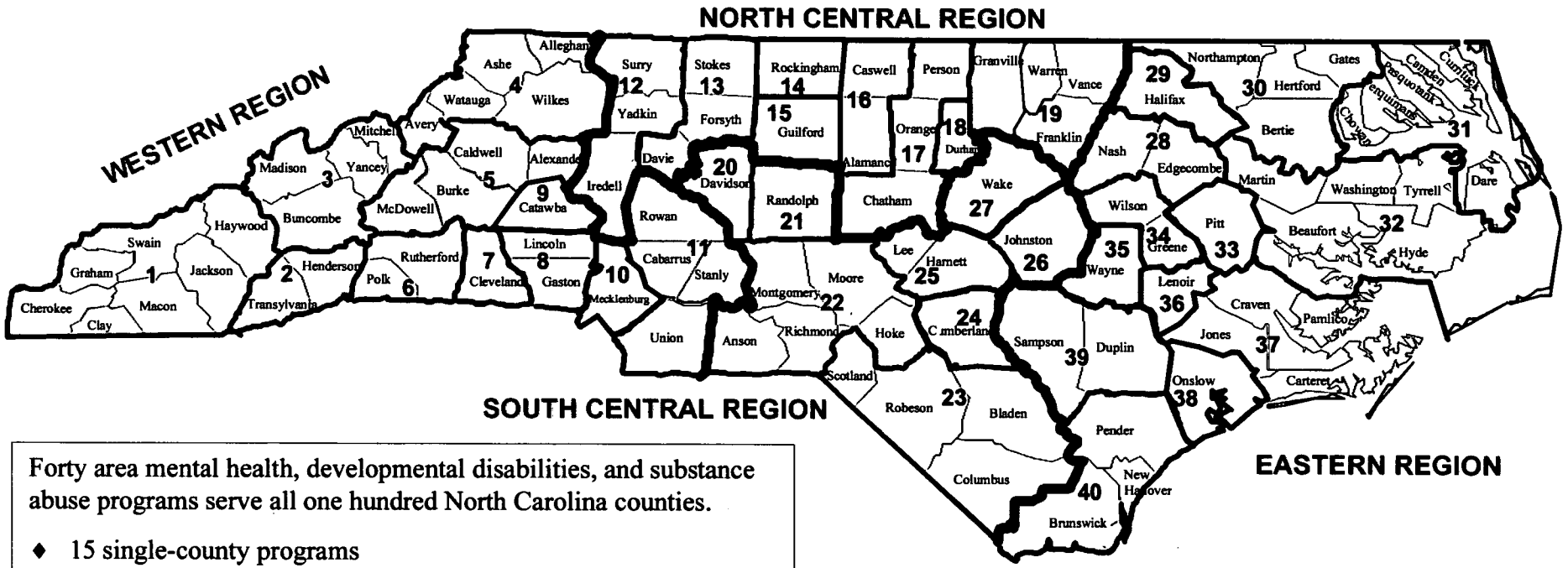
NAME	FIRM OR AGENCY AND ADDRESS
Janet Simoneau	NC Council of Community Programs
Allan Gaden	NC Council "
Sally Cameron	NC Psychological Assoc
Patricia Rowden	NCACC
Tammy Worth	CHS
Angela J. Trice	UNC-Charlotte
Delores H. Lee	UNC-Charlotte
June M. Smith	UNC Charlotte
Jim Trogdon	UNC Charlotte
Nathan Hart	UNC Charlotte
Wayne Williams	OSBM
Dwight E. Clark	NCPA / Council MH/DD/SA

AREA MENTAL HEALTH /DEVELOPMENTAL DISABILITIES /SUBSTANCE ABUSE SERVICES

AREA PROGRAMS

(Numerical order) Number = Area Program

1. Smoky Mountain
2. Trend
3. Blue Ridge
4. New River
5. Foothills
6. Rutherford-Polk
7. Cleveland
8. Gaston-Lincoln
9. Catawba
10. Mecklenburg
11. Piedmont
12. Crossroads
13. Centerpoint
14. Rockingham
15. Guilford
16. Alamance-Caswell
17. Orange-Person-Chatham
18. Durham
19. Vance-Granville-Franklin-Warren
20. Davidson
21. Randolph
21. Sandhills
23. Southeastern Reg.
24. Cumberland
25. Lee-Harnett
26. Johnston
27. Wake
28. Edgecombe-Nash
29. Riverstone
30. Roanoke-Chowan
31. Albemarle
32. Tideland
33. Pitt
34. Wilson-Greene
35. Wayne
36. Lenoir
37. Neuse
38. Onslow
39. Duplin-Sampson
40. Southeastern Area



Forty area mental health, developmental disabilities, and substance abuse programs serve all one hundred North Carolina counties.

- 15 single-county programs
- 25 multi-county programs

Prepared by DHHS/DMH/DD/Substance Abuse Services

A total of 296,724 persons were served in area programs during FY'98. This number represents:

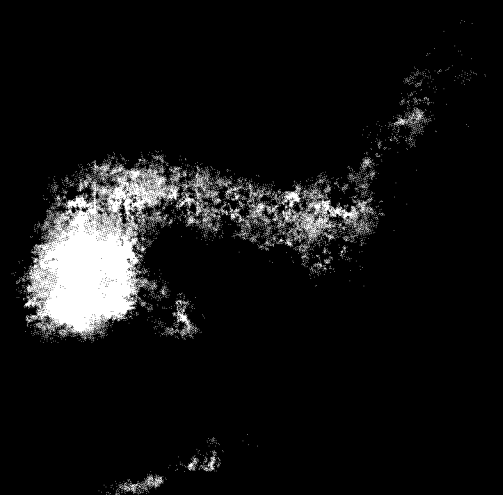
- 196,296 mental health clients
- 17,152 developmental disabilities clients
- 83,276 substance abuse clients

Handout # 1

Handout 2

NC COMMUNITY NEWS
UPDATE
• MENTAL HEALTH
• DEVELOPMENTAL DISABILITIES &
• SUBSTANCE ABUSE

PROGRAMS OF EXCELLENCE 1997-98



QUALITY SERVICES

to over 250,000 North Carolinians who have

Mental Illness

Developmental Disabilities

Addiction to Alcohol & Other Drugs

August 1998

Special Edition

Honoring the Dedicated Services of These Area Programs

NORTH CAROLINA COUNCIL OF COMMUNITY PROGRAMS • 1318 DALE STREET, SUITE 120 • RALEIGH, NC 27605

Mary Benson House

A Refuge to Overcome Addiction and Begin a New Life

BLUE RIDGE CENTER for MH/DD/SA Services

When "Beth," age 30, came to the Mary Benson House, she was a cocaine user and a mother of two who had never held down a job. Her oldest child of eight years had not lived with her since he was one year old, but she had retained custody of her one-year-old daughter.

> **"The difference in Beth from the time she came in, to the time she left eleven months later, was night and day."**

When Beth arrived at Mary Benson House, she communicated with her daughter by screaming, she lacked trust for the staff and was very abrasive.

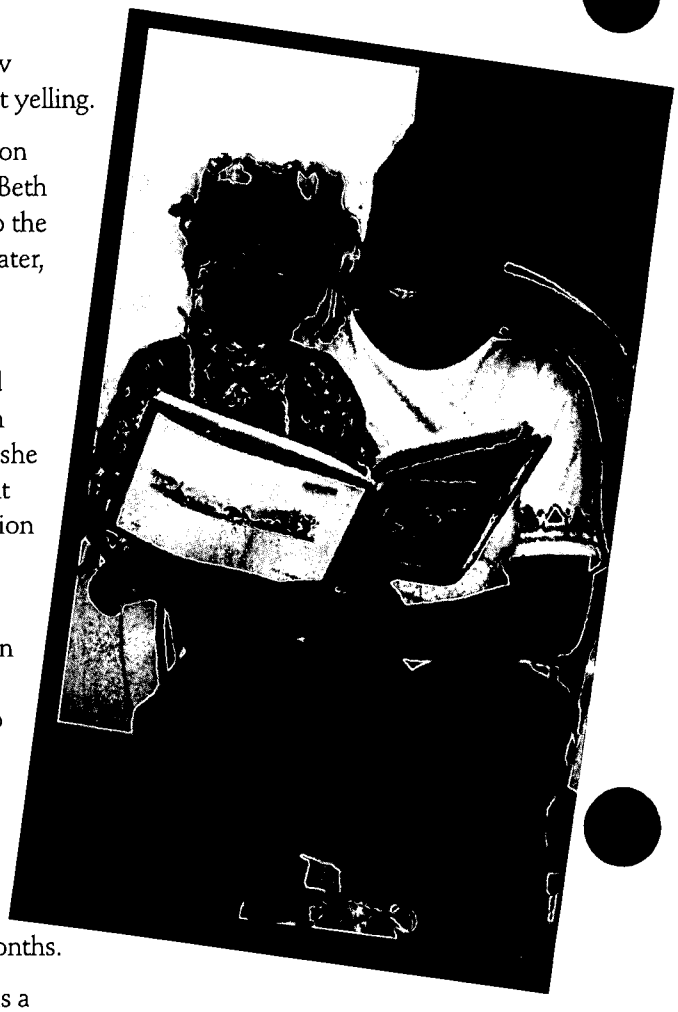
Through parenting classes, individual counseling, group therapy and a lot of love from staff, Beth began to mellow. Her confidence level bloomed and she became a leader for the house community. She also became more loving toward her daughter and now communicates to her without yelling.

Staff member Diana Carlson noted that "the difference in Beth from the time she came in, to the time she left eleven months later, was night and day."

During her time at Mary Benson House, Beth regained custody of her son and began attending school, two things she was very frightened about. At the completion of her education she had become a Certified Nursing Assistant.

Upon leaving Mary Benson House, Beth moved into her own apartment with her two children and began working as a Certified Nursing Assistant.

Today, Beth has been clean and sober for two years and working for ten months.



The Mary Benson House is a therapeutic home, located in a largely residential area. The house is designed to meet the need for available and accessible residential, treatment and wrap-around services for adult pregnant and parenting women with substance abuse disorders and their children ages birth to five years. Treatment planning and service delivery for each woman is done through an interdisciplinary collaborative team approach between Mary Benson House, other service providers and the community. △

ADULT SUBSTANCE ABUSE 97–98 WINNER

Adult Substance Abuse

People with alcohol and drug dependence suffer from a disease recognized by the medical community since the mid-1950s. It is estimated that more than 787,000 North Carolinians abuse and/or are addicted to substances. It is estimated that the lives of over 3 million North Carolinians (over half the population) are affected by those abusing alcohol or other substances. The number of arrests made in 1995 related to alcohol and substance abuse exceeded 100,000 which equals almost 69% of convicted individuals in State prison.

The costs of substance abuse in North Carolina now exceed $5 billion annually. These costs include lost work time, prison and jail construction, infant mortality, spread of AIDS, and an increased burden on the welfare system. A major cause of developmental disabilities among babies is the use of alcohol and other drugs by mothers during pregnancy. Clearly, these statistics demonstrate the enormity of the problem and the need to provide community treatment.

Evidence that treatment works is well documented. A recent study of treatment outcomes found that 1) the level of criminal activity declined by ⅔ from before treatment to after treatment, 2) declines of approximately ⅔ occurred in the use of alcohol and other drugs and 3) there was about a ⅓ reduction in hospitalizations. Positive impact on employment and economic situations was also noted. This study also found that the benefits to taxpaying citizens of alcohol and other drug treatment outweighed the costs of treatment by ratios of 4:1 to greater than 12:1, depending on the type of treatment.

HOUSE COMMITTEE ON MENTAL HEALTH

MARCH 30, 1999
10:00 a.m.
Room 415

AGENDA

Chair: Rep. Wayne Goodwin

Mental Health Legislative Initiatives

Michele Cotton, Legislative Liaison

MINUTES
HOUSE COMMITTEE ON MENTAL HEALTH
MARCH 30, 1999
RM. 415 LOB

The House Committee on Mental Health met on Tuesday, March 30, 1999 in Room 415 of the Legislative Office Building at 10:00 AM. The following members were present: Chairs- Representatives Crawford and Goodwin (Presiding), Representatives Esposito, Gardner, Horn, and Oldham. Kory Goldsmith and Linda Attarian, committee staff were also present. A visitor registration list is attached and made part of these minutes.

Representative Goodwin introduced the pages for the day. Michelle Cotton, Legislative Liason for the Division of Mental Health was introduced to give a presentation on Mental Health Legislative Initiatives. A handout was given to the members entitled, "North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services- Overview of Division Sections, State Institutions and Area Authorities". Ms. Cotton spoke on the Division's Mission and Primary Responsibilities and gave a brief overview of all departmental sections.

Representative Goodwin adjourned the meeting at 10:50 AM.

Respectfully submitted,

Rep. Wayne Goodwin
Chairman

Kristen Younts
Committee Assistant

*Meeting tape malfunctioned and cannot be listened to.

3-30-99

VISITOR REGISTRATION SHEET

MENTAL HEALTH
~~THE HOUSE APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES~~

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

	NAME	FIRM OR AGENCY
1.	Tommy Worth	Carolina Healthcare Systems
2.	Patrice Roulhac	NCACC
3.	Katherine Miller	Harry Kaplan
4.	Beth Melcher	NAMI NC
5.	Ashley Westbrook	Governors Office
6.	Leanne Kinnier	NCSBA
7.	[illegible]	NCPA / NC Council
8.	Janet Smith	NC Council
9.		
10.		
11.		
22.		
23.		
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26.		
27.		
28.		
29.		
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31.		

Area Programs - 1999 Legislators Matrix

AREA PROGRAM	LEGISLATORS
Alamance-Caswell	Rep. Cary Allred – R (25th) Rep. Nelson Cole – D (25th) **Rep. W.B. Teague – R (25th)** Sen. Hugh Webster – R (21st)
Albemarle (Camden, Chowan, Currituck, Dare, Pasquotank, and Perquimans counties)	Sen. Marc Basnight – D (1st) Rep. William Culpepper – D (86th) Rep. William Owens – D (1)
Blue Ridge (Buncombe, Madison, Mitchell, and Yancey counties)	**Rep. Phil Haire – D (52nd)** Rep. Charles Buchanan – R (46th) Sen. Robert Carpenter – R (42nd) Rep. Lanier Cansler – R (51st) **Sen. Charles Carter – D (28th)** **Sen. Steve Metcalf – D (28th)** **Rep. Trudi Walend – R (68th)** Sen. John Garwood – R (27th) **Rep. Robert Gillespie – R (49th)** Sen. Kenneth Moore – R (27th) Rep. Martin Nesbitt –D (51st) Rep. Liston Ramsey – D (52nd) Rep. Wilma Sherrill –R (51st) Rep. Gregg Thompson – R (46th)
Catawba County	Sen. Austin Allran – R (26th) Rep. Cherie Berry – R (45th) Rep. Joe Kiser – R (45th) **Rep. Mitchell Setzer – R (43rd)** Rep. Charles Buchanan – R (46th) Rep. Greg Thompson – R (46th) Rep. Edgar Starnes – R (91st)
CenterPoint (Forsyth and Stokes counties)	Rep. Rex Baker – R (40th) Rep. William Hiatt – R (40th) Rep. Gene Wilson – R (40th) Rep. Michael Decker – R (84th) Rep. Theresa Esposito – R – (88th) Rep. Lyons Gray – R (39th) Rep. Warren Oldham – D (67th) Rep. Paul Sexton – R (73rd) Rep. Larry Womble – D (66th) Sen. Betsy Cochrane – R (38th) Sen. Don East – R (12) Sen. Virginia Foxx – R (12)

CenterPoint cont.	Sen. Hamilton Horton – R (20th) **Senator Linda Garrou – D (20th)**
Cleveland Center	Rep. Debbie Clary – R (48th) Rep. Andrew Dedmon – D (48th) **Rep. Jim Horn – D (48th)** Sen. Walter Dalton – D (37th) Sen. David Hoyle – D (25th)
Crossroads (Iredell, Surry, and Yadkin counties)	Rep. Rex Baker – R (40th) Rep. William Hiatt – R (40th) Rep. Gene Wilson – R (40th) Rep. Mitchell Setzer – R (43rd) Rep. John Brown – R (41st) Rep. George Holmes – R (41st) Rep. Frank Mitchell – R (42nd) Sen. Don East – R (12th) Sen. Jim Forrester – R (39th) Sen. Virginia Foxx – R (12th) Sen. John Garwood – R (27th) Sen. Kenneth Moore – R (27th) Sen. Jim Phillips – D (23rd)
Cumberland	Rep. Rep. John Hurley – D (18th) Rep. Mia Morris – R (18th) Rep. Ted Kennedy – D (17th) Rep. Mary McAllister – D (17th) Rep. Ed Nye – D (96th) Rep. Douglas Yongue – D (16th) Sen. Tony Rand – D (24th) Sen. Larry Shaw – D (41st) Sen. David Winstein (D (30th)
Davidson	Sen. Betsy Cochrane – R (38th) Sen. Jim Phillips – D (23rd) Sen. Robert Shaw – D (18th) Rep. Jerry Dockham – R (94th) Rep. Julia Howard – R (74th) Rep. Paul McCrary – D (37th) Rep. Steve Wood – R (27th)
Davie	Sen. Betsy Cochrane – R (38th) Rep. Julia Howard – R (74th)
Duplin-Sampson	Sen. Charles Albertson D (5th) **Sen. Oscar Harris – D (15th)** Sen. David Weinstein – D (30th) Rep. Jerry Braswell – D (97th) Rep. Donald Davis – R (19th) **Rep. Leslie Cox – D (19th)** Rep. Ed Nye – D (96th) Rep. Nurham Warwick - D (12th)

Duplin-Sampson	**Rep. Russell Tucker – D (10th)**
The Durham Center	Rep. Russell Capps – D (92nd) Rep. Paul Luebke – D (23rd) Rep. Mickey Michaux – D (23rd) Rep. George Miller – D (23rd) Rep. Jane Mosley – D (63rd) Sen. Wib Gulley – D (13th) Sen. Jeanne Lucas – D (13th)
Edgecombe-Nash	Rep. Gene Arnold – R (72nd) Rep. Billy Creech – R (20th) Rep. Milton Fitch – D (70th) Rep. Thomas Hardaway – D (7th) **Rep. Edith Warren – D (8th)** Rep. Joe Tolson – D (71st) Sen. Roy Cooper – D (10th) Sen. Robert Martin – D (6th)
Foothills (Alexander, Burke, Caldwell, and McDowell counties)	Rep. John Brown – R (41st) Rep. George Holmes – R (41st) Rep. Charles Buchanan – R (46th) Rep. Gregg Thompson – R (46th) Rep. Walter Church – D – (47th) **Rep. Robert Gillespi – R (49th)** Rep. Edgar Starnes – R (91st) Sen. R.L. Clark – R (28th) Sen. John Garwood – R (27th) Sen. Kenneth Moore – R (27th)
Gaston-Lincoln	Rep. Cherie Berry – R (45th) Rep. Joe Kiser – R (45th) Rep. Debbie Clary – R (48th) Rep. Andrew Dedmond – D (48th) **Rep. Daniel Barefoot – D (44th)** **Rep. John Bridgeman – D (76th)** Rep. John Rayfield – R (93rd) **Rep. Jim Horn – D (48th)** Sen. Austin Allran – R (26th) Sen. James Forrester R (39th) Sen. David Hoyle – D (25th) Sen. T.L. Fountain Odom – D (34th)
Guilford	Rep. Alma Adams – D (26th) Rep. Joanne Bowie – R (29th) Rep. Flossie Boyd-McIntyre – D (28th) Rep. Harold Brubaker – R (38th) Rep. Arlie Culp – R (30th)

Guilford cont.	Rep. Michael Decker – R (84th) Rep. Mary Jarrell – D (89th) Rep. Maggie Jeffus – D (89th) Rep. Stephen Wood – R (27th) **Sen. Kay Hagan – D (32nd)** Sen. Don East – R (12th) Sen. Virginia Foxx – R (12th) Sen. Bill Martin – D (31st) Sen. Bob Shaw – R (19th)
Riverston Counseling and Personal Development (Halifax)	Rep. Gordon Allen – D (22nd) Rep. Jim Crawford – D (22nd) Rep. Thomas Hardaway – D (7th) Sen. Frank Ballance – D (2nd) Sen. Roy Cooper – D (10th)
Johnston	Rep. Billy Creech – R (20th) Rep. Leo Daughtery – R (95th) Sen. Oscar Harris – D (15th) Sen. Brad Miller – D (14th) Sen. Eric Reeves – D (14th) Sen. Allen Wellons – D (11th)
Lee-Harnett	Rep. Don Davis – R (19th) **Rep. Leslie Cox – D (19th)** Sen. Howard Lee – D (16th) Sen. Eleanor Kinnaird – D (16th) Sen. Oscar Harris – D (15th)
Lenoir	Rep. Phillip Baddour – D (11th) Rep. Carolyn Russell – R (77th) Rep. William Wainwright – D (79th) Sen. Luther Jordan – D (7th) Sen. John Kerr – D (8th) Sen. Ed Warren – D (9th)
Mecklenburg County Health, Mental Health, and Community Services	Rep. Martha Alexander – D (56th) Rep. Jim Black – D (36th) Rep. Pete Cunningham – D (59th) Rep. John Bridgeman – D (76th) Rep. Beverly Earle – D (60th) Rep. Ruth Easterling – D (58th) Rep. Jim Gulley – R (69th) Rep. William E. McMahan – R (55th) Rep. John Rayfield – R (93rd) Rep. Drew Saunders – D (54th) Rep. Connie Wilson – R (57th) Sen. Charlie Dannelly – D (33rd) Sen. Fountain Odom – D (34th) Sen. Bob Rucho – R (35th) **Sen. Daniel Clodfelter – D (40th)**

Neuse (Carteret, Craven, Jones, and Pamlico counties)	Sen. Charles Albertson – D (5th) Sen. Patrick Ballantine – R (4th) Sen. Luther Jordan – D (7th) Sen. Beverly Perdue – D (3rd) **Rep. Zeno Edwards – D (2nd)** **Rep. Scott Thomas – D (3rd)** Rep. Jean Preston – R (4th) Rep. Ronald Smith – D (4th) Rep. William Wainright – D (79th) **Rep. Russell Tucker – D (10th)**
New River (Alleghany, Ashe, Avery, Watauga, and Wilkes counties)	Rep. Rex Baker – R (40th) Rep. Bill Hiatt – R (40th) Rep. Gene Wilson – R (40th) Rep. John Brown – R (41st) Rep. George Holmes – R (41st) Rep. Charles Buchanan – R (46th) Rep. Gregg Thompson – R (46th) Sen. Don East – R (12th) Sen. Virginia Foxx – R (12th) Sen. John Garwood – R (27th) Sen. Kenneth Moore – R (27th)
Onslow	Sen. Charles Albertson – D (5th) Sen. Patrick Ballantine – R (4th) Sen. Luther Jordan – D (7th) Rep. Robert Grady – R (80th) Rep. Jean Preston – R (4th) Rep. Ronald Smith – D (4th) Rep. Nurham Warwick – D (12th) **Rep. Russell Tucker – D (10th)**
Orange-Person-Chatham	Rep. Gordon Allen – D (22nd) Rep. Jim Crawford – D (22nd) Rep. Cary Allred – R (25th) Rep. Nelson Cole – D (25th) **Rep. W. B. Teague – R (25th)** Rep. Arlie Culp – R (29th) Rep. Joe Hackney – D (24th) Rep. Verla Insko – D (24th) Sen. Wib Gulley – D (13th) Sen. Eleanor Kinnaird – D (16th) Sen. Howard Lee – D (16th) Sen. Jeanne Lucas – D (13th) Sen. Hugh Webster – R (21st)
Piedmont Behavioral Healthcare (Cabarrus, Rowan, Stanly, and Union counties)	Rep. Bobby Barbee – R (82nd) Rep. Charlotte Gardner – R (35th) **Rep.Pryor Gibson – D (33rd)** Rep. Eugene McCombs – R (83rd)

Piedmont cont.	Rep. Richard Moore – D (90th) **Rep. O. Max Melton – D (34th)** Rep. Timothy Tallent – R (81st) Sen. Betsy Cochrane – R (38th) Sen. Fletcher Hartsell – R)22nd) Sen. Jim Phillips – D (23rd) Sen. Aaron Plyler – D (17th) Sen. Bill Purcell – D (17th)
Pitt	**Rep. Marian McLawhorn – D (9th)** **Rep. Zeno Ewards – D (2nd)** **Rep. Edith Warren – D (8th)** Rep. Eugene Rogers – D (6th) Rep. Joe Tolson – D (71st) Sen. Robert Martin – D (6th) Sen. Edward Warren – D (9th)
Randolph	Rep. Harold Brubaker – R (38th) Rep. Arlie Culp – R (30th) Rep. Jerry Dockham – R (94th) Sen. Howard Lee – D (16th) Sen. Eleanore Kinnaird – D (16th) Sen. Robert Shaw – R (19th)
Roanoke-Chowan Human Services Center (Bertie, Gates, Hertford, and Northhampton counties)	Sen. Frank Ballance – D (2nd) Sen. Marc Basnight – D (1st) Rep. Howard Hunter – D (5th) Rep. Eugene Rogers – D (6th)
Rockingham	Rep. Cary Allred – R (25th) Rep. Nelson Cole – D (25th) **Rep. W.B. Teague – R (25th)** Rep. Wayne Sexton – R (73rd) Sen. Don East – R (12th) Sen. Virginia Foxx – R (12th)
Rutherford-Polk	Sen. Bob Carpenter – R (42nd) Sen. Walter Dalton – D (37th) Rep. Debbie Clary – R (48th) Rep. Andrew Dedmon – D (48th) **Rep. Jim Horn – D (48th)** Rep. Larry Justus – R (50th)
Sandhills (Anson, Hoke, Montgomery, Moore, and Richmond counties)	Rep. Donald Bonner – D (87th) Rep. Wayne Goodwin – D (32nd) **Rep. Pryor Gibson – D (33rd)** Rep. Richard Morgan – R (31st) Rep. Ronnie Sutton – D (85th) Rep. Douglas Yongue – D (16th) Sen. Eleanor Kinnaird – D (16th) Sen. Howard Lee – D (16th)

Sandhills cont.	Sen. Aaron Plyler – D (17th) Sen. Bill Purcell – D (17th) Sen. David Weinstein – D (30th)
Smoky Mountain Center (Cherokee, Clay, Graham, Haywood, Jackson, Macon, and Swain counties)	**Rep. Phil Haire – D (52nd)** Rep. Liston Ramsey – D (52nd) Rep. James Carpenter – R (53rd) Sen. Robert Carpenter – R (42nd) Sen. Dan Robinson – D (29th)
Southeastern (Brunswick, New Hanover, and Pender counties)	Sen. Charles Albertson- D (5th) Sen. Patrick Ballantine – R (4th) Sen. Luther Jordan – D (7th) Sen. R.C. Soles – D (18th) Rep. Dewey Hill – D (14th) Rep. David Redwine – D (14th) Rep. Danny McComas – R (13th) Rep. Edd Nye – D (96th) Rep. Nurham Warwick – D (12th) Rep. Thomas Wright – D (98th)
Southeastern Regional MHC (Bladen, Columbus, Robeson, and Scotland counties)	Rep. Donald Bonner – D (87th) Rep. Wayne Goodwin – D (32nd) Rep. Dewey Hill – D (14th) Rep. Edd Nye – D (96th) Rep. David Redwine – D (14th) Rep. Ronnie Sutton – D (85th) Rep. Thomas Wright – D (98th) Rep. Douglas Yongue – D (16th) Sen. Aaron Plyler – D (17th) Sen. Bill Purcell – D (17th) Sen. R.C. Soles – D (18th) Sen. David Weinstein – D (30th)
Tideland MHC (Beaufort, Hyde, Martin, Tyrrell, and Washington counties)	Sen. Marc Basnight – D (1st) Sen. Robert Martin – D (6th) Sen. Ed Warren – D (9th) Rep. William Culpepper – D (86th) Rep. Thomas Hardaway – D (7th) **Rep. Zeno Edwards – D (2nd)** **Rep. Edith Warren – D (8th)** Rep. Eugene Rogers – D (6th)
Trend (Henderson, and Transylvania counties)	Sen. Robert Carpenter – R (42nd) Sen. Dan Robinson – D (29th) Rep. Trudi Walend – R (68th) Rep. Larry Justus – R (50th)
Vance, Granville, Franklin, and Warren (VGFW)	Rep. Gordon Allen – D (22nd) Rep. Jim Crawford – D (22nd) Rep. Billy Creech -R (20th) Rep. Stan fox – D (78th)

VGFW cont.	Sen. Frank Ballance – D (2nd) Sen. Wib Gulley – D (13th) Sen. Jeanne Lucas – D (13th) Sen. Allen Wellons – D (11th)
Wake County Human Services	Rep. Daniel Blue – D (21st) Rep. Russell Capps – R (92nd) Rep. Rick Eddins – R (65th) Rep. Sam Ellis – R (15th) Rep. Robert Hensley – D (64th) Rep. David Miner – R (62nd) Rep. Jane Mosley – D (63rd) Rep. Charles Neely – R (61st) Sen. John Carrington – R (36th) Sen. Wib Gulley – D (13th) Sen. Jeanne Lucas – D (13th) Sen. Brad Miller – D (14th) Sen. Eric Reeves – D (14th)
Wayne MHC	Rep. Phillip Baddour – D (11th) Rep. Jerry Braswell – D (97th) Rep. Carolyn Russell – R (77th) Sen. John Kerr – D (8th)
Wilson-Greene	**Rep. Marian McLawhorn – D (9th)** Rep. Gene Arnold – R (72nd) Rep. Milton Fitch – D (70th) **Rep. Edith Warren – D (8th)** Rep. Carolyn Russell – R (77th) Rep. Joe Tolson – D (71st) Sen. Roy Cooper – D (10th) Sen. John Kerr – D (8th) Sen. Robert Martin – D (6th) Sen. Allen Wellons – D (11th)

***bold indicates new members**

House Republican Leaders
Rep. Leo Daughtry (R-Johnston) Minority Leader
Julia Howard (R-Davie) Minority Whip

Senate Republican Leaders
Patrick Ballantine (R-New Hanover) Minority Leader
Sen. Jim Forrester (R-Gaston) Minority Whip

Rep. Carolyn Russell (R-Wayne) Joint Caucus Leader

House Democratic Leaders

Rep. Jim black – Speaker
Rep. Joe Hackney (D-Orange) - Speaker Pro Tem
Rep. Phil Baddour (D-Wayne) - Majority Leader
Rep. Beverly Earle (D-Mecklenburg – Majority Whip
Rep. Any Dedmon (D-Cleveland) – Majority Whip

Democrats will hold a 35-15 advantage in the Senate and a 66-54 advantage in the House. (Last year, the Republicans had a 61-59 margin.)

North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

Overview of Division Sections, State Institutions and Area Authorities

March, 1999

DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES

Division Director: John F. Baggett, Ph.D. – (919) 733-7011
Deputy Director: Walter Stelle, Ph.D.
Legislative Liaison: Michelle Cotton
Health Services Liaison: Leslie Brown

Division's Primary Responsibility: The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services is North Carolina's lead agency directed with providing oversight, management and accountability for federal and state dollars for public mental health, developmental disabilities, and substance abuse services. The Division's primary responsibilities include administering federal and state funds designated for mental health, developmental disabilities and substance abuse services, operating state MH/DD/SAS institutions, ensuring that area programs meet the funding requirements for state and federal aid and the state standards for facility operations and licensing.

Division's Mission:
The mission of the Division is to enable North Carolina's most vulnerable and disabled persons with mental, developmental, and substance abuse problems to exercise their rights and responsibilities as citizens. This mission is supported by the Division's rule making body, the N.C. Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services. Appointed by the Governor and General Assembly, the Commission for MH/DD/SAS is composed of 26 members who serve as the official rule-making and advisory Commission to the Division.

The Division of MH/DD/SAS strives to meet the following goals for the consumers of MH/DD/SA services:

- **Education/Habilitation** —each should have age-appropriate education/habilitation experiences.
- **Health**—each should be physically and mentally healthy.
- **Housing/Support**—each should have basic food, clothing, and shelter in his/her natural home with his/her own family or in similar, safe living arrangements in a community of his/her choice.
- **Social**—each should have interpersonal relationships, which contribute to his/her well being and foster trust, self-esteem, and social competence. Each should also exercise social responsibility.
- **Vocation**—each should have gainful employment or a productive activity appropriate to his/her age and capabilities.

In order to carry out the State MH/DD/SAS policy as mandated in G.S.122C-2, the N.C. General Assembly adopted the following six long-range plans developed by the Mental Health Study Commission:

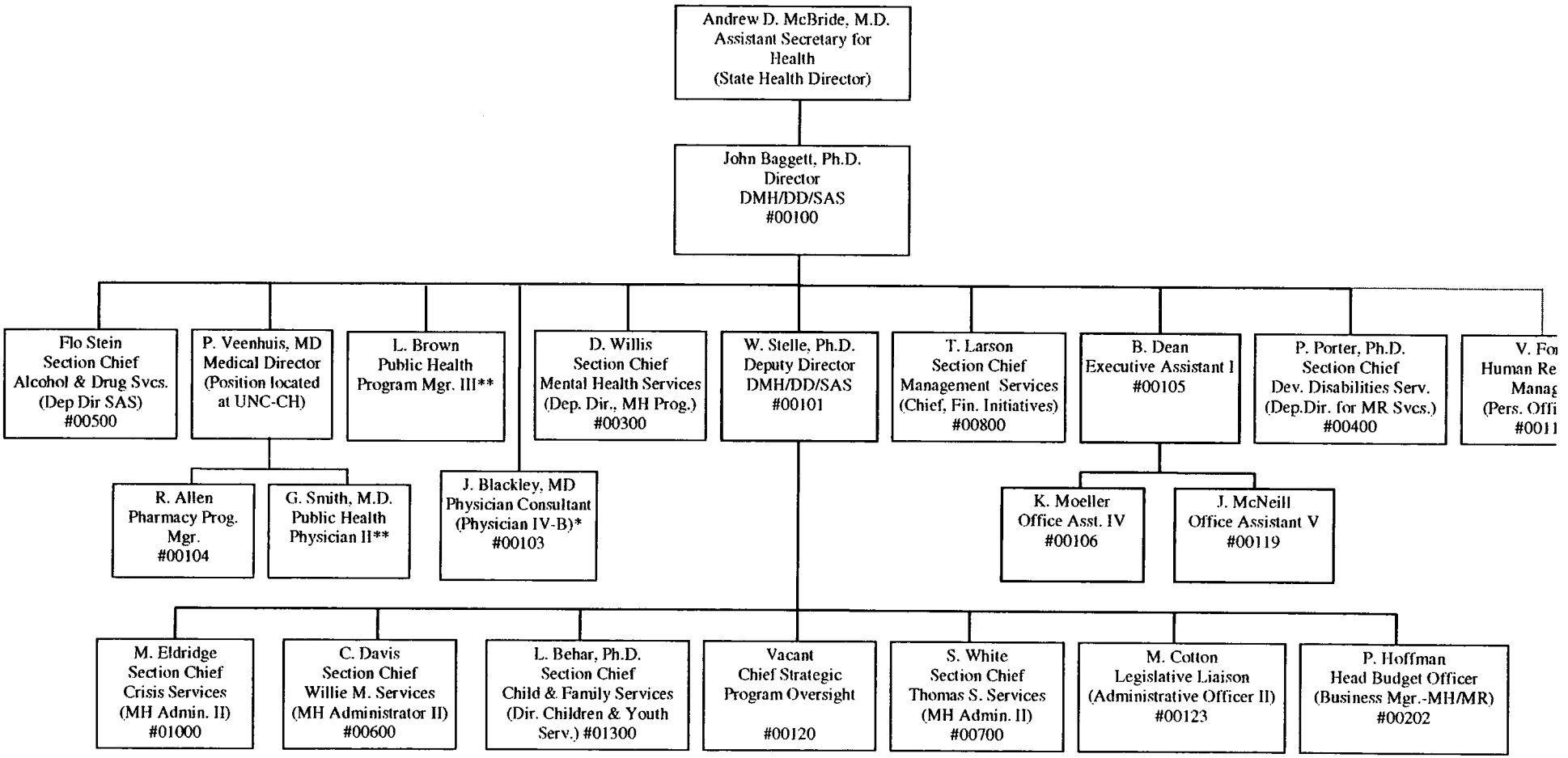
- Plan for Persons with Severe and Persistent Mental Illness
- Child Mental Health Plan
- Comprehensive Plan for Services and Supports for Persons with Developmental Disabilities
- Adult Substance Abuse Treatment Plan
- Child and Adolescent Alcohol and Other Drug Abuse Plan
- Plan for Services in Jails

Seven core disability and clinical service sections organize the Division of MH/DD/SAS, within the Department of Health and Human Services:

- Adult Mental Health
- Developmental Disabilities
- Child and Family
- Substance Abuse
- Crisis Services
- Willie M.
- Thomas S.

It is at the Division level that most decisions are made to ensure that sensible policy is created and implemented to buttress critical and viable mental health, developmental disabilities and substance abuse services throughout the State.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of MH/DD/SAS



MENTAL HEALTH SERVICES SECTION

Section Chief: Donison L. Willis - (919) 733-4660
Institution Services Branch: Curtis A. Farrance
Community Initiatives Branch: Bonnie Morell

Section's Primary Responsibility: This section is responsible for policy and resource development for the provision of community based and institutional services to adults with mental illness. The section coordinates the provision of comprehensive community based services including psychosocial rehabilitation, partial hospitalization, case management, other community support services, and special initiatives for persons who are deaf or homeless or who reside in adult care homes. The section supervises the operation of the state psychiatric hospitals (Broughton, Cherry, Dorothea Dix and John Umstead) and the North Carolina Special Care Center. The section also is responsible for assuring linkages between the Area Programs and State Hospitals.

Institution Services Branch: Institution Services Branch supports and coordinates operation of state psychiatric hospitals, and the NC Special Care Center. This includes working with the institutions through the budget cycle, monitoring institutional operations and gathering data and reporting information to regulatory and accrediting bodies.

Current Initiatives for the Institution Services Branch:

(1) Increasing active treatment in the psychiatric hospitals, which has a goal of every patient having the opportunity for participating at least six therapeutic activities each day. In addition, the treatment programming period is being expanded from the 9:00 a.m. to 5:00 p.m. Monday through Friday period to include therapeutic opportunities in the evenings and on weekends. This expansion of treatment offerings has necessitated flexing work hours so that social workers and psychologists are now meeting with clients and families on evenings and weekends. While each hospital is offering learning activities for their patients' unique needs, all of the active treatment initiatives include emphasis on medication compliance, knowledge of diagnoses and mental illnesses and effective use of the mental health system.

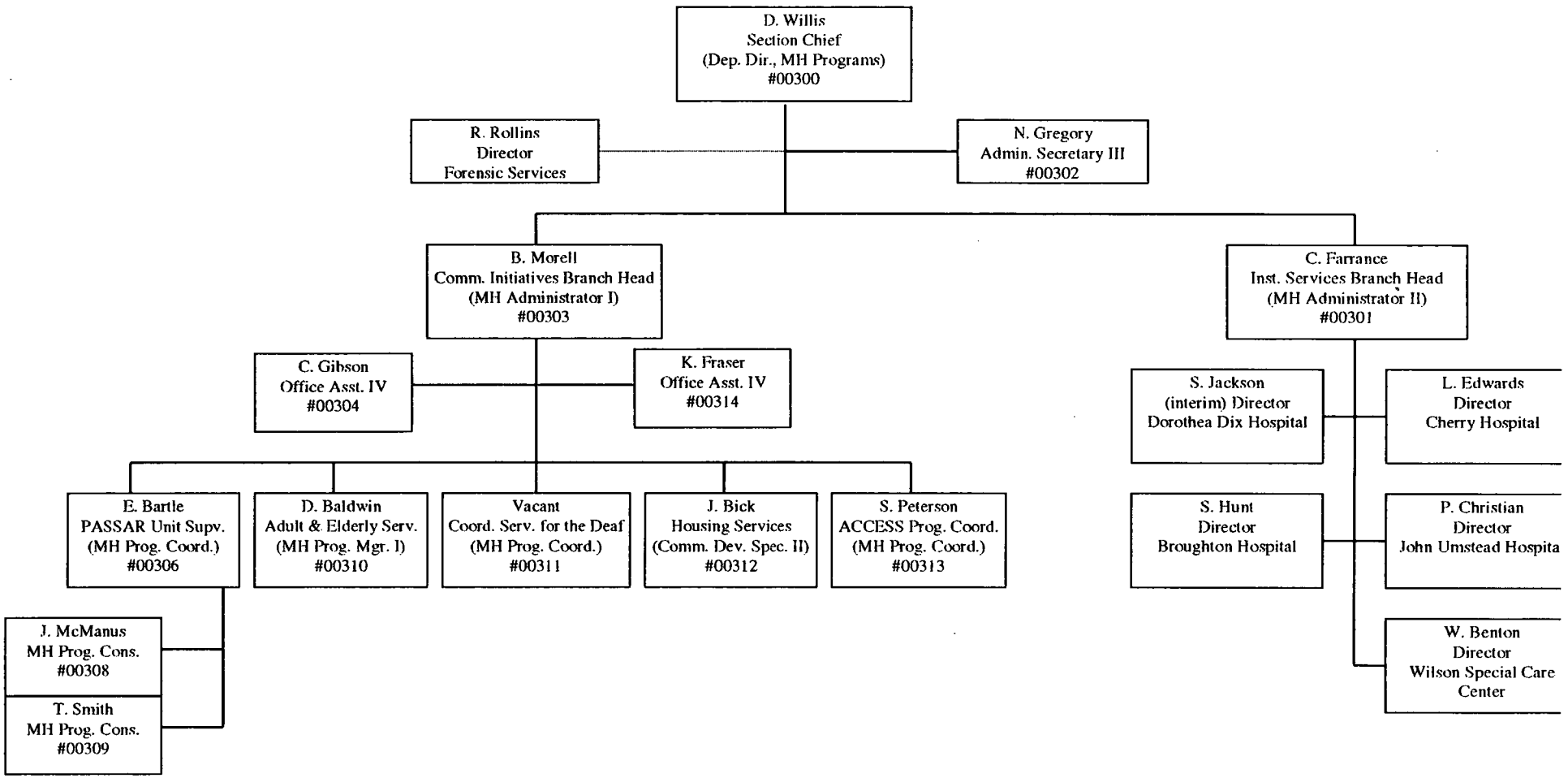
(2) Planning the new Dorothea Dix Hospital has included visiting and assessing three other states newly built psychiatric hospitals, selecting a designer and beginning the design process. Over the next several months, the design architects will be working with internal and external stakeholders to insure the hospital design encompasses essential elements, which the architects will integrate into an efficient and effective hospital design.

(3) Planning for changing the focus and location of treatment for three groups of patients presently served in the state psychiatric hospitals. These include nursing facility and long-term geropsychiatry patients; patients admitted with primary diagnoses of substance abuse; and youth requiring inpatient psychiatric treatment. Planning for redesign of these patient care systems is underway with proposals for alternative treatment systems to be finalized in the next few months.

Community Initiatives Branch: This Branch is responsible for policy, planning, allocation of funds, and technical assistance regarding community based mental health services for adults with serious mental illness. The Branch is also responsible for the administration of the Federal Mental Health Block Grant and other grants and contracts designed to promote the development of comprehensive services for adults with serious mental illness in the 40 area programs.
Current initiatives include:

(1) Activities to increase the availability of safe, affordable housing with the appropriate supportive services needed by people with serious, long-term mental illness, including the administration of Federal Shelter Plus Care rental assistance, partnering with non-profit developers and area programs in the development of HUD 811 Housing for Persons with Disabilities. Technical assistance and training are provided to area program staff on both maximizing existing housing resources and the development of additional supported housing opportunities in their communities.
(2) Activities to increase outreach and provision of mental health services for sub-groups with special needs. For people who are homeless and mentally ill activities include the administration of the Federal Projects for Assistance for Transition from Homelessness (PATH) formula grant and of a Federal demonstration project ACCESS grant. Coordination of specialized services is also provided for people who are mentally ill and deaf and for mentally ill residents of adult care homes.
(3) Training for area program staff regarding services for adults with severe mental illness and for adults who have co-occurring serious mental illness and substance abuse.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of MH/DD/SAS
Mental Health Section



CHILD AND FAMILY SERVICES SECTION

Section Chief: Lenore Behar, Ph.D. - (919) 733-0598
PEN-PAL/FACES Projects Branch: Martha Kaufman, M.S.
Policies and Services Branch: Susan E. Robinson, M. Ed.
Children and Adolescents Medicaid Branch: Tom Bainbridge, M.S.

Section's Primary Responsibility: The mission of the Child and Family Services Section is to ensure the continued growth and development of local systems of care which provide cost effective, individualized mental health services in the context of coordinated efforts with other agencies to meet the comprehensive needs of children and their families. A primary emphasis is to ensure that appropriate services are provided to children who have or are at risk of developing SED and to their families as outlined in the NC Child Mental Health Plan.

Overview of Section: The Child and Family Services Section provides supervision and support to the 40 Area Programs in their efforts to provide individualized, family-centered services to children ages birth to 18 years of age with mental health service needs and directly provides residential treatment services to children ages 5-12 and 13-17 years. Through the support of this Section, the Area Programs served over 64,000 children and their families in SFY 1998.

The Child and Family Services Section provides a conglomerate of administrative and technical assistance to Area Programs. Section programming is provided in five broad areas: Early Intervention (EI), Serious Emotional Disturbances (SED), Demonstration Projects which include cooperative relationships with university research and training centers (known as Public Academic Liaisons or PALs), residential treatment, and training provided through the System of Care Institute.

Pen-Pal/Faces Projects Branch: This Branch provides supervision and support to Area Programs and their community partners responsible for the implementation of two federally funded demonstration projects, the Pitt, Edgcombe and Nash Public Academic Liaison (PEN-PAL) and the Families and Communities Equal Success (FACES). These demonstration projects serve to develop models for further development of a 'system of care' in other communities through the support of cooperative relationships with university research and training centers.

Programs, Policies and Services Branch: This Branch is responsible for overall section leadership, coordination and supervision program and policy development, impacting effective Area Program service delivery to children with or at-risk for SED and their families statewide. The branch is responsible for implementing services as outlined in the state and federal block grant plans for children's mental health. Essential work of the branch is ongoing interagency coordination and collaboration in the development and evaluation of culturally competent and family-centered programs.

These include: prevention, early intervention, family preservation/support, respite and crisis care, services for homeless youth, intensive home visiting, child fatality prevention and other related school, health, social services or juvenile justice initiatives.

Children and Adolescents Medicaid Branch: This branch is responsible for supporting the Area Programs in the development of medically necessary treatment for those children and adolescents with complex service needs. Area Programs provide a wide range of traditional and non-traditional services to children and families including assessment, counseling, psychiatric treatment, case management, day treatment, residential treatment, emergency services, and inpatient psychiatric treatment. This branch is implementing services for sexually aggressive youth and those eligible under Criterion #5. (see below)

Wright School: This is one of two residential schools providing therapeutic and educational residential treatment services to children ages 5-12 years. A key component of this treatment program is the linkage with family members and community providers in implementing successful individualized plans while in treatment and in transition back to the community.

Whitaker School: This is one of two residential schools providing therapeutic and educational residential treatment services to children ages 13-17 years. Essential to this treatment program is the linkage with family members and community providers in implementing successful individualized plans while in treatment and in transition back to the community.

Current Initiatives

Family Involvement in the Implementation of the Child Mental Health Plan: Families are key to meeting the challenge to build capacity throughout North Carolina's human services, educational and juvenile justice agencies to develop a 'System of Care' that integrates an array of services to treating and meeting the complex needs of children suffering from mental and emotional disturbances. A key component of effective treatment provided to children in need of mental health services is the involvement of their family. As directed by Child and Family Services program treatment methodology, family members participate in planning of services for their children. To ensure that the needs of the family and the child are being met and responded to in a judicious manner, the Section works closely with organizations and advocacy groups who have a primary interest in child mental health. These groups include the Alliance for the Mentally Ill, the Mental Health Association, Families CAN, the Child Advocacy Institute, the Covenant for Children, Coalition 2000, and parent support groups in local communities.

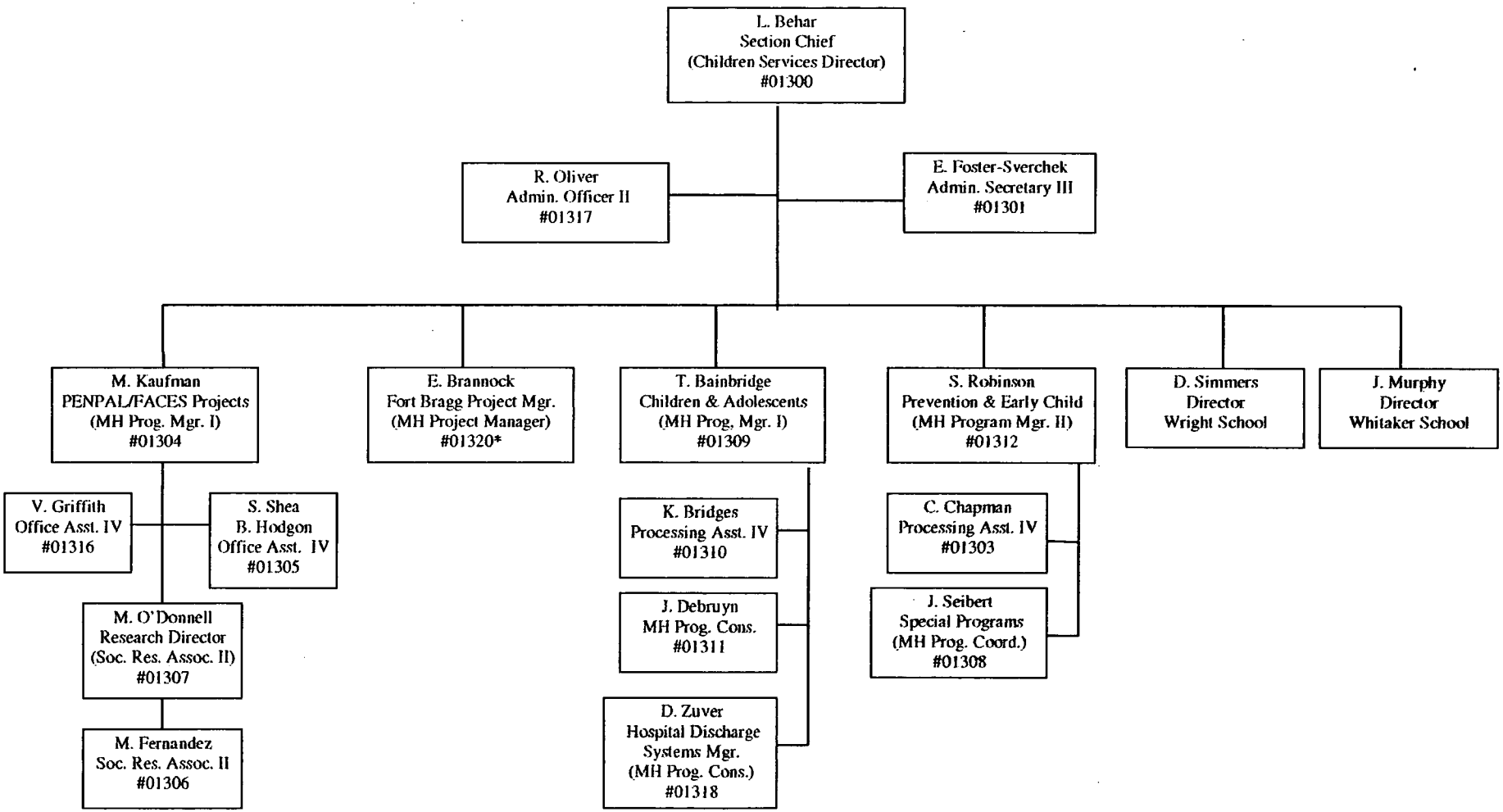
System of Care Institute: In collaboration with staff from the Jordan Institute on Families and Children at the UNC Chapel Hill School of Social Work System of Care Institutes are conducted for Area Program staff. As a result of these institutes, Area Programs in partnership with other child-serving agencies implement broad-based

community services for children with or at-risk for SED and their families based on System of Care principles. Public Academic Liaisons with East Carolina University, UNC-Charlotte, UNC-Asheville, Appalachian State University, Mars Hill College, and UNC-Greensboro are also participants.

Cultural Competence Initiative: In collaboration with the Division of Social Services and staff from the Jordan Institute on Families and Children at the UNC Chapel Hill School of Social Work, a Task Force on Cultural Competence has been formed, comprised of public and private agencies as well as family members and advocates. The Task Force is charged with developing a plan and identifying models for implementing best practices in providing services to children and families which reflect cultural competence in the areas of personnel, training, staff development, outreach and community partnerships, service delivery, and quality improvement.

Criterion #5: Criterion #5 of the NC Medicaid Criteria for Continued Inpatient Stay in a Psychiatric Facility (10NCAC 26B.011) became effective January 1, 1999. The rule establishes the conditions under which Medicaid clients are eligible for continued stay in a psychiatric hospital for acute inpatient care and for non-acute services. Under Criterion #5, reimbursement may be used for continued non-acute hospital services when an area program has found that appropriate discharge services are not available for a client who is no longer acute. Criterion #5 is targeted to children through the age of 17.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of MH/DD/SAS
Child & Family Services Section



DEVELOPMENTAL DISABILITIES SERVICES SECTION

Section Chief: Patricia B. Porter, Ph.D. -- (919) 733-3654
Children and Adolescent Services Branch: Duncan Munn
Special Population Services: Lynda Richard
Residential and Vocational Services Branch: Vacant
Planning and Evaluation Services Branch: Julie Bloomingdale

Section's Primary Responsibility: The Developmental Disabilities Services Section is responsible for the planning, development, coordination, and operation of highest quality services and supports for all North Carolinians with developmental disability, developmental delay, atypical development, and those at risk for these conditions. We are committed to the establishment of services, which encompass variety, flexibility, and accessibility. Services are consumer-driven, age appropriate, and decisions are made with participation by individuals with developmental disability and their families. All services are provided in the most natural setting possible based on the unique and individual needs of each person. We are committed to educating consumers, families, decision-makers, and the public at large about developmental disabilities and the nature and availability of quality services. In order to accomplish this mission, we work to ensure internal and external quality safeguard mechanisms, support for community programs and the five Regional Mental Retardation Centers, interagency coordination, funding access and promotion of an assertive and unified advocacy effort. All activities are planned and designed to recognize the dignity of each individual and to enhance the quality of his/her life. We are providing services and supports to 41,000 children and adults with developmental disabilities. Since 1992 we have experienced an 81% growth in the development of community services.

Special Population Services: The Special Population Services initiative represents a diverse array of specific activities and supports provided to individuals with low incidence, highly specialized disabilities or dual disorders. The goal is to be responsive to the individual and very diverse needs of clients served, as well as their families or primary caregivers. Coordinate with related agencies and provide crisis services and technical assistance to local programs.

Residential and Vocational Services Branch: Services in this area include a variety of options for persons with developmental disabilities to be involved in work training environments such as adult developmental vocational programs and supported employment and residential options such as group homes, supported living. Community Services are provided either by Area Programs, contracted to private not-for-profit providers, or provided by a combination of resources by private providers.

Children and Adolescent Services Branch: The primary purpose of the Children and Adolescent Services Branch is the planning, implementation, and monitoring of the statewide system of early intervention services for young children with or at risk for disabilities and their families which is required by state and federal early intervention

legislation. The legislation designates the Division of Mental Health, Developmental Disabilities and Substance Abuse Services as the lead agency. This statewide system, known as the North Carolina Infant-Toddler Program, is interagency, interdisciplinary, comprehensive, coordinated, and family focused. Specific responsibilities of the Branch related to the system include developing service delivery policies and procedures for submission to the Commission for Mental Health, Developmental Disabilities and Substance Abuse Services; identifying and accessing unmet service delivery and training/education of staff and technical assistance in the area of program development needs; and preparing and monitoring interagency agreements.

Planning and Evaluation Services Branch: This branch is responsible for the development of a broad and responsive array of services predicated upon collection and management of current data on services delivered and service needs. Activities within Planning and Evaluation Services include technical assistance and training to Mental Retardation Centers and Area Programs in management of this data and, then, its practical use in planning. In addition, coordination and support of monitoring, evaluation, grants, contracts, and research activities are located here.

Current Initiatives

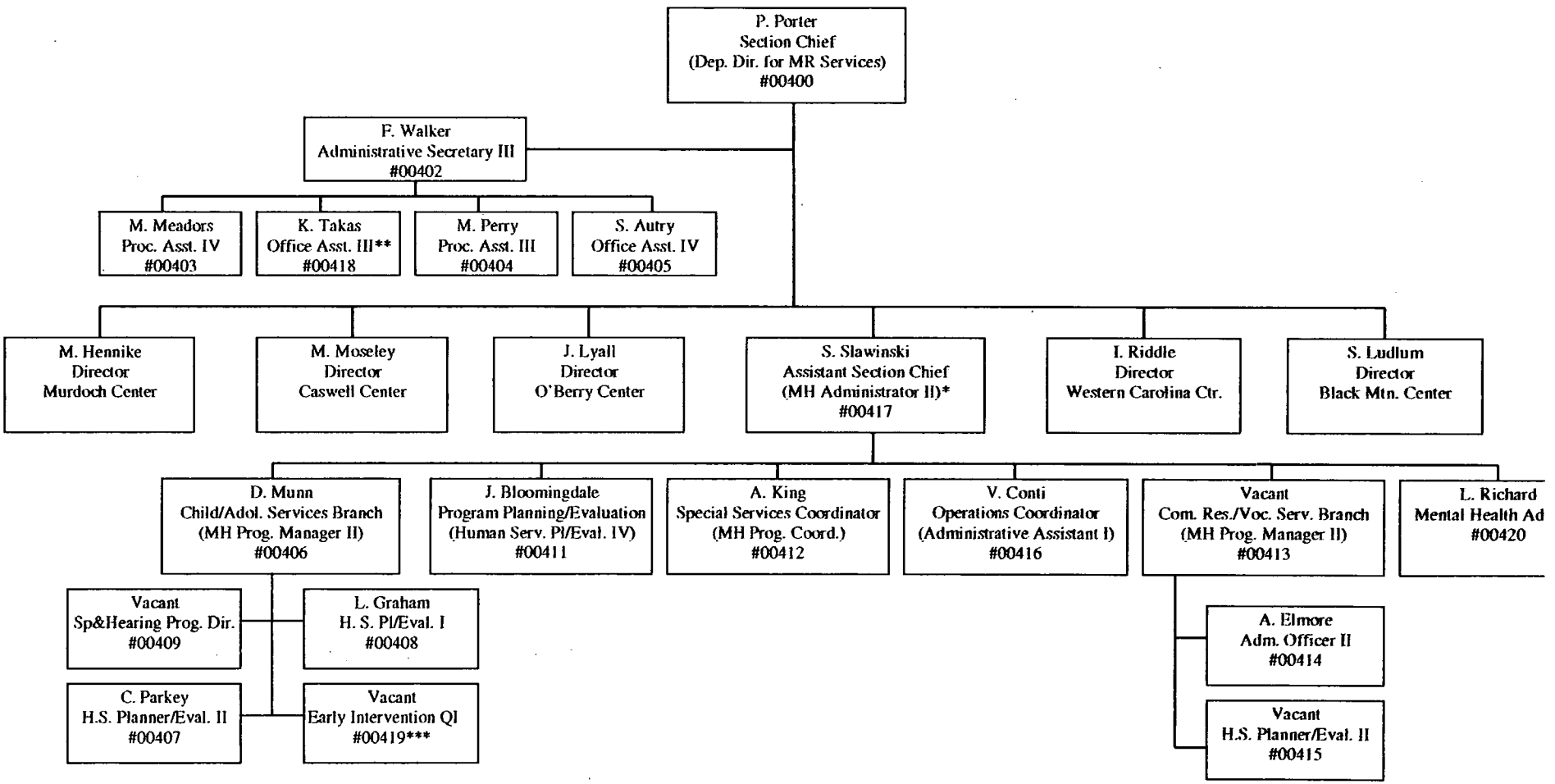
Reduction of the DD Waiting List: In January 1998 the Area Programs reported that 7,148 persons with Developmental Disabilities were waiting for service. Our priority is to use $3 million appropriated state funds and $3.3 million from a TANF transfer to place these North Carolinians into the services they need. We have allocated dollars to the Area Programs based on their waiting list numbers, have provided on-site technical assistance to them in how to spend the dollars wisely and well and are carefully tracking utilization so that we can report to the General Assembly in May. In addition we are working on the components of the special provision which accompanied the appropriation and we will provide a report to the legislature in response to these issues also in May.

Developmental Disabilities Single Portal of Entry/Exit: We have developed a Best Practices Manual on videotape demonstrating the Single Portal Process and are providing on-site technical assistance to Area Programs, their Interagency Councils and related agencies on the operation of this critical procedure required by statute. The development of the waiting list is part of this process. Our Accreditation Reviews of the Area Programs and feedback from consumers, advocates, and service providers has established the Single Portal Process as the core of the developmental disability services system at the Area level. We are focusing now on assuring that persons with dual disability and those in rest homes and nursing homes are identified and served.

Provider Directory: At the request of the Areas, Advocates and Consumers we have developed and distributed a Directory which includes names, addresses and certification status for all providers of services to people with developmental disabilities. This information is listed by service and geographic focus. This Directory has assisted Areas in locating providers of services for those on the waiting list.

Early Intervention: We are the lead agency for the infant-toddler component of the early childhood effort. We are working with five related agencies to improve the early identification and assessment components of this initiative. According to organizations with a national focus, including the National Early Childhood Technical Assistance System (NECTAS), we are one of the five finest Early Intervention Programs in the country. As such, we are providing technical assistance to the Divisions of Services for the Blind and Deaf and Hard of Hearing as well as Division TEACH to improve identification services and supports for babies with blindness and deafness as well as those diagnosed with autism.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of MH/DD/SAS
Developmental Disabilities Section



ALCOHOL AND DRUG SERVICES SECTION

Section Chief: Flo Stein, M.P.H. --(919) 733-4670
Adult Services Branch: Doug Baker
Child and Adolescent Services Branch: Spencer Clark
Prevention Branch: Arthur Jones
Employee Assistance Branch: Roy Sonovick
Driving While Impaired/Criminal Justice Branch: Pete Martin
Regulatory Unit: John Womble

Section's Primary Responsibility: The mission of the Alcohol and Drug Services Section is to provide dynamic leadership in the planning, development, and organization of a statewide system of alcohol and other drugs services. Through this leadership, the Section coordinates and communicates policies and strategies that educate, encourage, and empower individuals, families, organizations, and local communities to respond proactively to alcohol and other drug prevention, intervention, and treatment issues.

The Alcohol and Drug Services Section promotes policies, strategies, and services to prevent, reduce, or eliminate alcohol and other drug problems. Meaningful opportunities for prevention, treatment, and recovery are fostered, which support productive lives for individuals and reinforce healthy families and communities that are free of problems related to substances.

The Section promotes policies and strategies, which support a comprehensive system of, care within a compassionate, coordinated, and seamless system of prevention, intervention, and treatment services for children, adults, families, and communities in North Carolina. Policies and strategies are promoted which support consumer-focused services that are readily available, accessible, acceptable, and affordable.

The Section promotes services, which are consumer-driven, matched to consumer need, culture and gender sensitive, and provided by qualified, caring professionals. These services are guided by state-of-the-art practices, which include measurable standards of quality, and accountability and which are designed to be cost-effective and outcome-oriented. (See Appendix P for a summary of the Adult Substance Abuse Treatment Plan and the Child and Adolescent Alcohol and Other Drug Abuse Plan.) Primary support is provided to the 40 Area Programs and affiliated contract agencies in the implementation of the *Adult Substance Abuse Treatment Plan* and the *Child and Adolescent Alcohol and Other Drug Abuse Plan.*

Adult Services Branch: The mission of the Adult Services Branch is the promotion and provision of comprehensive health and human services to adult substance abusers through the development of interagency linkages. Programs for special populations include the coordination and development of programs to reduce the risk and spread of HIV/AIDS infection to citizens by providing expansion of methadone programs and other enhanced services to intravenous drug users. Another special program focus is the reduction of infant mortality, by the expansion and coordination of services to pregnant

and postpartum women substance abusers and their children. These goals are accomplished through technical assistance, consultation, training, and support for services throughout the continuum of care offered in the 40 Area Programs, their contact agencies, and the three ADATCs.

Child and Adolescent Services Branch: The goal of the Child Adolescent Services Branch is to provide professional leadership and support for the development and enhancement of a comprehensive system of substance abuse prevention and treatment services for children and youth in North Carolina. Basic tenets in the Child Adolescent Alcohol and Other Drug Abuse Plan emphasize the treatment of substance abuse as a primary disorder, the provision of accessible and appropriate services to children and youth, the involvement and support of the family, and the linkage with a full continuum of care.

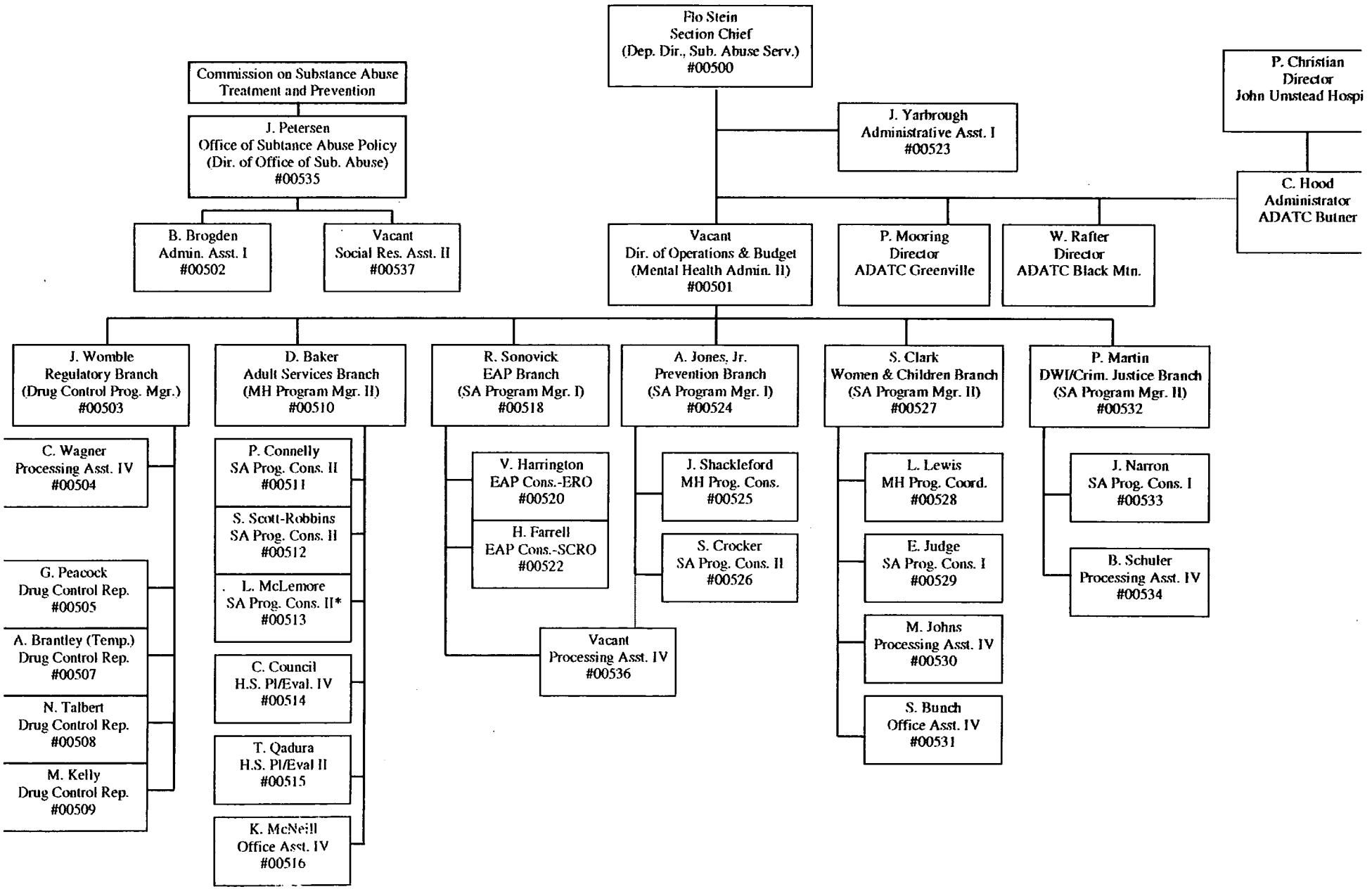
Prevention Services Branch: The primary mission of the Prevention Branch is to reduce, delay, or avoid the use and abuse of alcohol and other drugs by children, youth, and adults in North Carolina. An additional focus is to intervene with individuals who have experimented with alcohol and other drugs, and who are at risk for substance abuse and addiction. The branch also seeks to assist local communities in addressing the social conditions, which contribute to alcohol and drug misuse and in developing local and state strategies for integrating prevention actions.

Employee Assistance Program Branch: An Employee Assistance Program (EAP) is a work site based program designed to assist in the identification and resolution of productivity problems associated with employees impaired by personal concerns including, but not limited to: health, marital, family, financial, legal, alcohol, drug, emotional, stress or other personal concerns which may adversely affect job performance. EAP assists Area Programs through technical assistance, training, and promotion on a statewide basis. The Branch also provides EAP services to DHHS employees and provides guidance and direction in the implementation of DHHS Alcohol and Drug-Free Workplace initiative.

Driving While Impaired/Criminal Justice Branch: This branch provides state level leadership and support for intervention services targeted toward clients with criminal justice involvement, specifically: DWI substance abuse assessments, Alcohol and Drug Education Traffic Schools (ADETS), treatment services for DWI offenders, Treatment Alternatives to Street Crime (TASC), Drug Education Schools (DES), and the DHHS funded jail projects. This Branch also works cooperatively with all other state and local agencies working toward a comprehensive continuum of services for this population.

Regulatory Unit: The mission of the Controlled Substance Regulatory Unit is to insure the safety of the citizens of North Carolina through implementation of the regulatory responsibilities of the NC Controlled Substance Act. The overall goal of the Unit is to prevent the legitimately manufactured, distributed, and dispensed controlled substances from being diverted into the illicit market.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of MH/DD/SAS
Substance Abuse Services Section



CRISIS SERVICES SECTION

Section Chief: Mary N. Eldridge, J.D.—(919) 733-1763

Section Mission and Purpose

The Crisis Services Section was established in 1994 as a result of the work of a large task force of stakeholders who believed that crisis services for citizens with disabilities in North Carolina were inadequate in both scope and quality. The Section's mission is to have a positive impact on the lives of N.C. citizens with psychiatric and/or alcohol or drug disorders and/or developmental disabilities and on the safety of their communities by initiating and supporting the development and ongoing improvement of effective community-based crisis services.

The Section provides leadership in the development and oversight of area program crisis services for citizens of all ages and disabilities. Activities in this area of work include:

- developing and distributing Crisis Services Performance Expectations and monitoring area programs for compliance with these expectations;
- providing multiple training events to improve crisis prevention services for high-risk clients and crisis response services for clients of all ages and disabilities, including clients with multiple disabilities;
- providing on-site technical assistance to area program staff, including consultation about the needs of clients with multiple and complex disorders; and
- responding to calls from family members and consumers who have experienced difficulty in accessing needed crisis prevention or crisis intervention services.

The Crisis Services Section also takes responsibility for supporting implementation of the *Thomas S.* Diversion Law (Senate Bill 859). This law prohibits the admission of persons with mental retardation to State psychiatric hospitals, with limited exceptions. Activities in this area of work include:

- guiding and supporting the social workers and psychologists who work on the Thomas S. Screening and Diversion teams in the four state hospitals;
- 24 hours a day, 365 days a year, assisting area program staff in diverting clients from admission to state hospitals and serving as the Division Director's designees in approving exceptions to SB 859 for appropriate clients;
- providing leadership and collaborating with area programs and community hospitals to develop enhanced psychiatric inpatient services at five hospitals across the State; and
- providing short-term funding to support community stability of high-risk clients.

The Section also plays a pivotal role in the State's disaster response operations. Activities include:

- coordinating statewide Emergency/Disaster Response with all State institutions and area programs; and
- serving on the State Emergency Response Team as the Mental Health Disaster Coordinator when the State Emergency Operations Center is activated due to disasters created by humans and/or natural disasters such as hurricanes.

Major Crisis Services Section Initiatives

1. Supporting Change in the Culture of Service Provision: The impetus to change the culture of service provision is based on the understanding that (1) persons with mental health, developmental disabilities, and substance abuse (MH/DD/SA) service needs often have service needs in two or more disability service areas; and (2) the current structure of the MH/DD/SA service system often inhibits integrated service provision across disability areas. Supporting a change in the culture of service provision involves working collaboratively across single disability sections within the Division, as well as providing funding, technical assistance/consultation, and training to Area Programs and other service providers for the purpose of improving services for clients whose needs *cross the traditional disability service boundaries*. The major initiatives described below are key to supporting change in the culture of service provision.

2. The Development and Coordination of Cross-Disability Crisis Training Activities: In Fiscal Year 1998, eighteen different crisis prevention and crisis intervention training topics were provided in a total of fifty-three days of training to support improvements in services to persons with the following disabilities:

   - Serious Mental Illness and co-occurring Substance Abuse
   - Serious Emotional Disorders (youth) and Substance Abuse
   - Mental Retardation and co-occurring Substance Abuse
   - Mental Retardation and co-occurring Mental Illness *and* Substance Abuse
   - Autism, with or without co-occurring Mental Illness and/or Mental Retardation

3. The Mental Illness/Substance Abuse Integrated Treatment Initiative: This project began March 16, 1998 with the selection of 15 Area Programs that demonstrated a plan and a commitment to "integrate" mental illness and substance abuse treatment in order to meet the complex treatment needs of high-risk clients.

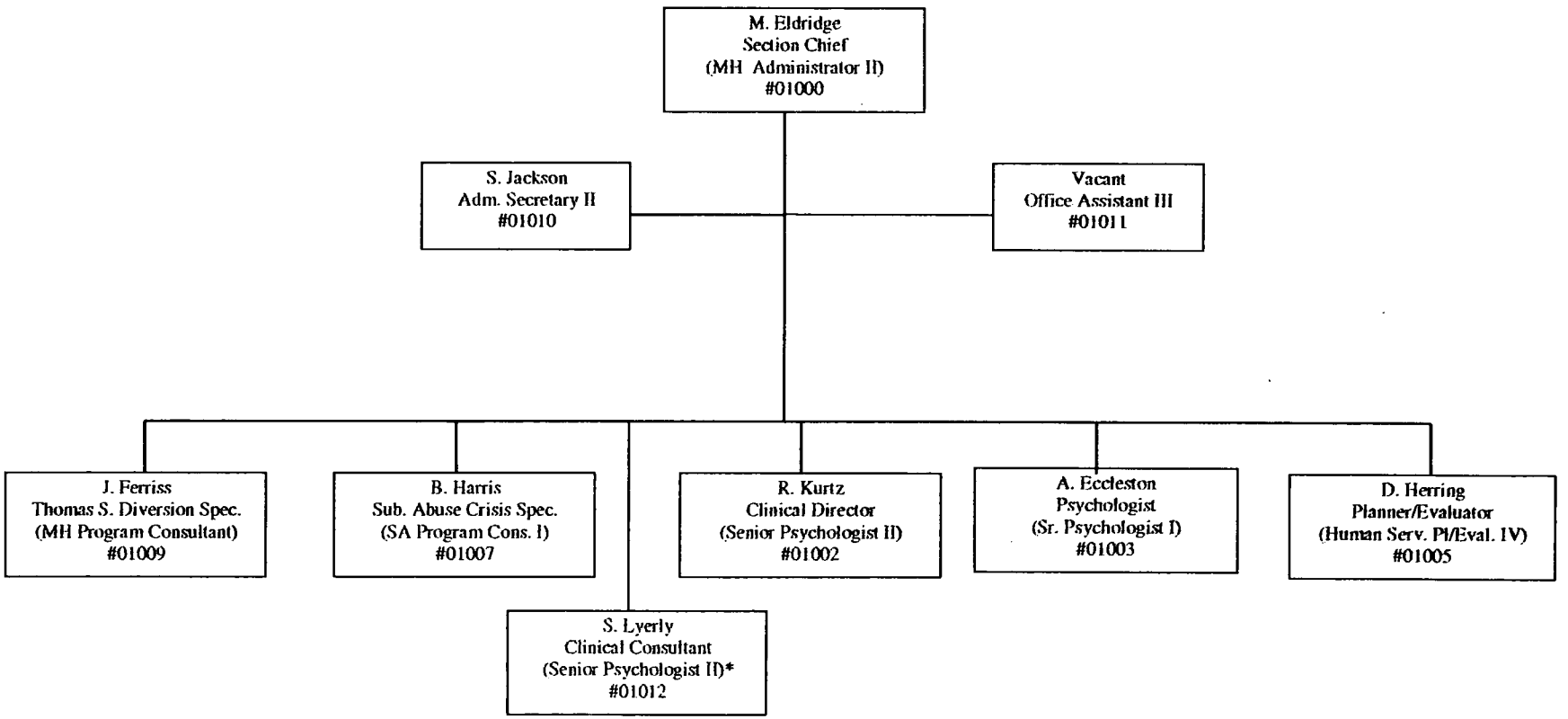
The 15 Area Programs have reported baseline measures for a total of 138 clients. The baseline outcome measures indicate each client's status for the year prior to beginning the MI/SA Initiative.

If Area Programs are successful in developing an integrated treatment approach for MI/SA clients, the following outcomes will be attained:

- Movement through the stages of treatment from engagement through active treatment to relapse prevention.
- Reduction in alcohol and drug use.
- Reduction in crisis episodes.
- Reduction in costly hospitalizations.
- Increase in the functioning level of clients.

Measures of client-specific clinical events and functioning will be reported to the Crisis Services Section after clients have been a part of the Initiative for 6 months, 12 month, 18 months, and 24 months. An analysis of repeated measures will be conducted to determine clinical outcomes for these "high-risk" clients and to assess the cost effectiveness of this initiative.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of MH/DD/SAS
Crisis Services Section



WILLIE M. SECTION

Section Chief: Charles Davis (919) 571-4900
Director of Operations: Wayne Smith
Client Eligibility Branch Head: Ann Baldwin
Service Management Branch Head: Ann Kaehler-Campbell
Program Evaluation Branch Head: Gustavo Fernandez
Information Systems Branch Head: Susan Ward
Training Branch Head: Joan Kaye

Primary Responsibility: The **Willie M.** Section oversees and directs the statutorily authorized program of services for Eligible Assaultive and Violent Children. Section staff provides rules, guidelines, training, monitoring and quality improvement assistance to Area Mental Health Programs in managing the local service systems. In order to manage the care of 1600 very difficult clients, Section staff allocate and monitor funds to Area Programs for client services, and reallocate funds around the State as service needs dictate. The Section also employs contractors to manage services or provide particular services in areas of the state or in specialties where Area Programs cannot. The Section also oversees secure residential treatment centers in Butner and Wilson. Due to the severe and complicated needs presented by many clients, the Section maintains a capacity for responding directly to case issues raised by families, advocates or local program staff. The Section has 30 employees and utilizes a number of private contract staff in specialty areas such as eligibility determination, research and evaluation, and training. An additional 123 staff work in the Adolescent Treatment Centers.

The Client Eligibility Branch receives and processes applications for service and renders determinations on individual applicants' eligibility for service as assaultive and violent children. Branch staff and contracted professional reviewers processed 477 new applications and rendered 559 decisions during 1998. Branch staff also provides guidance and training to local agencies that assist families in preparing applications and answer questions from parents and the public about **Willie M.** eligibility criteria and procedures.

The Service Management Branch provides consultation, monitoring and direct case management assistance to **Willie M** staff in Area Programs. The Branch staff (Regional Service Managers) concentrate on assisting local programs in managing a local system of services responsive to the needs of clients and coordinated with other agencies' efforts in the locality. This is done through review and approval of budget requests for individual client services, preparation and presentation of monitoring reports, interpretation of service, cost and outcome data and facilitation of local system improvement plans to guide service developments in the area. Staff work very closely with Department of Public Instruction staff to ensure that mental health and school services for clients are coordinated for all children. When needed, Service Managers will intervene with local programs on behalf of families or arrange access to specialty

services outside of the area. The Service Managers provide the critical link to the local service providers that allow the Section to ensure appropriate services to the most difficult to serve clients.

The Program Evaluation Branch conducts a variety of research and analytical projects designed to assess the performance of the program and to advance the knowledge base about treatment of children and adolescents. These studies include service and cost studies, client data analysis, client outcome reports and case studies. The client outcome monitoring process developed and implemented by this Branch over the past 6 years has been a model for the Division and the child mental health field in general. Data from this process has been instrumental in demonstrating the value of the services provided through the **Willie M.** Program and was a key factor in eliminating Federal Court oversight of the program.

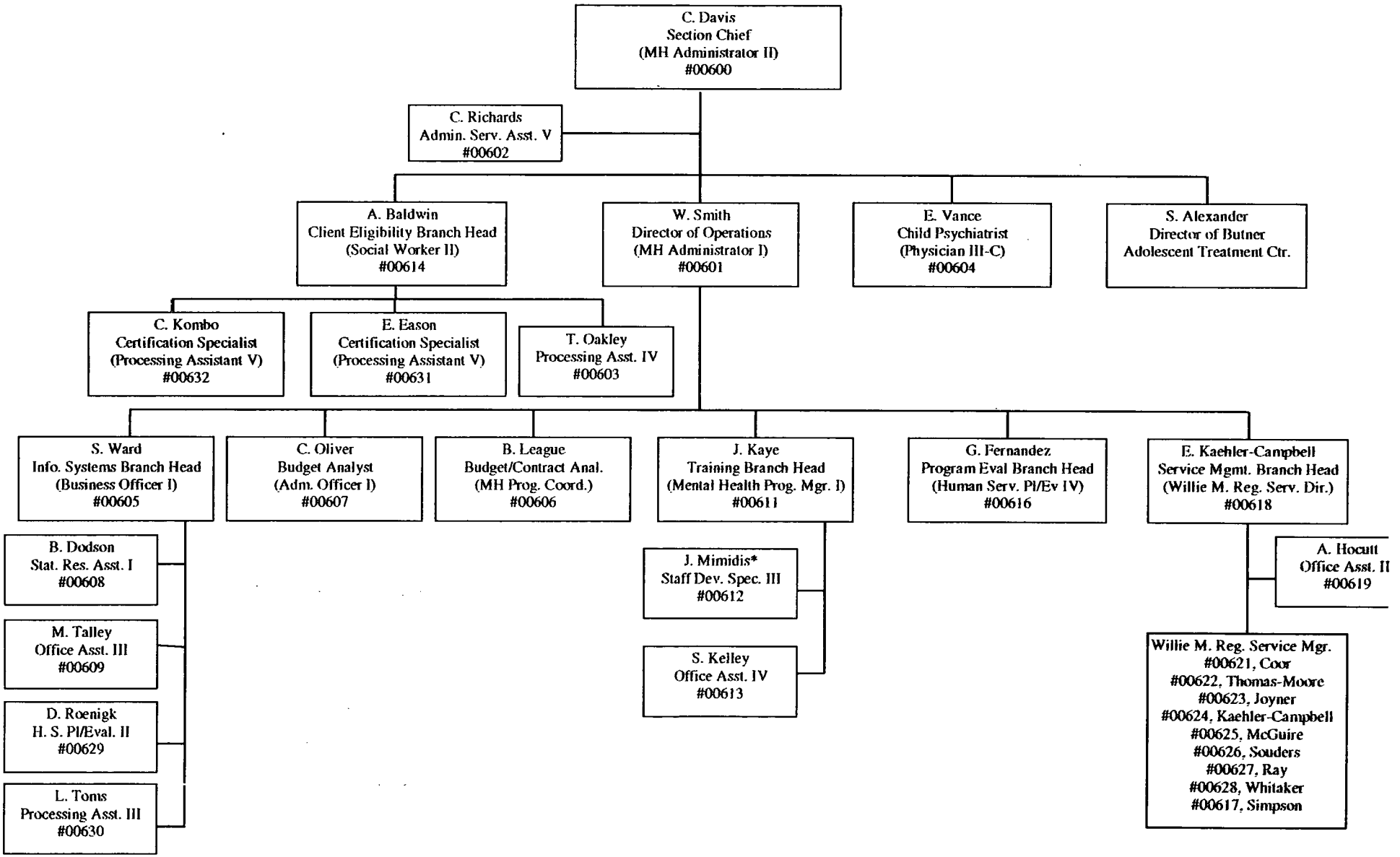
The Information Systems Branch maintains and oversees an automated system that links local programs with the state for sharing of client and cost reimbursement data on 1600+ eligible clients. The system is used for all budgeting and reimbursement functions for the program, and includes a wealth of client information used for case management and client tracking purposes. The resulting database, incorporating client assessment and outcome, and demographic data, service and cost data, is the basis for all of the Section's program evaluation and quality improvement processes. The Branch also troubleshoots problems with the WMIS, provides ad hoc reports, monitors system fluctuations, and provides technical assistance to the Area Programs in operation of the system.

The Training Branch provides training and development opportunities to staff of Area Programs and private providers to ensure that all persons working with **Willie M.** clients are skilled at recognizing and dealing with the very special problems that brought clients into the program. This Branch develops, administers, coordinates, and evaluates training programs and events, oversees curriculum development for large formalized programs, and works with a variety of contractors, Universities and community colleges to arrange delivery of training programs.

Initiatives: The Willie M Section and Child and Family Services Section are jointly sponsoring a broad stakeholders' group, known as the Futures Committee. The Committee will assess the state's variety of behavioral health services, review the history of various initiatives and the Child Mental Health Plan, and provide recommendations to the Division and General Assembly about future funding, structural and programmatic features of a comprehensive child and family behavioral health system for the state. This group will make a report in April to the Division, with initial attention paid to responding to the MGT study on the state's psychiatric hospitals. In addition, the **Willie M.** Section and Child and Family Services Section are collaborating on several tasks designed to better coordinate the **Willie M.** services system with other child mental health initiatives. These include the promotion of "systems of care" for each local catchment area and training programs conducted by each Section that address very similar subjects and audiences.

The Section has begun a periodic process of publishing detailed data about the client outcomes, service patterns, costs, and other aspects of the program for each Area Program. Three or four times a year, we produce a set of forty Area-specific statistical reports that provide individual Area Program data about outcomes, services, and costs and comparisons of the Area Program's performance in these areas to other Areas and the state averages. The intent of these publications is to enhance the quality improvement activities at the local level by giving frequent, detailed feedback to Areas about their performance in producing positive outcomes and managing services.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of MH/DD/SAS
Willie M. Section



THOMAS S. SERVICES SECTION

Section Chief: Susan White – (919) 420-7995
Branch Head: Jim Jarrard, Program Support and Information Management
Branch Head: Peggy Balak, Planning and Evaluation
Client Services Administrators: Danny Graves, Judy Bright

Section's Primary Responsibility: To oversee the implementation of services and supports for persons meeting the criteria for membership in the Thomas S. class action of 1988, and thus vested in that court action. With the dissolution of the court order in 1998, and per that dissolution order, the Section serves to implement these services and supports by:

- Identifying and maintaining lists of those vested in the Thomas S. court action,
- Creating person-centered plans to serve them,
- Creating a process for training and privileging staff who support them,
- Managing and arranging services to meet the requirements of those plans, and
- Monitoring the individual plans.

Most of these individuals have multiple challenging disabilities and have been committed one or more times to state psychiatric hospitals. The Section, working with area programs and provider agencies, has developed expertise in working with a population that does not fit typical discreet disability groupings. A strong local infrastructure and provider system has been developed to serve the population.

Current Initiatives:

- Initiating and Maintaining Services and Supports. The Section oversees area programs in maintaining services and supports to 1162 persons who are already being served. A minimum of additional 235 persons is identified to be served by the end of this fiscal year.

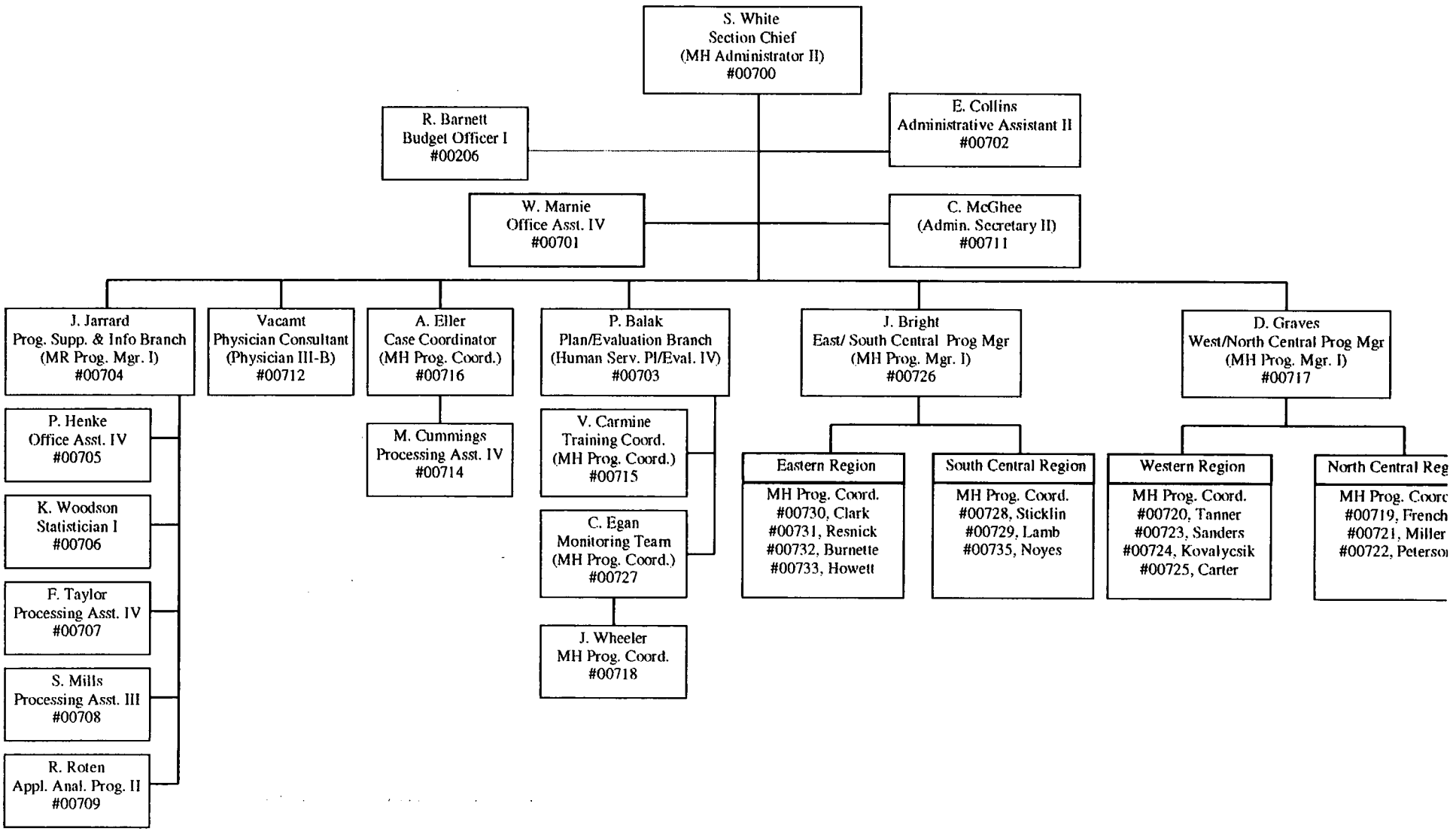
- Implementation of 1997 Thomas S. Cost-Containment Special Provision. The section is implementing components of this Special Provision to the end that costs for persons with challenging multiple disabilities may be effectively and appropriately served in community-based settings. This includes:

  - Developing long-term supports for people while minimizing expensive institutional or high-cost medical services.
  - Seeking more flexible Medicaid waivers and more unified funding streams;
  - Maintaining a capitated funding system while expanding services to more people.
  - Developing strong community partnerships to promote social inclusion of people with disabilities.
  - Encouraging the use of administrative services separate from a provider system, including fiscal intermediaries and personal advocates/brokers.

- Piloting and Evaluating Self-Determination and Participant-Driven models of supports. Self-Determination and Participant-Driven Managed Care are national models of supports, which provide more control to persons who receive those services and supports. Using a capitated budget, the persons and their support systems decide on and purchase the supports needed. Participants tend to choose only what they need rather than what professionals believe they need, therefore choosing relevant and cost-effective services.

- Developing a Strong Quality Improvement and Local Planning System. The Section is working diligently with area programs to develop strong, consumer-focused quality improvement and planning, which is a critical component in a competitive market and is necessary for safeguards to consumers.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of MH/DD/SAS
Thomas S. Services Section



MANAGEMENT SERVICES SECTION

Section Chief: Tara Larson --(919) 733-0596
Quality Improvement: Sue Creighton
CAP-MR/DD Branch: Cindy Kornegay
Decision Support Branch: Gary Immes
Medicaid Services Branch: Darlene Steele

Section's Primary Responsibility: The Management Services Section is responsible for the management and operational support for the Division of Mental Health/Developmental Disabilities/Substance Abuse Services exclusive of the Budget Office. The Section facilitates and oversees the administration and operation of state and federal funding sources and reporting, quality improvement activities such as the Client Satisfaction Surveys and Client Outcomes Initiative, decision support and the automation for the division. The Section is responsible for the linkage with State and Federal Medicaid/Medicare programs as it pertains to the delivery of mental health, developmental disabilities and substance abuse services.

The section is responsible for coordinating with the DHHS Controller's Office and other departmental agencies the process of cost finding and rate setting for both state and federal funding.

Quality Improvement Branch: The Quality Improvement Branch is responsible for the coordination, policy development and implementation for the accreditation and monitoring of area programs and their contract agencies. In addition, the Branch is responsible for rule making and manual publications for area program policies and standards such as medical record requirements, client rights rules, and service/program standards. The Branch provides training and technical assistance regarding the implementation of standards and policies established by the Commission of MH/DD/SAS. The Branch is responsible for the linkage with the Division of Facility Services regarding licensure as well as the other agencies and departments involved with the development and implementation of rules and requirements for area programs, state psychiatric hospitals and the mental retardation centers

Community Alternatives Program for People with Mental Retardation and/or Developmental Disabilities (CAP-MR/DD): The CAP-MR/DD Branch is responsible for the operation and administration of the Home and Community Based Medicaid waiver program for people with mental retardation. The Branch works collaboratively with the Division of Medical Assistance in the oversight of CAP-MR/DD program regarding compliance and policy guidance to 40 area programs. The waiver currently has the capacity to service 5,127 people who meet the habilitation and training criteria outlined in the Medicaid waiver. The Branch provides on-site technical assistance, monitoring, case consultation and provider training to both area programs and private providers regarding waiver policy, rules, standards and best practices.

Medicaid Services Branch: The Medicaid Services Branch is responsible for the operation and administration of the Carolina Alternatives Wavier, a Medicaid behavioral health managed care waiver in 10 area programs, and the Medicaid mental health, developmental disabilities and substance abuse fee for service coverage offered through the area programs. The Branch plays a coordinative role at the Division level in the development of Medicaid policies and initiatives. Medicaid policy interpretation, billing and documentation training, and technical assistance to the area programs are also responsibilities of this Branch.

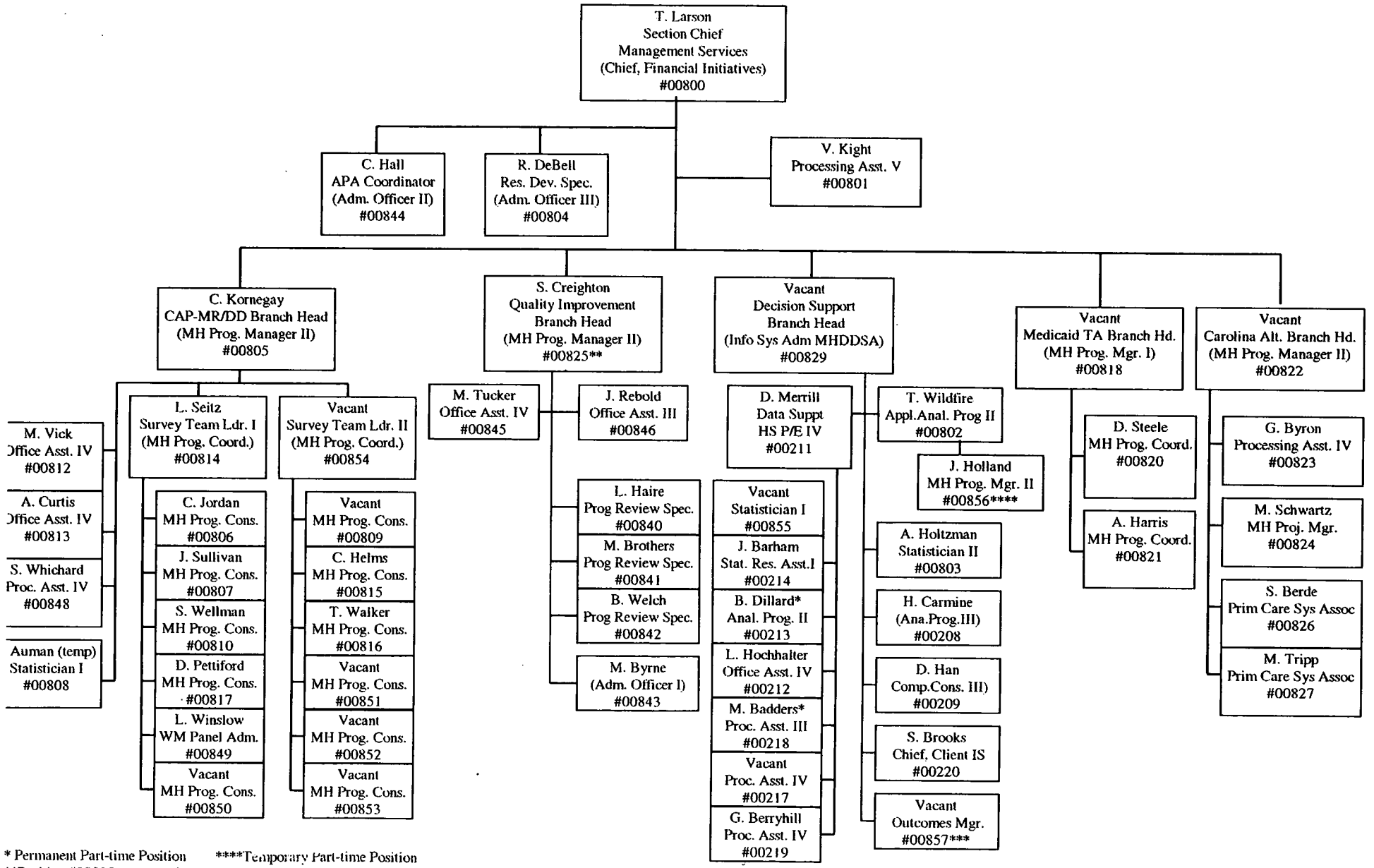
Decision Support Branch: The Decision Support Branch is responsible for strategic automation system planning, technology research, and information system design, operations for client information systems, and data collection and management. This branch manages the principal data analysis and management with the division. The branch is also responsible for computer equipment purchases, LAN system management and linkages with the Division of Information Resource Management (DIRM). The Branch carries out the production of routing, ad hoc and special data analysis of Medicaid information, client information, service utilization and outcome analysis.

Most Important Initiatives: Implementation of the area program accountability plan that includes national accreditation, Medicaid monitoring of area programs, Client outcomes and client satisfaction surveys.

Participation with and provision of analytical/technical support of the Division Design team regarding the redesign of MH/SA services for people in North Carolina.

Collaboration with the Developmental Disabilities Section with the redesign and expansion of CAP-MR/DD

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of MH/DD/SAS
Management Services Section



* Permanent Part-time Position ****Temporary Part-time Position
**Position #00825 was transferred to replace position #00900, MH Adm. II, which is temporarily on loan to the DHR, Office of the Secretary.
***Position pending classification approval.

STATE INSTITUTIONS

MENTAL HEALTH

The mission of the mental health institutions is to function as part of the mental health delivery system, which provides inpatient facilities to treat persons with psychiatric disorders and to provide and promote education and research.

Broughton
Director: Seth P. Hunt, Jr.
1000 South Sterling St.
Morganton, NC 28655
(828) 433-2324

Broughton Hospital was established by the Enabling Act passed in 1874. The first patient, a medical doctor, was admitted in 1883. In 1890, the name of the hospital was changed from Western North Carolina Insane Asylum to State Hospital at Morganton and retained this name until 1959, when it was named Broughton Hospital after Governor J. Melville Broughton. The Hospital served 52 counties until 1965, when the State divided into 4 regions, each containing a mental hospital. Today it serves approximately 3,700 per year (average daily census for FY '92 of 623) from the 35 westernmost counties. The hospital is organized into seven treatment divisions: adult admissions, adolescent, geriopsychiatry, rehabilitation, extended care, mental retardation, and medical-surgical. In addition to special diagnostic services, training and recreation facilities are also provided in preparation for the patients' return to their home community.

Cherry
Director: Liston G. Edwards, DPA.
201 Stevens Mill Rd.
Goldsboro, NC 27530-1057
(919) 731-3202

Established in 1880 as an Asylum for Colored Insane, the hospital served the entire Black population of the State for its first 85 years. In 1961, the name was changed to Cherry Hospital in honor of Governor Gregg Cherry. In 1965, it desegregated, along with the other institutions, and began serving the eastern region of the State (33 counties). It has a bed capacity of 667, with an average daily census for FY '92 of 563. The units and programs the hospital offers are: acute/admissions unit, behavior modification, resocialization & revitalization, psychiatric rehabilitation, children and youth unit, high management unit, geriatric unit, geriatric ICF unit, nursing care (ICF & SNF), infirmary, community placement day program, and a tubercular unit.

Dorothea Dix
Director: Steve Johnson
820 S. Boylan Ave
Raleigh, NC 27603
(919) 733-5324

In 1848, Dorothea Lynde Dix came to Raleigh on a crusade to rally legislative support for the care of North Carolina's mentally ill citizens. Through statewide surveys, detailed investigations, and personal expense, Miss Dix searched for the people of her concern. Numerous cases were discovered of the mentally ill being housed in jails and "poor houses." Frequently, these people were chained to the floor or confined in dark, damp cellars. An official legislative report read, "Some are confined within such limits and under such shelters as would seem fit only for untamed beasts." Miss Dix embarked on a venture to persuade key legislators to take action toward providing a state mental hospital for the citizens of North Carolina. The first hospital unit was erected to accommodate 40 patients and opened in 1856. The hospital now serves more than 3,000 mentally ill patients from the South Central Region each year. Services include psychiatric care to child and adolescent patients, adult rehabilitation, adult short-term acute care, medical-surgical care, and pre-trial evaluation of persons when requested by the courts.

John Umstead
Director: Patricia Christian, Ph.D.
1003 12th Street
Butner, NC 27509
(919) 575-7229

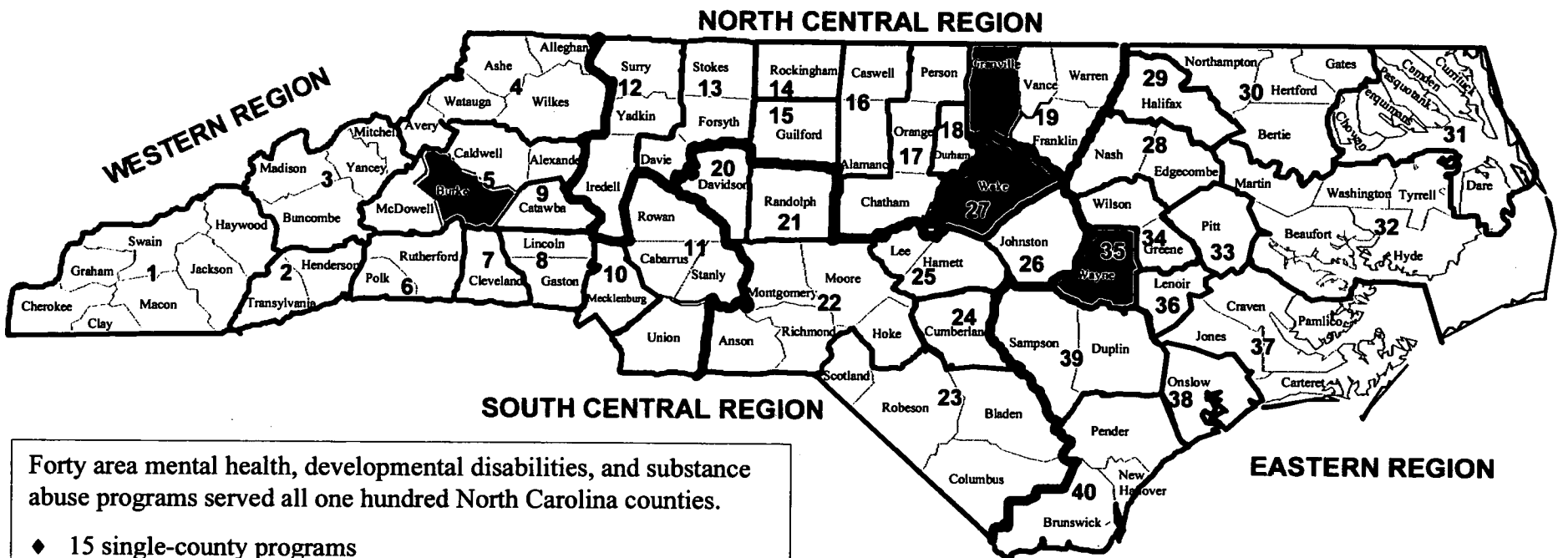
John Umstead Hospital, purchased from the federal government that had built the facilities as a prisoner of war compound, admitted the first patients in 1947. The hospital serves the sixteen counties of the North Central Region. The hospital's primary purpose is to provide an inpatient facility to diagnose and treat persons with psychiatric disorders, to restore them to an optimal level of functioning, and to return them to the community. This service is provided for those clients from age 6 years until felt by the area programs to be in need of treatment beyond their capacity to provide. Other important hospital functions are to promote education and research in mental health.

AREA MENTAL HEALTH /DEVELOPMENTAL DISABILITIES /SUBSTANCE ABUSE SERVICES

AREA AUTHORITIES: PSYCHIATRIC HOSPITALS

(Numerical order) Number = Area Program

1. Smoky Mountain
2. Trend
3. Blue Ridge
4. New River
5. Foothills
6. Rutherford-Polk
7. Cleveland
8. Gaston-Lincoln
9. Catawba
10. Mecklenburg
11. Piedmont
12. Crossroads
13. Centerpoint
14. Rockingham
15. Guilford
16. Alamance-Caswell
17. Orange-Person-Chatham
18. Durham
19. Vance-Granville-Franklin-Warren
20. Davidson
21. Randolph
22. Sandhills
23. Southeastern Regional
24. Cumberland
25. Lee-Harnett
26. Johnston
27. Wake
28. Edgecombe-Nash
29. Riverstone
30. Roanoke-Chowan
31. Albemarle
32. Tideland
33. Pitt
34. Wilson-Greene
35. Wayne
36. Lenoir
37. Neuse
38. Onslow
39. Duplin-Sampson
40. Southeastern Area



Forty area mental health, developmental disabilities, and substance abuse programs served all one hundred North Carolina counties.

- 15 single-county programs
- 25 multi-county programs

Prepared by DHHS/DMH/DD/Substance Abuse Services

- 16,530 clients were served at the four state Psychiatric Hospitals for fiscal year 1998.
- 14,464 admissions during FY'98. 54% (7,800) were readmissions and transfers and 46% (6,664) were first admissions.

MENTAL RETARDATION CENTERS

There are five regional mental retardation centers operated by the Division of MH/DD/SAS providing comprehensive residential services for up to 2,712 persons statewide. Of this number, 2,604 receive ICF/MR level of care. Persons eligible for admission to the centers are 16 years of age or older, with severe or profound mental retardation. The Area Programs refer persons to the regional center when this is the best available residential alternative. Residents whose catchment area covers their county of origin are admitted to the regional center. Each center has an active Outreach and Regional DD Coordinative component, the purpose of which is to work closely with communities to provide training, technical assistance, consultation, and direct client support.

Black Mountain
Director: Sally Ludlum
Old Highway 70
Black Mountain, NC 28711
(704) 669-3101

The initial facility was constructed in 1935 as a TB Hospital. Black Mountain Center now serves as the western regional DD facility. The Center provides a program of care and active treatment services for the developmentally disabled individuals who are primarily severely or profoundly handicapped. The Center is committed to meeting the highest standards of health care and training to each developmentally disabled individual through the practices of interdisciplinary team program evaluation and development. The Center advocates and supports the principles of normalization and the least restrictive concept as central philosophies of operation.

In addition to the DD program, Black Mountain Center operates a 35 bed residential unit serving Alzheimer's patients. Services are provided to individuals throughout North Carolina who meet admissions criteria, which is specifically designed to serve individuals whose aggressive or combative behaviors make other living arrangements unrealistic. The Alzheimer's Program utilizes the interdisciplinary team concept to provide the highest caliber of services to residents and their families. The facility also operates a respite residential and adult day care program designed to assist caregivers and prevent institutionalization.

Caswell
Director: Mike Mosley
2415 West Vernon Ave.
Kinston, NC 28501
(252) 559-5221

Caswell Center was authorized by the 1911 General Assembly. It was the first facility opened to serve mentally retarded individuals and is the largest institution in the Department of Health and Human Services. For approximately 50 years, Caswell was the only facility serving all of North Carolina. For this reason, its census includes individuals from all across the state, some of whom are quite elderly. After the other three large centers opened in the 1950s and `60s, the Caswell Center began primarily to serve people from eastern North Carolina. Caswell is noted for its national accreditation and positive relationships with families and community programs.

Murdoch
Director: J. Michael Hennike
C Street
Butner, NC 27509
(919) 575-7736

The Butner Training School, known as "The Colony," opened in 1947 in an old army barracks and received its first transfers from Caswell Center in June of 1948. Transfers continued from Caswell during the 1950's when the census reached 361. In 1955, construction began on the site which is now Murdoch Center. In December 1957, the staff and clients from "The Colony" moved to the new Butner Training School. With various construction, the capacity increased to 1,624 in 1965. The name of Butner Training School was changed to Murdoch School and eventually to Murdoch Center (The Center was named after Dr. James Murdoch who led to the beginning of a new era of reform in mental health in North Carolina). Today, Murdoch Center's approximately 1,620 staff positions provide comprehensive residential care for 700 severely/profoundly mentally retarded residents from 16 counties in the North Central Region. Respite care and extensive outreach services are also provided.

O'Berry
Director: Jerry Lyall, Ph.D.
400 Old Smithfield Road
Goldsboro, NC 27530
(919) 731-3545

In 1943, Governor Joseph Broughton appointed a commission to study the "condition, care, treatment and training" of black mentally retarded citizens at Cherry Hospital (then referred to as "Goldsboro State Hospital"). "Goldsboro Training School" (O'Berry Center) opened in 1957 as the first institution for black mentally retarded citizens with 150 mentally retarded clients transferred from psychiatric services at Cherry Hospital. The treatment philosophy then was limited academic/vocational training for mildly retarded, custodial care for moderate, severe, and profound. In 1966, O'Berry Center and other State mental retardation facilities desegregate in response to the 1964 Civil Rights Act, reducing O'Berry's service region from 100 to 23 counties. Today, approximately 430 clients from the South Central Region. The treatment philosophy is to assist clients with independence in self-help skills with vocational programs that emphasize real work skills instead of "make" work.

Western Carolina
Director: Iverson Riddle, MD
300 Enola Road
Morganton, NC 28655
(828) 433-2711

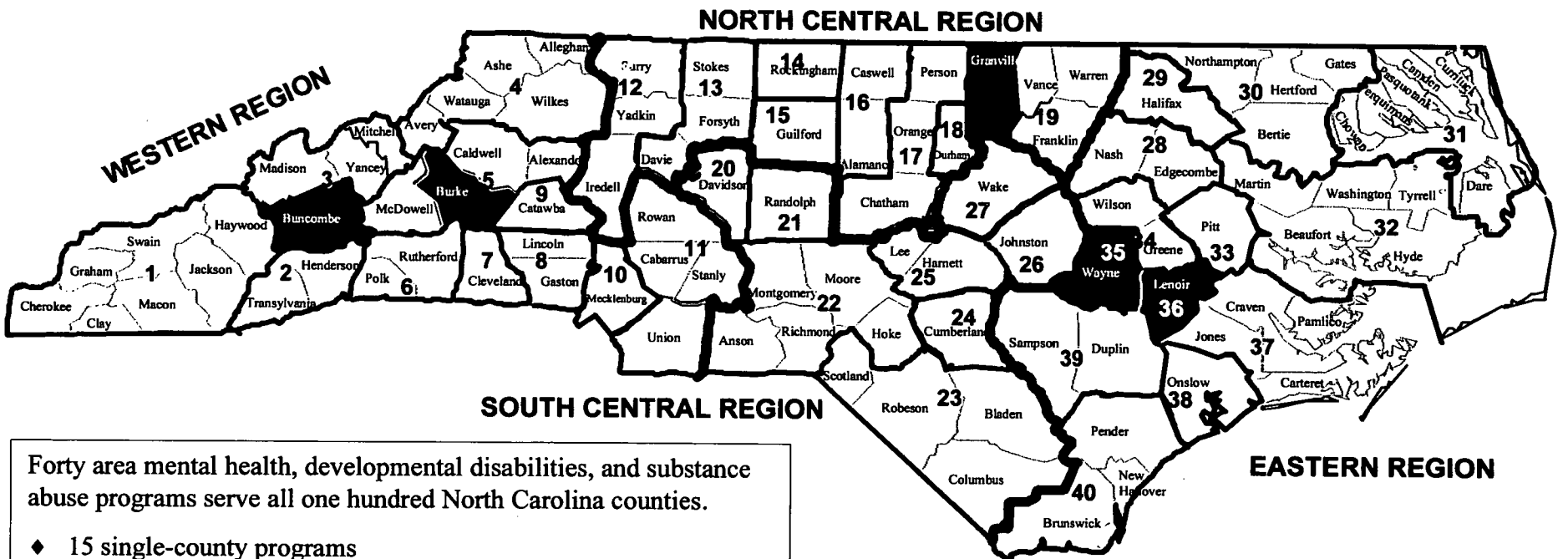
Western Carolina Center is an intermediate care facility (ICF) serving citizens of western North Carolina who are severely/profoundly mentally retarded. The average chronological age of persons residing at Western Carolina Center is 37, while the average mental age is two. Philosophically, the Center does not support institutionalizing children; children are, however, considered for admission under extreme circumstances. Western Carolina Center is committed to assisting persons residing at the facility and in the Western Region to achieve their maximum potential in independence as well as providing the best possible quality of life. Western Carolina Center is also dedicated to the promotion of consumer and family empowerment in all of the facility's decisions.

AREA MENTAL HEALTH /DEVELOPMENTAL DISABILITIES /SUBSTANCE ABUSE SERVICES

AREA AUTHORITIES: MENTAL RETARDATION CENTERS

(Numerical order) Number = Area Program

1. Smoky Mountain
2. Trend
3. Blue Ridge
4. New River
5. Foothills
6. Rutherford-Polk
7. Cleveland
8. Gaston-Lincoln
9. Catawba
10. Mecklenburg
11. Piedmont
12. Crossroads
13. Centerpoint
14. Rockingham
15. Guilford
16. Alamance-Caswell
17. Orange-Person-Chatham
18. Durham
19. Vance-Granville-Franklin-Warren
20. Davidson
21. Randolph
22. Sandhills
23. Southeastern Reg.
24. Cumberland
25. Lee-Harnett
26. Johnston
27. Wake
28. Edgecombe-Nash
29. Riverstone
30. Roanoke-Chowan
31. Albemarle
32. Tideland
33. Pitt
34. Wilson-Greene
35. Wayne
36. Lenoir
37. Neuse
38. Onslow
39. Duplin-Sampson
40. Southeastern Area



Forty area mental health, developmental disabilities, and substance abuse programs serve all one hundred North Carolina counties.

- 15 single-county programs
- 25 multi-county programs

Prepared by DHHS/DMH/DD/Substance Abuse Services

- There were 285 admissions to N.C. Mental Retardation Centers during FY'98.
- 2,508 persons were served during FY'97-98. This total includes, 2,284 residents (2,178 residents and 106 Alzheimers's Unit at Black Mountain Center) and 224 respite care clients.

ALCOHOL AND DRUG ABUSE TREATMENT CENTERS

Services available to clients include around the clock medical and nursing services which are vital to the recovery process, individual and group counseling, introduction to the first five steps of Alcoholics/Narcotics Anonymous teachings, relevant lectures and videos, basic adult education programs, and a therapeutic activity program. Admission is through the single portal of entry concept whereby clients are pre-screened for admission by the area program and then referred to the ADATC for treatment. The ADATC serves as the lead agency in offering residential treatment to citizens who, for the most part, have depleted their family and personal resources. The ADATC operates as a short-term, intensive residential treatment program with an average length of stay for most clients of 28 to 30 days. There are extended stays up to 42 days as indicated for cocaine and crack addicts. The ADATC bases its treatment program upon the firm conviction that alcohol and other drug dependence is a chronic, progressive, primary disease which affects the physical, emotional, social, and spiritual aspects of the lives of our clients and their families.

Julian F. Keith
Director: William Rafter
301 Tabernacle Rd.
Black Mountain, NC 28711
(828)669-3402
(704) 669-3400

The "Alcohol Rehabilitation Center" was established in 1969. From 1969 to 1977, the ADATC treatment was administered by psychiatrist directors/clinical directors with a full complement of medical and nursing staff. The majority of clinical interventions were directed toward medical detoxification and pharmacological interventions. In 1977, the psychiatric model was discontinued, and an AA 12-step program (modeled after Fellowship Hall in Greensboro) was initiated. Between 1985 and 1989, the clinically-directed facility operation was replaced by an administrative-directed operation. Clients in treatment during this time were younger and poly-drug dependent and presented more complex problems and behavioral challenges. Due primarily to the fact that ADATC had not kept current with the changing substance abuse population and concurrent treatment ramifications, the facility lost its JCAHO accreditation based on serious deficiencies cited in the 1989 survey. In early 1990, the ADATC began to address the organizational and program deficiencies resulting from standardized and discipline-separated treatment for clients. After reviewing the organizational structure of several nationally prominent chemical dependence facilities, a decision was made to establish three specialized treatment units (for male, female, and medically fragile clients) in the current dormitories. Following the JCAHO survey in 1991, the ADATC received a full three-year certification.

Butner
Director: Cliff Hood
101 N Broad Street
Butner, NC 27509
(919) 575-7928

In 1949, the General Assembly passed the Alcoholic Rehabilitation Act. Arrangements were made for the establishment of the NC Alcohol Rehabilitation Center (ARC) at Butner, and its doors were opened for male patients in 1950. By 1954, women were being accepted for treatment. Initially, the ARC operated under the direction of the superintendent of John Umstead Hospital, and it became an independent facility in 1959. In recognition of the changing patient population, the General Assembly changed the name of the three ARCs to Alcohol and Drug Abuse Treatment Centers (ADATCs) in 1989. Butner serves men and women from the 16 counties of the North Central Region, as well as ten counties of the South Central Region.

Walter B. Jones
Director: Phillip Mooring, M.S., CSAC
2577 West Fifth Street
Greenville, NC 27834
(252) 830-3426

Accredited by the Joint Commission on Accreditation of Healthcare Organizations, this 76-bed, short term residential treatment center opened in June, 1969. The center serves 33 counties in the Eastern Region and five counties in the South Central Region. Persons who are deaf or hard of hearing may be admitted from any of North Carolina's 100 counties as the Greenville ADATC is the only residential treatment center in North Carolina for deaf/ hard of hearing substance abusers.

In addition to serving deaf and hard of hearing clients, the Greenville center also provides treatment for pregnant and postpartum women and their infants and has an on-site maternal unit. The center has a Family Services Department under the supervision of a certified Marriage and Family Therapist, and all substance abuse counselors are either certified by the N.C. Substance Abuse Professional Certification Board or are working toward certification.

The Center offers practicums and internships from undergraduate to post doctoral levels and has recently received students from UNC Chapel Hill, ECU, The University of Miami, the University of Ontario, and Campbell College. Several of the Center's professional staff hold adjunct professorship appointments with ECU and the ECU School of Medicine.

In partnership with the ECU School of Medicine, the Greenville ADATC has been instrumental in the development of the ECU Center for Alcohol and Drug Studies, and is forging a relationship with the ECU School of Medicine to become an internationally recognized research site. The center offers training opportunities for medical school students and residents.

Outcome studies conducted over the past several years consistently show that 70 percent of the Greenville center clients are sober/drug free six months after discharge.

AREA MENTAL HEALTH /DEVELOPMENTAL DISABILITIES /SUBSTANCE ABUSE SERVICES

AREA AUTHORITIES: ALCOHOL AND DRUG ABUSE TREATMENT CENTERS

(Numerical order) Number = Area Program

1. Smoky Mountain
2. Trend
3. Blue Ridge
4. New River
5. Foothills
6. Rutherford-Polk
7. Cleveland
8. Gaston-Lincoln
9. Catawba
10. Mecklenburg
11. Piedmont
12. Crossroads
13. Centerpoint
14. Rockingham
15. Guilford
16. Alamance-Caswell
17. Orange-Person-Chatham
18. Durham
19. Vance-Granville-Franklin-Warren
20. Davidson
21. Randolph
22. Sandhills
23. Southeastern Reg.
24. Cumberland
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26. Johnston
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28. Edgecombe-Nash
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32. Tideland
33. Pitt
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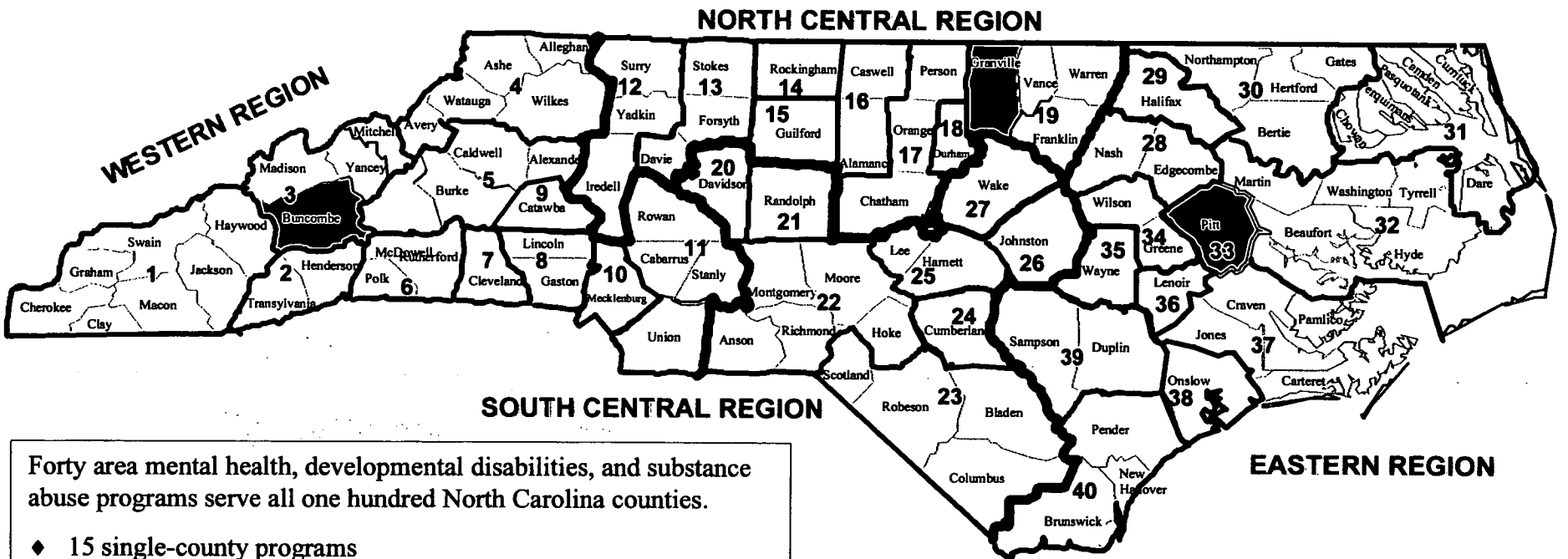
35. Wayne
36. Lenoir
37. Neuse
38. Onslow
39. Duplin-Sampson
40. Southeastern Area



Forty area mental health, developmental disabilities, and substance abuse programs serve all one hundred North Carolina counties.

- 15 single-county programs
- 25 multi-county programs

Prepared by DHHS/DMH/DD/Substance Abuse Services

- There were 2,553 admissions to N.C. Alcohol and Drug Abuse Treatment Centers in FY'98.
- There were 2,718 persons served in FY'98. *This figure shows a decrease from 3,159 in FY'97 due to the closing of Butner ADATC on December 31, 1996.

NORTH CAROLINA SPECIAL CARE CENTER

Director: William R. (Rusty) Benton, Jr.
4761 Ward Boulevard
Wilson, NC 27893
(919) 399-2112

Created in 1943 as a tuberculosis sanatorium, it was originally called the Eastern NC Sanatorium. In 1973, with anti-tuberculosis medication on the market for awhile, the role of this facility changed to specializing in chronic pulmonary diseases as a "specialty hospital with the faculty and assistance of UNC Memorial Hospital in Chapel Hill." In 1978, the North Carolina Special Care Center was created to serve the geriatric population in the State's psychiatric hospitals. There were many older patients who needed nursing care, but who did not need the specialized services and treatment of a psychiatric hospital. Private facility operators contacted in the state indicated that they could not provide the necessary care for these "special" patients. Age range of patients is late 20s to 93 years of age. Admissions to this nursing facility are limited to people who no longer need treatment in the state psychiatric hospitals and for whom no community-based nursing facility services can be arranged.

SCHOOLS FOR THE EMOTIONALLY DISTURBED

Whitaker

Director: Joseph Murphy, Ph.D.
L Street, Building 76
Butner, NC 27509
(919) 575-7927

Whitaker School, located in Butner, is a long-term residential treatment program for emotionally handicapped adolescents, the majority of whom are Willie M., ages 13-17, possessing secondary handicapping conditions including educational, social, behavioral, neurological, and intellectual deficits. Adolescents can stay up to a year in this non-medical alternative treatment program which emphasizes the re-educational model of service.

Through Whitaker School, staff mobilizes the home community resources to build a network of services to meet the students' individual needs and the needs and expectations of the family, school, and community. Adolescents are provided individual treatment on increasing academic, social, and behavioral competencies which can be demonstrated and transferred into less restrictive environments. Area Programs serve as the primary portal of entry to Whitaker School.

Wright
Director: Debbie Simmers
3132 Roxboro Road
Durham, NC 27704
(919) 560-5790

Wright School is the smallest freestanding DHHS facility. Begun in 1963 as part of "Project Re-Ed", a National Institute of Mental Health demonstration project, Wright School's ecological treatment philosophy foreshadowed, on a child by child basis, the development of the coordinated community-based services model currently in development across North Carolina and the nation. Wright School targets not just psychopathology within the child, but has a mission to energize, educate, and coordinate all the adults in a child's ecological system to step forward and participate in meeting the needs of each seriously disturbed, and often multi-problem child and family.

Teachers/Counselors, the primary change agents at Wright School, provide special education and residential treatment to the 24 children at the north Durham facility each Monday through Friday. On Friday afternoon, each child returns to his/her local community to practice new skills and behaviors within the family system. Teachers/Counselors also work with parents, extended family, local schools, Social Services, Mental Health, court counselors, voluntary agencies, community recreation, neighbors, and everyone and anyone who can provide a part of the treatment and/or support the child and family needs. Each weekend new skills, resources, and support systems are practiced by a family rested by the respite of their child's Wright School stay and restored by newly committed local providers.

BUTNER ADOLESCENT TREATMENT CENTER

Director: Stephanie Alexander
11th Street, Bldg. 42
Butner, NC 27509
(919) 575-7954

Butner Adolescent Treatment Center (BATC) is a secure, non-medical 12 bed treatment facility serving Willie M. class members who require a locked environment in order to participate in appropriate treatment services. The Center's capacity is currently 12 beds, with the further capability of handling one or two additional clients for short-term crisis stabilization. The Center operates on the campus of John Umstead Hospital in Butner.

An additional 10 to 12 unlocked treatment beds are available at the Oakview Apartments program, a supervised independent living program operated by BATC also on the Umstead campus. Oakview consists of five apartment units in a single building with 24-hour staffing.

AREA MENTAL HEALTH /DEVELOPMENTAL DISABILITIES /SUBSTANCE ABUSE SERVICES

AREA AUTHORITIES: YOUTH FACILITIES

(Numerical order) Number = Area Program

1. Smoky Mountain
2. Trend
3. Blue Ridge
4. New River
5. Foothills
6. Rutherford-Polk
7. Cleveland
8. Gaston-Lincoln
9. Catawba
10. Mecklenburg
11. Piedmont
12. Crossroads
13. Centerpoint
14. Rockingham
15. Guilford
16. Alamance-Caswell
17. Orange-Person-Chatham
18. Durham
19. Vance-Granville-Franklin-Warren
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22. Sandhills
23. Southeastern Reg.
24. Cumberland
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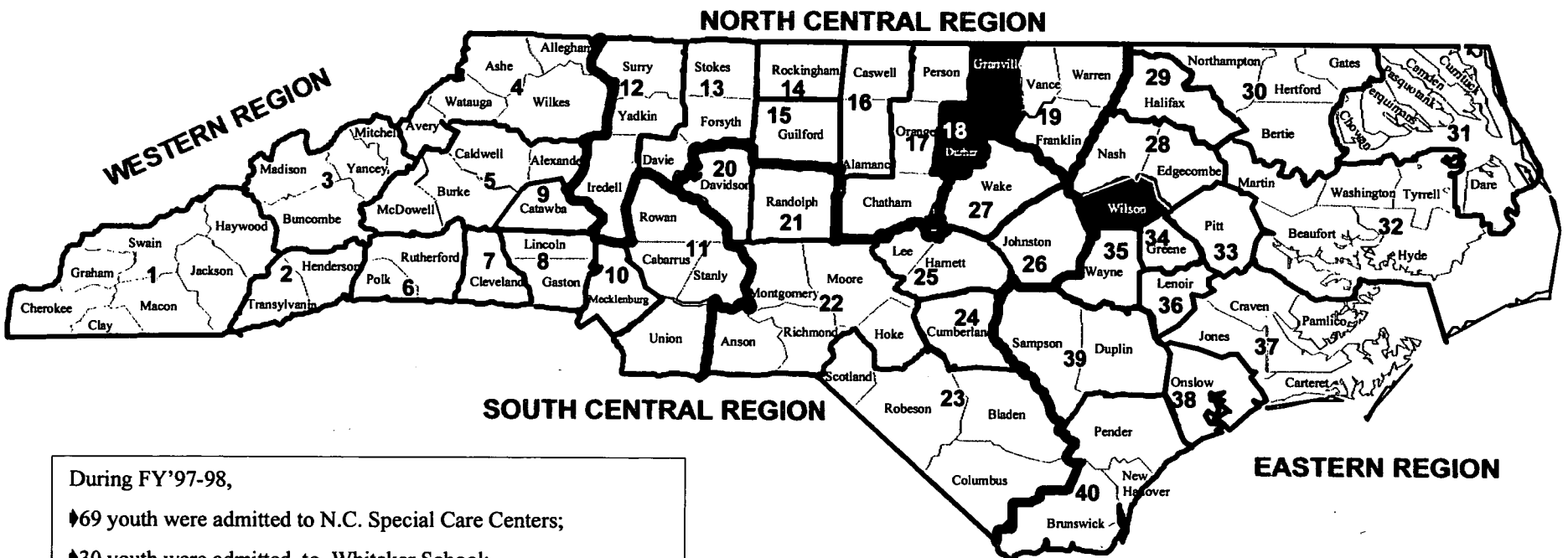
32. Tideland
33. Pitt
34. Wilson-Greene
35. Wayne
36. Lenoir
37. Neuse
38. Onslow
39. Duplin-Sampson
40. Southeastern Area



During FY'97-98,

- 69 youth were admitted to N.C. Special Care Centers;
- 30 youth were admitted to Whitaker School;
- 44 youth were admitted to Wright School; and
- 16 youth were admitted to Butner Adolescent Treatment Center.

Prepared by DHHS/DMH/DD/Substance Abuse Services

AREA AUTHORITIES

Forty area mental health, developmental disabilities, and substance abuse programs serve all one-hundred North Carolina counties. There are sixteen single county programs and twenty-five multi-county programs. Area programs are local political subdivisions, each governed by an area board which is a 15-25 member body appointed by county commissioners. Board members by law must include specific categories: a county commissioner from each county (not required for single county area); two physicians, including one psychiatrist when possible; at least one other professional from the fields of psychology, social work, nursing or religion; primary and family consumers and organization representatives for mental illness, developmental disabilities, alcoholism, and drug abuse; and an attorney.

By statute (G.S. 122C-117), the area authority has the following powers and duties:

- Engage in comprehensive planning, budgeting, implementing, and monitoring of community-based mental health, developmental disabilities, and substance abuse services;
- Provide services to clients in the catchment area;
- Determine the needs of the area authority's clients and coordinate with the Secretary of the Department of Health and Human Services the provision of services to clients through area and State facilities;
- Develop plans and budgets for the area authority subject to the approval of the Secretary of the Department of Health and Human Services;
- Assure that the services provided by the area authority meet the rules of the Commission for Mental Health, Developmental Disabilities and Substance Abuse Services and the Secretary of the Department of Health and Human Services;
- Appoint an area director; and
- Comply with federal requirements as a condition of receipt of federal grants.

Each area program is required to provide certain services, either directly or by contracting with other public or private entities. Most area programs provide a combination of mandated and optional services. Services required by law include the following:

- ***outpatient services*** for individuals of all disability groups (at least one clinic that holds office hours no less than 40 hours per week);
- ***emergency services*** for individuals of all disability groups (24 hours per day, seven days per week, on a non-scheduled basis to individuals for immediate screening or assessment of problems);
- ***consultation and education services*** for individuals of all disability groups (consultation to agencies, organizations, or practitioners; education to community groups, families, schools businesses, churches, civic, and community groups);

- ***case management*** for individuals of all disability groups (a support service designed to integrate multiple services from other agencies with area program services and to assist clients in meeting "total needs," i.e., treatment, educational, vocational, residential, health, financial, social, and any others);
- ***forensic screening and evaluation*** for all disability groups (to assess capacity of criminal offender to proceed to trial);
- ***inpatient psychiatric services*** for children, adolescent, adult, and elderly individuals who are acutely mentally ill (intensive treatment and supervision in a controlled environment on a 24-hour basis);
- ***a psychosocial rehabilitation program*** (day program with peer support group) to help chronically mentally ill persons achieve and maintain independent living, ***or a partial hospitalization service*** (day program providing intensive treatment) intended to prevent psychiatric hospitalization;
- ***early childhood intervention services*** (ECI) for children who are mentally retarded, are otherwise developmentally disabled or delayed, have atypical development, or are at risk of the preceding conditions (support and information to families on child-rearing skills and available services; assessment and programming in cognitive, language and communication, physical, self-help, and psychosocial skill development in the client's home and at other sites);
- ***developmental day services for preschool children*** with developmental disabilities or delays, or at high risk for mental retardation, in a specialized child care center (habilitative programming in self-help, physical, language, cognitive, and psychosocial skills, that is available 8 hours/day, five days/week, 12 months/year);
- ***adult developmental activity programs*** (ADAP) for adults who are substantially mentally retarded or severely physically disabled (to prepare the individual to live and work as independently as possible);
- ***alcohol and drug education traffic schools*** (ADETS) for first offenders convicted of driving while impaired;
- ***drug education schools*** (DES) for drug offenders;
- ***inpatient hospital detoxification services*** for alcohol or drug abusers (in need of detoxification who cannot be safely withdrawn from the substance in any other setting, i.e., life threatening physical problems or accompanying psychiatric or behavioral problems); and
- ***nonhospital or outpatient detoxification services*** for alcoholics.

List of area programs

Alamance-Caswell
Albemarle (Camden, Chowan, Currituck, Dare, Pasquotank)
Blue Ridge (Buncombe, Madison, Mitchell, Yancey)
Catawba
Cleveland
Crossroads Behavioral Health Care (Iredell, Surry-Yadkin)
Cumberland
Davidson
Duplin-Sampson
Durham
Edgecombe-Nash
Foothills (Alexander, Burke, Caldwell, McDowell)
Forsyth-Stokes (Davie)
Gaston-Lincoln
Guilford
Halifax
Johnston
Lee-Harnett
Lenoir
Mecklenburg
Neuse (Carteret, Craven, Jones, Pamlico)
New River (Alleghany, Ashe, Avery, Watauga, Wilkes)
Onslow
Orange-Person-Chatham
Piedmont (Cabarrus, Rowan Stanly, Union)
Pitt
Randolph
Roanoke-Chowan (Bertie, Gates, Hertford, Northampton)
Rockingham
Rutherford-Polk
Sandhills (Anson, Hoke, Montgomery, Moore, Richmond)
Smoky Mountain (Cherokee, Clay, Graham, Haywood, Jackson, Macon, Swain)
Southeastern (Brunswick, New Hanover, Pender)
Southeastern Regional (Bladen, Columbus, Robeson, Scotland)
Tideland (Beaufort, Hyde, Martin, Tyrrell, Washington)
Trend (Henderson, Transylvania)
Vance, Warren, Granville and Franklin
Wake
Wayne
Wilson-Greene

AREA MENTAL HEALTH /DEVELOPMENTAL DISABILITIES /SUBSTANCE ABUSE SERVICES

AREA PROGRAMS

(Numerical order) Number = Area Program

1. Smoky Mountain
2. Trend
3. Blue Ridge
4. New River
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8. Gaston-Lincoln
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10. Mecklenburg
11. Piedmont
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15. Guilford
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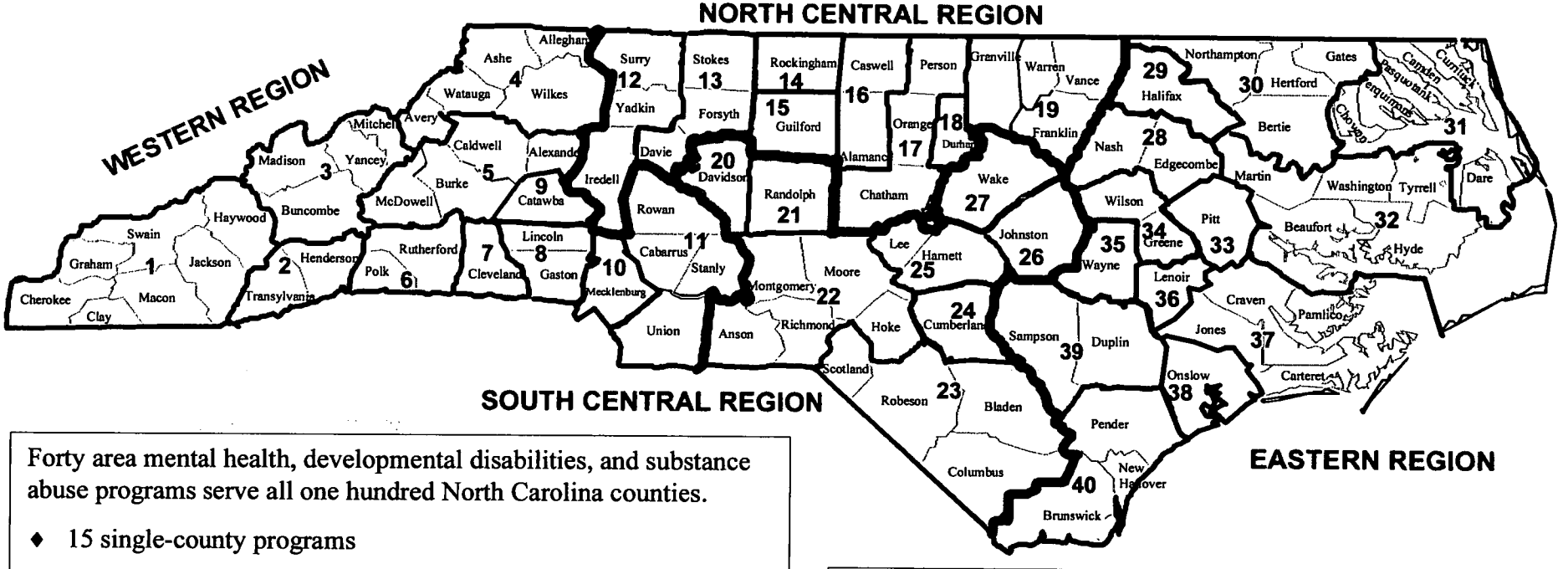


Forty area mental health, developmental disabilities, and substance abuse programs serve all one hundred North Carolina counties.

- 15 single-county programs
- 25 multi-county programs

Prepared by DHHS/DMH/DD/Substance Abuse Services

A total of 296,724 persons were served in area programs during FY'98. This number represents:

- 196,296 mental health clients
- 17,152 developmental disabilities clients
- 83,276 substance abuse clients

HOUSE COMMITTEE ON MENTAL HEALTH

APRIL 6, 1999
10:00 a.m.
Room 415

AGENDA

Chair: Rep. Jim Crawford

Infrastructure Needs for Mental Health

Flo Stein, Chief, Alcohol and Drug Services, Division of Mental Health

MINUTES
HOUSE COMMITTEE ON MENTAL HEALTH
APRIL 6, 1999

The House Committee on Mental Health met on Tuesday, April 6, 1999 in Room 415 of the Legislative Office Building at 10:00 a.m. The following members were present: Chairman Jim Crawford, Representatives Goodwin, Cansler, Esposito, Gardner, Horn, McAllister, Nye, Oldham, and Warwick. Linda Attarian and Kory Goldsmith, staff counselors, attended. A visitor registration list is attached and made part of these minutes.

Chairman Crawford introduced the pages for the day and new members present who have been added to the committee.

Chairman Crawford introduced Flo Stein, Chief, Alcohol and Drug Services, Division of Mental Health. Ms. Stein explained the redesign process the division is developing (handout). The redesign team is made up of persons from each section of the division and public members from each of the disability areas represented in the system. The team will analyze the current system, look at all the options available for services, and make recommendations for changes. Ms. Stein discussed the goals of the study and emphasized that all consumers and other interested parties have ongoing opportunities to contribute to the new design. A website is available to submit comments. This agency mandated study will collaborate and coordinate with the legislative mandated auditors report. The team plans to have a final plan by November 1999 with implementation to begin by July 2000.

Michelle Cotton handed out a 1998 supplement to division laws.

Chairman Crawford adjourned the meeting at 10:45.

Respectfully submitted,

James M. Crawford Jr.
Representative Jim Crawford
Chairman

Linda Winstead
Linda S. Winstead
Committee Assistant

VISITOR REGISTRATION SHEET

MENTAL HEALTH

Name of Committee | Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Janet Simonsen	NC Council of Community Programs
Jo Wilson	NCALTC 7
C. Porter	Bone & Associates
Jimmy Jo Bain	NCMS
Terry Stelle	DMHDDSA
John Baggett	"
MICHELLE COTTON	DMH/DD/SAS
Rogers Bain	Bone Tatum
Katherine Miller	R. Harry Kapler

DHHS-DMH/DD/SAS SYSTEM REDESIGN PROCESS

- ANALYSES
- OPTIONS
- RECOMMENDATIONS

- Final Plan: November, 1999

1 H

System Redesign: Overview

- Division moving from being a relatively passive "funder" of services to a more proactive "purchaser" of services
- System is in need of major overhaul
- Substantial room for improving the quality, access, accountability and cost-effectiveness of purchased services
- Everything on the table; nothing is sacred

System Redesign: Goals

- Develop consistency in quality, availability & access of services across the state
- Strengthen clinical and financial accountability
- Utilize competition to improve quality
- Clarify and recommend optimal roles of Division, counties, and service providers
- Develop & manage performance contracts
- Implement utilization management

System Redesign: Stakeholder Involvement

- There is no "predetermined" plan.
- The Division is committed to an open process in which all consumers, families, advocates, and other interested stakeholders have ongoing opportunities to contribute to the new system design.
- Send comments to:

  www.state.nc.us/dhr/dmh

System Redesign: Primary Components

- Priority populations
- Benefit design; covered services
- System structure and provider network
- Quality management
- Management Information Systems (MIS)
- Financial structure & strategies
- Consumer issues: rights, protections, and meaningful involvement

System Redesign: Key Policy Issues

- Overall system structure and service provider network
- Community-based & institutional services: structural and financial relationship
- Establishment of clinical & financial accountability throughout system
- Role of competition & marketplace in redesigned system

System Redesign: Design Plan & Auditor Report

- Complementary studies; commitment to coordination / collaboration
- Auditor Report:
  - Legislatively mandated study of MGT recommendations and of Area Programs
  - Final recommendations due April 1, 2000
- Design Plan:
  - Division mandated study
  - Final recommendations due November 19, 1999

System Redesign: Workplan

Design Team/SAT: Report Development	Jan-May, 1999
Draft 1	May 28
Public input/ public forums	June
Draft 2	September 17
Public input / public forum	Sept 17-Oct 4
Final Division Plan	November 19
Auditors Final Report	April 1, 2000
Implementation Plan: Phase 1	July1, 2000
Implementation Plan: Phase 2 & 3	2001, 2002

HOUSE COMMITTEE ON MENTAL HEALTH

APRIL 13, 1999
10:00 AM
ROOM 415 LOB

AGENDA

Chair: Rep. Jim Crawford

HB 298-Inpatient Commit./Condt'l Release/AB
Bill Sponsor- Rep. Hackney

MINUTES
HOUSE COMMITTEE ON MENTAL HEALTH
APRIL 13, 1999
RM. 415 LOB

The House Committee on Mental Health met on Tuesday, April 13, 1999 in Room 415 of the Legislative Office Building at 10:00 AM. The following members were present: Chairman Representative Crawford, Representatives Gardner, Horn, Nye and Hackney. Staff members also present were Kory Goldsmith and Linda Attarian. A visitor registration list is attached and made part of these minutes.

Representative Crawford introduced the pages for the day. Rep. Joe Hackney introduced HB 298- Inpatient Commit./Condt'l Release to the committee. Rep. Gardner makes a motion to discuss committee substitute. Several committee members asked questions of Rep. Hackney. Also, commenting were, Dr. John Baggett, Head of NC Department of Mental Health and Mr. John Tote of the Mental Health Coalition. Rep. Nye made a motion to give the committee substitute a favorable report and the bill passes unanimously.

Rep. Crawford adjourned the meeting at 10:45 AM.

Respectfully submitted,

Rep. Jim Crawford
Chairman

Kristen Younts
Committee Assistant

VISITOR REGISTRATION SHEET

Mental Health 4/13/99

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY
1. Wayne Wilson	ASBM
2. Pamela Best	AOC
3. Tommy Worth	Carolina Healthcare Systems
4. [illegible]	NC Council
5. Joanne Robison	NC Nurses Assoc.
6. Adam Searing	NCMAC
7. MT Burnette	GACPD
8. [illegible]	MHA/NC
9. [illegible]	NASW-NC
10. Mark Botts	Institute of Gov't
11. MICHELLE COTTON	DMH/DD/SAS
12. Mac Brooks	GACPD
13. [illegible]	CYPC
14. Ann Rodriguez	NC Council of Community Programs
15. Dave Richie	Hrllc
16. Ellen DePue	Novartis
17. Katherine Miller	Harry Kaplan
18.	
19.	
20.	
21.	

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Crawford and Goodwin** for the Committee on **Mental Health**.

☐ Committee Substitute for
H.B. 298 A BILL TO BE ENTITLED AN ACT TO PROVIDE FOR THE MONITORING AND SUPERVISION OF PERSONS ON CONDITIONAL RELEASE FROM STATE PSYCHIATRIC HOSPITALS.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☒ With a favorable report as to committee substitute bill, which changes the title, unfavorable as to original bill and recommendation that the committee substitute bill be re-referred to the Committee on Judiciary I.

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

2/24/99

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 298
Committee Substitute Favorable 4/15/99

Short Title: Inpatient Commit./Condt'l Release/AB. (Public)

Sponsors:

Referred to:

March 4, 1999

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR THE MONITORING AND SUPERVISION OF PERSONS ON CONDITIONAL RELEASE FROM STATE PSYCHIATRIC HOSPITALS, AND TO APPROPRIATE FUNDS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 122C-277 reads as rewritten:

"**§ 122C-277. Inpatient commitment; release ~~Release~~ and conditional release; judicial review.**

(a) Except as provided in subsections ~~(b) and (b1)~~ (e) and (f) of this section, the attending physician shall discharge a committed respondent unconditionally at any time ~~he~~ the attending physician determines that the respondent ~~is~~ no longer meets the criteria for inpatient commitment specified in G.S. 122C-263(d)(2). ~~in need of inpatient commitment.~~ Notice of discharge shall be furnished to the clerk of superior court of the county where the petition was initiated and of the county in which the facility is located. However, if the attending physician determines that the respondent meets the criteria for outpatient commitment as defined in G.S. 122C-263(d)(1), ~~he~~ the attending physician may request the clerk to calendar a supplemental hearing to determine whether an outpatient commitment order shall be issued.

(b) Except as provided in subsections ~~(b) and (b1)~~ (e) and (f) of this section, the attending physician may also release a respondent conditionally on a trial visit for periods not in excess of 30 days on specified medically appropriate conditions. Violation of the conditions is grounds for return of the respondent to the releasing

facility. A law-enforcement officer, on request of the attending physician, shall take a ~~conditional releasee~~ respondent on trial visit release into custody and return ~~him~~ the respondent to the facility in accordance with G.S. 122C-205. Notice of ~~discharge and of conditional~~ trial visit release shall be furnished to the clerk of superior court of the county ~~of commitment~~ where the petition was initiated and of the county in which the facility is located.

(c) Except as provided in subsections (e) and (f) of this section, during a period of inpatient commitment, the attending physician may release a respondent conditionally for a period of time not to exceed the remainder of the period of inpatient commitment if the attending physician determines all of the following:

(1) The respondent continues to meet the criteria of G.S. 122C-263(d)(2).

(2) The respondent's current mental status and behavior is stable, and respondent is free of symptoms associated with previous episodes of dangerous conduct.

(3) Based on respondent's psychiatric history, there is a reasonable probability of future dangerous conduct if respondent is discharged to the community without continued treatment, supervision, and the assistance of others.

(4) Adequate treatment, supervision, and assistance for the respondent is available from the area authority that serves the community where respondent will reside upon release.

(5) Based on respondent's psychiatric history, there is a reasonable probability that respondent will not voluntarily seek or comply with recommended treatment upon release to the community unless adequate supervision and assistance are given pursuant to a conditional release plan developed in accordance with subsection (d) of this section.

(d) A respondent may be conditionally released pursuant to subsection (c) of this section only after an individualized outpatient treatment plan has been developed and an area authority has been designated to administer, and has agreed to provide, treatment in accordance with the treatment plan and with G.S. 122C-273(e). With the participation of the respondent, the treatment plan shall be jointly developed by the respondent's attending physician at the releasing facility and the area director, or the area director's designee, for the area authority that serves the community where the respondent will reside upon conditional release. With the consent of the respondent, and as part of the treatment planning process, the area authority shall consult with the respondent's next-of-kin or other family members on strategies designed to support respondent's continued mental stability and reduce the risk of future dangerous conduct. In addition to meeting the requirements of G.S. 122C-273(e), the treatment plan shall include, but need not be limited to, the following:

(1) Based upon an assessment of the respondent's psychiatric history and risk factors, requirements for treatment or services designed to reduce the respondent's risk for future dangerous conduct

including, if any, requirements for medication, case management, supervision, and other services for the treatment of mental illness, developmental disabilities, or substance abuse.

(2) Based upon an assessment of the respondent's psychiatric history and risk factors, requirements, if any, for assistance in obtaining basic needs such as employment, transportation, food, clothing, shelter, or other support services, when this assistance is necessary to reduce the respondent's risk for future dangerous conduct.

(3) Conditions that the respondent must meet to be eligible for continued conditional release and without which there exists a reasonable probability of future dangerous conduct, including, as applicable, such requirements as periodic reporting to treatment professionals at designated time intervals, continuation of medication, and abstention from alcohol and other drugs.

(4) The address of the residence where the respondent is to live upon conditional release and the name of the person in charge of the residence, if any.

Before conditional release, the attending physician of the releasing facility shall provide to the respondent or the respondent's legally responsible person a copy and full explanation of the treatment plan and conditions for release. With the consent of the respondent, a copy and full explanation of the treatment plan and conditions for release shall be provided to the respondent's next-of-kin. Notice of conditional release shall be furnished to the clerk of superior court of the county where the petition was initiated, the county where conditional release will be supervised, and of the county in which the 24-hour facility is located. The respondent's violation of conditions for release is grounds for return of the respondent to a 24-hour facility in accordance with G.S. 122C-273(e).

~~(b)~~ (e) If the respondent was initially committed as the result of conduct resulting in his being charged with a violent crime, including a crime involving an assault with a deadly weapon, and respondent was found incapable of proceeding, 15 days before the respondent's ~~discharge~~ discharge, trial visit, or conditional release the attending physician shall notify the clerk of superior court of the county in which the facility is located of his determination regarding the proposed ~~discharge~~ discharge, trial visit, or conditional release. The clerk shall then schedule a rehearing to determine the appropriateness of respondent's release under the standards of commitment set forth in G.S. 122C-271(b). The clerk shall give notice as provided in G.S. 122C-264(d). The district attorney of the district where respondent was found incapable of proceeding may represent the State's interest at the hearing.

~~(b1)~~ (f) If the respondent was initially committed pursuant to G.S. 15A-1321, 15 days before the respondent's ~~discharge~~ discharge, trial visit, or conditional release the attending physician shall notify the clerk of superior court. The clerk shall calendar a hearing and shall give notice as provided by G.S. 122C-264(d1). The district attorney for the original trial may represent the State's interest at the hearing. The hearing shall be conducted under the standards and procedures set forth in G.S. 122C-268.1.

Provided, that in no event shall ~~discharge~~ discharge, trial visit, or conditional release under this section be allowed for a respondent during the period from automatic commitment to hearing under G.S. 122C-268.1.

~~(c)~~ (g) If a committed respondent under subsections (a), (b), ~~or (b1)~~ (c), (e), or (f) of this section is from a single portal area, the attending physician shall plan jointly with the area authority as prescribed in the area plan before discharging or releasing the respondent.

(h) Maintenance and transfer of court files pertaining to the conditional release of a respondent under this section shall be as provided under G.S. 122C-264(g)."

Section 2. G.S. 122C-273 is amended by adding the following new subsection to read:

"(e) Unless prohibited by Chapter 90 of the General Statutes, if the respondent on inpatient commitment is conditionally released in accordance with G.S. 122C-277(c) and (d), the area authority designated in the treatment plan, and any of its area facilities, may administer to the respondent reasonable and appropriate medication and treatment that are consistent with accepted medical standards. Before the respondent is conditionally released, the inpatient facility releasing the respondent shall provide a copy of the respondent's treatment plan and conditions for release to the area authority designated to administer the treatment plan. As a condition of release, and in addition to any other conditions required by G.S. 122C-277(d)(3), the initial treatment plan shall require the respondent to meet face-to-face with a responsible professional no less than once every seven days to ensure that the respondent is complying with the conditions for release and is receiving treatment, supervision, and assistance necessary to prevent future dangerous conduct or the need for treatment in a 24-hour facility. All of the following apply to conditional release authorized under G.S. 122C-277(c) and (d) and this section.

(1) The medical director for the area authority shall require periodic reports concerning the condition of respondents on conditional release from any person assigned by the area authority to supervise a conditional release treatment plan. The medical director, or the medical director's designee, shall review the condition of a respondent on conditional release at least once every 30 days. In conducting the review, the medical director or the medical director's designee shall consider all reports and information received and may require the respondent to report for further evaluation.

(2) The area authority medical director, or the medical director's designee, may modify the treatment plan, including conditions for release, when modification is consistent with the requirements of G.S. 122C-277(d). The respondent shall be involved in and informed of any changes to the treatment plan and conditions of release. A copy of the modified treatment plan shall be placed in the respondent's medical record and copies shall be provided to

the respondent and any other persons who received copies of the initial treatment plan in accordance with G.S. 122C-277(d).

(3) Notwithstanding the respondent's compliance with the conditions for release, at any time that the area authority finds that conditional release is no longer appropriate and the respondent is in need of inpatient treatment, the area authority responsible for managing and supervising the respondent's treatment shall request the court of the county where the conditional release is being supervised to order the respondent taken into custody for the purpose of transportation to a 24-hour facility designated by the area authority. Upon receipt of this request, the clerk or magistrate shall issue an order to a law enforcement officer to take the respondent into custody and to take the respondent immediately to the designated 24-hour facility. Transportation to the 24-hour facility shall be provided as specified in G.S. 122C-251. Within 24 hours of arrival at the 24-hour facility, the respondent shall be examined by a physician who shall act in accordance with the procedures specified in G.S. 122C-266. If the respondent meets the criteria of G.S. 122C-266(a)(1), the 24-hour facility shall notify the clerk of court for the county in which the 24-hour facility is located and request a supplemental hearing as specified in G.S. 122C-274.1.

(4) If the respondent violates a condition of release, and unless compliance is obtained within 24 hours of the violation, the area authority responsible for management and supervision of the respondent's treatment shall immediately request the court of the county where the conditional release is being supervised to order the respondent taken into custody for the purpose of examination. Upon receipt of this request, the clerk or magistrate shall issue an order to a law enforcement officer to take the respondent into custody and to take the respondent immediately to the designated area authority for examination. The law enforcement officer shall turn the respondent over to the custody of the area authority for examination by a physician or eligible psychologist. Upon examination, if efforts to solicit compliance with conditions for release are successful and the respondent is not in need of treatment in a 24-hour facility, the respondent shall be released and returned home after the examination. If efforts to solicit compliance with conditions for release fail or the physician or eligible psychologist determines that conditional release is no longer appropriate and the respondent needs inpatient treatment, the law enforcement officer shall transport the respondent to a 24-hour facility designated by the area authority. Transportation to the 24-hour facility shall be provided as specified in G.S. 122C-251.

Within 24 hours of arrival at the 24-hour facility, the respondent shall be examined by a physician who shall act in accordance with the procedures specified in G.S. 122C-266. If the respondent meets the criteria of G.S. 122C-266(a)(1), the 24-hour facility shall notify the clerk of court for the county in which the 24-hour facility is located and request a supplemental hearing as specified in G.S. 122C-274.1.

(5) When an area authority physician seeks the return of the respondent to an inpatient facility, the physician shall document and report grounds for the return to the inpatient facility and the clerk of superior court of the county where the conditional release is being supervised.

(6) Except as otherwise provided in this subdivision, during any period of conditional release, if the area facility determines that the respondent no longer meets the criteria set out in G.S. 122C-263(d)(2), the area facility shall notify the court and the case shall be terminated. If the respondent was initially committed as a result of conduct resulting in the respondent being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found incapable of proceeding, the designated area facility shall so notify the clerk of superior court of the county in which the area facility is located and the clerk shall schedule a rehearing and provide notice in accordance with G.S. 122C-276. If the respondent was initially committed pursuant to G.S. 15A-1321, the area facility shall so notify the clerk of superior court of the county in which the area facility is located and the clerk shall schedule a rehearing and provide notice in accordance with G.S. 122C-276.1.

(7) Fifteen days before the end of the initial or subsequent periods of commitment for a respondent on conditional release, the attending area facility physician shall review and evaluate the condition of the respondent. If the physician determines that the respondent continues to meet the criteria of G.S. 122C-263(d)(2), the physician shall so notify the clerk of superior court of the county in which the area facility is located and the clerk shall schedule a rehearing and provide notice in accordance with G.S. 122C-276. If the court orders inpatient recommitment and the attending area facility physician determines that the criteria for conditional release set out in G.S. 122C-277(c) continue to exist, the attending physician shall continue the respondent on conditional release for a period not to exceed the period of inpatient commitment. Continuation of conditional release during a second or subsequent inpatient recommitment order shall not require the respondent's return to a 24-hour facility."

Section 3. Article 5 of Chapter 122C of the General Statutes is amended by adding the following new section to read:

"§ 122C-274.1. Supplemental hearings; conditional release.

(a) Upon receipt of a request for a supplemental hearing requested pursuant to G.S. 122C-273(e), the clerk shall calendar a hearing to be held within 10 days and shall notify, at least 72 hours before the hearing, the petitioner, the respondent, the respondent's attorney, and the area authority responsible for managing and supervising the respondent's conditional release. Notice shall be provided in accordance with G.S. 122C-264(c). The procedures for the hearing shall be in accordance with G.S. 122C-268.

(b) At the supplemental hearing, the court may make one of the following dispositions:

(1) If the court finds by clear, cogent, and convincing evidence that the respondent has violated conditions for release, it shall order the conditional release revoked.

(2) If the court finds by clear, cogent, and convincing evidence that the criteria for conditional release specified in G.S. 122C-277(c) are no longer met and that respondent continues to meet the criteria for inpatient commitment, the court shall order the conditional release revoked.

(3) If the court finds by clear, cogent, and convincing evidence that the respondent continues to meet the conditional release criteria specified in G.S. 122C-277(c) and that the respondent has not violated any condition for release, the court shall order the respondent released under a conditional release program recommended by the 24-hour facility and the designated area authority in accordance with G.S. 122C-277(d)."

Section 4. G.S. 122C-269(a) reads as rewritten:

"(a) In all cases where the respondent is held at a 24-hour facility pending hearing as provided in G.S. 122C-268, ~~G.S.~~ 122C-268.1, 122C-274.1, 122C-276.1, or 122C-277(b1), unless the respondent through counsel objects to the venue, the hearing shall be held in the county in which the facility is located. Upon objection to venue, the hearing shall be held in the county where the petition was initiated, except as otherwise provided in subsection (c) of this section."

Section 5. G.S. 122C-264(f) reads as rewritten:

"(f) Except as otherwise provided in this subsection, the ~~The~~ clerk of superior court of the county where inpatient commitment hearings and rehearings are held shall provide all notices, send all records and maintain a record of all proceedings as required by this ~~Part; provided that if~~ Part. If the respondent has been committed to a 24-hour facility in a county other than ~~his county of residence~~ the county where the petition was initiated and the district court hearing is held in the county of the facility, the clerk of superior court in the county of the facility shall forward the record of the proceedings to the clerk of superior court in the county ~~of respondent's residence,~~ where the petition was initiated, where they shall be maintained by

receiving clerk. If a respondent on conditional release has been returned to a 24-hour facility for a hearing under G.S. 274.1, and the records of the proceedings pertaining to the respondent's inpatient commitment hearings, rehearings, and supplemental hearings are maintained by the clerk of superior court of the county where the petition was initiated, then the clerk of superior court shall forward the record of the proceedings to the clerk of superior court in the county of the facility to which the respondent was returned, where they shall be maintained by the receiving clerk."

Section 6. G.S. 122C-264 is amended by adding the following new subsection to read:

"(g) If a respondent is conditionally released under G.S. 122C-273(e) and the conditional release will be supervised in a county other than the county where the petition was initiated, the court shall order venue for further court proceedings to be transferred to the county where the conditional release will be supervised. Upon an order changing venue, the clerk of superior court in the county where the petition was initiated shall transfer the file to the clerk of superior court of the county where the conditional release will be supervised."

Section 7. G.S. 122C-276(c) reads as rewritten:

"(c) Subject to the provisions of G.S. 122C-269(c) and G.S. 122C-273(e), rehearings shall be held at the facility in which the respondent is receiving treatment. The judge is a judge of the district court of the district court district as defined in G.S. 7A-133 in which the facility is located or a district court judge temporarily assigned to that district."

Section 8. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health the sum of seven hundred fifty-three thousand three hundred seventy dollars ($753,370) for the 1999-2000 fiscal year and the sum of three million one hundred sixty-four thousand four dollars ($3,164,004) for the 2000-2001 fiscal year to implement this act.

Section 9. This act becomes effective January 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 298

Short Title: Inpatient Commit./Condt'l Release/AB. (Public)

Sponsors: Representatives Hackney; Luebke, Gardner, and Goodwin.

Referred to: Mental Health, if favorable, Judiciary I.

March 4, 1999

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR THE MONITORING AND SUPERVISION OF PERSONS ON CONDITIONAL RELEASE FROM STATE PSYCHIATRIC HOSPITALS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 122C-277 reads as rewritten:

"**§ 122C-277. Inpatient commitment; release ~~Release~~ and conditional release; judicial review.**

(a) Except as provided in subsections ~~(b) and (b1)~~ (e) and (f) of this section, the attending physician shall discharge a committed respondent unconditionally at any time ~~he~~ the attending physician determines that the respondent ~~is~~ no longer meets the criteria for inpatient commitment specified in G.S. 122C-263(d)(2). ~~in need of inpatient commitment.~~ Notice of discharge shall be furnished to the clerk of superior court of the county of commitment and of the county in which the facility is located. However, if the attending physician determines that the respondent meets the criteria for outpatient commitment as defined in G.S. 122C-263(d)(1), ~~he~~ the attending physician may request the clerk to calendar a supplemental hearing to determine whether an outpatient commitment order shall be issued.

(b) Except as provided in subsections ~~(b) and (b1)~~ (e) and (f) of this section, the attending physician may also release a respondent conditionally on a trial visit for periods not in excess of 30 days on specified medically appropriate conditions. Violation of the conditions is grounds for return of the respondent to the releasing facility. A law-enforcement officer, on request of the attending physician, shall take a ~~conditional releasee~~ respondent on trial visit release into custody and return ~~him~~ the

respondent to the facility in accordance with G.S. 122C-205. Notice of ~~discharge and of conditional~~ trial visit release shall be furnished to the clerk of superior court of the county of commitment and of the county in which the facility is located.

(c) Except as provided in subsections (e) and (f) of this section, during a period of inpatient commitment the attending physician may release a respondent conditionally for a period of time not to exceed the remainder of the period of inpatient commitment if the attending physician determines all of the following:

(1) The respondent continues to meet the criteria of G.S. 122C-263(d)(2).

(2) The respondent's current mental status and behavior is stable and respondent is free of symptoms associated with previous episodes of dangerous conduct.

(3) Based on respondent's psychiatric history, there is a reasonable probability of future dangerous conduct if respondent is discharged to the community without continued treatment, supervision, and the assistance of others.

(4) Adequate treatment, supervision, and assistance for the respondent is available from the area authority that serves the community where respondent will reside upon release.

(5) Based on respondent's psychiatric history, there is a reasonable probability that respondent will not voluntarily seek or comply with recommended treatment upon release to the community unless adequate supervision and assistance are given pursuant to a conditional release plan developed in accordance with subsection (d) of this section.

(d) A respondent may be conditionally released pursuant to subsection (c) of this section only after an individualized outpatient treatment plan has been developed and an area authority has been designated to administer, and has agreed to provide, treatment in accordance with the treatment plan and with G.S. 122C-273(e). With the participation of the respondent, the treatment plan shall be jointly developed by the respondent's attending physician at the releasing facility and the area director, or the area director's designee, for the area authority that serves the community where the respondent will reside upon conditional release. With the consent of the respondent, and as part of the treatment planning process, the area authority shall consult with the respondent's next-of-kin or other family members on strategies designed to support respondent's continued mental stability and reduce the risk of future dangerous conduct. In addition to meeting the requirements of G.S. 122C-273(e), the treatment plan shall include, but need not be limited to, the following:

(1) Based upon an assessment of the respondent's psychiatric history and risk factors, requirements for treatment or services designed to reduce the respondent's risk for future dangerous conduct including, if any, requirements for medication, case management, supervision, and other services for the treatment of mental illness, developmental disabilities, or substance abuse.

(2) Based upon an assessment of the respondent's psychiatric history and risk factors, requirements if any, for assistance in obtaining basic needs such as employment, transportation, food, clothing, shelter, or other support services, when this assistance is necessary to reduce the respondent's risk for future dangerous conduct.

(3) Conditions that the respondent must meet to be eligible for continued conditional release and without which there exists a reasonable probability of future dangerous conduct, including, as applicable, such requirements as periodic reporting to treatment professionals at designated time intervals, continuation of medication, and abstention from alcohol and other drugs.

(4) The address of the residence where the respondent is to live upon conditional release and the name of the person in charge of the residence, if any.

Before conditional release, the attending physician of the releasing facility shall provide to the respondent or the respondent's legally responsible person a copy and full explanation of the treatment plan and conditions for release. With the consent of the respondent, a copy and full explanation of the treatment plan and conditions for release shall be provided to the respondent's next of kin. Notice of conditional release shall be furnished to the clerk of superior court of the county of commitment, the county where conditional release will be supervised, and of the county in which the 24-hour facility is located. The respondent's violation of conditions for release is grounds for return of the respondent to a 24-hour facility in accordance with G.S. 122C-273(e).

~~(b)~~ (e) If the respondent was initially committed as the result of conduct resulting in his being charged with a violent crime, including a crime involving an assault with a deadly weapon, and respondent was found incapable of proceeding, 15 days before the respondent's ~~discharge~~ discharge, trial visit, or conditional release the attending physician shall notify the clerk of superior court of the county in which the facility is located of his determination regarding the proposed ~~discharge~~ discharge, trial visit, or conditional release. The clerk shall then schedule a rehearing to determine the appropriateness of respondent's release under the standards of commitment set forth in G.S. 122C-271(b). The clerk shall give notice as provided in G.S. 122C-264(d). The district attorney of the district where respondent was found incapable of proceeding may represent the State's interest at the hearing.

~~(b1)~~ (f) If the respondent was initially committed pursuant to G.S. 15A-1321, 15 days before the respondent's ~~discharge~~ discharge, trial visit, or conditional release the attending physician shall notify the clerk of superior court. The clerk shall calendar a hearing and shall give notice as provided by G.S. 122C-264(d1). The district attorney for the original trial may represent the State's interest at the hearing. The hearing shall be conducted under the standards and procedures set forth in G.S. 122C-268.1. Provided, that in no event shall ~~discharge~~ discharge, trial visit, or conditional release under this section be allowed for a respondent during the period from automatic commitment to hearing under G.S. 122C-268.1.

~~(e)~~ (g) If a committed respondent under subsections (a), (b), ~~or (b1)~~ (c), (e), or (f) of this section is from a single portal area, the attending physician shall plan jointly with the area authority as prescribed in the area plan before discharging or releasing the respondent."

Section 2. G.S. 122C-273 is amended by adding the following new subsection to read:

"(e) Unless prohibited by Chapter 90 of the General Statutes, if the respondent on inpatient commitment is conditionally released in accordance with G.S. 122C-277(c) and (d), the area authority designated in the treatment plan, and any of its area facilities, may administer to the respondent reasonable and appropriate medication and treatment that are consistent with accepted medical standards. Before the respondent is conditionally released, the inpatient facility releasing the respondent shall provide a copy of the respondent's treatment plan and conditions for release to the area authority designated to administer the treatment plan. As a condition of release, and in addition to any other conditions required by G.S. 122C-277(d)(3), the initial treatment plan shall require the respondent to meet face-to-face with a responsible professional no less than once every 7 days to ensure that the respondent is complying with the conditions for release and is receiving treatment, supervision, and assistance necessary to prevent future dangerous conduct or the need for treatment in a 24-hour facility. All of the following apply to conditional release authorized under G.S. 122C-277(c) and (d) and this section.

(1) The medical director for the area authority shall require periodic reports concerning the condition of respondents on conditional release from any person assigned by the area authority to supervise a conditional release treatment plan. The medical director, or the medical director's designee, shall review the condition of a respondent on conditional release at least once every 30 days. In conducting the review, the medical director or the medical director's designee shall consider all reports and information received and may require the respondent to report for further evaluation.

(2) The area authority medical director, or the medical director's designee, may modify the treatment plan, including conditions for release, when modification is consistent with the requirements of G.S. 122C-277(d). The respondent shall be involved in and informed of any changes to the treatment plan and conditions of release. A copy of the modified treatment plan shall be placed in the respondent's medical record and copies shall be provided to the respondent and any other persons who received copies of the initial treatment plan in accordance with G.S. 122C-277(d).

(3) Notwithstanding the respondent's compliance with the conditions for release, at any time that the area facility finds that conditional release is no longer appropriate and the respondent is in need of inpatient treatment, the area facility responsible for managing and

supervising the respondent's treatment shall request the court to order the respondent taken into custody for the purpose of transportation to a 24-hour facility designated by the area facility. Upon receipt of this request, the clerk or magistrate shall issue an order to a law enforcement officer to take the respondent into custody and to take the respondent immediately to the designated 24-hour facility. Transportation to the 24-hour facility shall be provided as specified in G.S. 122C-251. Within 24 hours of arrival at the 24-hour facility, the respondent shall be examined by a physician who shall act in accordance with the procedures specified in G.S. 122C-266. If the respondent meets the criteria of G.S. 122C-266(a)(1), the 24-hour facility shall notify the clerk of court for the county in which the 24-hour facility is located and request a supplemental hearing as specified in G.S. 122C-274.1.

(4) If the respondent violates a condition of release, and unless compliance is obtained within 24 hours of the violation, the area facility responsible for management and supervision of the respondent's treatment shall immediately request the court to order the respondent taken into custody for the purpose of examination. Upon receipt of this request, the clerk or magistrate shall issue an order to a law enforcement officer to take the respondent into custody and to take the respondent immediately to the designated area facility for examination. The law enforcement officer shall turn the respondent over to the custody of the area facility for examination by a physician or eligible psychologist. Upon examination, if efforts to solicit compliance with conditions for release are successful and the respondent is not in need of treatment in a 24-hour facility, the respondent shall be released and returned home after the examination. If efforts to solicit compliance with conditions for release fail or the physician or eligible psychologist determines that conditional release is no longer appropriate and the respondent needs inpatient treatment, the law enforcement officer shall transport the respondent to a 24-hour facility designated by the area facility. Transportation to the 24-hour facility shall be provided as specified in G.S. 122C-251. Within 24 hours of arrival at the 24-hour facility, the respondent shall be examined by a physician who shall act in accordance with the procedures specified in G.S. 122C-266. If the respondent meets the criteria of G.S. 122C-266(a)(1), the 24-hour facility shall notify the clerk of court for the county in which the 24-hour facility is located and request a supplemental hearing as specified in G.S. 122C-274.1.

(5) When an area authority physician seeks the return of the respondent to an inpatient facility, the physician shall document

and report grounds for the return to the inpatient facility and the clerk of superior court of the county where the conditional release is being supervised.

(6) Except as otherwise provided in this subdivision, during any period of conditional release, if the area facility determines that the respondent no longer meets the criteria set out in G.S. 122C-263(d)(2), the area facility shall notify the court and the case shall be terminated. If the respondent was initially committed as a result of conduct resulting in the respondent being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found incapable of proceeding, the designated area facility shall so notify the clerk of superior court of the county in which the area facility is located and the clerk shall schedule a rehearing and provide notice in accordance with G.S. 122C-276. If the respondent was initially committed pursuant to G.S. 15A-1321, the area facility shall so notify the clerk of superior court of the county in which the area facility is located and the clerk shall schedule a rehearing and provide notice in accordance with G.S. 122C-276.1.

(7) Fifteen days before the end of the initial or subsequent periods of commitment for a respondent on conditional release, the attending area facility physician shall review and evaluate the condition of the respondent. If the physician determines that the respondent continues to meet the criteria of G.S. 122C-263(d)(2), the physician shall so notify the clerk of superior court of the county in which the area facility is located and the clerk shall schedule a rehearing and provide notice in accordance with G.S. 122C-276. If the court orders inpatient recommitment and the attending area facility physician determines that the criteria for conditional release set out in G.S. 122C-277(c) continue to exist, the attending physician shall continue the respondent on conditional release for a period not to exceed the period of inpatient commitment. Continuation of conditional release during a second or subsequent inpatient recommitment order shall not require the respondent's return to a 24-hour facility."

Section 3. Article 5 of Chapter 122C of the General Statutes is amended by adding the following new section to read:

"**§ 122C-274.1. Supplemental hearings; conditional release.**

(a) Upon receipt of a request for a supplemental hearing requested pursuant to G.S. 122C-273(e), the clerk shall calendar a hearing to be held within 10 days and shall notify, at least 72 hours before the hearing, the petitioner, the respondent, the respondent's attorney, and the area authority responsible for managing and supervising the respondent's conditional release. Notice shall be provided in

accordance with G.S. 122C-264(c). The procedures for the hearing shall be in accordance with G.S. 122C-268.

(b) At the supplemental hearing, the court may make one of the following dispositions:

(1) If the court finds by clear, cogent, and convincing evidence that the respondent has violated conditions for release, it shall order the conditional release revoked.

(2) If the court finds by clear, cogent, and convincing evidence that the criteria for conditional release specified in G.S. 122C-277(c) are no longer met and that respondent continues to meet the criteria for inpatient commitment, the court shall order the conditional release revoked.

(3) If the court finds by clear, cogent, and convincing evidence that the respondent continues to meet the conditional release criteria specified in G.S. 122C-277(c) and that the respondent has not violated any condition for release, the court shall order the respondent released under a conditional release program recommended by the 24-hour facility and the designated area authority in accordance with G.S. 122C-277(d)."

Section 4. G.S. 122C-269(a) reads as rewritten:

"(a) In all cases where the respondent is held at a 24-hour facility pending hearing as provided in G.S. 122C-268, ~~G.S.~~ 122C-268.1, 122C-274.1, 122C-276.1, or 122C-277(b1), unless the respondent through counsel objects to the venue, the hearing shall be held in the county in which the facility is located. Upon objection to venue, the hearing shall be held in the county where the petition was initiated, except as otherwise provided in subsection (c) of this section."

Section 5. G.S. 122C-264(f) reads as rewritten:

"(f) Except as otherwise provided in this subsection, the ~~The~~ clerk of superior court of the county where inpatient commitment hearings and rehearings are held shall provide all notices, send all records and maintain a record of all proceedings as required by this ~~Part; provided that if~~ Part. If the respondent has been committed to a 24-hour facility in a county other than ~~his~~ the respondent's county of residence and the district court hearing is held in the county of the facility, the clerk of superior court in the county of the facility shall forward the record of the proceedings to the clerk of superior court in the county of respondent's residence, where they shall be maintained by receiving clerk. If a respondent on conditional release has been returned to a 24-hour facility for a hearing under G.S. 274.1, and the records of the proceedings pertaining to the respondent's inpatient commitment hearings, rehearings, and supplemental hearings are maintained by the clerk of superior court of the county of the respondent's residence, then the clerk of superior court shall forward the record of the proceedings to the clerk of superior court in the county of the facility to which the respondent was returned, where they shall be maintained by the receiving clerk."

Section 6. G.S. 122C-210.1 reads as rewritten:

"**§ 122C-210.1. Immunity from liability.**

No facility or any of its officials, staff, or employees, or any physician or other individual who is responsible for the custody, examination, management, supervision, treatment, or release of a client and who in good faith follows accepted professional judgment, practice, and standards is civilly liable, personally or otherwise, for actions arising from these responsibilities or for actions of the client. This immunity is in addition to any other legal immunity from liability to which these facilities or individuals may be entitled and applies to actions performed in connection with, or arising out of, the admission or commitment of any individual pursuant to this Article."

Section 7. G.S. 122C-276(c) reads as rewritten:

"(c) Subject to the provisions of G.S. 122C-269(c) and G.S. 122C-273(e), rehearings shall be held at the facility in which the respondent is receiving treatment. The judge is a judge of the district court of the district court district as defined in G.S. 7A-133 in which the facility is located or a district court judge temporarily assigned to that district."

Section 8. This act becomes effective January 1, 2000. Section 6 of this act applies to actions taken on or after the effective date of this act.

HOUSE BIL 298:
Inpatient Commit./Condt'l Release/AB.

BILL ANALYSIS

Committee:	House Mental Health	**Introduced by:**	Rep. Hackney
Date:	April 13, 1999	**Summary by:**	Kory Goldsmith
Version:	H298-CSRC-001		Committee Counsel

SUMMARY: ***HB298 amends the mental health commitment laws to allow the conditional release of respondents who are currently stable but: mentally ill; dangerous to themselves or others; likely to engage in future dangerous conduct if discharged without continued treatment; and unlikely to seek or comply with recommended treatment. An respondent who is conditionally released would have to comply with a conditional release plan, and could be taken into custody without a hearing. The bill also appropriates $753,370 for fiscal year 1999-2000, and $3,164,004 for fiscal year 2000-2001.***

CURRENT LAW: An respondent who is subject to inpatient commitment because they are mentally ill and dangerous to themselves and others may be released from inpatient commitment as follows: (1) the attending physician determines the respondent is no longer mentally ill and dangerous to themselves and others: (2) the attending physician determines the respondent meets the criteria for outpatient commitment; or (3) the attending physician allows a temporary, conditional release that may not exceed 30 days. An respondent who has been unconditionally discharged can not be re-committed without a hearing.

BILL ANALYSIS: HB 298 creates a long-term conditional release from inpatient commitment. In order to be eligible for conditional release, the following must apply: (1) the respondent must be mentally ill and dangerous to themselves or others; (2) the respondent must be currently stable and free from symptoms related to previous episodes of dangerous behavior; (3) there must be a reasonable probability that the respondent will engage in future dangerous behavior is discharged without continued supervision and treatment; (4) adequate treatment, supervision, and support is available from the area authority that serves the community where the respondent will be released; and (5) there is a reasonable probability the respondent will not voluntarily seek or comply with recommended treatment upon release unless given adequate supervision and assistance. No hearing is required prior to the conditional release unless the respondent was initially committed because of conduct that resulted in the respondent being charged with a violent crime and the respondent also was found incapable of proceeding or unless the respondent was initially committed because the respondent was found not guilty by reason of insanity and was also found incapable of proceeding. Notice of the conditional release must be provided to the clerk of superior court of the county where the petition to commit the respondent was initiated, the county where the conditional release will be supervised, and the county where the 24-hour facility is located.

The respondent may be released only after an respondentized outpatient plan has been developed and an area mental health authority has agreed to provide treatment under the plan. The plan must include: requirements for treatment or services designed to reduce the respondent's risk for future dangerous conduct; the respondent's requirements for assistance in obtaining basic needs; periodic reporting to treatment professionals; continuation of medication; abstention from alcohol and other drugs; and the address where the respondent will live while on conditional release. The respondent also must meet at least once every 7 days with a responsible professional to ensure that the respondent is receiving the

treatment, supervision,and assistance necessary to prevent future dangerous behavior. In addition to administering the conditional release plan, the medical director of the area authority must provide for a monthly review of all respondents on conditional release and assigned to that area authority. The medical director may modify the conditional release plan.

An respondent who violates the conditionals for release may be returned to a 24-hour facility without a hearing. The respondent also may be taken into custody and returned to a 24-hour facility if the area authority finds that conditional release is no longer appropriate. A physician shall examine the respondent. If the physician finds the respondent is mentally ill and dangerous to himself or others, the 24-hour facility shall notify the clerk of court for the county in which the 24-hour facility is located and request a supplemental hearing. The court shall revoke the conditional release if it finds by clear, cogent, and convincing evidence that: (1) the respondent violated the conditional release; or (2) the criteria for conditional release are no longer met and the respondent meets the criteria for inpatient commitment.

The area mental health authority also may order the respondent taken into custody and examined if the respondent violates the conditional release and refuses to come into compliance. The respondent shall be released if after the examination, the physician determines the respondent is not in need of treatment in a 24-hour facility and the respondent agrees to come into compliance with the terms of the conditional release. If the respondent will not agree to come into compliance, or if the physician determines the respondent is in need of treatment in a 24-hour facility, then the 24-hour facility shall notify the clerk of court for the county in which the 24-hour facility is located and request a supplemental hearing. The court shall revoke the conditional release if it finds by clear, cogent, and convincing evidence that: (1) the respondent violated the conditional release; or (2) the criteria for conditional release are no longer met and the respondent meets the criteria for inpatient commitment.

If the area authority finds that an respondent on conditional release is no longer mentally ill and dangerous to self or other, the area authority shall notify the court and the case shall be terminated.

Fifteen days before the end of the conditional release, the attending area facility physician shall review and evaluate the condition of the respondent. If the respondent continues to be mentally ill and dangerous to self and others, the physician shall notify the clerk of superior court in the county where the area facility is located and the clerk shall schedule a rehearing. If the court orders inpatient recommitment and the attending physician determines the respondent is eligible for conditional release, the attending physician shall continue the respondent on conditional release for a period not to exceed the period of inpatient commitment.

The bill appropriates $753,370 for fiscal year 1999-2000, and $3,164,004 for fiscal year 2000-2001.

The bill becomes effective January 1, 2000.

The bill should be re-referred to Appropriations.

H298-SMRC-001

UBLIC BILL

H.B. 0208

SESSION LAW _____

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR THE MONITORING AND SUPERVISION OF PERSONS ON CONDITIONAL RELEASE FROM STATE PSYCHIATRIC HOSPITALS.

Introduced by Representative(s) Hackney Gardner Fulk Goodwin

Principal Clerk's Use Only

PASSED 1st READING
MAR 4 1999
AND REFERRED TO COMMITTEE
ON Mental Health,
Favorable, Judiciary I

HOUSE COMMITTEE ON MENTAL HEALTH

APRIL 20, 1999
10:00 a.m.
Room 415

AGENDA

Chair: Rep. Wayne Goodwin

HB 972 Transportation Costs/Involuntary Commitment

Susan Robinson Child & Family Services

MINUTES
HOUSE COMMITTEE ON MENTAL HEALTH
APRIL 20, 1999

The House Committee on Mental Health met on Tuesday, April 20, 1999 in Room 415 of the Legislative Office Building at 10:00 a.m. The following members were present: Chairman Wayne Goodwin, Representatives Crawford, Esposito, Horn, Insko, McAllister, Nye, Oldham, and Warwick. Linda Attarian and Kory Goldsmith, staff counselors, attended. A visitor registration list is attached and made part of these minutes. Chairman Goodwin introduced the pages for the day.

HB 972 A BILL TO BE ENTITLED AN ACT TO PROVIDE THAT THE COST AND EXPENSES OF TRANSPORTING A RESPONDENT IN AN INVOLUNTARY COMMITMENT PROCEEDING MAY BE RECOVERED FROM THE RESPONDENT'S COUNTY OF RESIDENCE. Chairman Goodwin introduced Rep. Insko to present and explained the purpose of the bill. Rep. Esposito asked for data on expenses incurred by counties. Rep. Oldham moved for a favorable report, Rep. Warwick seconded, and the motion passed.

Chairman Goodwin introduced Susan Robinson to give an overview of the Child and Family Services Section of the Division of MH/DD/SAS (3 handouts). Ms. Robinson discussed the current initiatives of the section and provided data on meeting the mental health needs of children and youth ages birth to 18. Reps. Nye and Esposito asked for additional data on the increase of clients in the last year, the kinds of services provided, and reason for the increase. Rep. McAllister asked for further information on cultural competence. The agency will provide that information at the next meeting.

Chairman Goodwin adjourned the meeting at 10:50.

Respectfully submitted,

Representative Wayne Goodwin
Chairman

Linda S. Winstead
Committee Assistant

VISITOR REGISTRATION SHEET

MENTAL HEALTH — Name of Committee

4-20-99 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mary Eldridge	Div MH, DD, SAS - Crisis Services
Don Willis	" " " " "
Susan Robinson	DMHDDSAS - Child Branch
Terry Stella	DMHDDSAS
MICHELLE COTTON	DMH/DD/SAS
Alex Myers	NCPA, Murdoch Center
Beth Melchor	NAMI NC
[illegible]	MHA INC
Ron Brock	NCACC
Dwight Spencer	Tarheel Behavioral Associates
Kevin Howell	Governor's Office

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Reps. Jim Crawford and Wayne Goodwin** for the Committee on **Mental Health**.

☐ Committee Substitute for
H.B. 972 A BILL TO BE ENTITLED AN ACT TO PROVIDE THAT THE COST AND EXPENSES OF TRANSPORTING A RESPONDENT IN AN INVOLUNTARY COMMITMENT PROCEEDING MAY BE RECOVERED FROM THE RESPONDENT'S COUNTY OF RESIDENCE

☒ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report as to committee substitute bill (#), ☐ which changes the title, unfavorable as to (original bill) (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

2/24/99

FOR JOURNAL USE ONLY

____ Pursuant to Rule 36(b), the bill is placed on the Calendar of _____.

____ The (committee substitute) bill/resolution (, as amended,) is (ordered engrossed and) re-referred to the Committee on _____.

____ The bill/resolution is re-referred to the Committee on _____.

____ On motion of (Rep. _____,) (the Chair,) the (committee substitute) bill/resolution is (ordered engrossed and) re-referred to the Committee on _____.

____ Pursuant to Rule 36(b), the (House)committee substitute bill (No. ____)/resolution is placed on the Calendar of _____. (The original bill) (House Committee Substitute Bill No. ____)/resolution is placed on the Unfavorable Calendar.

____ On motion of Rep. _____, (the rules are suspended) (Rule ____ is suspended) and the bill/resolution is placed on today's calendar. (for immediate consideration.)

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ On motion of Rep. _____, Committee Amendment No.(s) _____ is/are adopted (by EV____ ____).

____ Rep. _____ offers Amendment No. _____ which (is adopted.) (fails of adoption.) (by EV ____ ____.) ( ) This amendment changes the title.

____ The bill/resolution (, as amended,) passes its second reading (by following vote, ____ ____ RC) (, by EV ____ ____,) and (remains on the Calendar,) (and there being no objection is read a third time).

____ The bill/resolution (, as amended,) passes its third reading (by the following vote, ____ ____ RC) (, by EV ____ ____,) and is ordered
____ sent to the Senate.
____ without engrossment. ____ by Special message.
____ sent to the Senate for concurrence in
_____ House amendment (s).
_____ House committee substitute.
____ enrolled.

____ On motion of Rep. _____, the House concurs in the (material) Senate _____ (by the following vote, ____ ____ RC) (, by EV ____ ____,) and the bill is ordered enrolled.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 972*

Short Title: Transp. Costs/Invol. Commitment. (Public)

Sponsors: Representatives Insko and Hackney.

Referred to: Mental Health.

April 12, 1999

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT THE COST AND EXPENSES OF TRANSPORTING A RESPONDENT IN AN INVOLUNTARY COMMITMENT PROCEEDING MAY BE RECOVERED FROM THE RESPONDENT'S COUNTY OF RESIDENCE.

The General Assembly of North Carolina enacts:

Section 1. G.S. 122C-251(h) reads as rewritten:

"(h) The cost and expenses of transporting a respondent to or from a 24-hour facility is the responsibility of the county of residence of the respondent. The State (when providing transportation under G.S. 122C-408(b)), a city, or a county is entitled to recover the reasonable cost of transportation from ~~either (i) the respondent or some other individual liable for his support and maintenance, if there is property sufficient to pay the cost; or (ii) the county of residence of an indigent respondent.~~ the county of residence of the respondent. The county of residence of the respondent shall reimburse the State, another county, or a city the reasonable transportation costs incurred as authorized by this subsection. The county of residence of the respondent is entitled to recover from its resident respondent or some other individual liable for the resident respondent's support and maintenance if there is property sufficient to pay the cost, unless its resident respondent is indigent, the reasonable cost of transportation that it has paid to another county."

Section 2. This act is effective when it becomes law.

HOUSE BILL 972:
Transportation Costs/Invol. Committment

BILL ANALYSIS

Committee: House Mental Health
Date: April 18, 1999
Version: 1

Introduced by: Reps. Insko and Hackney
Summary by: Linda Attarian
Committee Counsel

SUMMARY: ***House Bill 972 provides that the State, counties, and cities may recover the costs and expenses of transporting respondents under involuntary mental health or substance abuse commitment proceedings, including admissions and discharges, from the respondent's county of residence.***

CURRENT LAW: G.S. 122C-151 sets forth the current law pertaining to issues concerning transportation of respondents to or from 24-hour facilities. A "24-hour facility" is defined as a facility that provides a structured living environment and services for a period of 24 consecutive hours or more and includes hospitals that provide mental health and substance abuse services. A "respondent" is the individual who is the subject of the involuntary mental health or substance abuse commitment proceeding.

The general rules of law include:

1. If the 24-hour facility is within the respondent's county of residence:

- The *city* must transport the respondent to or from (i.e. admission and discharge) a 24-hour facility if the respondent is a resident of the city or the respondent was taken into custody within the city limits.
- The *county of residence* must transport the respondent to or from a 24-hour facility if the respondent resides outside the city limits or was taken into custody outside the limits of the respondent's city of residence.

2. If the 24-hour facility is not within the respondent's county of residence:

- The *county where the respondent was taken into custody* shall provide transportation for admission to the 24-hour facility.
- The *respondent's county of residence* shall provide transportation for discharge from the 24-hour facility.

3. The costs and expenses associated with transporting a respondent to or from a 24-hour facility are the responsibility of the *respondent's county of residence*.
4. Under G.S. 122C-408, special police officers at Camp Butner (a Division of the NC Department of Crime Control and Public Safety) are authorized to transport individuals transferred to or from any State facility within a specified territorial jurisdiction (areas surrounding Camp Butner) to or from the psychiatric service of the University of North Carolina Hospitals at Chapel Hill.

The following is the text of G.S. 122C-252, with the key provisions bolded for your reference.

(a) **Except as provided in subsections (f) and (g), transportation of a respondent within a county under the involuntary commitment proceedings of this Article, including admission and discharge, shall be provided by the city or county.** The city has the duty to provide transportation of a respondent who is a resident of the city or who is taken into custody in the city limits. The county has the duty to provide transportation for a respondent who resides in the county outside city limits or who is taken into custody outside of city limits. However, cities and counties may contract with each other to provide transportation.

(b) **Except as provided in subsections (f) and (g) or in G.S. 122C-408(b), transportation between counties under the involuntary commitment proceedings of this Article for admission to a 24-hour facility shall be provided by the county where the respondent is taken into custody.** Transportation between counties under the involuntary commitment proceedings of this Article for respondents held in 24-hour facilities that have requested a change of venue for the district court hearing shall be provided by the county where the petition for involuntary commitment was initiated. **Transportation between counties under the involuntary commitment proceedings of this Article for discharge of a respondent from a 24-hour facility shall be provided by the county of residence of the respondent. However, a respondent being discharged from a facility may use his own transportation at his own expense.**

(c) **Transportation of a respondent may be by city- or county-owned vehicles or by private vehicle by contract with the city or county.** To the extent feasible, law enforcement officers transporting respondents shall dress in plain clothes and shall travel in unmarked vehicles. Further, law enforcement officers, to the extent possible, shall advise respondents when taking them into custody that they are not under arrest and have not committed a crime, but are being transported to receive treatment and for their own safety and that of others.

(d) In providing transportation of a respondent, **a city or county shall provide a driver or attendant who is the same sex as the respondent,** unless the law-enforcement officer allows a family member of the respondent to accompany the respondent in lieu of an attendant of the same sex as the respondent.

(e) In providing transportation required by this section, the law-enforcement officer may use reasonable force to restrain the respondent if it appears necessary to protect himself, the respondent, or others. No law-enforcement officer may be held criminally or civilly liable for assault, false imprisonment, or other torts or crimes on account of reasonable measures taken under the authority of this Article.

(f) **Notwithstanding the provisions of subsections (a), (b), and (c) of this section, a clerk, a magistrate, or a district court judge, where applicable, may authorize the family or immediate friends of the respondent, if they so request, to transport the respondent in accordance with the procedures of this Article.** This authorization shall only be granted in cases where the danger to the public, the family or friends of the respondent, or the respondent himself is not substantial. **The family or immediate friends of the respondent shall bear the costs of providing this transportation.**

(g) The governing body of a city or county may adopt a plan for transportation of respondents in involuntary commitment proceedings in this Article. **Law-enforcement personnel, volunteers, or other public or private agency personnel may be designated to provide all or parts of the transportation required by involuntary commitment proceedings.** Persons so designated shall be trained and the plan shall assure adequate safety and protections for both the public and the respondent. Law enforcement, other affected agencies, and the area authority shall participate in the planning. If any person other than a law-enforcement agency is designated by a city or county, the person so designated shall provide the transportation and follow the procedures in this Article. References in this Article to a law-enforcement officer apply to this person.

(h) **The cost and expenses of transporting a respondent to or from a 24-hour facility is the responsibility of the county of residence of the respondent. The State (when providing transportation under G.S. 122C-408(b)), a city, or a county is entitled to recover the reasonable cost of transportation from either (i) the respondent or some other individual liable for his support and**

maintenance, if there is property sufficient to pay the cost; or (ii) the county of residence of an indigent respondent.

BILL ANALYSIS:

Section 1 amends G.S. 122C-151(h) to specify that the respondent's county of residence must reimburse the State, another county, or a city that provides transportation to or from 24-hour facilities pursuant to the provisions of the statute. The respondent's county of residence may recover the costs it paid to another county from the respondent or some other individual liable for the respondent's support, unless the respondent is indigent.

Section 2: Effective date: When the bill becomes law.

BACKGROUND:

The current law is clear as to whom or which governmental entity is responsible for the transportation needs of respondents under commitment proceedings. It is also clear that the respondent's county of residence is responsible for the *costs* incurred when transporting respondents to or from 24-hour facilities. However, the law does not provide guidance or any mandates as to how governmental entities can obtain reimbursements from the respondent's county of residence for those costs. The bill proposes to close this gap in the law.

Child and Family Services Section
Division of MH/DD/SAS

Mission/Purpose

The mission of the Child and Family Services Section is to ensure the continued growth and development of local systems of care which provide cost effective, individualized mental health services in the context of coordinated efforts with other agencies to meet the comprehensive needs of children and their families. A primary emphasis is to ensure that appropriate services are provided to children who have or are at risk of developing SED and to their families as outlined in the NC Child Mental Health Plan.

Overview of Section

The Child and Family Services Section provides supervision and support to the 40 Area Programs in their efforts to provide individualized, family-centered services to children ages birth to 18 years of age with mental health service needs and directly provides residential treatment services to children ages 5-12 and 13-17 years. Through the support of this Section, over 76,000 children and their families were served in SFY 1998 by the Area Programs.

The Child and Family Services Section of the Division provides a conglomerate of administrative and technical assistance to Area Programs. Section programming is provided in five broad areas: Early Intervention (EI), Serious Emotional Disturbances (SED), Demonstration Projects which include cooperative relationships with university research and training centers (known as Public Academic Liaisons or PALs), residential treatment, and training provided through the System of Care Institute.

Current Initiatives

Family Involvement in the Implementation of the Child Mental Health Plan:

Families are key to meeting the challenge to build capacity throughout North Carolina's human services, educational and juvenile justice agencies to develop a 'System of Care' that integrates an array of services to treating and meeting the complex needs of children suffering from mental and emotional disturbances. A key component of effective treatment provided to children in need of mental health services is the involvement of their family. As directed by Child and Family Services program treatment methodology, family members participate in planning of services for their children. To ensure that the needs of the family and the child are being met and responded to in a judicious manner, the Section works closely with organizations and advocacy groups who have a primary interest in child mental health. These groups include the Alliance for the Mentally Ill, the Mental Health Association, Families CAN, the Child Advocacy Institute, the Covenant for Children, Coalition 2000, and parent support groups in local communities.

System of Care Institute and Program Implementation:

In collaboration with staff from the Jordan Institute on Families and Children at the UNC Chapel Hill School of Social Work are conducting System of Care Institutes for Area Program staff. As a result of these institutes, Area Programs in partnership with other child-serving agencies will implement broad-based community services for children with or at-risk for SED and their families based on System of Care principles. Demonstration programs such as PEN-PAL and FACES are providing technical assistance for the development of community systems of care.

Public Academic Liaisons (PALs) with East Carolina University, UNC-Charlotte, UNC-Asheville, Appalachian State University, Mars Hill College, and UNC-Greensboro are instrumental to the development of pre-service and inservice curricula.

Collaborative Efforts in Providing Support to Children in DSS Custody:
In collaboration with the Division of Social Services, this Section is developing programs for comprehensive screening of all children in DSS custody in order to identify and provide necessary mental health treatment and related services. A system response is being developed both at the state and community levels in order to improve the health and well-being of these children. Related collaborative efforts with the Division of Social Services are addressing joint staff training and the development of a culturally competent system of care for children and their families served by both agencies.

Cultural Competence Initiative:
In collaboration with the Division of Social Services and staff from the Jordan Institute on Families and Children at the UNC Chapel Hill School of Social Work, have formed a Task Force on Cultural Competence comprised of public and private agencies as well as family members and advocates. The Task Force is charged with developing a plan and identifying models for implementing best practices in providing services to children and families which reflect cultural competence in the areas of personnel, training, staff development, outreach and community partnerships, service delivery, and quality improvement.

Early Intervention Mental Health Training Initiative:
In collaboration with the Children's Mental Health Project at the UNC Chapel Hill School of Social Work, have established a jointly funded position to provide infant mental health training, technical assistance and consultation to Area Programs and communities addressing the mental health needs of children with or at-risk for atypical development and their families.

Sexually Aggressive Youth (SAY) Initiative:
The Child and Family Services Section sponsors training opportunities for child-serving agencies who serve sexually aggressive youth (SAY). A special task force made up of mental health providers and a representative from the Administrative Office of the Court is writing a treatment guide for the special assessment and treatment of sexually aggressive youth. Upon completion, it will be distributed through workshops to all child-serving professionals who work with this special population of SAY. Annually, the section sponsors a training conference that addresses a wide variety of treatment concerns; this year the partnership between juvenile justice and mental health will be highlighted.

Criterion #5:
Criterion #5 of the NC Medicaid Criteria for Continued Inpatient Stay in a Psychiatric Facility (10NCAC 26B.011) became effective January 1, 1999. The rule establishes the conditions under which Medicaid clients are eligible for continued stay in a psychiatric hospital for acute inpatient care and for non-acute services. Under Criterion #5, reimbursement may be used for continued non-acute hospital services when an area program has found that appropriate discharge services are not available for a client who is no longer acute. Criterion #5 is targeted to children through the age of 17.

Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

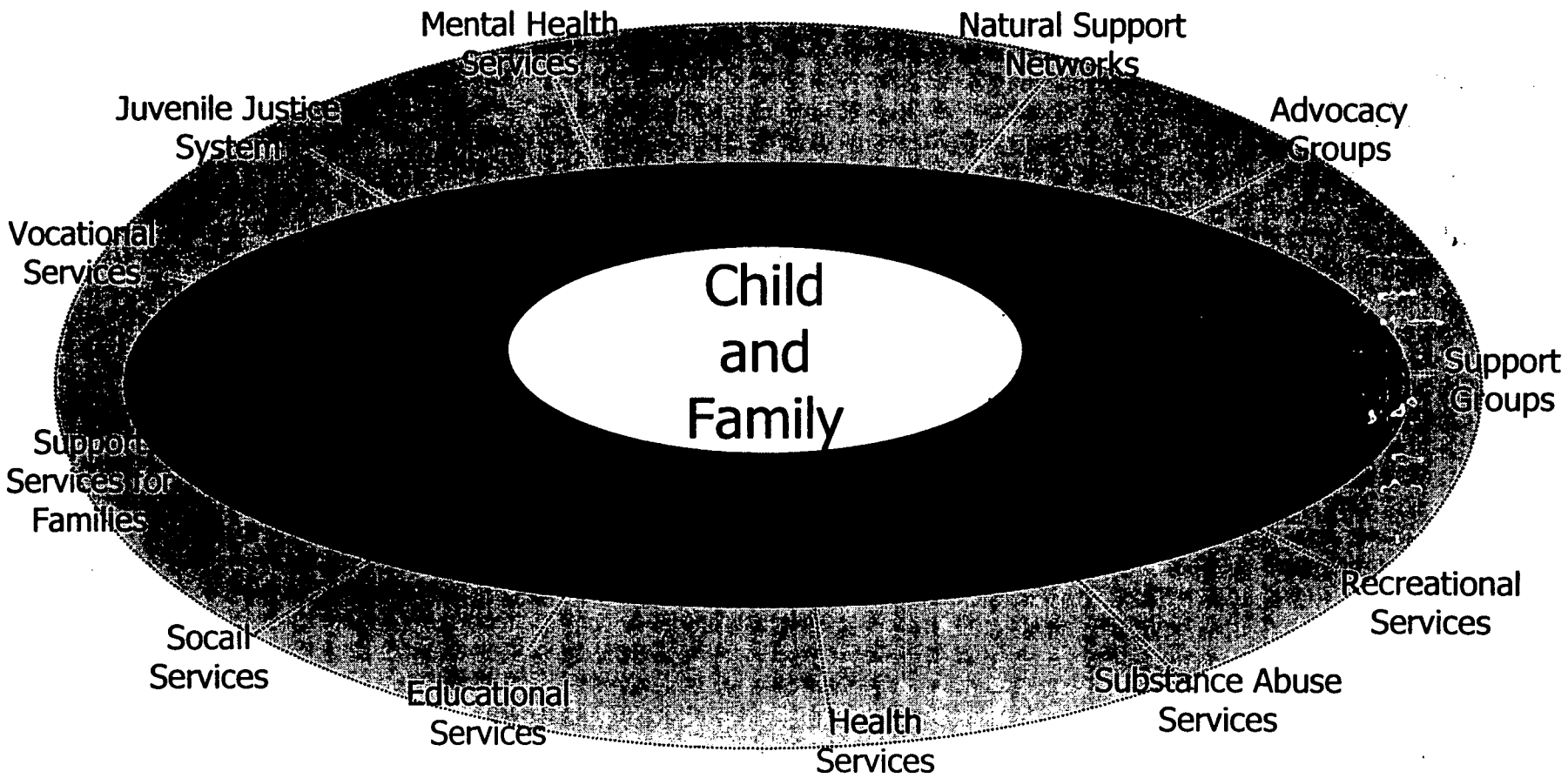
Child and Family Services Section

Lenore Behar, Ph.D.

Chief

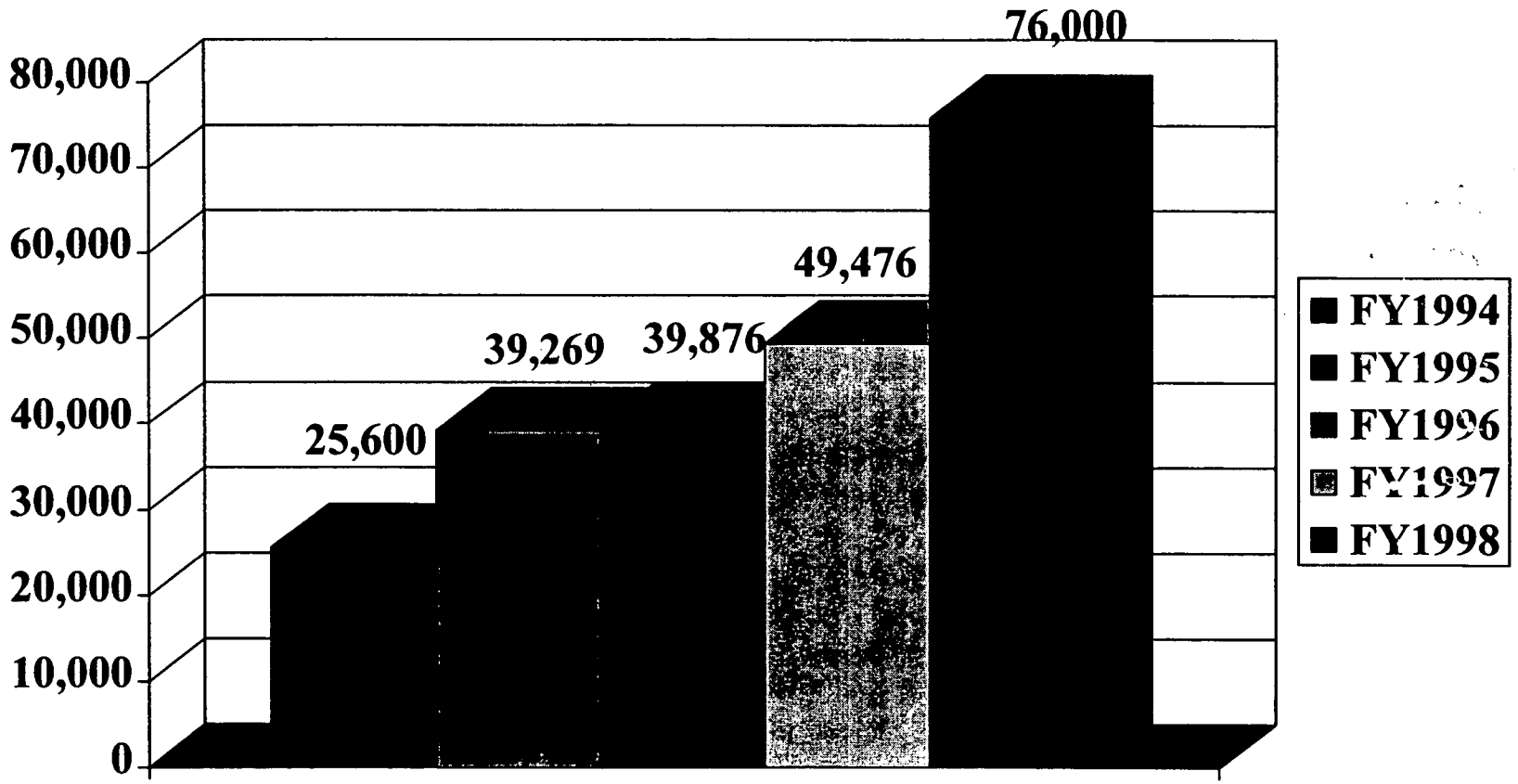
#2

Service Network to Meet Mental Health Needs of Children and Adolescents and Their Families



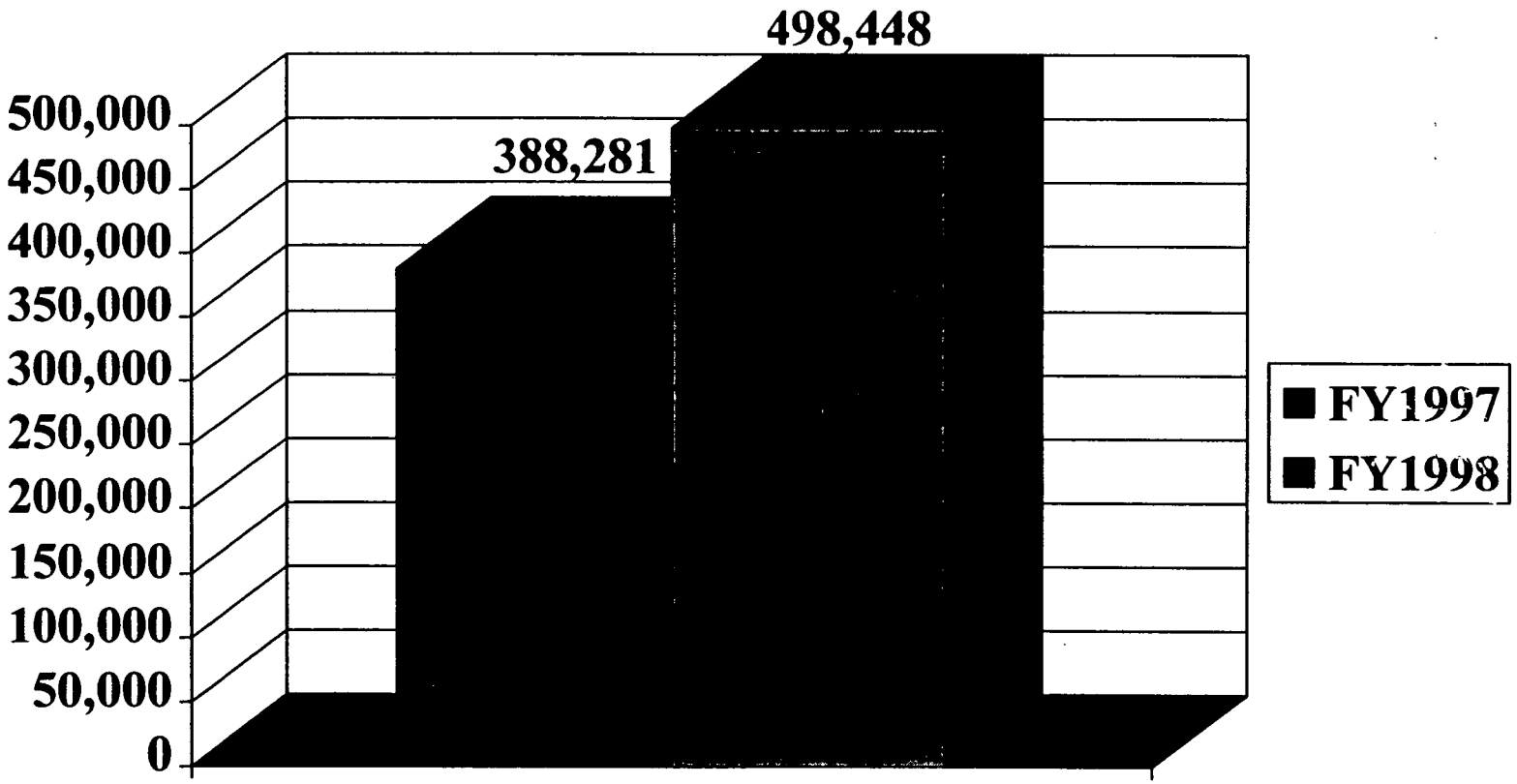
DMH/DD/SAS, Child and Family Services

Number of Children and Adolescents Receiving Services from Area Programs



DMH/DD/SAS, Child and Family Services

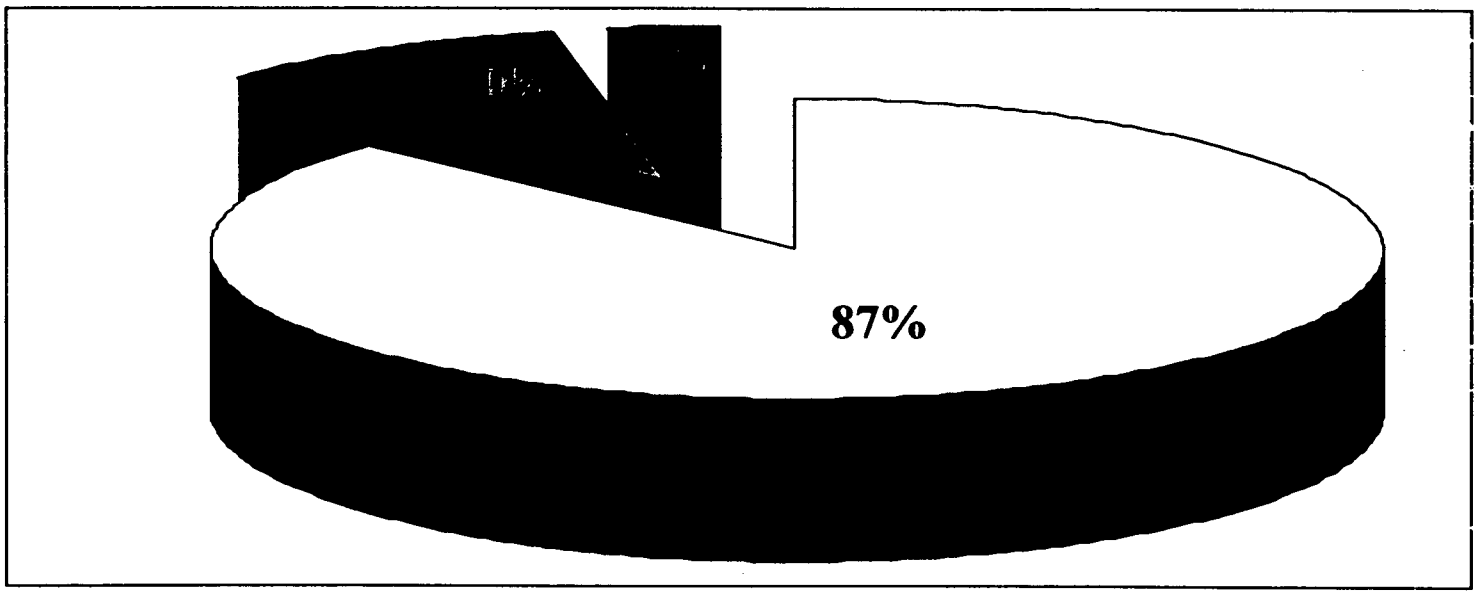
Units of Case Management Provided to Children and Adolescents in Area Programs



Unit = 15 minutes

DMH/DD/SAS, Child and Family Services

Level of Severity of Children Served by Area Programs During FY98



DMH/DD/SAS, Child and Family Services Section

A report from:

Duke University Medical Center

Department of Psychiatry and Behavioral Sciences

E. Jane Costello, Ph.D.

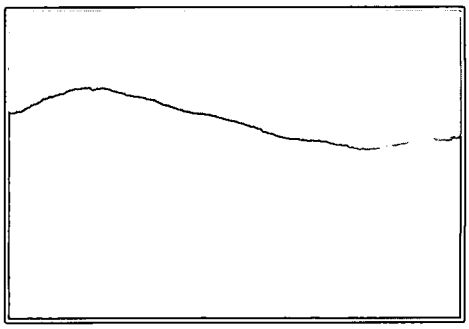
Adrian Angold, M.R.C.Psych.

Barbara J. Burns, Ph.D.

and

North Carolina State Division of Developmental Disabilities, Mental Health, and Substance Abuse Services

Lenore Behar, Ph.D.



Improving Mental Health Services for Children in North Carolina

Why does North Carolina need to be concerned with mental health services for children?

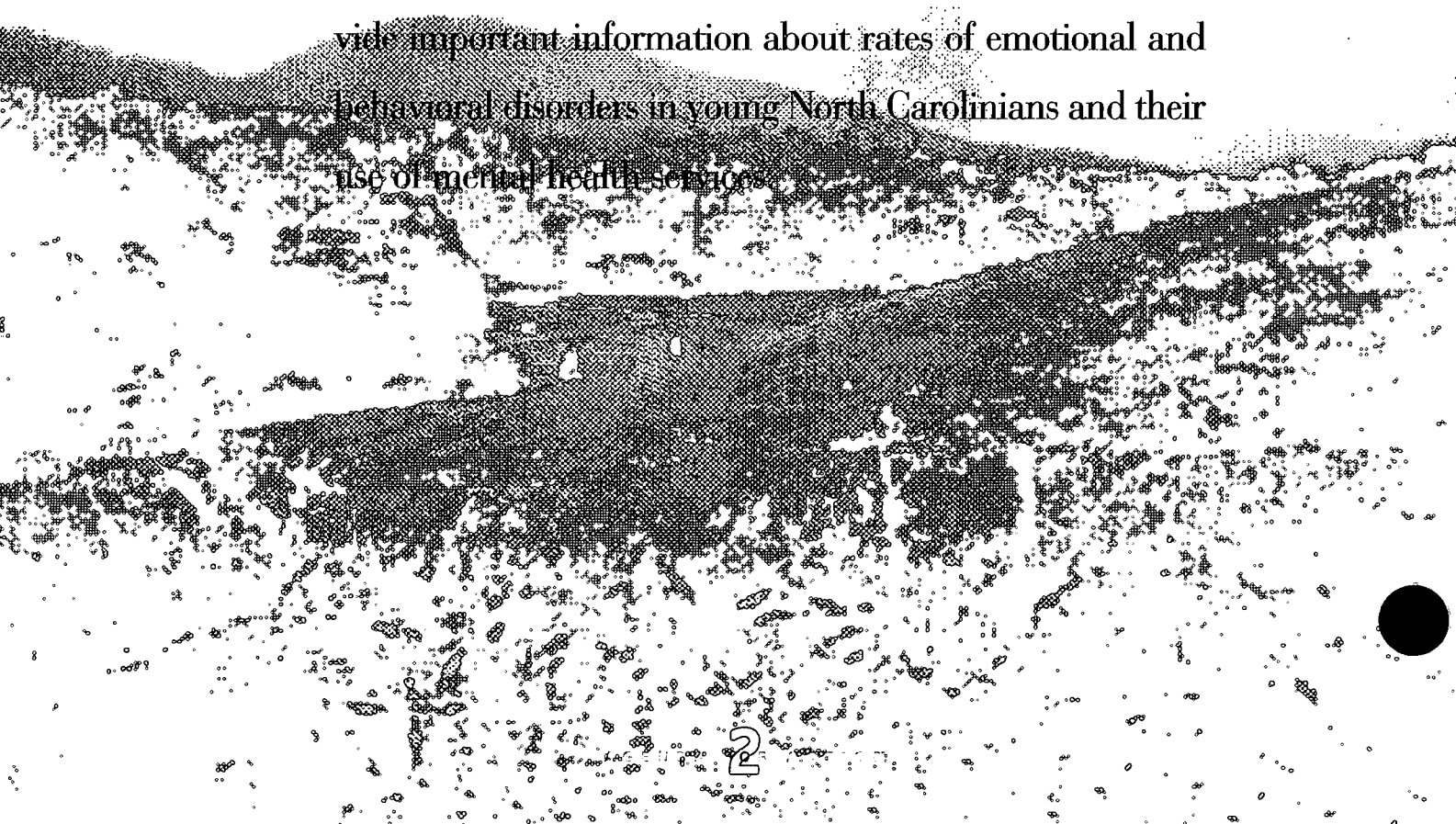
Most of America's children will have relatively normal, healthy childhoods and will grow up to be productive, well adjusted adults. But five out of every 100 children will not. These children, at an early age, will develop an emotional or behavioral disorder that meets the federal definition of *serious emotional disturbance* (SED), which requires both a psychiatric diagnosis and functional impairment.* They will need mental health and other special services, such as special education, not only during childhood but, in many cases, throughout their lives. For them, mental health services are essential. Another group of 20 to 25 out of every 100 children will develop a less severe emotional or behavioral problem that can resolve with proper care, but they run the risk of disabling mental health problems as adults. ***It is this in-between group of vulnerable children for whom timely and appropriate mental health intervention can make a real difference in long-term outcome.*** Yet only about one in four children with a moderate or serious emotional or behavioral problem has seen a mental health professional in the past year.

How can North Carolina make informed mental health policy decisions?

Rates of childhood emotional and behavioral disorders in North Carolina mirror those observed nationally, based on studies conducted to date; and the state, to its credit, has been a national leader in comprehensive and coordinated mental health services for children. Nonetheless, current, accurate local-level information can help North Carolina take this enlightened policy to the next level of excellence, providing tangible benefit to the state's children, from birth to age 18, while continuing to set a national example.

An important program of research, the *Duke Developmental Epidemiology Program*, is currently under way in North Carolina to evaluate mental health service needs and use in an ethnically diverse sample of the state's children. The *Great Smoky Mountains Study*, which is summarized in this report, is the first component of this research program to yield findings. These findings can assist the state to respond to the mental health needs of its children.

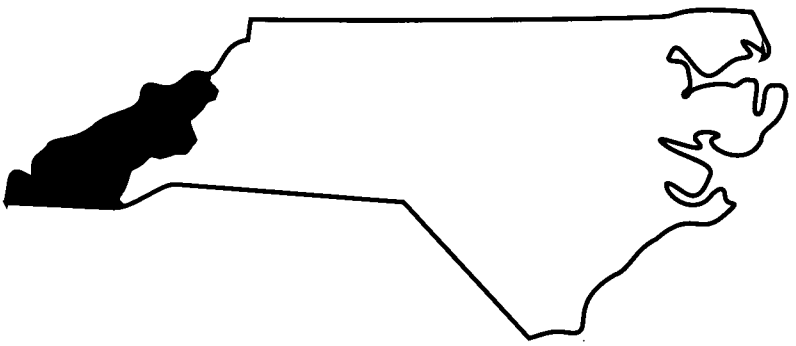
The *Great Smoky Mountains Study* (GSMS) is a longitudinal, population-based community survey of children and adolescents in North Carolina funded by the National Institute of Mental Health. The study is a collaboration between *Duke University* and the *North Carolina State Division of Developmental Disabilities, Mental Health, and Substance Abuse Services*. It began in 1992 and will continue until 2003. The findings from GSMS will provide important information about rates of emotional and behavioral disorders in young North Carolinians and their use of mental health services.



What are the study's goals?

Among the *goals* of the Great Smoky Mountains Study are to *estimate* :

- The number of children with emotional and behavioral disorders
- The number of new cases of such disorders that develop in children each year
- The persistence of emotional and behavioral disorders in children and adolescents over time
- The need for and use of services for emotional and behavioral disorders
- The effects of family income, health insurance, and other related factors on service use
- Which children are most at risk for emotional and behavioral disorders
- Which children are most at risk for bad outcomes (school dropout, teen pregnancy, encounters with the criminal justice system, etc.)



Who is participating in the Great Smoky Mountains Study?

The participants in the Great Smoky Mountains Study are:

- 1,073 children aged 9 through 16, and their parents, from 11 counties in western North Carolina (8.1% of the children are African-American, which is consistent with the proportion of African-Americans in the counties surveyed). These counties include both urban and rural areas. Children were selected on the basis of a screening questionnaire completed by the child's parent. All children scoring above a predetermined point on questions about behavioral problems were invited to participate in the study. A random one-in-ten sample of children scoring in the normal range was also recruited. Eighty percent of invited families agreed to participate.
- 349 children who are enrolled members of the Eastern Band of the Cherokee Nation (80% of families with a child in the study's age group)
- All agencies providing child mental health services in the 11-county area

Participating Counties

Buncombe

Cherokee

Clay

Graham

Haywood

Jackson

Macon

Madison

Mitchell

Swain

Yancey

How is the study being conducted?

Starting in 1992, each child in the Great Smoky Mountains Study, and one of his/her parents, is visited once a year by trained interviewers for a face-to-face interview using structured evaluation instruments. Between these annual interviews, each child and family has received a telephone follow-up call once every three months. In addition, three teachers have completed questionnaires about each child. The study also includes a comprehensive study of mental health service providers working in schools, social services, juvenile justice, and child welfare, as well as those working in specialty mental health settings.

Children and their parents are interviewed using instruments that evaluate the child's symptoms of behavioral and emotional disorders, physical health, and development. These instruments seek to answer the following questions:

- Does the child meet diagnostic criteria for a specific emotional or behavioral disorder?
- Does he or she exhibit impaired functioning (inability to function in developmentally appropriate ways at school, at home, and with peers)?
- Does he or she need mental health services?

Federal guidelines define children to be suffering from *serious emotional disturbance* (SED) if they have a psychiatric diagnosis that impairs their ability to develop and function normally at home, at school, or in their relationships with others. Since many federal agencies target their services specifically to these children, North Carolina has also adopted this definition of urgent need for mental health care.

The GSMS also evaluates the following:

- Family psychiatric history
- Impact of the child's illness on the family
- Impact of family resources, including health and mental health insurance, on service use
- Services sought and received for the child's disorder
- Access and barriers to this care

A *distinguishing characteristic* of the Great Smoky Mountains Study is that *service use is linked to mental health problems*. The study is evaluating how children use services in five sectors:

Mental health
psychiatric hospital, psychiatric unit in a general hospital, residential treatment center, group home, partial hospitalization, therapeutic foster care, mental health center, detoxification unit, outpatient drug/alcohol clinic, case management, private mental health professional

Education
guidance counselor/school psychologist, special schools and classes

Health
family doctor/other non-psychiatric physician, community health center, medical inpatient unit, hospital emergency room, nontraditional healer

Child welfare
social services counseling, therapeutic foster care, child protective services

Juvenile justice
detention center/jail, probation officer/court counselor

Mental health resources in the study area

It is important to note that the 11 counties participating in GSMS are served by a relatively well developed service system. The area comprises two public mental health authorities: the Blue Ridge Area Program and the Smoky Mountain Area Program. Both programs are recognized throughout the state for their comprehensive, up-to-date services for children and their families. From 1989 to 1994, these programs were among seven sites across the nation that participated in the Robert Wood Johnson Foundation's Mental Health Services Program for Youth. This program contributed resources to local communities to enrich the availability of community-based programs and also emphasized interagency collaboration. As a result, the area programs improved, solidified, and formalized their relationships with other agencies serving children in an effort to ***actively implement the principles of a system and continuum of care.*** All of this was already well under way when the Great Smoky Mountains Study began.

TRAVIS:
The need for services

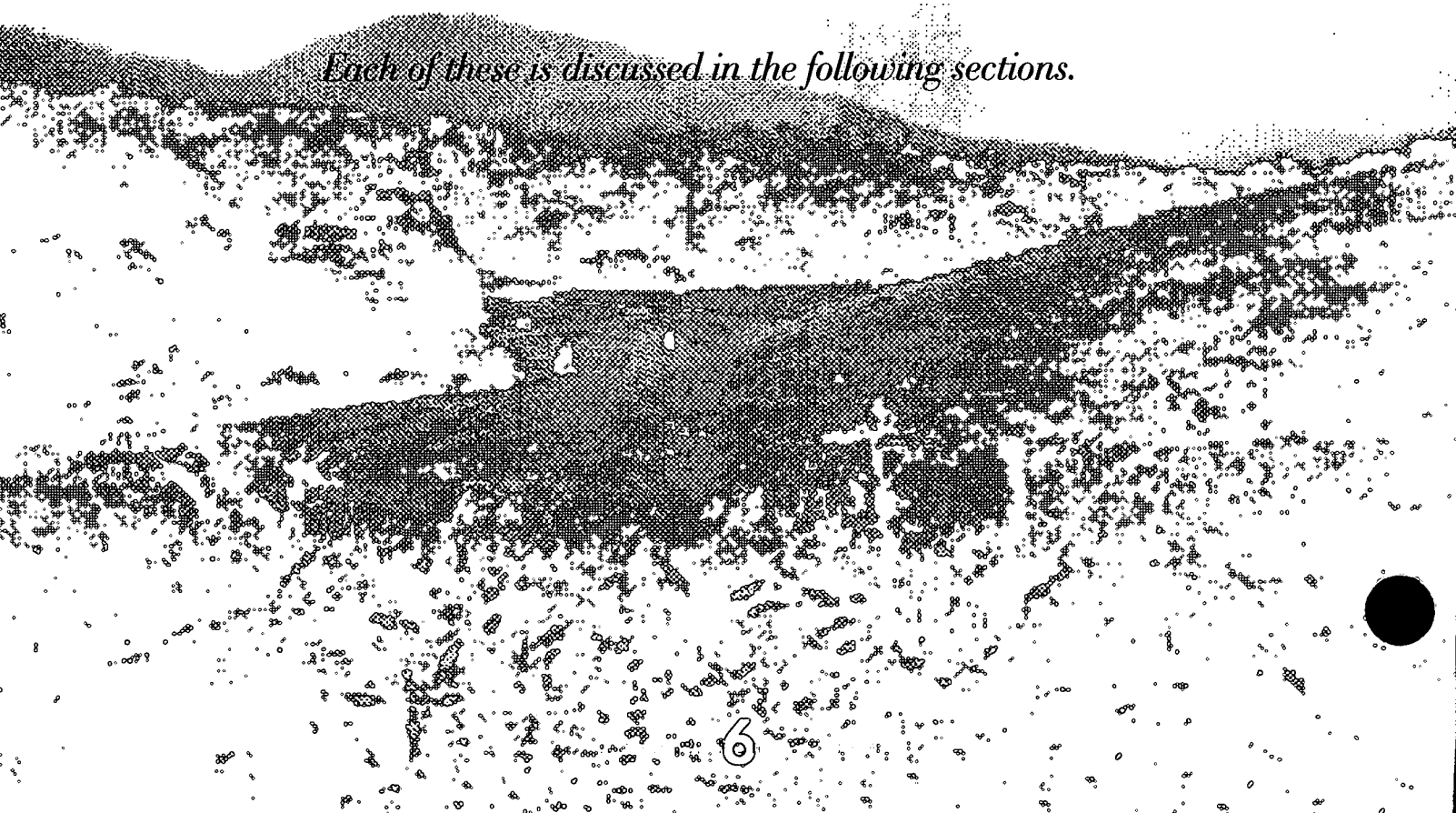
Travis, age 10, has a variety of behavioral and emotional problems. He was eight when his parents divorced and, since then, has moved back and forth between them with no consistency. While with his father, he was repeatedly taken to an outbuilding and raped by teenage boys in the neighborhood. At one point, Travis set a fire that burned down the trailer in which his family was living. Travis is currently living with his mother, stepfather, and sisters. He shows a range of behavior problems that make people afraid to be around him. His older sister tried to commit suicide, and his younger sister has a neurological disorder. Travis knows he has problems but cannot control his behavior. This upsets him because he wants people to like him. Travis's mother knows her family needs help and is trying to identify and use those health and social services for which her family qualifies. However, she has difficulty negotiating the "red tape." This family continues to participate in the Great Smoky Mountains Study because the mother believes participation will help her get the services she needs for her children.

All vignettes included in this report are composites of several actual cases created for illustrative purposes.

The Great Smoky Mountains Study has provided policy-relevant information in the areas of:

1. need for mental health services,
2. risks for emotional and behavioral disorders,
3. outcomes of serious emotional disorders,
4. use of mental health services across sectors, and
5. effectiveness of mental health care.

Each of these is discussed in the following sections.



How many children need mental health services?

- Most children will *never* need professional mental health care: In each year of GSMS, seven children out of ten (70%) *had no diagnosable emotional or behavioral disorder.*
- Another 25% had *moderately severe*, though still distressing, disorders.
- The remaining 5% of children have serious emotional or behavioral disorders (SED) accompanied by *marked impairment* in ability to develop and function normally at school, at home, or with peers.
- Among the children with SED,

  70% have a disruptive behavior disorder

  27% have an anxiety disorder

  20% have a depressive disorder

  16% have a substance use disorder

  13% have attention deficit hyperactivity disorder (ADHD)

  4% have tic disorders

  2% have an eating disorder (anorexia or bulimia)

  1% are encopretic

  41% have more than one of these disorders
- African-American and Indian children have rates of disorder and comorbidity similar to those of white children.
- Rural and urban children have similar levels of need for mental health care.

What puts children at risk for serious emotional disturbance?

The risk of SED increases with the number of *family stress factors*. Compared with children with mild or no emotional or behavioral disorders, children with SED had one or more of these stress factors in their lives:

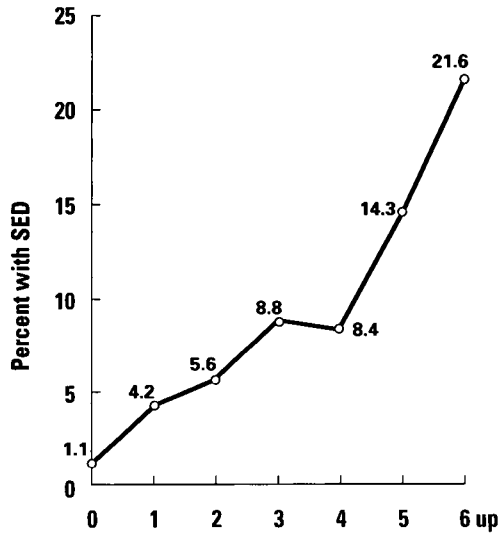
- Twice as likely to be living in poverty (40% versus 22%)
- 40% more likely to have a parent who has been arrested (17% versus 12%)
- 50% more likely to have a parent with a drug or alcohol problem (11% versus 7%)
- Three times as likely to have a mother who is depressed (18% versus 6%)
- 25% more likely to have a parent who did not finish high school (42% versus 32%)
- Nearly three times as likely to have a poor relationship with his/her parents (49% versus 17%)
- Nearly twice as likely to have witnessed physical violence between parents (13% versus 8%)
- Nearly twice as likely to have one or both parents unemployed (17% versus 9%)
- 50% more likely to come from a family other than one with two biological or adoptive parents (77% versus 50%)

Among children living with six or more stress factors, one in five has SED. This is *forty times* the rate of SED in children with no stress factors.

SED was slightly more common in boys, children over 12, and African-American or American Indian children. However, these differences were small, with one exception: by age 15, substance abuse was increasing faster among American Indian youths than in other groups.

Figure 1.

How family stress factors increase risk of SED



Family stress factors:

Parent with less than high school education

Unemployment

Poverty

Family mental illness

Parental drug or alcohol problems

Parental criminal conviction

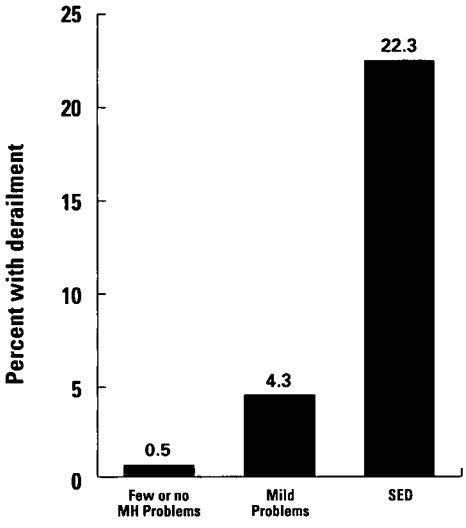
Violence between parents

Poor relations with children

Mother depressed

Figure 2.

How mental illness increased risk of "derailment"



Types of derailment

School dropout

Expelled from school

Unplanned teen pregnancy

Convicted of a crime

Drug or alcohol abuse

How well do children with mental health problems cope with daily life?

Without guidance and support, children can be "derailed" in their path to healthy adulthood. For example, they can:

- Be expelled from school
- Drop out of school
- Become pregnant
- Be convicted of a crime
- Begin using alcohol and illicit drugs

Most young people successfully avert such derailments. Children with few or no mental health problems were highly unlikely to experience such a derailment (only one in 200 did so). The rate was 4.3% in children with mental health disorders without functional impairment but rose to *22.3% of children with SED* (Figure 2). Thus, childhood SED had long-term educational, legal, and reproductive consequences that could seriously affect children's futures and their adult lives.

The risk of derailment among children with less severe disorders, while lower than in SED youths, was still eight times that of healthy children (Figure 2). ***Efforts to reduce risk in this group could have a substantial impact on outcomes for adolescents because they make up 20% of the population.***

Does mental health treatment work?

The Great Smoky Mountains Study is one of t first studies nationally to look at whether treatment in community mental health settings improves children's mental health. Those children whose symptoms were getting worse between assessments, that is, those children who clearly needed help, were identified and followed for another year to see who would receive treatment and whether this treatment would have an effect a year later. Outcomes examined included emotional and behavioral problems, functioning at school and home, and impact on parents.

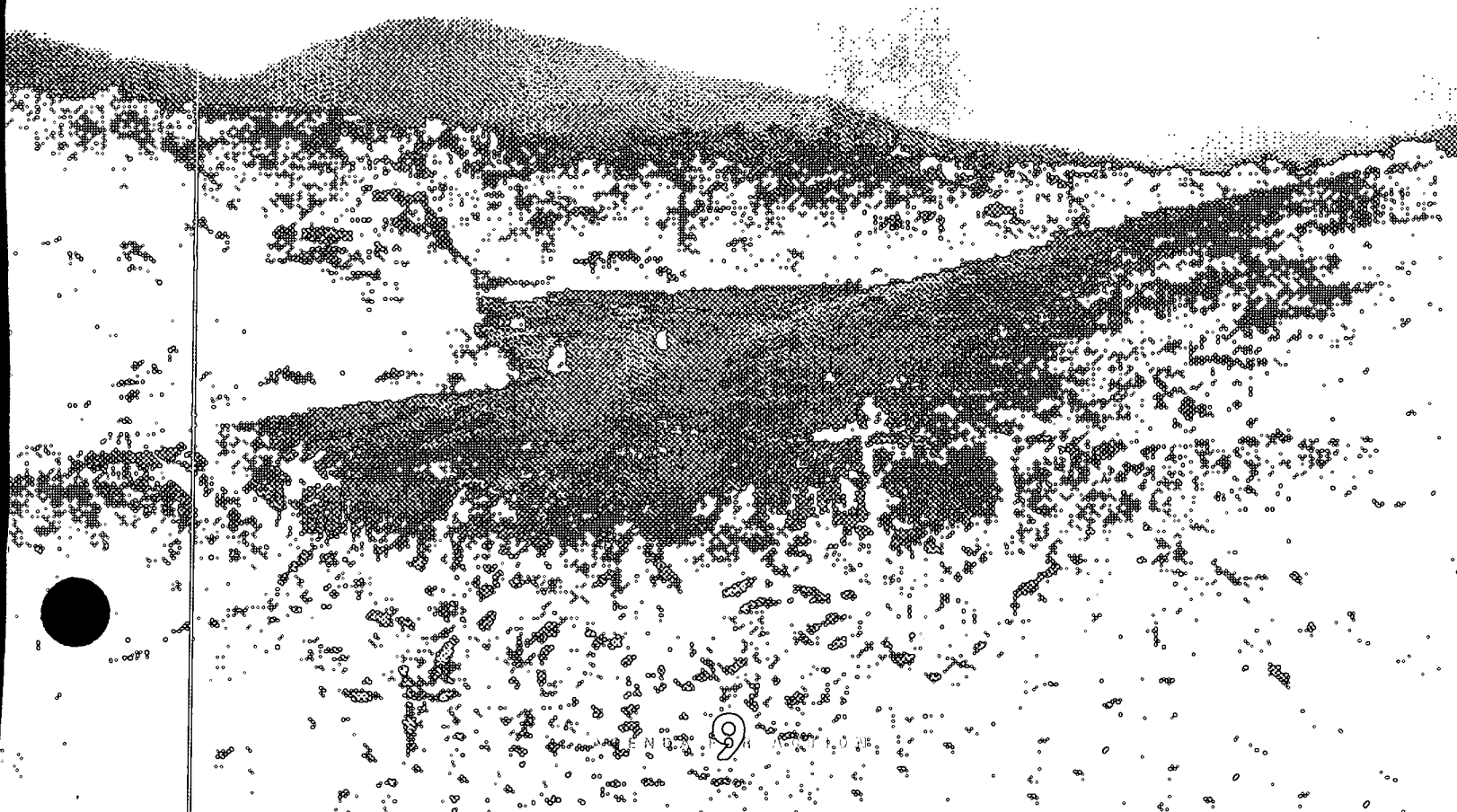
- Compared with untreated youths, those who had nine or more sessions with a mental health professional had *significantly fewer emotional and behavioral problems* following treatment.
- Children receiving fewer than nine sessions of treatment showed no improvement.
- The more treatment children had (about nine sessions) the fewer symptom were displayed a year later, demonstrating a *dose–response effect* for treatment.

These findings suggest that, given adequate treatment (at least nine sessions on average), children's emotional and behavioral symptoms showed a marked improvement over a year. However, a year may be *too short a time* to see a marked improvement in functioning at school or at home in seriously disturbed youths. Serious problems require serious intervention.

In a climate of shrinking mental health benefits, it is important to know what mental health services children use, how long they stay enrolled in services, how much service they receive, and what helps and hinders their use of services. These data can then be used to ask the questions:

① Are children who need mental health care getting it?

② Does insurance lead to overuse by children with low need?



How many children and adolescents need mental health services?

The Great Smoky Mountains Study divided participating children and adolescents into three groups based on *level of need*

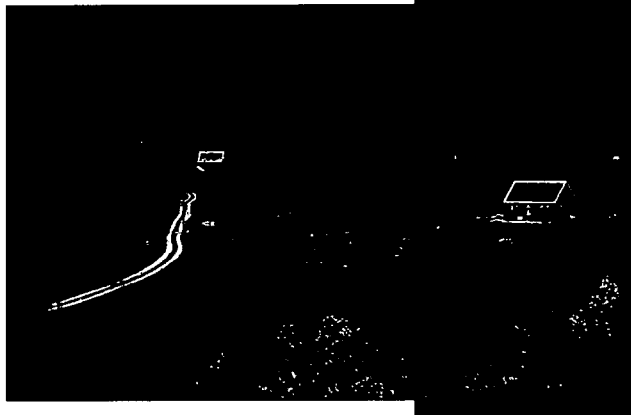
- **High need** children, defined as SED (seriously emotionally disturbed), had both a psychiatric diagnosis and impaired functioning. This group made up 5% of the sample in any one year, and 10% over the course of the study.
- **Moderate need** children had either a diagnosis or impaired functioning but not both. This group made up 25% of the sample in any year, and 45% over the course of the study.
- **Low need** children had neither a diagnosis nor impairment at their annual assessment but might have some symptoms. They made up 70% of the sample in any year, and 45% over the course of the study.

Results from GSMS to date have shown the following:

- Every year, *only one in five children with a diagnosable disorder saw a mental health specialist* (psychiatrist, psychologist, psychiatric social worker).
- In the course of a year, *70% of the children with SED had received some mental health services from one or more agencies serving children* (mental health, pediatric primary care, schools, child welfare, juvenile justice).
- However, *only two in five SED children received care from a specialty mental health agency.*

How do children get to a mental health care provider?

One key to children receiving services is *parental recognition* of an emotional or behavioral problem in the child or adolescent. Parental recognition of the child's problem is more likely when the problem impinges on the parents' life. Parental recognition that a child with SED had a problem was associated with a *doubling of the rate of mental health service use* (from 20% to 40%) in the study. Children's problems could affect parents in many ways: they could be forced to give up work, to have to take a lower-paying job, or to work fewer hours. Children's problems could cause friction or breakdown in relations with spouses, children, family, or friends. Some parents became depressed or felt shame or embarrassment because of their child's behavior, which led some to seek mental health treatment for themselves. In other words, parents' help-seeking for their child's problems was often driven by problems of their own.



EVELYN:

School as a source of mental health care

Evelyn, age 14, has been diagnosed with manic depressive disorder and regularly has auditory hallucinations of a male voice similar to her father's telling her that she is "no good." She also has flashbacks to age five when her father beat her for spilling her milk. Evelyn has made several suicide attempts, none of them life-threatening and all in conjunction with an episode of illness. She began drinking at age 12 and has already undergone rehabilitation for her alcohol problem. Evelyn currently lives with her mother and brother; she no longer sees her father. Evelyn's mother, who is highly stressed herself, is concerned enough about her daughter to have sought help for her, and Evelyn sees both an outpatient therapist and the guidance counselor at her school.

Where do children and adolescents typically receive mental health services?

Data from the Great Smoky Mountains Study have yielded findings regarding use of various service sectors that should be of great interest in planning future mental health services for the state's youths.

- Over the course of a year, 40% of children in the study received some type of mental health service, though not necessarily from a trained mental health professional.
- *School counselors and psychologists* provided mental health services to more children than did any other mental health professionals. More than *75% of children receiving mental health services* were seen in the education sector. For many children, the education sector was *the sole source of care.*
- Twelve percent of children received services from the *specialty mental health sector*, most via a public mental health center or private professional.
- The *general medical sector* provided mental health-related services to only 6% of youths in the study, mainly the younger ones. For most (89%), such services were provided by the child's primary physician.
- In-home services, partial hospitalization, and specialized substance abuse services were used rarely.
- Older children were less likely to use school mental health services and more likely to be seen in the juvenile justice sector.
- Overall, 50% of children who used services during the year received services *from only one agency.* One in four used two agencies, and the rest used three or more. More than 50% of children who used only one agency received their services through the *education system.*

Use of both outpatient and inpatient services was dramatically influenced by *level of need.* Thus, Figure 3 shows that although youths with SED were only 5% of the population, they made up over a quarter of those using specialty mental health and school guidance services and almost half of those seen in the juvenile justice system.

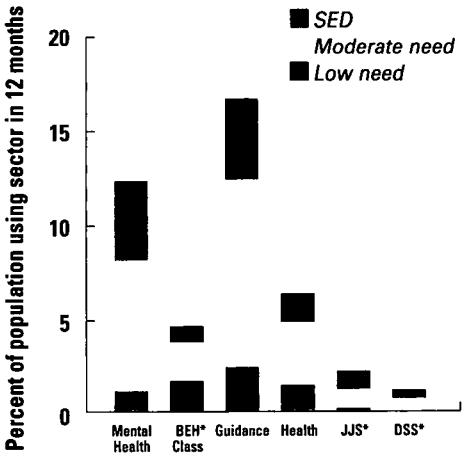
High need youths also tended to use multiple services, as shown in Figure 4. Although they are only 5% of the population in any year, four out of five youths with SED use services, and half use services in two or more sectors.

The great majority of mental health service use occurred in outpatient settings, including day hospitals, drug/alcohol clinics, mental health centers, and private mental health professionals.

The role of the specialty mental health system was greatest for children with the most severe problems. Moreover, the care of children with severe problems tended to involve multiple agencies, particularly the school and mental health agencies, pointing to the importance of *coordination across agencies.*

Figure 3.

Role of the major sectors in providing mental health services to children by child's clinical status



DSS Department of Social Service
JJS Juvenile Justice Services
BEH Class for behavioral or emotional problems

Figure 4.

Number of service sectors used in one year by low, moderate, and high need children

How persistent and intense is service use?

Persistence of service use refers to the *continuation in service across time*. There was a complex pattern of movement into and out of services across the year in the Great Smoky Mountains Study. Fewer than 10% of children persisted in service use for more than three months at a time. However, many came back into the system after a year or two.

In the Great Smoky Mountains Study, *intensiveness* referred to the level of service provided by a particular agency. In general, children who received highly intensive service were the exceptions. For example, fewer than 2% of children received out-of-home placements in any year. Of those who did, 50% were in such placements for fewer than five days, and only 15% were in such a placement for more than a month.

No children with low need received out of home placements, but 15% of youths with SED spent at least one night away from home in a treatment setting in the course of a year, compared with 3.6% of moderate need youths. But only 1% of moderate need youths spent more than a week out of home, compared with 10% of SED youths. The average annual out-of-home stay was half a day for moderate need youths, compared with four days for SED youths.

Persistent service users were more likely to be *older* and to come from families with *less education*, with *incomes below the federal poverty line*. Persistent service users had more emotional and behavioral problems, and their families suffered *high levels of economic, social, and psychological hardship*.

Who pays for services?

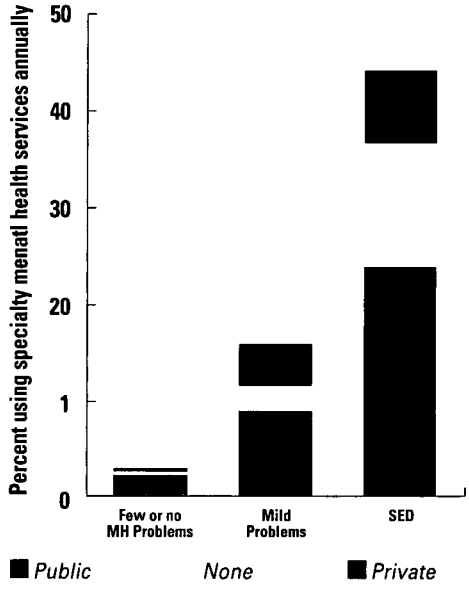
In the Great Smoky Mountains Study, 70% of families had private insurance, 19% had public insurance (Medicaid), and 11% had no insurance, closely resembling the distribution for the entire state. For those families with private insurance, 18% of plans offered full mental health coverage and 58% offered partial coverage. Typical benefit packages under private insurance were 20-30 outpatient visits with a 50% co-payment and 30-60 days of psychiatric hospitalization.

Key findings related to insurance status and use of mental health services include the following:

- Service use was driven more by *level of need* than by insurance status. Among high need youths, about two in ten received some mental health care regardless of insurance type. Fewer than one in five youths with moderate need, and only 2% of low need youths, received specialty mental health care.
- Given need for care, *public insurance (Medicaid)* increased service use more than private insurance. Although uninsured and publicly insured youths were only 30% of the population, they made up half of all children with SED receiving specialty mental health care.
- Almost no children with low need and public or no insurance received specialty mental health care. **Public insurance did not lead to unneeded access to mental health services.**

Figure 5.

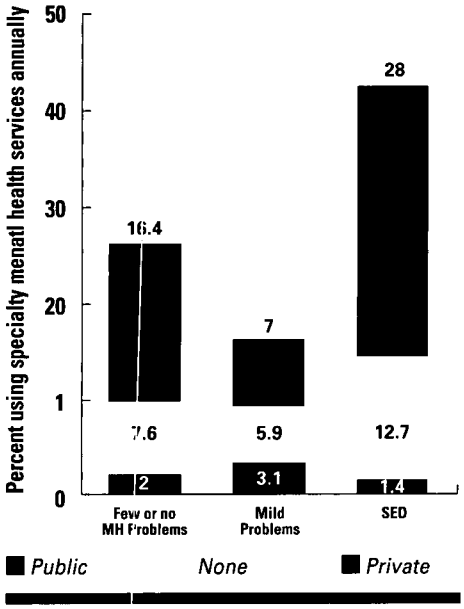
Impact of health insurance on likelihood of one or more mental health visits by level of need



- Relatively few privately insured youths received any inpatient care, *regardless of level of need*. For youths with public insurance, there was a strong positive relationship between level of need and receipt of inpatient care. The number of outpatient visits was also strongly associated with level of need, with high need youths receiving the most visits within each insurance group. Nonetheless, even children with high need received mental health care at low rates, particularly children *with private insurance*, suggesting *limited treatment once contact with the service system occurred*. This is worrisome when taken in conjunction with the findings cited earlier, that only youths receiving nine or more visits showed significant improvement a year later.

Figure 6.

Mean number of specialty mental health visits in one year, by health insurance and level of need



Uninsured youths in the Great Smoky Mountains Study fared as well as privately insured youths, in part due to the availability of "free" or "no cost" care provided by public mental health services. However, uninsured children and families were characterized by high rates of poverty, family histories of mental illness for all levels of need, and high family burden—thus, a group with multiple needs for service use.

To summarize, in the Great Smoky Mountains Study area, even with relatively advanced child mental health services systems and generous Medicaid benefits, *only 44% of youths with SED received professional mental health care at any time during a two-year period.* SED children with Medicaid were better served than children covered by private insurance or no insurance, especially in terms of the volume of services received. The reason for the difference was not due to the high level of services provided to Medicaid patients but to the *very low level of services provided to privately insured and uninsured children.* Since uninsured children had a high level of need for care, this last group is particularly disturbing.

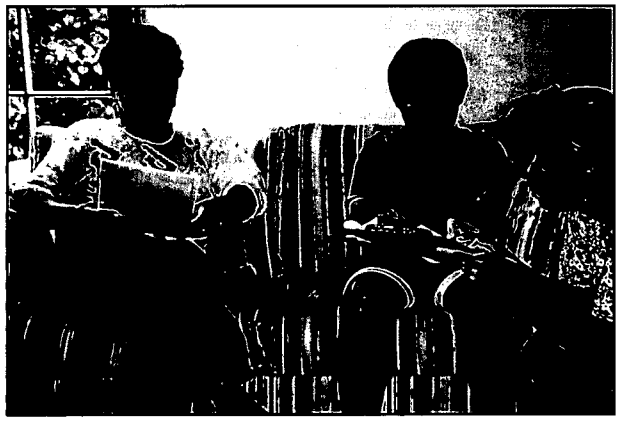
How has North Carolina's Medicaid waiver affected service provision?

In North Carolina, child mental health services have been managed in ten pilot areas under a Medicaid waiver since 1994. A study by the Duke Developmental Epidemiology Program has looked at the impact of a Medicaid carve-out pilot, Carolina Alternatives (CA), on mental health service use, service setting, and cost. Carolina Alternatives is public sector-managed with a single portal of entry into services and a phase-in of full risk after two years. The two Area Mental Health Programs covered by GSMS were included in the CA study.

Overall access to and volume of mental health and substance abuse services increased over the study time period (1992-1996), although substantial variation by service type occurred. A strong shift from inpatient to alternative treatment and outpatient services was observed. Intensive services (group homes, therapeutic foster care, partial hospitalization), which could potentially serve as an alternative to inpatient care, were developed or their capacity increased over the study period. Use of these alternative services increased until 1995 (by 150% in the Great Smoky Mountains sample) but began to decline when Area Programs assumed full fiscal risk.

Changes in costs between 1992 and 1996 were reflected in a dramatic reduction in inpatient costs and a corresponding increase in outpatient costs from roughly one-third to over one-half of Medicaid costs (with one-third of costs being in alternative treatments). The costs per eligible enrollee increased across CA sites until 1995 and then declined in 1996, an indication of the transition to full risk and a reduction in the capitation rates that occurred in 1996. Mean capitation rates increased from $321 to $532 between 1992 and 1995, then declined to $395 by 1996.

This first longitudinal examination of public sector-managed mental health and substance abuse services for children on Medicaid with significant mental health need (more than 20% with SED) reveals overall success in achieving the goals of CA. The pilot demonstrates that institutional care can be dramatically reduced while increasing access to community-based services and continuing to provide a substantial volume of intensive, community-based care. After initial increases, costs appear to have stabilized with full risk, but further years of observation are needed to confirm this trend.



The Great Smoky Mountains Study has produced several important findings related to mental health service utilization and financing in children and adolescents that may be relevant as the state sets future health care policy.

- ***Serious emotional disturbance*** is strongly related to use of any mental health services.
- The family's ***history of psychiatric illness*** is among the most consistent and powerful predictors of use of mental health services. Others include ***poverty*** and ***the impact of the child's mental health problems on the family.***
- Service use is much more likely to occur with ***public insurance coverage*** (Medicaid) than either private or no insurance.
- Considerable unmet need was observed even for youths with SED.
- School-based counseling services potentially substituted for professional mental health services.
- Current services provide only minimal care for most children, even those with SED.
- There was little ***unnecessary use*** of mental health services in the low need group.

The findings of multiple sector use, particularly in high need youths, in the Great Smoky Mountains Study reinforce the importance of ***interagency relationships*** between specialty mental health and other child-serving sectors. Relatively few children received services solely from the specialty sector. Rather, specialty mental health was a common provider for children who received services from multiple sectors. This finding suggests that coordination, ***particularly with schools***, is crucial for the provision of services.

How can the state respond to unmet need in a cost-effective way?

A number of factors must work together to achieve positive outcomes for children with emotional and behavioral disorders. Among them are principles of care, adequacy of the service system, including, quality of treatment, and child and family preferences.

Principles of care that currently guide both public and private sector mental health service delivery include:

- ***Individualization*** of services based on the specific needs of the individual child and family
- Involvement of the ***child's family*** as a partner in treatment
- Provision of services in ***community-based settings*** rather than in institutions
- Provision of service in the ***least restrictive setting*** to normalize and mainstream the child and his/her experiences as much as possible
- Services that are sensitive to ***ethic and cultural values***

A number of questions directed toward the service system address its overall adequacy:

- Is the full continuum of care in place?
- Are the services provided ones with evidence-based, demonstrable effectiveness?
- Are the resources in the continuum sufficient to meet the needs of the population?
- Are mental health services coordinated with those provided in other human services sectors?
- Are families involved in service planning and delivery?
- Are services provided in a timely and flexible manner?

When these questions can be answered in the affirmative, North Carolina's children and adolescents will be more likely to get the care they need for emotional and behavioral disturbances. However, in evaluating the effectiveness of such a service system, it is important to keep three assumptions in mind:

- *Treatment is a process, not an event.* Children with persistent (chronic) conditions need a range of treatment interventions over time.
- *Outcomes are affected by a larger world than formal treatment.* Thus, it is not sufficient to assess mental health specialist services only; inclusion of other sectors and informal services is also essential. The role of schools in service provision has been well demonstrated in the Great Smoky Mountains Study.
- *Outcomes will vary with the type and stage of treatment and the child's developmental status.* Thus, it is important to assess both short- and long-term outcomes.

The high proportion of mental health care provided to North Carolina's children and adolescents through the education sector raises a question about the potential of school personnel with limited mental health expertise to respond adequately to the clinical needs of emotionally and behaviorally disturbed youths. This concern is underscored by the high rate of seriously emotionally and behaviorally disturbed children seen only in the education sector and suggests a need to *improve the linkages between schools and mental health centers*. Mental health advocates are pursuing federal legislation to strengthen school-based services for the entire child population as well as for children identified as seriously emotionally disturbed. North Carolina is in the process of following this lead by adding mental health services to school-based health clinics. The state should be commended for this effort.

Recommendations for Action

Results to date from the Great Smoky Mountains Study suggest that North Carolina can take a number of steps to improve state-wide mental health services to children and adolescents and to sustain this improvement over time. Recommendations for consideration include the following:

- Increase *professional mental health resources in the schools*, where children can easily take advantage of them. Develop and expand models for area health programs to deliver services in schools.
- Adopt *standardized assessment methods and instruments to examine children for early detection of SED* and access to services. Such instruments can be utilized in real-world settings by child welfare workers, disability examiners, school psychologists, and other mental health care providers.
- Take active steps to enhance *interagency relationships* between specialty mental health and other child-serving sectors, particularly schools.
- Incorporate *need for services* into policy as the criterion for use of psychiatric benefits instead of arbitrary benefit limits.

HOUSE COMMITTEE ON MENTAL HEALTH

APRIL 27, 1999
10:00 a.m.
Room 415

AGENDA

Chair: Rep. Jim Crawford

HB 1142 Physical Restraint Restrictions

HB 1156 Amend Psychology Practice Act

Child & Family Services
Dr. Lenore Behar, Director
Susan Robinson

MINUTES
HOUSE COMMITTEE ON MENTAL HEALTH
APRIL 27, 1999

The House Committee on Mental Health met on Tuesday, April 27, 1999 in Room 415 of the Legislative Office Building at 10:00 a.m. The following members were present: Chairman Jim Crawford, Representatives Goodwin, Berry, Cansler, Esposito, and Horn. Linda Attarian and Kory Goldsmith, staff counselors, attended. A visitor registration list is attached and made part of these minutes. Chairman Crawford introduced the pages for the day.

HB 1142 AN ACT TO ENSURE THE SAFETY OF PERSONS SUBJECT TO THE USE OF RESTRAINTS was taken off the calendar at the request of the sponsor.

HB 1156 AN ACT TO AMEND THE PSYCHOLOGY PRACTICE ACT. Chairman Crawford appointed a subcommittee to further study and make recommendations to the full committee. Rep. Cansler will chair the subcommittee composed of Reps. Esposito and McAllister.

Chairman Crawford introduced Dr. Lenore Behar, Director, Child and Family Services, to provide responses to questions raised a the prior week's meeting regarding the reported growth of the number of children receiving mental health services. Dr. Behar said that data on suicide rates of youth will be given at a later time. She provided data on the number served, the kinds of services received, and the kinds of problems addressed (handout). The second handout was an explanation of the cultural competence initiative which was requested at the previous meeting.

Chairman Crawford adjourned the meeting at 10:35.

Respectfully submitted,

James W. Crawford, Jr.
Representative Jim Crawford
Chairman

Linda Winstead
Linda S. Winstead
Committee Assistant

MINUTES
HOUSE COMMITTEE ON MENTAL HEALTH
APRIL 28, 1999

The House Committee on Mental Health met around Chairman Crawford's desk on Wednesday, April 28, 1999 in the House Chamber at12:00 noon. The following members were present: Chairman Jim Crawford, Representatives Goodwin, Berry, Cansler, Esposito, Horn and McAllister.

HB 1156 AN ACT TO AMEND THE PSYCHOLOGY PRACTICE ACT. A proposed committee substitute was presented, and Rep. McAllister moved that it be considered. Rep. Cansler moved to give the original bill an unfavorable report and that the committee substitute be reported without prejudice and re-referred to the Committee on Rules. The motion passed.

Chairman Crawford adjourned the meeting at 12:10 p.m.

Respectfully submitted,

Representative Jim Crawford
Chairman

Linda S. Winstead
Committee Assistant

VISITOR REGISTRATION SHEET

MENTAL HEALTH

Name of Committee | Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sandra Long	NC Assoc of Professional Psychologists
Jim Tate	MHA in NC
Debbie Kennedy	Nurse for the day
Richard Olivia	DMH/DD/SAS
Susan E Robinson	DMH/DD/SAS
Terry Stelle	DMHDDSAS
Michelle Cotton	DMH/DD/SAS
Mike Hollingsworth	NCAPP
Flora Dunlap	NCAPP
Sally Camera	NC Psychological
Katherine Miller	Harry Kaplan
[illegible]	NCPA

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Crawford & Goodwin** for the Committee on **MENTAL HEALTH**.

☐ Committee Substitute for
H.B. 1156 A BILL TO BE ENTITLED AN ACT TO AMEND THE PSYCHOLOGY PRACTICE ACT

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☒ Without Prejudice as to committee substitute bill, unfavorable as to original bill and recommendation that the committee substitute bill be re-referred to the Committee on RULES.

☐ With a favorable report as to House committee substitute bill (#), ☐ which changes the title, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

2/24/99

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 1156
Proposed Committee Substitute H1156-PCS7229-RM

Short Title: Amend Psychology Practice Act. (Public)

Sponsors:

Referred to:

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO AMEND THE PSYCHOLOGY PRACTICE ACT.

The General Assembly of North Carolina enacts:

Section 1. G.S. 90-270.5(c) reads as rewritten:

"(c) All individuals who have yet to apply and who are practicing or offering to practice psychology in North Carolina, and all applicants who are practicing or offering to practice psychology in North Carolina, shall at all times comply with supervision requirements established by the Board. The Board shall specify in its rules the format, setting, content, time frame, amounts of supervision, qualifications of supervisors, disclosure of supervisory relationships, the organization of the supervised experience, and the nature of the responsibility assumed by the supervisor. Individuals shall be supervised for all activities comprising the practice of psychology until they have met the following conditions:

(1) For licensed psychologist applicants, until they have passed the examination to which they have been admitted by the Board, have been notified of the results, have completed supervision requirements specified in subsection (d) of this section, and have been informed by the Board of permanent licensure as a licensed psychologist; or

(2) For licensed psychological associate applicants, until they have passed the examination to which they have been admitted by the Board, have been notified of the results, and have been informed by the Board of permanent licensure as a licensed psychological

associate, after which time supervision is required only for those activities specified in subsection (e) of this ~~section.~~ section when performed by licensed psychological associates who are not exempt from supervision as provided in G.S. 90-270.5(e1)."

Section 2. G.S. 90-270.5(e) reads as rewritten:

"(e) A licensed psychological ~~associate~~ associate, who is not exempt from supervision as provided in G.S. 90-270.5(e1), shall be supervised by a qualified licensed psychologist, or other qualified professionals, in accordance with Board rules specifying the format, setting, content, time frame, amounts of supervision, qualifications of supervisors, disclosure of supervisory relationships, the organization of the supervised experience, and the nature of the responsibility assumed by the supervisor. A licensed psychological ~~associate~~ associate, who is not exempt from supervision as provided in G.S. 90-270.5(e1) and who provides health services shall be supervised, for those activities requiring supervision, by a qualified licensed psychologist or licensed psychological associate holding health services provider certification or by other qualified professionals under the overall direction of a qualified licensed psychologist or licensed psychological associate holding health services provider certification, in accordance with Board rules. Except as provided below, supervision, including the supervision of health services, is required only when a licensed psychological ~~associate~~ associate, who is not otherwise exempt from supervision, engages in: assessment of personality functioning; neuropsychological evaluation; psychotherapy, counseling, and other interventions with clinical populations for the purpose of preventing or eliminating symptomatic, maladaptive, or undesired behavior; and, the use of intrusive, punitive, or experimental procedures, techniques, or measures. The Board shall adopt rules implementing and defining this provision, and as the practice of psychology evolves, may identify additional activities requiring supervision in order to maintain acceptable standards of practice."

Section 3. Article 18A of Chapter 90 of the General Statutes is amended by adding a new subsection to read:

"(e1) The Board may grant an exemption from supervision to any licensed psychological associate who fulfills the following requirements:

(1) Holds permanent licensure and a masters, specialist, or doctoral degree.

(2) Has been approved for the highest level of reduced supervision after having completed the requisite years and hours of post-licensure supervised practice associated with that level.

(3) Meets minimum graduate training standards as defined by the Board.

(4) Passes the national psychology examination at a level prescribed by the Board.

(5) Holds health provider certification as a psychological associate (HSP-PA).

(6) Submits a letter of recommendation from the current Board-approved supervisor endorsing the applicant's exemption from supervision.

Notwithstanding the provisions of this subsection, any person who was licensed as a licensed psychological associate prior to January 1, 1999, holds HSP-PA certification, and is approved for the highest level of reduced supervision may, with the written recommendation of his or her Board-approved supervisor, apply for and be granted an exemption from supervision."

Section 4. G.S. 90-270.18(b) reads as rewritten:

"(b) Fees for activities specified by this Article are as follows:

(1) Application fees for licensed psychologists and licensed psychological associates per G.S. 90-270.11(a) and (b)(1), or G.S. 90-270.13, shall not exceed one hundred dollars ($100.00).

(2) Fees for the national written examination shall be the cost of the examination to the Board plus an additional fee not to exceed fifty dollars ($50.00).

(3) Fees for additional examinations shall be as prescribed by the Board.

(4) Fees for the renewal of licenses, per G.S. 90-270.14(a)(1), shall not exceed two hundred fifty dollars ($250.00) per biennium. This fee may not be prorated.

(5) Late fees for license renewal, per G.S. 90-270.14(a)(1), shall be twenty-five dollars ($25.00).

(6) Fees for the reinstatement of a license, per G.S. 90-270.15(f), shall not exceed one hundred dollars ($100.00).

(7) Fees for a duplicate license, per G.S. 90-270.14(b), shall be twenty-five dollars ($25.00).

(8) Fees for a temporary license, per G.S. 90-270.5(f) and 90-270.5(g), shall be twenty-five dollars ($25.00).

(9) Application fees for a health services provider certificate, per G.S. 90-270.20, shall be fifty dollars ($50.00).

(10) File review fees for licensed psychological applicants applying for an exemption from supervision per G.S. 90-270.5(e1) shall be five dollars ($5.00)."

Section 5. G.S. 90-270.20(a) reads as rewritten:

"(a) Health services, as defined in G.S. 90-270.2(4) and G.S. 90-270.2(8), may be provided by qualified licensed psychological associates, qualified licensed psychologists holding provisional, temporary, or permanent licenses, or qualified applicants. Qualified licensed psychological associates, who are not otherwise exempt from supervision, qualified licensed psychologists holding provisional or temporary licenses, or qualified applicants may provide health services only under supervision as specified in the duly adopted rules of the Board."

Section 6. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1156

Short Title: Amend Psychology Practice Act. (Public)

Sponsors: Representatives Crawford; Berry (Primary Sponsors) and Cansler.

Referred to: Health.

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO AMEND THE PSYCHOLOGY PRACTICE ACT.

The General Assembly of North Carolina enacts:

Section 1. G.S. 90-270.5(c) reads as rewritten:

"(c) All individuals who have yet to apply and who are practicing or offering to practice psychology in North Carolina, and all applicants who are practicing or offering to practice psychology in North Carolina, shall at all times comply with supervision requirements established by the Board. The Board shall specify in its rules the format, setting, content, time frame, amounts of supervision, qualifications of supervisors, disclosure of supervisory relationships, the organization of the supervised experience, and the nature of the responsibility assumed by the supervisor. Individuals shall be supervised for all activities comprising the practice of psychology until they have met the following conditions:

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(2) For licensed psychological associate applicants, until they have passed the examination to which they have been admitted by the Board, have been notified of the results, and have been informed by the Board of permanent licensure as a licensed psychological associate, after which time supervision is required only for those

activities specified in subsection (e) of this ~~section.~~ section when performed by licensed psychological associates who are not exempt from supervision as provided in G.S. 90-270.5(e1)."

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Section 3. Article 18A of Chapter 90 of the General Statutes is amended by adding a new subsection to read:

"(e1) The Board may grant an exemption from supervision to any licensed psychological associate who fulfills the following requirements:

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(3) Meets minimum graduate training standards as defined by the Board.

(4) Passes the national psychology examination at a level prescribed by the Board.

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Section 5. This act is effective when it becomes law.

FOLLOW-UP REPORT
TO THE
NC HOUSE MENTAL HEALTH COMMITTEE
ON THE
GROWTH OF CHILD MENTAL HEALTH SERVICES

Presented by Lenore Behar, Ph.D., Section Chief,
Child and Family Services, Division of MH/DD/SAS

During the House Mental Health Committee meeting on April 20, 1999, several questions emerged regarding the reported growth of the number of children receiving mental health services in the Area MH/DD/SA Programs. This report addresses those questions.

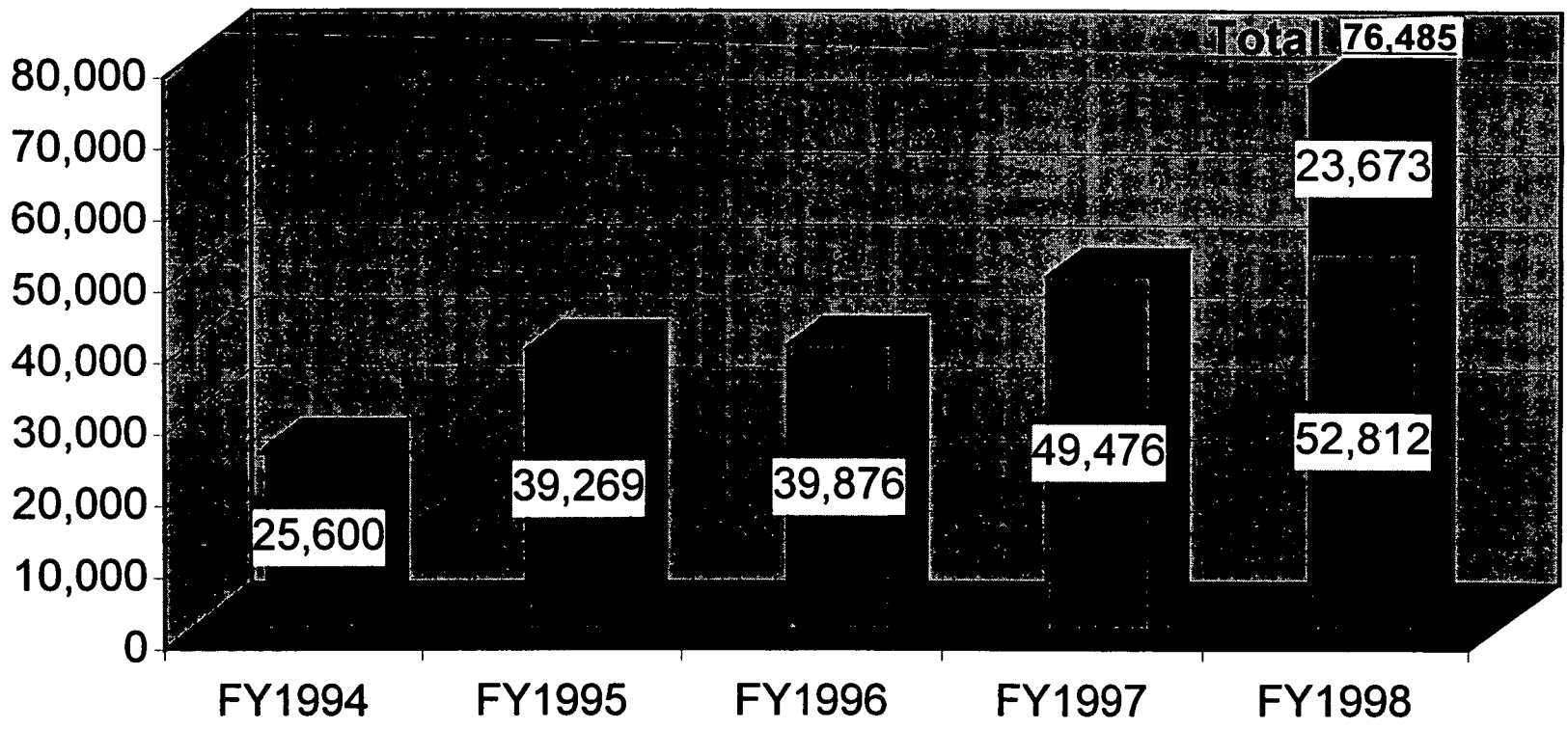
Figure 1, attached, reflects the data on children served which was presented last week. In question was the increase from SFY 97 to SFY 98 of 27,009 children. Understandably, questions were raised regarding what were the mental health needs of the children who were reflected in this increase.

The SFY 98 number of 76,485 reflects a broader definition of children served. In previous years the number of children served was based on those children with a principal mental health diagnosis who received mental health treatment services through the Area Programs. While very useful information, this count does not reflect children with dual diagnoses and those for whom diagnoses are pending results of comprehensive evaluations. The figure for SFY 98 reflects an improved approach to counting children served which includes *all children with a mental health diagnosis, including those who have a principal diagnosis in the area of developmental disabilities or substance abuse and also have need of mental health treatment.*

We believe that this approach better reflects the number of children served with mental health treatment needs. To reflect this improved approach, the data for SFY 98 is being presented in two parts: the children served, which is calculated using the same approach as in previous years (the lighter portion of the bar graph) and the additional children served when the dual diagnosis count is included (the darker portion of the bar graph). Thus, the increase from SFY 97 to 98 is better understood as being the difference between 49, 476 and 52,812 or 3, 336 children. The additional 23,763 reflected for SFY 98 are children whose principal diagnosis is in the developmental disabilities or substance abuse areas *and who also have a mental health diagnosis and received mental health treatment.* We will continue to reflect this data in future years as the treatment of children with dual diagnoses is one of the three target populations identified by the General Assembly in the NC Child Mental Health Plan.

Table 1, Child Mental Health Statistics, attached, provides a summary of the total number of children served by the Area Programs, the institutions with child psychiatric units and Wright and Whitaker Schools.

Figure 1. Number of Children and Adolescents Receiving Mental Health Services from Area Programs



p. 2

Formerly reported as 76,000, a rounded figure. The total of 76,485 children includes 52,812 with principal MH diagnosis and 23,188 with dual diagnoses.

Table 1				
Child Mental Health Statistics- FY 1998				
	Area Programs	**Psychiatric Hospitals**	**Wright**	**Whitaker**
Active 7-1-97	46,082	159	33	31
Admissions	30,403	1,289	44	30
Termination	17,706	1,273	40	21
Active 6-30-98	58,779	160	37	40
Persons Served	**76,485**	**1,331**	**77**	**61**

As a result of the Committee's discussion after the last presentation, several additional questions were raised concerning the profile of the children served through Area Programs. The data which follows is for SFY 98, unless otherwise noted. Table 2, below, reflects the number of children served in the area of child mental health by specific Pioneer services, a summary of the volume of service units provided to children with a principal mental health diagnosis in each of the service areas is provided.

Table 2

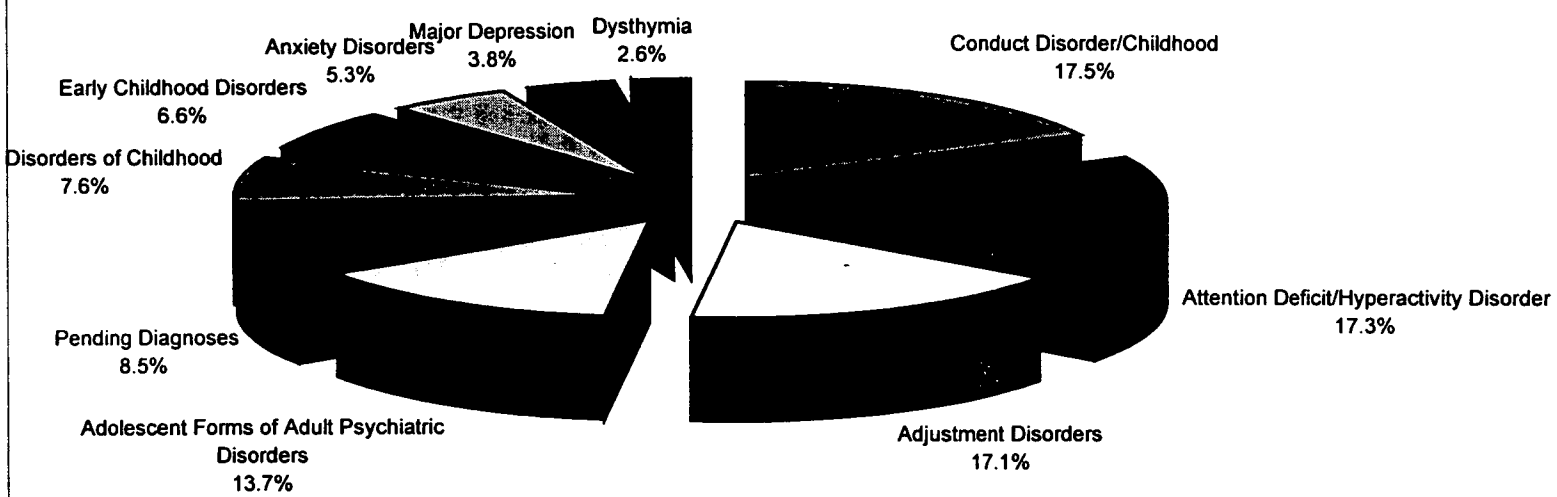
Number of Children Served and the Volume of Pioneer Services Provided In SFY 98

Pioneer Service	# Children Served	Volume of Service Provided	
		Unit	Volume
Personal Assistance	20	Hour	610
CBI	69	Hour	559,160
General Periodic	52,812	Hour	939,350
Developmental Day	58	Hour	12,916
Sheltered Workshop	3	Hour	1,186
Day Activity	174	Hour	9,819
Day Treatment/PH	499	Hour	165,253
Partial Hospital	255	Hour	26,221
Community Respite	297	Hour	11,305
Family Living Moderate	515	Day	68,095
Group Living Low	7	Day	190
Group Living Moderate	341	Day	54,569
Group Living High	776	Day	76,018
Detox, Social Setting	7	Day	77
Facility Based Crisis	86	Day	9,032
Inpatient Hospital	583	Day	8,520

Note: The number of children served reflects a duplicated count, as some children received more than general periodic services.

Figure 2 that follows on the next page reflects the percentage of total children served by the most commonly occurring diagnosis.

Figure 2. Diagnostic Profile of Children Served in FY1998



NC DMH/DD/SAS
Child and Family Services
Cultural Competence Initiative

Over the past four years, the Child and Family Services Section of the North Carolina Division of MH/DD/SAS has led the cultural competence initiative, "Weaving An Agenda for Progress" by sponsoring two statewide conferences on providing culturally responsive care to children and their families. In partnership with the University of North Carolina at Chapel Hill, Old North State and the Urban League of Winston-Salem, regional and community trainings have been held throughout the state. Public Academic Liaisons (PALs) with this Section and community mental health service providers have integrated components of this initiative as pre-service and inservice training initiatives are developed.

The Child and Family Services Section and the NC Division of Social Services have a collaborative agreement to develop a comprehensive training plan for cultural competence. This long-range training plan will involve the partnership of health care service providers, educational agencies, family and advocate agencies, universities, community colleges, historically black colleges and several community based non-profit agencies. Training will be designed for area mental health program and county social services staff as well as staff of other child-serving agencies.

The proposed plan will have a broad focus and will address various training needs such as pre-service training, inservice training and integration into existing DMH/DD/SAS and DSS training efforts and curricula. The plan will target a broad-based audience of community service providers and community members. Training strategies and incentives that will be developed to support area boards, social services boards, program administration and staff.

This planning process will be driven by a comprehensive needs assessment which will provide a baseline evaluation of a local program's cultural competence. Items evaluated will include local program's administrative focus on cultural competence, ability of programs to provide culturally appropriate interventions and staff diversity issues. This information will also assist in developing targeted training opportunities for area mental health programs and their partner agencies. This initiative will have lasting impact on children and families services, enhancing the current implementation of and future provision of pre-service provider preparation, program administration and service delivery in North Carolina.

Cultural Competence Task Force
On
Child and Family Mental Health Services

Child and Family Services Section
Division of MH/DD/SAS

A Working Definition of Cultural Competence

While there are many definitions of cultural competence, for our purposes, the one developed by the National Center for Cultural Competence (NCCC) located at the Georgetown University Child Development Center. The National Center for Cultural Competence posits that to become culturally competent, a community system of services and supports for children and families must have the following:

- a defined set of values, principles, structures, attitudes and practices that encompass cultural competency;
- a belief that cultural competence occurs both at the organizational and individual levels and is an ongoing process of development; and
- The belief that cultural competence must be incorporated at every level of an organization, including policy making, administrative, practice and consumer/family levels. Agencies, school systems and other organizations should work on being culturally competent, not just service providers, teachers and others interacting directly with families.

The NCCC further defines cultural competence at the individual level as having the values, skills, knowledge, attitudes and attributes to work effectively in cross-cultural situations.

Using this definition as a starting point and building on System of Care principles, we propose to work together to develop a broad base plan to assist Area Mental Health Programs provide services in a more culturally competent manner.

Task Force Subcommittee Topical Areas of Focus

— **Personnel Issues-** which focuses on strategies for recruitment, hiring, supervision, and retention practices to promote a culturally competent and culturally diverse workforce

— **Training and Staff Development-** which focuses on strategies for increasing the knowledge and skills necessary for culturally competent supervision and service delivery.

— **Best Practice in Service Delivery-** which focuses on strategies for culturally competent and culturally specific programs and interventions.

— **Quality Improvement-** which focuses on strategies to ensure quality of services and to integrate cultural competence into new and existing accreditation criteria.

— **Outreach and Community Partnerships-**, which focuses on strategies to enhance, access to services by culturally diverse populations and strategies to build supportive relationships between providers, service agencies, and culturally diverse communities.

HOUSE COMMITTEE ON MENTAL HEALTH

MAY 4, 1999
10:00 AM
Room 1425

AGENDA

Chair(s): Rep. Wayne Goodwin

INTRODUCTIONS

SPEAKERS Dr. Pat Porter, PhD-Chief, Developmental Disabilities Services Section, DMH
Mary Eldridge, Chief, Crisis Services Section, DMH

DISCUSSION

ADJOURNMENT

MINUTES
HOUSE COMMITTEE ON MENTAL HEALTH
MAY 4, 1999
RM. 415 LOB

The House Committee on Mental Health met on Tuesday, May 4, 1999 in Room 415 of the Legislative Office Building at 10:00 AM. The following members were present: Chairs- representatives Crawford and Goodwin (Presiding), Representatives Horn, Insko, Nye, Oldham. Kory Goldsmith and Linda Attarian, committee staff, were also present. A visitor registration list is attached and made part of these minutes.

Representative Goodwin introduced the pages for the day, and members of Coalition 2001 in the audience stood and introduced themselves. Dr. Pat Porter, Chief of Developmental Disabilities Services at the Department of Mental Health was introduced. Dr. Porter spoke from a handout entitled "Developmental Disability Services of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services". She gave an overview of services available, explained the Single Portal of Entry/Exit, and discussed the waiting list for Developmental Disabilities Services. Several members of the committee asked questions about the various programs. Mary Eldridge, Chief of Crisis Services was asked to return due to shortness of time.

Rep. Goodwin adjourned the meeting at 10:50 AM.

Rep. Wayne Goodwin
Chairman

Kristen Younts
Committee Assistant

VISITOR REGISTRATION SHEET

Mental Health — Name of Committee

5/4/99 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

28

NAME	FIRM OR AGENCY AND ADDRESS
Michelle Cotton	DMH/DD/SAS
Terry Stelle	DMH/DD/SAS
Mary Eldridge	DMH/DD/SAS
Pat Porter	DMH/DD/SAS
Patrice Roesler	NCACC
Peggy Mangum	GPM INC
[illegible] Bowe	Bowe + Assoc.
Lou B. Wilson	NCALTCF.
John Tote	MHANC - C2001
[illegible] Simoneau	NC Council
Max Brownlee	GACPD - Coal For 2001
Josie Douglas	NCAD + Coalition 2001
Katherine Miller	Harry Kaplan
Larry Thompson	Blue Ridge Center
Nancy Carey	Blue Ridge, MHA in NC, NAMI-NC, PAIMI
Martha Stewart	MHA - High Point + NC
Ellen [illegible]	MHA - High Point
Bob Hedrick	CNC - Raleigh, N.C.
Melissa Boyette	Johnston Co. MHA
Curt Eccleston	Div. MH/DD/SAS
Paul W. Schmeyer	N.C. Assoc. of the Deaf - Adv Council for MHDHH
Linda Nelson	NC Assoc of the Deaf - NC Mental Health Adv. Council
Kathy Beetham	Legislative Services - Sign Lang Interprete.
Martha Williamson	Legislative Services - Sign Language Interpreter
Myrna Miller	NASW-NC
[illegible]	Tarheel Political [illegible]
Mary Miller	NAMI-Forsyth CenterPoint
Rachel Radford	NAMI NC

VISITOR REGISTRATION SHEET

Mental Health — 5/4/99
Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Norma Moorefield	Mental Health Assn. Davidson Co.
Margie Doty	Mental Health Ass. Davidson Co.
Judy Hanson	" " " "
Kay K. Sanderson	" " " "
Janet W. Ward	" " Randolph Co.
Sheila M. McCain	" " Randolph Co.
RUTH ELLIOT Leg Sec'y	" " RANDOLPH CO.
Karen Luken	NCRTA -
Vince Richard	AFR/NC

Developmental Disability Services

of the

Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

Patricia B. Porter, Ph.D., Chief

Overview

- Disabilities occur within the developmental period or at any age for persons with traumatic brain injury.
- Includes all ages.
- Causes vary widely.
- Services and supports are life long.
- Early intervention works.

Services and Supports

- Goal and outcome for each person is to live in the least restrictive environment, to be as productive and independent as possible, and to participate fully in the life of the community.
- The array of services and supports is very large.

Single Portal of Entry/Exit

- Door to services is through the Area Programs.
- The person and his family are at the center of the process.
- Service and support plan is custom developed for each individual.
- Resources are brought together by the Area Interagency Council.
- Available services are provided immediately – if services are unavailable, the individual's name is placed on the computerized DD Waiting List.

Current Services

- 40,000 people with developmental disabilities are receiving services.
- There has been an 81% increase in community services during the past six years.
- Reduced number of persons living in mental retardation centers by 17%; increased outreach by 500%.
- North Carolina is sixth in the country in our investment in family support.
- North Carolina is among the top five states in early intervention services.
- Too many people remain unemployed.
- Need for more small, cost effective community residential options.
- Need to assure access to services and supports.
- Need to give consumers and families more control over services they receive and persons who provide those services.
- Need to assure a stable, well-trained service coordination and direct support work force.
- Reduce the number still waiting.

Developmental Disabilities Waiting List

- Implemented five years ago as part of the Single Portal statute.
- Invaluable in identification of service gaps and needs.
- January 1998, 7,178 children and adults were waiting.
- $12.5 million appropriated by the General Assembly; $6 million state dollars, $6 million TANF transfer, $500,000 for management of the effort to reduce numbers on the list. (DHHS reduced TANF by $2.7 million in February 1999)
- Money allocated to Area Programs based on their waiting list numbers.
- Technical assistance, program support, and utilization tracking have been provided to Area Programs.
- Outcomes
  - Areas can serve people wisely and well. (See attached data.)
  - It is easier to place people in already existing services.
  - Private vendors are willing and able to provide services.
  - Availability of technical assistance is critical.
  - The $500,000 appropriated to assist in management must be continued.
  - Single Portal requires clear focus and local administrative support.
  - Funds appropriated must be flexible.
  - People are still waiting.

Individuals Removed From DD Waiting List (Summary)
(All Input to Date)

Region Area Program	Goals	Individuals	CAP	State	TANF 1-98	TANF 7-98	TANF 1-99	State +TANF	Consortium	Medicaid	Other	TBI	Sum of Services	Average of Services
Eastern														
Southeastern	24	30	12	10	2	0	0	12	0	16	8	2	82	2.7
Onslow	30	171	0	155	17	0	0	172	0	0	0	1	293	1.7
Wayne	6	8	1	6	0	0	0	6	0	2	0	0	8	1.0
Wilson-Greene	11	44	9	2	2	0	0	4	0	29	9	1	51	1.2
Edgecombe-Nash	8	42	22	6	0	0	0	6	0	6	28	0	44	1.0
Halifax	13	104	16	3	1	0	0	4	0	61	46	1	195	1.9
Neuse	9	56	9	10	2	0	0	12	0	22	46	1	78	1.4
Lenoir	8	6	1	4	0	0	0	4	0	0	1	0	6	1.0
Pitt County	8	34	9	2	0	0	0	2	0	18	30	0	45	1.4
Roanoke-Chowan	5	19	7	3	0	0	0	3	0	2	11	0	23	1.2
Tideland	6	23	12	8	2	1	0	11	0	0	3	0	23	1.0
Albemarle	5	16	1	8	3	0	0	11	0	0	11	3	16	1.0
Duplin-Sampson	5	11	2	0	0	0	0	0	0	8	2	0	15	1.4
Region Totals:	139	564	101	217	29	1	0	247	0	164	195	9	879	1.6
North Central														
Crossroads	13	24	14	4	0	0	0	4	0	2	10	1	27	1.1
Centerpoint	25	62	27	14	1	0	0	15	0	9	17	4	80	1.3
Rockingham	1	8	7	0	0	0	0	0	0	2	1	0	18	2.3
Guilford	33	96	11	6	1	0	0	7	0	3	87	8	114	1.2
Alamance-Caswell	10	6	0	5	0	0	0	5	0	1	4	0	6	1.0
O-P-C	22	84	31	14	0	0	0	15	1	6	12	1	122	1.6
Durham	9	23	11	7	0	0	0	7	0	0	4	1	33	1.4

Area Program	Region Goals	Individuals	CAP	State	TANF 1-98	TANF 7-98	TANF 1-99	State +TANF	Consortium	Medicaid	Other	TBI	Sum of Services	Average of Services
V-G-F-W	8	10	3	7	0	0	0	7	0	0	0	2	10	1.0
Region Totals:	121	313	104	57	2	0	0	60	1	23	135	17	410	1.3
South Central														
Davidson	14	22	7	7	6	0	0	13	0	18	9	1	21	1.1
Sandhills	12	13	4	7	0	1	0	8	0	0	1	0	13	1.0
Southeastern Reg.	18	40	19	5	1	0	0	6	0	19	11	6	92	2.3
Cumberland	15	117	63	0	0	0	1	1	0	9	42	1	111	1.4
Lee-Harnett	9	18	0	14	1	0	0	15	0	2	1	2	18	1.0
Johnston	3	1	0	0	0	0	0	0	0	1	1	0	1	1.0
Wake	55	160	103	31	0	0	0	31	0	2	43	0	176	1.1
Randolph	4	30	12	8	0	0	0	8	0	13	10	1	30	1.0
Region Totals:	130	401	208	72	8	1	1	82	0	64	118	11	462	1.3
Western														
Smoky Mtn.	19	48	7	18	6	0	0	24	0	24	42	2	90	1.9
Blue Ridge	27	46	21	17	0	0	0	17	0	5	23	6	81	1.8
New River	9	29	11	8	1	1	0	10	0	3	9	2	50	1.8
TREND	15	17	3	8	0	0	0	8	0	9	1	0	18	1.1
Foothills	18	24	7	17	0	0	0	17	0	7	1	3	19	0.9
Rutherford-Polk	4	13	9	0	0	0	0	0	0	1	4	1	11	1.0
Cleveland	23	34	5	7	0	0	0	7	0	22	7	0	42	1.2
Gaston-Lincoln	23	39	2	5	0	0	0	5	0	1	4	3	11	0.3
Catawba	12	14	8	3	0	0	0	3	0	0	4	1	23	1.6
Mecklenburg	26	35	0	25	0	0	1	26	0	14	23	1	73	2.1
Piedmont	19	62	28	21	0	0	0	21	0	0	14	0	63	1.9
Region Totals:	189	361	101	129	7	1	1	138	0	86	132	19	481	1.5
State Totals:	578	1639	514	475	46	3	2	527	1	337	580	56	2232	1.4

HOUSE COMMITTEE ON MENTAL HEALTH

May 11, 1999
10:00 a.m.
Room 415

AGENDA

Chair: Rep. Jim Crawford

INTRODUCTIONS

SPEAKERS Willie M Program and Services
Charles Davis, Director Willie M Services

Futures Committee Report
Dr. Lenore Behar, Chief, Child and Family Services

DISCUSSION

ADJOURNMENT

MINUTES
HOUSE COMMITTEE ON MENTAL HEALTH
MAY 11, 1999

The House Committee on Mental Health met on Tuesday, May 11, 1999 in Room 415 of the Legislative Office Building at 10:00 a.m. The following members were present: Chairman Jim Crawford, Representatives Esposito, Horn, Nye, Oldham, and Warwick. Linda Attarian and Kory Goldsmith, staff counselors, attended. A visitor registration list is attached and made part of these minutes. Chairman Crawford introduced the pages for the day.

Chairman Crawford introduced Charles Davis, Director, Willie M. Services. Mr. Davis provided members a copy of "Report to the Governor and the General Assembly on the Willie M. Program, 1998-1999." Rep. Warwick asked for a current definition of Willie M. which Mr. Davis described as emotionally, neurologically or behaviorally handicapped children with violent or assaultive behavior. He provided data on client make-up, diagnoses which comprise Willie M, and costs. The current cost per client is $51,456 with the majority of cost going for residential care. At the direction of the General Assembly, DHHS developed an assessment and outcome instrument and can provide several years' data on results. Mr. Davis talked about the future challenges to the program with the most important being maintaining an individualized service system for high-risk children.

Chairman Crawford introduced Dr. Lenore Behar, Director, Child and Family Services. Dr. Behar handed out copies of "Report of the Futures Committee" which she co-chaired with Charles Davis. The Futures Committee was created to review the recommendation of the MGT Study regarding closure of the child and adolescent inpatient psychiatric units at State Hospitals and to review efforts to develop local systems of care and to make recommendations for change. The 70 member committee was made up of state staff, local agency staff, parents, providers, attorneys, etc. and had very little disagreement. Dr. Behar discussed the recommendations from the committee and the tasks that need to be addressed—one being updating the *Child Mental Health Plan.* At Rep. Esposito's request, Dr. Behar indicated that resource persons with early intervention expertise will be used when updating the plan.

Chairman Crawford adjourned the meeting at 11:00.

Respectfully submitted,

Representative Jim Crawford
Chairman

Linda S. Winstead
Committee Assistant

VISITOR REGISTRATION SHEET

MENTAL HEALTH
Name of Committee

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

	NAME	FIRM OR AGENCY AND ADDRESS
1	Wayne Wilson	OSBM
2	Bob Hedrick	CNC, Inc.
3	Sally Cameron	NCPA
4	Sandra Lane	NCAPP
5	Wayne Lynch	MH/DD/SAS
6	Jerene Bellen	MH/DD/SAS
7	MICHELLE COTTON	DMH/DD/SAS
8	Terry Stelle	DMH/DD/SAS
9	Tommy Worth	Carolina Health Care System
10	Katherine Miller	Mary Kay Inc
11	AL DeTECH	DOA/VAID
12	Karen Chester	NC - ICC
13	Janet Simmons	NC Council

WILLIE M. PROGRAM

PRESENTATION TO THE HOUSE MENTAL HEALTH COMMITTEE

CHARLES DAVIS,
CHIEF,
WILLIE M. SECTION

MAY 11, 1999

THE WILLIE M. PROGRAM

- WHO ARE THE **WILLIE M.** CLIENTS?
- WHAT SERVICES DO WE PROVIDE?
- WHAT DO **WILLIE M.** SERVICES COST?
- WHAT ARE THE OUTCOMES OF **WILLIE M.** SERVICES?
- FUTURE CHALLENGES

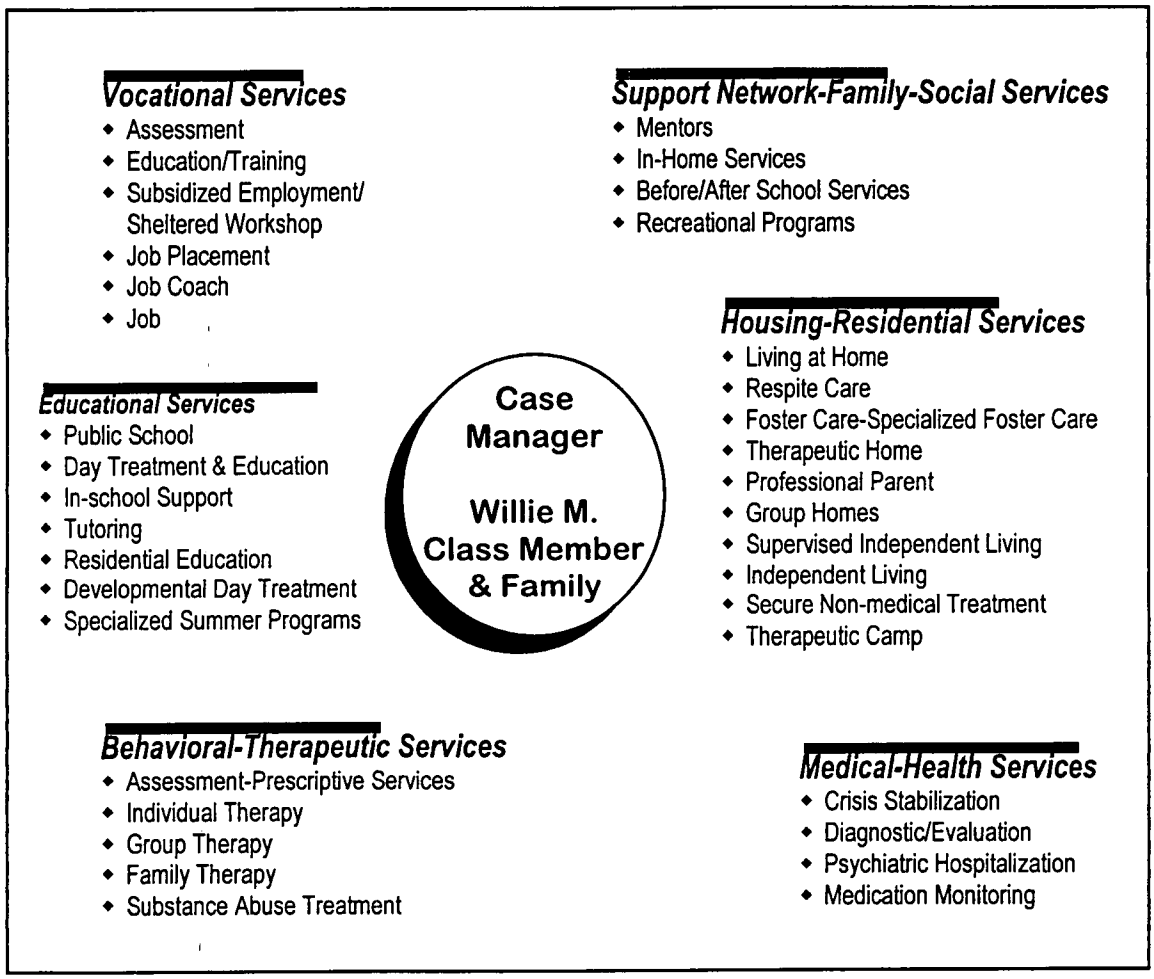
WILLIE M. CLIENTS

- Emotionally, neurologically or behaviorally handicapped with accompanying violent or assaultive behavior
- Slightly less than 1 in every 1,000 children
- Average age 14.7; 25% are 12 or under
- 82% male; 18% female
- 54% white; 41 % African-American; 5% other ethnic backgrounds
- Variety of diagnoses:
  - Conduct Disorder
  - Attention Deficit/Hyperactivity
  - Depressive Disorders
  - Mental Retardation
  - Post-Traumatic Stress
  - Plus many others

WILLIE M. SERVICES

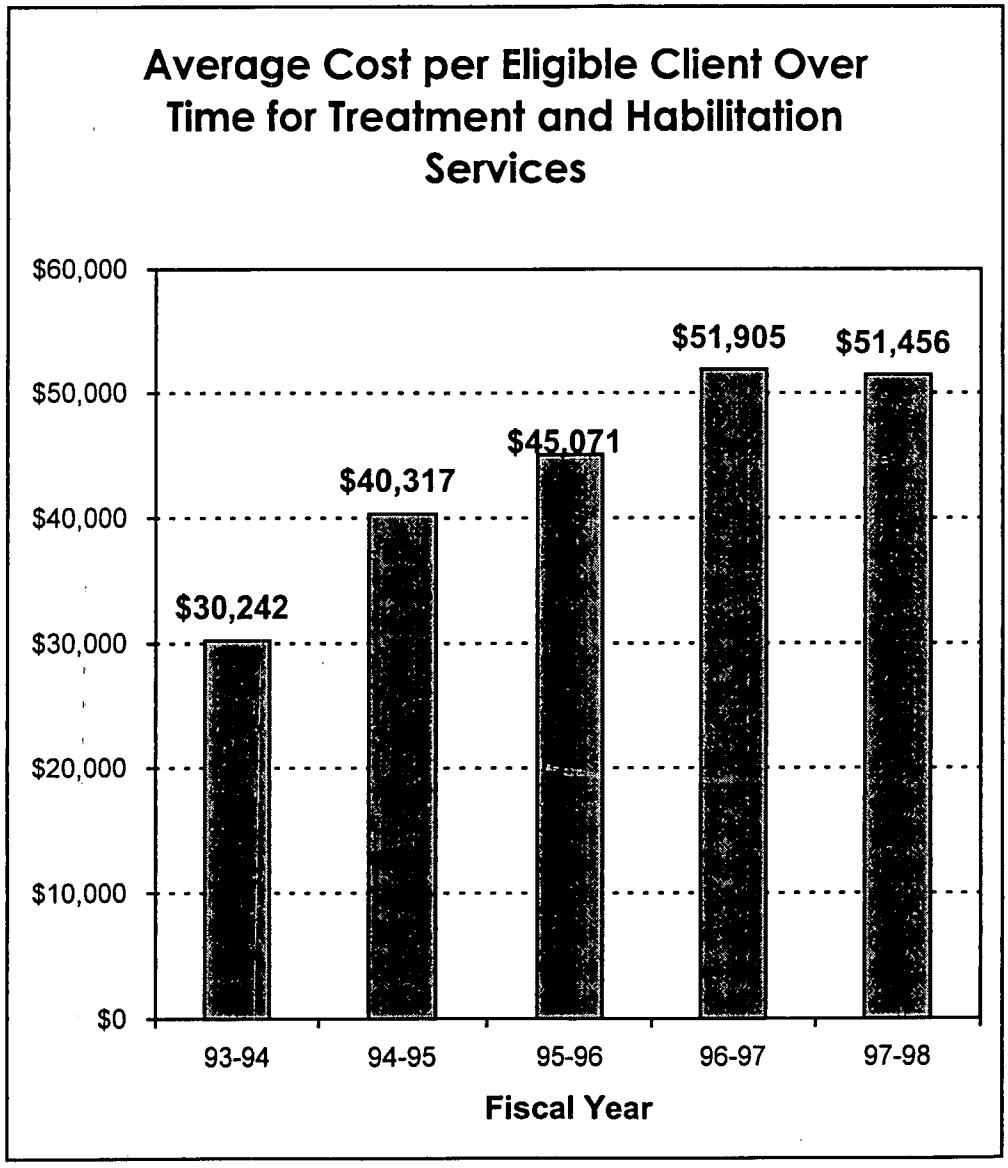
- All children receive comprehensive annual assessments
- The Treatment/Habilitation Plan (THP) is created by interdisciplinary team in concert with parent/guardian and child
- An individual case manager assigned to every client

WILLIE M.
SYSTEM OF SERVICES



COSTS OF WILLIE M. SERVICES

- Average costs of services per child $51,456 in 1997-98
- For comparison — average cost for child in training school for 1 year is $48,000



COSTS OF WILLIE M. SERVICES

Willie M. Service Costs 1997-98

Case Management	$ 7,188,152
Other Staff Services	$ 17,411,121
Alternative Family Living	$ 5,461,434
Group Residential	$ 44,445,939
Day Services	$ 3,772,950
Total	$ 78,279,596

OUTCOMES OF WILLIE M. SERVICES

- General Assembly required comprehensive assessments of **Willie M.** clients
- DHHS developed Assessment and Outcome Instrument (AOI)
- The AOI has over 300 items about functioning levels, psychiatric symptoms, risk and protective factors
- We have several years of data on many clients now — and can measure results

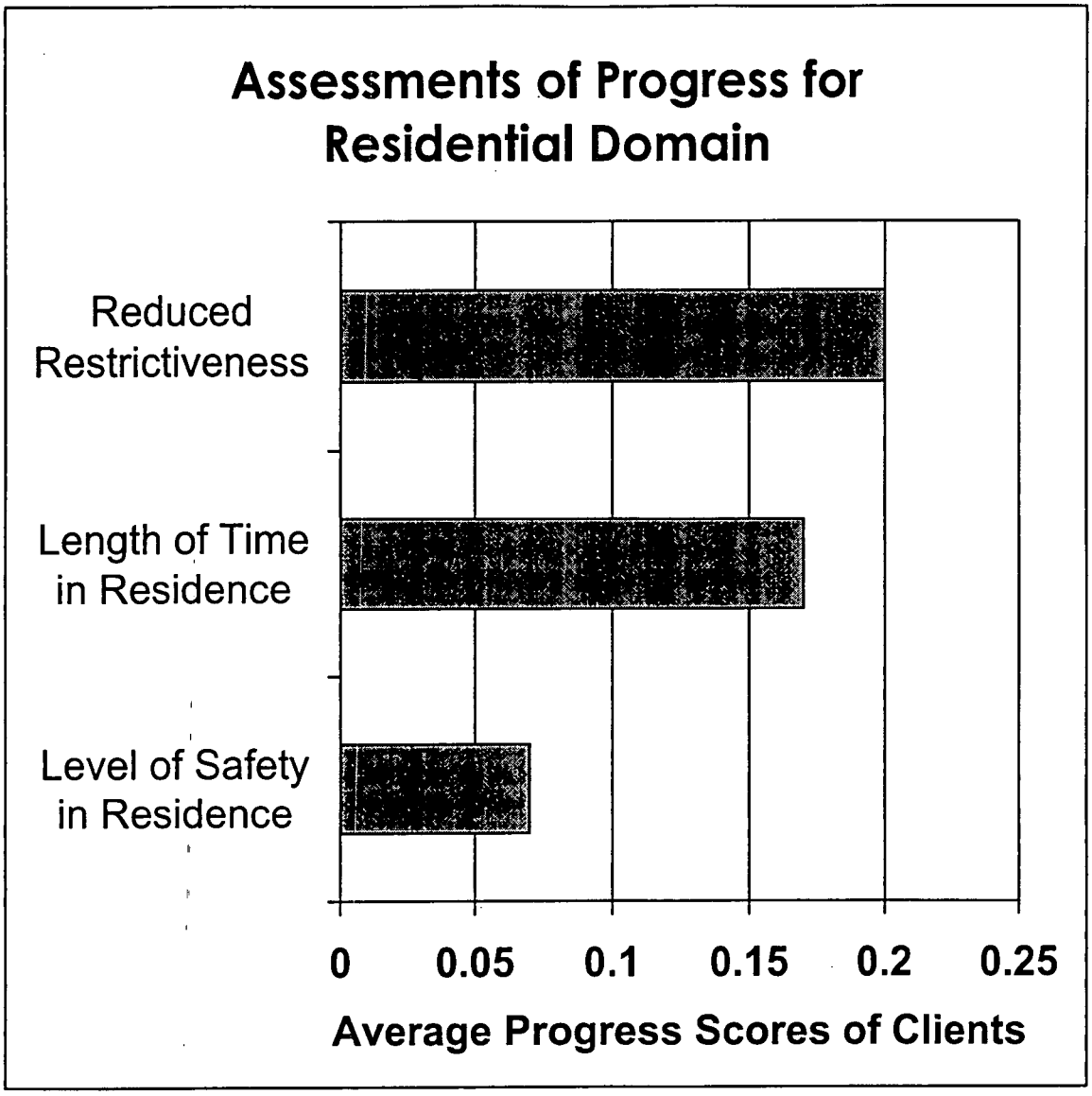

Assessments of Progress for Residential Domain
Reduced Restrictiveness
Length of Time in Residence
Level of Safety in Residence
0
0.05
0.1
0.15
0.2
0.25
Average Progress Scores of Clients

Figure 11
Progress in Reducing Psychiatric Symptoms

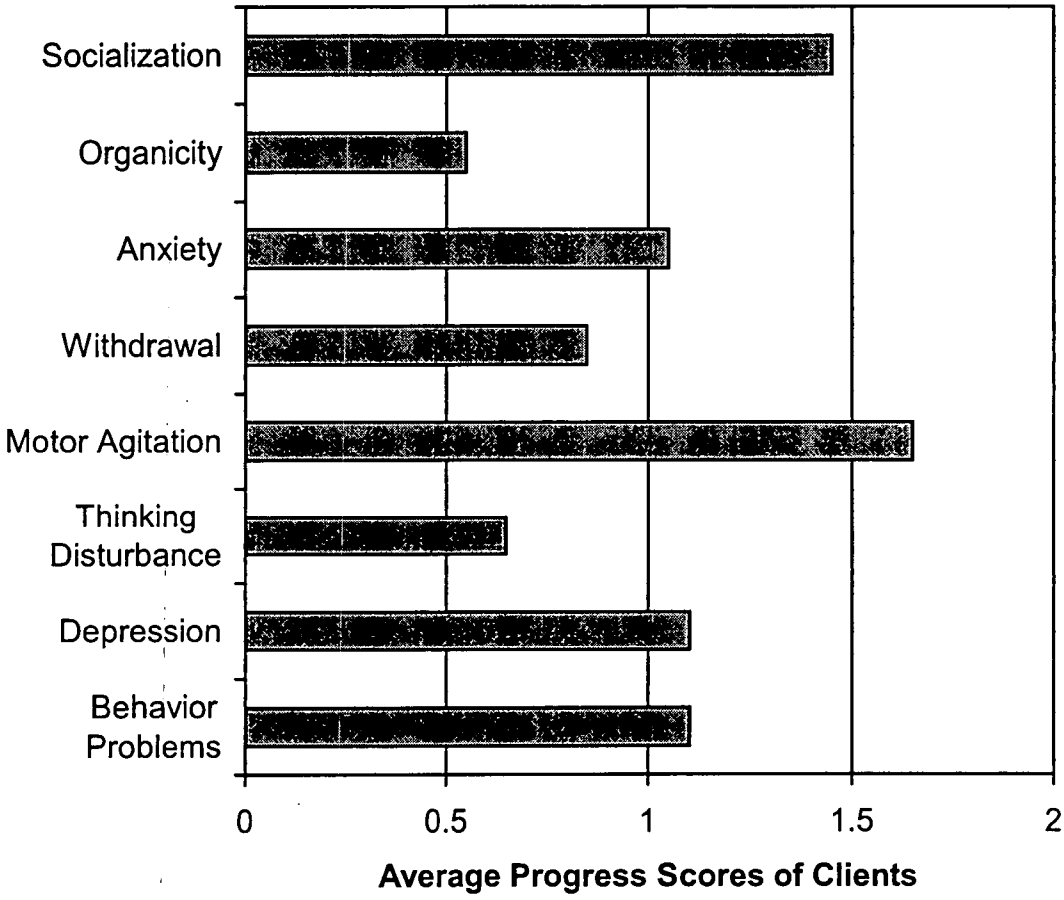
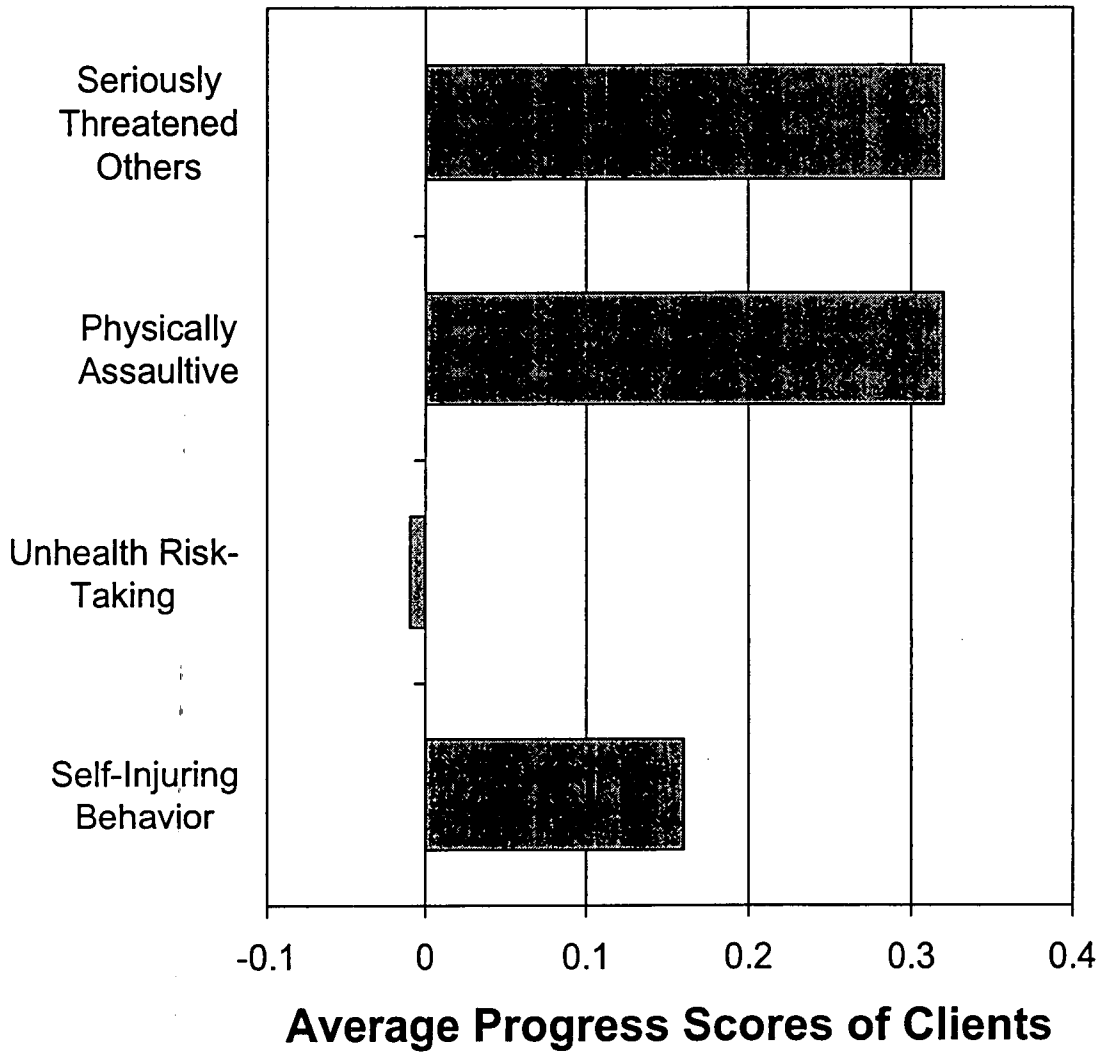


Figure 12
Progress in Behavioral Functioning



FUTURE CHALLENGES

- Maintain individualized service system for high-risk children
- Respond to new demands:
  - Higher caseloads
  - Demands from Juvenile Courts
  - Demands from local schools
- Increased coordination and joint programming with other child programs
- Provide models for Design Process
- Futures Committee

#2

REPORT TO THE GOVERNOR
AND
THE GENERAL ASSEMBLY
ON
THE WILLIE M. PROGRAM

1998-1999

NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Mental Health, Developmental Disabilities
and Substance Abuse Services
325 North Salisbury Street
Raleigh, North Carolina 27603-5906

AND

NORTH CAROLINA
DEPARTMENT OF PUBLIC INSTRUCTION
Exceptional Children Support Team
301 North Wilmington Street
Raleigh, North Carolina 27601-2825

May 1, 1999

REPORT OF THE FUTURES COMMITTEE

MENTAL HEALTH SERVICES FOR CHILDREN[1] AND FAMILIES

March 10, 1999

TABLE OF CONTENTS

[1] The term "children" includes those from birth to age 18.

FORWARD

The Child Futures Committee was established to respond to the Legislature's request for a study of hospital services, including the child and adolescent inpatient psychiatric units in State hospitals, and to develop a plan for reconfiguring the services provided by the hospitals for children and adolescents. The impetus for planning developed out of two separate circumstances. The first involved recommendations from a recent study by *MGT*, a consulting firm engaged by the Legislature, that called for the inpatient child and adolescent hospital to be moved out of the State hospitals. The second impetus for action were the retrospective reviews of Medicaid clients by First Mental Health, Inc. that indicated many of the children and adolescents served in the hospitals were inappropriately placed. Evaluation of these issues caused the Child Futures Committee to expand its consideration of planning alternatives to include community services as an option to hospitalization and location of possible aftercare services for those hospitalized.

The members of the Child Futures Committee listed in Appendix A, represent a broad cross-section of people concerned about children, and the families of children, needing behavioral health services. Although their perspectives differed considerably, their views about services to this population were amazingly similar. Accordingly, the report reflects a true consensus of the members on these issues. And, it is noted that this consensus was reached with great ease. It is not an exaggeration to say that the parents and professionals from many walks of life came together with a unified view of how behavioral health services ought to be provided in North Carolina.

The final product reflected here grew out of considerable work on the part of the members—25 hours of formal meetings of the whole group and an equal number of subcommittee meetings between December 1, 1998 and March 15, 1999. We are grateful to the membership for their individual and collective dedication to the task, for their wisdom in shaping the report and, above all, for their commitment to the children and families that permeated every minute of their work. It was a remarkable pleasure to chair this committee.

Lenore Behar, Ph.D.
Chief, Child & Family Services

Charles Davis
Chief, Willie M. Services

I. EXECUTIVE SUMMARY

The Child Futures Committee is a broad-based group convened to review the full range of diagnostic and treatment needs of North Carolina's children with behavioral health needs as well as the support requirements of the families that nourish them. The Committee adopted and proposes a set of Values and Principles that they believe must underlie any established system of services. Moreover, the Committee has delineated a "System of Services" that it believes must be available in order for the effective treatment of children with behavioral health service needs to be achieved. The agreed upon Values and Principles and a listing of the Services Needed to Support an Effective System of Care are provided in detail in Sections 4 and 5 of the Committee's full report. The following specific recommendations are made as initial steps toward implementation of that system and are delineated more fully in Section 3 of the Report:

- The child and adolescent in-patient psychiatric units located at the State Psychiatric Hospitals must not be closed.
- No major changes should be made to one aspect of the child and family service system without considering the possible end-result effects on all other aspects of the system.
- Services must be outcome driven and have improved functioning of the child and family as their primary goal.
- Child behavioral health service delivery must be prioritized toward specific populations.
- There must be one cross-agency (public and private) plan for the child that assures the delivery of comprehensive, coordinated services.
- The child behavioral health service system must be designed and managed to ensure the delivery of timely, clinically sound, effective, and cost efficient services to both the children with behavioral health needs and families that nourish them.
- There must be adequate resources (staff, programs, and funds) to provide needed services for all children.
- The following tasks need to be addressed in the future:
    - Update the *Child Mental Health Plan*
    - Examine distribution of high-end residential treatment resources

II. INTRODUCTION

In November 1998, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) convened a large group of stakeholders to form the Child Futures Committee (see Appendix A for a membership list). The Committee was charged with a two-fold responsibility. The first charge focused on review of the recommendations in the *MGT* Study regarding closure of the child and adolescent inpatient psychiatric units located at the State Hospitals and the associated initial response from the Department of Health and Human Services. The second charge directed the Committee to review North Carolina's efforts to develop local systems of care which are responsive to the full range of diagnostic and treatment needs of the child population and of their families, and to make recommendations for change.

The purpose and value of State operated psychiatric inpatient services and other high end residential services were considered in this broader context. The Child Futures Committee activity was carefully planned to ensure that all salient issues were identified and examined. The Committee held five day-long meetings between November of 1998 and March of 1999. Each of the recommendations contained herein provides support for the continued development of child and adolescent services in North Carolina. The Committee's recommendations are associated with the following source of information, administrative association, and expressed beliefs:

- ***MGT* Study:** In 1997 the North Carolina General Assembly commissioned a study of the psychiatric hospital services provided by DMH/DD/SAS in order to gain greater insight into program efficiency and obtain recommendations related to strengthening program operation. The consulting firm of *MGT of America* was contracted to undertake this research. Included in the final *MGT* Study was Recommendation 9.3, which addressed closing child and adolescent inpatient psychiatric units in State hospitals, by stating: *"Develop a strategy in conjunction with area authorities to close youth units and utilize community resources for these patients."*

  The Department of Health and Human Service's (DHHS) response to the *MGT* Study rejected Recommendation 9.3 and called for the creation of a stakeholder group to "assess the services that the State hospitals currently provide to children and adolescents and to make recommendations for system improvement." This report represents the results of that initial assessment.

- **Design Team:** In January 1999, Dr. John Baggett, Director of DMH/DD/SAS, commissioned a work group to prepare recommendations for a new Division business plan model for use in coordinating the Division's work with Area Programs and the private sector. The Design Team's objective is to help the Division become a better "purchaser" of care for clients. The group will recommend priority populations, service strategies, structural, and the financing details of a desired public system of

services. Dr. Baggett has asked that a variety of stakeholder groups with specific interests in parts of the public system provide input to the Design Team on behalf of the clients or providers they represent. This report will be used by the Design Team to help define system features relevant to children's needs and services. The Child Futures Committee serves as a Specialty Advisory Group to the Design Team.

- **Legislative Discussion:** The Futures Committee believes that the General Assembly desires broad-based input into its deliberations about budgeting and substantive legislation regarding services for children and adolescents with behavioral health needs. In 1987, the North Carolina General Assembly, through the efforts of the Mental Health Study Commission, adopted the *North Carolina Child Mental Health Plan.* This *Plan* has heretofore provided the conceptual framework for all subsequent program and service development. Likewise, the *Child Mental Health Plan* has ensured that the development of services and programming has been consistent with the intentions of the needs of the citizens of North Carolina and the intentions of their legislative assembly. This current report is viewed as a starting point for an update of the *NC Child Mental Health Plan.*

III. RECOMMENDATIONS

The Child Futures Committee convened to review the full range of diagnostic and treatment services necessary to the ongoing support of those children with behavioral health service needs and the families that nourish them. The Committee adopted, and proposes, a set of Values and Principles that need to underlie any established system of services. Moreover, the Committee has delineated a "System of Services" that it believes must be available in order for the effective treatment of children with behavioral health service needs to be achieved. The agreed upon Values and Principles, and a listing of the Services Needed to Support an Effective System of Care, are presented in Sections 4 and 5 of this Report. The Committee is united in offering the following specific recommendations:

- **The child/adolescent units at the State psychiatric hospitals must not be closed.**

  The Child Futures Committee strongly disagrees with recommendation 9.3 in the *MGT* Study. The State hospitals are very much needed for children and adolescents with severe emotional disturbance (SED) and for those who have SED along with other serious behavioral and/or developmental problems.

  It should always be understood that the State psychiatric hospitals provide treatment for children with extreme needs. Even the **Willie M.** Program, with a fully financed system of services and a strong philosophy of "least restrictive settings," averages over 100 clients in acute care, long term high-end treatment, or in training schools awaiting long-term treatment.

- **No changes should be made to one aspect of the child and family service system without considering the possible end result effects on all other aspects of the system.**

  Since the adoption of the *North Carolina Child Mental Health Plan* by the General Assembly in 1987, efforts have been made to develop programming and services within the framework of an overall system. In general, any system change must be considered in the context of the full range of services that may be available on a regional or statewide basis in the public and private sectors.

  The Child Futures Committee recommends that the General Assembly give no consideration to restructuring the hospital services or 'high end' residential treatment services without an impact analysis on all aspects and components of the system. Any behavioral health system of care must provide a range of services, which corresponds to the full range of need in the consumer population.

- **Services must be outcome driven and have as their goal the improved functioning of the child and family.**

  Service planning should be driven by individual service outcome data. Individual consumer response to services should be carefully monitored and interventions should be modified, as needs change over time or when services fail to achieve intended outcomes. Individual outcome data should be aggregated to assess program and system effectiveness. Treatment decisions need to focus on the relevancy of the service rather than just on cost savings.

- **Child behavioral health service delivery should be prioritized toward specific populations.**

  The children of today are the adults of tomorrow. It is essential that children receive needed services to prevent more serious illness and the requirement of services as adults. The report is about real North Carolina children who are hurting and have needs for services.

  Included in this list are children:

  - in need of early intervention and prevention of worsening emotional disturbance,
  - with severe emotional disturbance (SED), and
  - with dual and/or multiple diagnoses.

Children with the SED[2] and/or dual/multiple diagnoses are likely to have:

- had multiple hospitalizations,
- had multiple crisis events,
- been abused and/or neglected,
- experienced significant decreases in ability to function in the community,
- received special education services in schools, and/or
- been served by the Office of Juvenile Justice and Department of Social Services (DSS).

- **There must be one cross-agency (public and private) plan for the child, that provides for comprehensive, coordinated services.**

The efforts of all child-serving agencies should be coordinated into a seamless system of care. Community plans should be developed for all children needing services from two or more agencies. For example, the success of behavioral health interventions is often dependent upon the provision of a variety of supports from multiple agencies such as the local Area Program, Department of Public Instruction, Office of Juvenile Justice, and/or the Department of Social Services. Indeed, few children are effectively serviced by a single agency.

- The child behavioral health service system must be designed and managed to ensure the delivery of timely, clinically sound, timely, effective and cost-efficient services to both the children with behavioral health needs and the families that nourish them. Effective intervention is dependent upon services from the public and private sector.

  To accomplish this the following should be implemented:

  - Clinically sound and humane practices should be implemented to manage services. In part this will involve replicating those aspects of the Carolina Alternatives system, which have proven useful.

  - A State-mandated Management Information System must be developed to gather data on all key points of system operation and service outcomes.

  - Case management or utilization management needs to be conducted by a single agency at the local level. While service provision can take many forms and

[2] The Center for Mental Health Services defines children with serious emotional disturbance as persons from birth up to age 18, who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified with *DSM-III-R*, that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community. (*Federal Register, 58 (95) 29422-29425, 1993*)

private sector participation should be encouraged in this arena, we believe that children and those that support them will be best served by a single agency holding the responsibility for care coordination and utilization management.

- Cost-effective strategies for managed services need to be adopted throughout the system.

- **There must be adequate resources (staff, programs and funds) to provide needed services for all children.**

  Excess capacity within the system should be identified and appropriately re-configured before new services are developed. Service resources should expand in response to unmet needs and growth in the service population. Dollars should be flexible to fund services across the continuum for all clients, and funding of services should also be flexible across agencies.

- **The following tasks need to be addressed in the future:**

  Update the *Child Mental Health Plan* - While the basic structure and intent of the *North Carolina Child Mental Health Plan* approved by the NC General Assembly in 1987, remains sound today, the *Plan* needs to be updated in the light of recent developments in managed care. Support for this position is found in a variety of actions and locations, e.g., changes in Medicaid policy, the end of Federal Court oversight in the **Willie M.** lawsuit, and our experience with various initiatives designed to implement elements of the *Plan*. The General Assembly is strongly encouraged to ask the *Legislative Study Commission on Mental Health, Developmental Disabilities and Substance Abuse* to review the *Plan* with the objective of reauthorization in the next Legislative Session.

  Examine distribution of high-end residential treatment resources - The distribution of acute psychiatric and high-end residential treatment resources should be examined at the State, regional and local levels. While the Committee believes strongly that the State hospital units should be maintained, there is a need to ensure that the specific types and distribution of beds across the State are responsive to specific needs of the clients. The Committee suggests additional study of current bed utilization and the overall need for such resources. Specific attention should be paid to the number of beds and types of resources provided by State and private hospitals and treatment centers.

IV. VALUES AND PRINCIPLES UNDERLYING AN EFFECTIVE SYSTEM OF CARE

Central to the effective delivery of services is the importance of a shared vision based on common values and principles. The Committee believes that a common, cross-agency mission statement should reflect the values and principles of the system of care around which it is organized. To this end, the Child Futures Committee recognizes the soundness, and worthiness for guidance, of the following values and principles:

- Each child is unique and individually worthy and shall receive services that recognize this individuality.
- Each child should be treated as a whole person who has social, emotional, educational, medical, and vocational needs that are interconnected.
- Family participation must be an integral and important part of the decision-making process.
- The system of care must provide services in the least restrictive and most appropriate setting (public or private) with emphasis placed on the development of community services.

SYSTEM, AGENCY, FUNDING

- There must be consistent, common core services available to citizens statewide.
- Standards of nationally recognized practice must be utilized in service delivery.
- There must be adequate resources (staff, programs and funds) to provide needed services
- Excess capacity within the system should be appropriately re-configured before new delivery systems are developed.
- Child needs must drive services, not dollars or politics. Dollars should be flexible to fund services across the continuum, and funding of services should also be flexible across agencies. Treatment should be tailored to the needs of the child.
- The system of care must provide services in the least restrictive and most appropriate setting, with emphasis placed on development of community services.
- There should be one cross-agency plan for a child, and treatment/support dollars should follow the child.
- Turf issues (cross-agency, cross-provider, etc.) should be resolved.

- The state psychiatric hospitals have a critical and needed role in providing services to children and should be an integral part of the system of care.

- Services for children should expand as the population of the state expands.

- Accountability measures within the system should assure children/families and policymakers that the system is meeting the needs of the child.

CHILD, FAMILY, TREATMENT

- Children should have access to mental health, developmental disabilities and substance abuse services if the parent/guardian/caretaker is concerned there is a problem.

- Children who have a need will be served in a timely manner.

- The system of care must be child-centered and family-focused, with the needs of the child and family dictating the types and mix of services provided.

- There should be a choice of providers.

- Service and choice/preference planning should be community-based with all stakeholders involved. It is crucial that families be involved as partners in all planning, interventions, and treatment.

- The uniqueness of the child in regard to race, gender, treatment needs, must be valued and respected.

- Children with long-term needs must be served with equal intensity as those with short-term needs.

- Opportunities should be provided for families and caregivers to receive appropriate training related to the specific needs of their child.

- Families and caregivers should be provided information about the service delivery system most closely associated with the needs of their child in order to assist them in accessing services, participating in service planning, and accessing appeal and grievance procedures.

SUPPORTS

- The system should have quality assurance and accountability through outcome measures.

- The system should include internal and external advocacy, and a grievance process, which includes due process and significant consequences.

- There should be an appropriate flow of information between and within agencies and with families.

- Prevention and early intervention must be an integral part of the service delivery system.

- Appropriate transitional services must be provided to prevent/minimize recidivism and relapse.

- The system of care should be culturally competent, with agencies, programs and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve. Services should be provided by competent staff who understands cultural diversity and are respectful of the child and family.

- All staff working with children and adolescents should be adequately prepared and properly trained to carry out their responsibilities effectively.

- Data should be used to develop and drive the planning process.

- Treatment and system decisions should be supported by appropriate outcome measures.

- A process to identify needs and appropriately match the child with services should be established and implemented on a statewide basis.

V. SERVICES NEEDED TO SUPPORT AN EFFECTIVE SYSTEM OF CARE

Service System Characteristics:

The Committee recognizes the importance of first defining a general service model in order to determine the specific type of behavioral health services (including mental health, substance abuse, and developmental disability services) that are needed. The services, which are outlined in this *Report*, are based on the following assumptions about the service delivery system:

- Family Based. Services for children must be provided in the context of their family system and be responsive to needs identified by families.

- Least Restrictive/Most Appropriate. Children are entitled to treatment in the least restrictive setting in which they can sustain their highest level of functioning.

- Community Based Services. Services should be, to the greatest practical extent, community based and result in the least disruption to the child's involvement in family, friendships, neighborhood activities, and school.

- Coordinated Care. Behavioral health service must be fully coordinated among all child-serving agencies and providers.

- Strength Based Focus Integrated With Problem Focus. Services should be provided from the perspective of what works with individual families, which is synonymous with family strengths.

- Respect for Family Diversity. Services should be respectful of the full range of values and approaches to family life that occur in the community. Providers should endeavor to develop and maintain supportive, caring, partnering and non-judgmental relationships with the child and family which are absent of blame and fault finding.

- Service Access is Ensured. All services should be provided in a convenient and accessible manner so as to eliminate systemic barriers to service delivery. This should specifically include the provision of non-center based services, family friendly appointment scheduling, and prompt referral to other related services. Service delivery systems should continually work to identify and lower barriers to service access.

- Comprehensive and Integrated Services. The critical array, quantity, and quality of services that are necessary to respond to the full range of needs should be available to all children/families. The seamless delivery of behavioral health services is essential to meeting this objective and is understood to be completely integral in any child/family responsive service system. This approach should also be inclusive of related services such as education, vocational rehabilitation, physical health, child welfare system, and juvenile justice.

- Services are Responsive to the Needs of Individuals. All services should be responsive to the needs of individual children and their families. Services should be provided in response to comprehensive assessments including a realistic understanding of each child/family's needs and changes in functioning levels over time. Services should assist children and families in developing disability management skills when functional problems are likely to persist.

- Service Provision is Outcome Driven. The use of traditional and nontraditional services should be integrated based on assessment of individual child/family outcomes. These outcomes should drive service delivery rather than preconceived assumptions regarding service appropriateness that may be held by professionals or

families. Child/family satisfaction with services, providers, and self-report of service outcomes should be integrated into outcome efforts.

- Service Programming is Responsive To Community Needs. Service programming should be responsive to community needs as assessed by surveys or other systematic and comprehensive needs assessment activities.

Needed Services:

Within a service delivery system characterized by the features discussed above, there is a reduced need to define specific services and programs. This reduction is related to the emphasis on individualized and family responsive nature of many of the services provided. The services, which are listed below, should be understood in the context of the envisioned system. Additionally, these services should be assumed to be provided in a behavioral health system that fully integrates mental health, substance abuse and developmental disabilities as described above.

COMPREHENSIVE ASSESSMENT

- Fully comprehensive problem assessments including medical, psychiatric, and psychological evaluation focusing on substance abuse, mental health and developmental disabilities service needs
- Educational, social and developmental assessments
- Assessment of community integration
- Assessment of Global Functioning
- Assessment of strengths
- Specialized assessments (Sexually Aggressive Youth, Hearing Impaired, etc.)
- Assessment of the degree to which problems are likely to persist over time, their anticipated impact on the child's level of functioning, and the resulting care demands on the family.

SERVICE PLANNING, PROVISION, AND COORDINATION

- Case management
- Child and family/legal guardian involvement in planning process
- Education regarding clients' rights, client advocacy groups, and grievance/appeals procedures
- Community teams for planning and collaboration on complicated, interagency cases
- Service planning reflecting all needed mental health services
- Service planning reflecting coordination of multiple agency services (community plans) as needed
- Service planning regarding transitions between levels of care or age disability categories to achieve continuity of care
- Utilization management using service outcomes to continue or modify services in response to child/family needs as they change over time.

COMMUNITY BASED SERVICES

- Early intervention and prevention services
- Outreach
- Individual, group and family therapy
- Community integration services (liaison with other support agencies and natural community supports)[3]
- School based services
- Family preservation and family support
- Wraparound services (HRI, CBI)
- Emergency/crisis intervention, center based
- Emergency/crisis intervention, mobile
- Psychiatric/psychopharmacological treatment
- Intensive outpatient
- Day treatment
- Partial hospitalization

SUPPORT SERVICES

- Respite care
- Community inclusion
- Community re-integration
- After school and summer programs
- Vocational services[4]
- Family support and advocacy

RESIDENTIAL

The distribution of residential services requires some departure from the principle of community based service provision. As a general guideline, most out-of-home services should be readily available to children and families either within the community or within a short distance of their home community; therapeutic homes and group homes should be included in this category. Services needed

[3] There is difference of opinion regarding whether community integration, community inclusion, and community re-integration (in Support Services, below) are discrete services or whether they are subsumed under case management and wraparound services. Current guidelines, which focus on the provision of medically necessary treatment, may not recognize efforts designed to assist families in becoming integrated into naturally occurring (i.e. non-medical) supports; such lack of recognition translates into lack of reimbursement for the service. This issue may be resolved either by creating a service and recognizing it at a professional level or clarifying current policies to ensure support of these activities.

[4] It is recognized that vocational services are not mental health services, per se. However, there is general agreement that there is a need, particularly in working with older adolescents, to include vocational services in comprehensive service planning. This underscores the importance of a fully integrated service planning effort among all child serving agencies in the community. This is the goal of a comprehensive system of care (see Service System Characteristics, above). At a minimum, physical health services, school services, juvenile justice services and protective services/foster care services should be included along with vocational rehabilitation in community service plans, as needed.

with very low frequency should be regionalized or centralized. For example, specialized residential programming for children who are sexually aggressive or have extreme needs for behavior management would fall into this category. This approach, requiring macro planning, will address the problem that no one area program is likely to have sufficient need or resources to establish highly specialized residential services, which frequently results in those services not being developed.

- Therapeutic homes (multiple levels)
- Group homes (multiple levels)
- Therapeutic camps
- Residential treatment centers for intensive treatment and management of severe problems
- Acute-care psychiatric hospitals

The proposed array of services, necessary to support an effective system of care, is available through many of the area programs across the State. Within most area programs, the Willie M. Program provides an example of a complete system, albeit for a small part of the total child mental health population. However, for the whole population in need, the volume of services is not sufficient in some areas of the State. In other areas, access to such services is unavailable. The foundation for an effective system is essentially in place the minds of professionals, advocates and families, but requiring considerable expansion of existing services and the creation of new services to meet the needs of children and their families. This document provides a blueprint from which to build concrete plans for an enhanced service system.

VI. APPENDIX - LIST OF COMMITTEE MEMBERS

Stephanie Alexander
Butner Adolescent Treatment Center

Dale Armstrong
Ramsay Health Care, Inc.

Bob Atkinson
Office of Juvenile Justice

Tom Bainbridge, Ph.D.
DMH/DD/SAS

Lenore Behar, Ph.D.
DMH/DD/SAS

Jim Brawley
Holly Hill/Charter NCHA

Ann Wolfe, MDMPH
Women & Children's Health

Barbara Burns, Ph.D.
Duke University Medical Center

Sally Cameron
NC Psychological Association

Christina Medlin
Covenant w/NC's Children

Beth Melcher
NAMI-NC

Lin Mizell, JD
Families Can

Spencer Clark
Adolescent Services
DMH/DD/SAS

Austin Connors
NCARCCFS

Dennis Cotton
Office Of Juvenile Justice

Charles Davis
Willie M. Services

Asenath Devaney
Whitaker School

Kevin Fitgerald
Division of Social Services

Chuchi Gicana-Vocalan, MD
Cherry Hospital

Donn Hargrove
Office of Juvenile Justice/Juvenile Court

Lowell Harris
Department of Public Instruction

David Orovitz
John Umstead Hospital

Cindy Parkey
DMH/DD/SAS - DD Section

Ann Parrish
John Umstead Hospital

Christine Heinberg
Carolina Legal Assistance for the Mentally Handicapped

Seth P. Hunt Jr., Director
Broughton Hospital

Katherine Hux
NC Psychiatric Association

Andrea Jiminez, MD

Randy Johnson, MD
Wake County Human Services

Joseph Knight, Ph.D.
Department of Public Instruction

Tara Larson
Division of MH/DD/SAS

Bernadette McAllister
NC Council of Community Programs

Ed McCauley
NC Hospital Association

Edith Foster
Child & Family Services

Debbie Simmers
Wright School

Sandra Sink
Division of Social Services

Thea Monet
DIADH

Gail Moore
Eastern Adolescent Treatment Program/NCSCC

Jim Moore, Ph.D.
Broughton Hospital

Richard Munger
Child & Family Services/Blue Ridge Area Program

Duncan E. Munn, Head
Child & Adolescent Branch/DD Section

Joe Murphy, Ph.D.
Whitaker School

Dick Oliver
Child & Family Services

Mary Tripp
Medicaid Services - DMH/DD/SAS

Mike Vicario
NCHA

Dennis Williams
Rural Health Research & Development

Paula Wolf
Covenant for Children

Ellen Burnett, Director of Community Programs
Riverstone Counseling & Personal Development

Dick Peruzzi
Division of Medical Assistance

Martin Pharr, Ph.D.
Office of Juvenile Justice

Betsy Phillips
NC Mental Health Association

Susan Corriher
Ramsay Health Care, Inc.

Carol Robertson
Division of Medical Assistance

Dale Roenigk, Ph.D.
Willie M. Services

Joel Rosch
Governor's Crime Commission

Kathryn Grey
John Umstead Hospital

Don Herring
Crisis Services-DMH/DD/SAS

Allie Wiggins
Cumberland Area Program

Jim Mayo, MD
DDH, Cherry Building

Stacy Smith
NC Child Advocacy

Wayne Smith, DSW
Willie M. Services

Allan Spader
NC Council on MH/DD/SAS

Lou Stein, MD
Dorothea Dix Hospital

Ed Taylor
Office of Juvenile Justice

Shealy Thompson, Ph.D.
Willie M. Services

John Tote
NC MH Association

Peter Horner, Ph.D.
V-G-F-W Area Program

Barbara Leach
UNC-CH
Children's MH Project

Troy Livingston
UNC-CH
Children's MH Project

Carl Miller
Lutheran Family Services

#4

Mental Health Services

for Children and Families

Report of the Futures Committee

Lenore Behar, Ph.D., Chief, Child and Family Services Section

Charles Davis, Chief, Willie M. Section

Presentation to House Mental Health Committee

May 11, 1999

FUTURES COMMITTEE REPORT

- **Background of Committee and Report**
- **Committee Membership and Consensus**
- **Study Recommendations**
- **Next Steps (See Last Recommendation)**

FUTURES COMMITTEE RECOMMENDATIONS

- **The child/adolescent units at the State psychiatric hospitals must not be closed.**
- **No changes should be made to one aspect of the child and family service system without considering the possible end result effects on all other aspects of the system**
- **Services must be outcome driven and have as their goal the improved functioning of the child and family.**
- **Child behavioral health service delivery should be prioritized toward specific populations.**
- **There must be one cross-agency (public and private) plan for the child, that provides for comprehensive, coordinated services.**
- **There must be adequate resources (staff, programs and funds) to provide needed services for all children.**
- **The following tasks need to be addressed in the future:**
  - **Update the *Child Mental Health Plan***
  - **Examine distribution of high-end residential treatment resources.**

HOUSE COMMITTEE ON MENTAL HEALTH

MAY 18, 1999
10:00 AM
Room 415

AGENDA

Chair(s): Rep. Wayne Goodwin

INTRODUCTIONS

SPEAKERS Susan White, Chief, Thomas S Program, DMH
Mary Eldridge, Chief, Crisis Services Section, DMH

DISCUSSION

ADJOURNMENT

MINUTES
HOUSE COMMITTEE ON MENTAL HEALTH
MAY 18, 1999
RM. 415 LOB

The House Committee on Mental Health met on Tuesday, May 18, 1999 in Room 415 of the Legislative Office Building at 10:00 AM. The following members were present: Chairs- Representatives Crawford and Goodwin (Presiding), Representatives Cansler, Esposito, McAllister, Nye, Warwick. Committee staff members Kory Goldsmith and Linda Attarian also attended. A visitor registration sheet is attached and made part of these minutes.

Rep. Goodwin introduced the pages for the day, and the speaker for the meeting- Mary Eldridge, Chief of Crisis Services at the Department of Mental Health. Ms. Eldridge handed out a Summary of Crisis Services Section's Recent Initiative and Training Activities, and a Crisis Prevention, Response, and Stabilization handout. She spoke about funding for Crisis Services, the different Area Programs, and the need to train staff properly.

Rep. Goodwin then introduced the next speaker, Susan White- Chief of Thomas S. Program at the Department of mental Health. Ms. White gave out two handouts; a Thomas S. Transition Plan, and An Overview of Thomas S. Class Members, Services, Costs and Outcomes. She spoke briefly on these and was asked to come back due to lack of time.

Rep. Goodwin adjourned the meeting at 10:50 AM.

Respectfully submitted,

Rep. Wayne Goodwin
Chairman

Kristen Younts
Committee Assistant

VISITOR REGISTRATION SHEET

MENTAL HEALTH — 6-16-99

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Tote	MHA/NC - C2001
Patricia Reeves	NCACC
Janet Simmons	NC Council
Marian White	DMH - Thomas S.
Dave Rinkal	Theo/Inc
MICHELLE COTTON	DMH/DD/SAS
Wayne Wilson	DSBM
Peggy Bradsher	Thomas S. MH/DD/SAS
Lisa Gordon	Thomas S.
Will Edgerton	MHA/NC & NC PA
Katherine Miller	Harry Kaplan
Mary Eldridge	Div MH, DD, SAS - Crisis Section
Bob Hedrick	CNC

Summary of Crisis Services Section's Recent Initiative and Training Activities

For Coalition 2001, March 8, 1999

1. The Mental Illness/Substance Abuse Integrated Treatment Initiative.

This project began March 16, 1998 with the selection of 15 Area Programs that demonstrated a plan and a commitment to "integrate" mental illness and substance abuse treatment in order to meet the complex treatment needs of individuals with co-occurring mental illness and substance abuse disorders.

The 15 Area Programs have reported baseline measures for a total of 138 clients. The baseline outcome measures indicate each client's status for the year prior to beginning the MI/SA Initiative. If Area Programs are successful in developing an integrated treatment approach for MI/SA clients, the following outcomes will be attained:

- Movement through the stages of treatment from engagement through active treatment to relapse prevention.
- Reduction in alcohol and drug use.
- Reduction in crisis episodes.
- Reduction in costly hospitalizations.
- Increase in the functioning level of clients.

Measures of client-specific clinical events and functioning will be reported to the Crisis Services Section after clients have been a part of the Initiative for 6 months, 12 month, 18 months, and 24 months. An analysis of repeated measures will be conducted to determine clinical outcomes for these "high-risk" clients and to assess the cost effectiveness of this initiative.

2. The Development and Coordination of Cross-Disability Crisis Training Activities.

In Fiscal Year 1998-1999, the following training activities were presented and/or are scheduled to be presented.

Crisis Response in Substance Use Disorders Teleconference. 4/14/98 (47 attendees – Durham, Concord, and Kenansville)

Diagnosing Mental Retardation: Criteria & Critical Issues Teleconference. 11/10/98 (18 attendees –Raleigh, Winston-Salem, Greenville, Newton)

Crisis Response Planning Seminars. This is a training regarding the issues of Crisis Plan development and intervention for individuals with high-risk, co-occurring MH/DD/SA problems, who are frequently hospitalized, when alternatives can be planned prior to crisis events. This training takes place on a monthly basis, rotating from Kinston to Burlington (now Greensboro) to Morganton, total attendees for 1998 = 115. This was also given, upon request at Pitt Area Program (Greenville) for 50 attendees on 6/10/98.

Both Riverstone (Halifax County) and Rutherford-Polk have asked for trainings on-site in 1999 and this will be completed by 7/1/99.

Crisis Intervention in Behavioral Healthcare. This is a three-day training, focusing on Crisis Response, Crisis Stabilization and Crisis Prevention for Individuals with MH, SA, DD and co-occurring disorders, as well as staff responding to crisis calls. Below are the trainings presented in 1998 and plannned for 1999:

- Wilmington at Coastal AHEC 1/20/98, 2/9/98, 2/16/98 = 41 attendees X 3 days
- Fayetteville at S. Regional AHEC 3/23/98, 3/30/98, 4/21/98 = 36 attendees X 3 days
- Rocky Mount at Area L AHEC 5/19/98, 5/26/98, 6/9/98 = 31 attendees X 3 days
- Greenville at Eastern AHEC 9/14/98, 9/21/98, 9/28/98 = 20 attendees X 3 days
- Asheville at Mountain AHEC 11/9/98, 11/23/98, 11/30/98 = 28 attendees X 3 days
- Greensboro at Greensboro AHEC 2/15/99, 2/22/99, 3/1/99
- Charlotte at Charlotte AHEC 4/15/99, 4/22/99, 4/29/99
- Rocky Mount at Area L 5/18/99, 5/25/99, 6/8/99

Crisis Response for Individuals with Mental Illness and Co-occurring Substance Use Disorders. 10/7/98 at Rocky Mt. (Area L AHEC) with 11 attendees; same planned for Fayetteville (S. Regional AHEC) on 1/27/99 and Asheville (Mountain AHEC) on 4/16/99

Crisis Prevention & Intervention for Individuals with Autism. 10/8/98 in Asheville (Mountain AHEC) with 11 attendees, 10/16/98 in Wilmington (Coastal AHEC) with 40 attendees, 11/13/98 in Greensboro (AHEC) with 40 attendees and on 3/12/99 in Raleigh at Wake AHEC

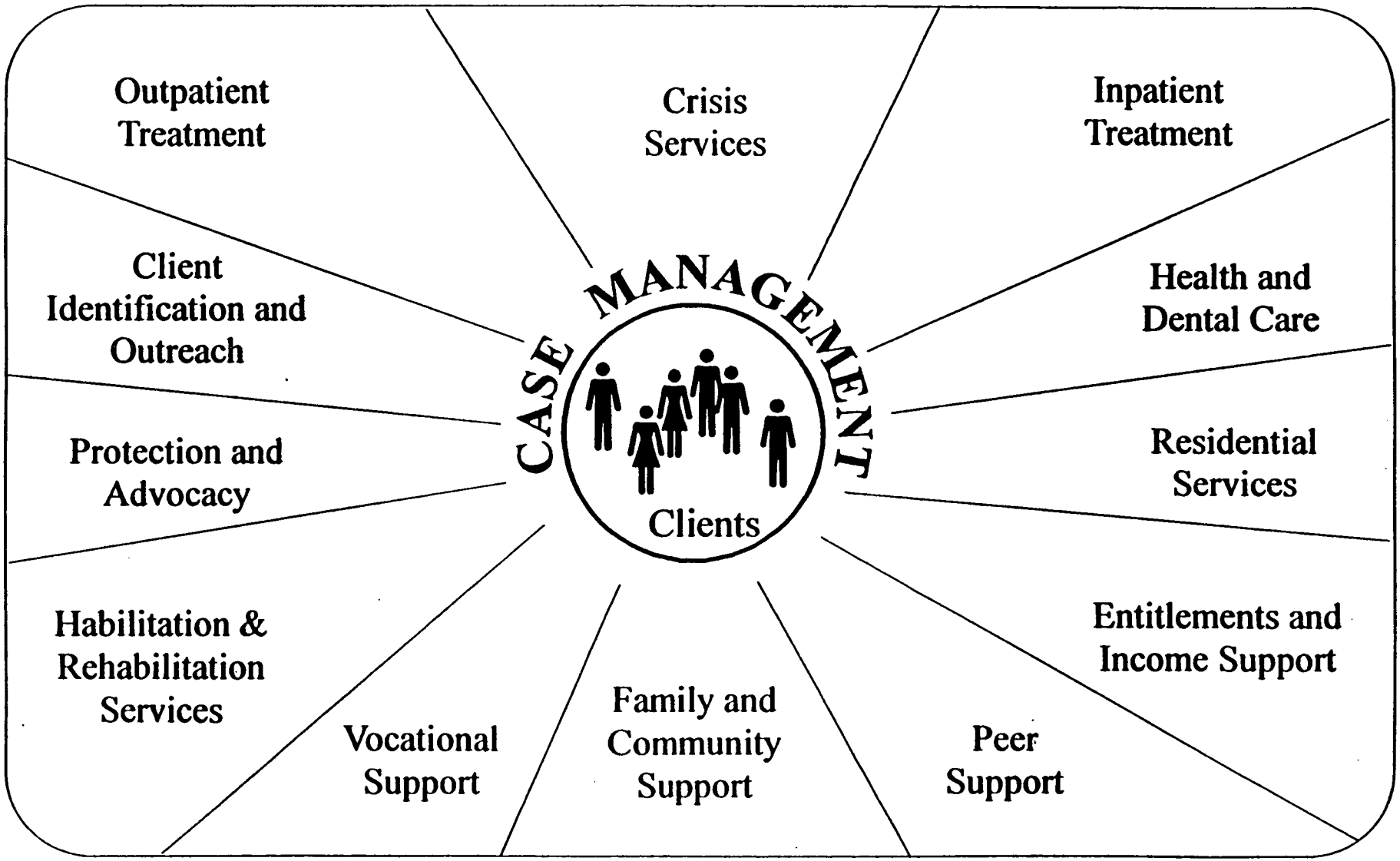
Crisis Response for Individuals with Mental Retardation and Co-morbid Mental Illness and/or Substance Use Disorders.
Asheville (Mountain AHEC) on 3/8/99, Greenville (Eastern AHEC) on 4/23/99, and Wilmington (Coastal AHEC), Greensboro(AHEC) and/or Fayetteville (S. Regional AHEC) in May, 1999

Dialectical Behavior Therapy Training at NC Clinical Update. Presented by Dr. Liz Simpson, MD on 9/14/98 at Southern Pines with 60 attendees

Treating Mental Illness/Substance Use Disorders in a Managed Care Environment at NC Council Conference. Presented by Dr. Kenneth Minkoff, MD at Pinehurst on 12/7/98 with 75 attendees

Exhibit I

A Client-Centered Comprehensive MH/DD/SA System



AREA MH/DD/SAS Program

#2

CRISIS PREVENTION

* Identification of Consumers at High-Risk for Crises
* ACT Teams
* Education in identifying early signs
* Immediate or next day assistance and assertive follow-up:
  - ✓ Education about causes
  - ✓ How to avoid future crises
* Respite (families need this and consumers who live with their families also need it)
* Discretionary cash fund
* Representative payees
* Suggestions from Consumers
  To be believed:
  - ✓ Let consumers be equal partners in treatment planning;
  - ✓ Hire consumers;
  - ✓ Weekend clubhouse with transportation
* Weekend consumer peer support
* Community relationships with non-consumers
* To be needed

CRISIS RESPONSE

* Area program should be entry point
* 24 hours x 365 days
* Immediate and cost-effective response by staff trained to serve all ages and disabilities
* 24-Hour Crisis Telephone
* Walk-In Crisis Services
* Mobile Response Teams
* Emergency Transportation
  - Law enforcement to be used only when there is serious criminal action involved or imminent/actual danger to self or others
  - EMS involvement when this is the most effective mode of transportation
* Staff recognize windows of opportunity
* Staff help consumers feel safe and secure and help them understand procedures
* Training of all relevant parties: e.g., staff, law enforcement officers, magistrates, consumers, families, EMS personnel
* Advance Instructions for MH Treatment

CRISIS STABILIZATION

* Staff trained to handle all emergencies (with use of backups and referrals as needed)
* An array of intervention strategies of varying intensity
* Provided at the most appropriate site (most effective and cost-effective, least restrictive, and nearest - or in - the consumer's home)

In-home stabilization (may include CBI)
Ambulatory acute care (e.g., ER, partial hosp.)
Advance Instructions for MH Treatment
Observation and assessment units
Crisis stabilization units
Medical and social-setting detox units
Inpatient acute care
Continuity of care case management
Transitional living services (e.g., host homes)
Crisis follow-up

An Overview of Thomas S. Class Members, Services, Costs and Outcomes

Thomas S. Services: Current Statistics and Indicators.

1397 individuals are eligible for services (projected for June 30, 1999). Another 1201 persons are prospective class members that are not yet funded;

1160 confirmed class members are currently receiving a full complement of services and supports;

These services and supports include residential services, employment and educational services, and services designed to help class members become more a part of the communities in which they live;

Class members live in a variety of settings, most of which are in their home communities:

- 28% live independently, or semi-independently;
- 6% live with their families;
- 7% live in alternative family homes;
- 24% live in community-based individual or group homes with personal support staff;
- 12% live in rest homes or family care homes;
- 5% live in Intermediate Care Facilities for Persons with Mental Retardation (ICF-MR);
- 1% are in a correctional facility;
- 2% live in a nursing home;
- 8% live in non-community based settings (state psychiatric hospital, MR center).

Cost of Services

Total Federal and State funds for class member service and supports: Medicaid claims totaled $32,594,164, and State dollars totaled $64,250, 255 for a total of State Cost Per Class Member: in FY 1998 were **$76,322**, (Down from $94,505 in FY 1994) and they are projected to be **$67,144** per funded individual in FY 1999.

Revenue Adjustment for FY 1998 (Utilization of Medicaid and other third-party revenues to offset State costs for Thomas S. Class Members): **$27,919,019** (Up from $417,116 in FY 1994).

Brief History of the Program.

Thomas S., et al. v. Flaherty (now Bruton) **decision, November 21, 1988**

Thomas S. Services Section established in **January 1992.**

Focus Class/Evaluation Alternative Test Agreement limiting class size, establishing Prospective and Confirmed class membership categories, **February 4, 1994.**

Petition for relief from court oversight filed, **December 21, 1995.**

Establishment of **Crisis Services Section** for Thomas S. Diversion and Crisis Management: **1996**

HB 859 Thomas S. Diversion Law goes into effect, prohibits most admissions of persons with mental retardation to the state psychiatric hospitals, **January 1, 1997.**

Federal Judge issues **order removing 1988 Injunction**. Judge cites system in place for placement, monitoring, funding and accreditation of class, rules Special Master and Plaintiffs' Attorney monitoring no longer necessary, **January 24, 1998.**

Milestones and Benchmarks – Thomas S. Services Section.

Removal of Court Order: In 1998, Judge Voorhees removed the 1988 court order, based upon the establishment of a community based system of identification and support of persons defined as members of the Thomas S. class.

National Accreditation: In 1996, The Section contracted with the national Accreditation Council to accredit each area program's services. In FY 1997, only 3 area programs were not accredited, and the Thomas S. Section had been awarded a 2–year accreditation (The only state-level accreditation one of its kind in the nation).

Participant-Driven Managed Supports Demonstration Project – In 1997, the Section initiated a projecting demonstrating a consumer-driven alternative to traditional managed care models. 49 Prospective and Confirmed class members are being served with funding initially established only for the confirmed class members.

Supporting initiatives to encourage community integration for persons with disabilities (especially those with dual or multiple diagnoses): Projects include support for: Community capacity-building, natural supports, consumer-owned businesses, home ownership, supported employment and self-determination.

THOMAS S. TRANSITION PLAN
May 18, 1999

A Transition Plan from Court Ordered Services to A Cross Disability Community Based System of Specialized Supports (as An Alternative to Institutional Living)

Synopsis

The Thomas S. Services System has existed since 1992 for the purpose of implementing the 1988 Thomas S. et. al. v. Flaherty class action suit. In January 1998, the Federal Judge dismissed the 1988 court injunction on the grounds that through the Thomas S. Service System, North Carolina had established an effective mechanism for serving the population identified in the original court action.

In 1998 a small group of representatives from the Division of MH/DD/SAS, the Thomas S. Section, DHHS, the Attorney General's Office, and legislative staff began to meet to develop a transition plan for Thomas S. services. The plan for transitioning from a court ordered program to a Cross Disability Community Based System of Specialized Supports formed the basis for the continuation of Thomas S. funding for the upcoming biennium. The plan further outlines implementation strategies for three major goals: maintaining the services and supports which were the basis for the 1998 dismissal of the court injunction; expanding the positive practices and lessons learned in the Thomas S. lawsuit to the larger service delivery system, and; increasing cost effectiveness by expanding the number of persons served and supported through this specialized service system. The resulting plan will maintain good faith with the 1998 court action, improve cost-effectiveness by expanding the population to be served, and allow the State to serve persons who have not been served with consistent success through traditional means. The State will be using the innovations, service planning and service supports which the implementation of the Thomas S. court case required, to address the needs of a larger group of persons who have traditionally presented challenges for the MH/DD/SAS service delivery system and who may be at risk for inappropriate institutionalization.

Charting the Transition

1. Maintenance of a Good Faith Effort to Provide Community-Based Alternatives to Institutionalization.

The dismissal of the 1988 Thomas S. lawsuit is not based solely on the fact that the State has successfully served the population identified in the 1988 action, but rather that the State has established a system for serving the population. The 1998 decision notes: *"...at the time of the 1988 decree, the State had no system in place,"* to serve the population, but, *"...the picture almost ten years later is radically different,"* (1998 Decision, p. 21). Specifically, the components of that system which commend dismissal of the 1988 action are that the State:

- ✓ Has initiated a process for identifying class members,
- ✓ Has created person-centered plans to serve them,
- ✓ Has created a process for training and privileging staff,
- ✓ Manages and arranges services to meet the requirements of those plans,
- ✓ Monitors the plans, and
- ✓ Expends necessary funds to support the process.

The 1998 Dismissal Order concludes that,

"... the Secretary acted reasonably in creating and implementing the new Thomas S. service delivery system..." and that, *"... the new system has and will continue to provide constitutionally required treatment and to remedy injuries caused to individual class members by their constitutionally inappropriate treatment in the past."*

2. It is beneficial to support individuals with challenging and multiple disabilities in ways that will minimize the possibility of inappropriate institutionalization

The original Thomas S. action was taken because the partnership of State and local service systems was not able to provide appropriate, stable, long-term community-based supports for persons with challenging and multiple disabilities. For many such individuals, this scarcity of alternatives to community-based natural settings creates a dependence on State institutions and State oversight that is both costly and restrictive. The Thomas S. Services System has developed cost-effective community-based services and supports for some 1250 persons in the Thomas S. class. These approaches may profitably be expanded to other persons with challenging and multiple disabilities who are at risk of inappropriate institutionalization.

1. The development of person centered rather program centered service delivery system components is beneficial to the larger service delivery system.

Often the long-term benefits to a State in satisfying the requirements of a class action suit are in the changes to the system that the implementation of that suit requires. Some specific innovations and system enhancements that have come from the Thomas S. lawsuit include:

- Individualized Information Systems. The 1988 Court Order required the State to document and maintain a list of persons who met the court criteria for class membership. The presence of this detailed data allows for the tracking and review of services and supports per individual. This database has been expanded to include information on other persons eligible for TS funding as specified in the TS Special Budget Provision. In the current climate of managed care, identification of targeted service populations is crucial for cost-containment, utilization review and the maintenance of appropriate levels of service and supports.

- A Unit-Cost Reimbursement and Reporting System. The Unit Cost Reimbursement System for Thomas S. (UCR-TS) was modified from the Division's Pioneer reimbursement system, with one important distinction - the addition of a Unique Identifier (Unique ID) for each person. That distinction allows the State to track the cost of services not only by service, but also by individual. This capability, in turn, allows the Thomas S. Services Section to track costs by area program, and comparing UCR-TS costs with Medicaid data generated by the Division of Medical Assistance (DMA) provides a compilation of true costs of services and supports for each individual. It has also allowed the TS Section to track trends in costs and services and, in effect, to generate data for meaningful utilization review of services of individuals being supported with Thomas S. funds supported.

- Expansion of Service Provider Options. Many service providers of national reputation came to North Carolina seeking to serve the MI-MR population. Other service

providers already in the state were challenged to learn new ways to support persons with challenging disabilities. The result has been an expanded and more proficient provider community. Since the expertise required to serve persons with the challenges presented by Thomas S. class members is not unique to class members the support choices for other persons with disabilities and their families has expanded as well.

- Person-Centered Planning. The Thomas S. class action did not introduce Person-Centered Planning to the broader service delivery system in North Carolina, but in insisting that all services and supports issue from a person-centered plan, the individual and his or her family and friends have effectively replaced professional interdisciplinary treatment teams as the primary decision-makers for services and supports, and as the final arbiters of the individual's life and success. The priority of the individual and his or her family and friends in planning services and supports prepares the way for the implementation of self-determination and participant-driven community support models of service implementation for person's requiring long term supports. Self determination models are nationally recognized as adjuncts to streamlining service and support infrastructures and to containing and even reducing costs per individual.

- Expertise in Serving Persons with Co-Occurring Disabilities. The main reason the State was found at fault in the 1988 Order was that there was not the expertise and infrastructure in place to serve persons with dual or multiple diagnoses. These deficits were not so much in the mental health or DD service options in the community as it was the lack of long-term supports that, if available, allow persons with co-occurring disabilities to more successfully function within and integrate into their communities. The Thomas S. Services System is recognized nationally in the National Association for Dual Diagnosis (NADD) and The American Association for Mental retardation (AAMR) as having furthered the facilitation of services and supports for persons with dual and multiple (i.e., "co-occurring") diagnoses.

- Cost Containment for High Utilizers of State-Funded Services and Supports. The Division recognized that once the State had successfully implemented the 1988 Court Order and was then free from Court oversight, the necessity for maintaining services and supports for those vested in the Thomas S. Court Order would remain present. As a result the State enacted the Thomas S. Cost-Containment Special Provision (HB97DHR-H058A), which directed the Thomas S. Services Section to study costs containment for services and supports for class members. The results of that study are reported in separate reports to the General Assembly and, will allow the system to undertake cost-containment procedures for the larger population identified in the TS Special Provision.

2. During court oversight of the Thomas S. lawsuit, it proved impractical to integrate all the important innovations of the lawsuit throughout the system; however, increased integration of the knowledge and best practices developed is the long term goal of the Division.

Separate from the consideration that the 1998 Dismissal Order was predicated on the existence of an identifiable system to continue to implement the 1988 Order, the expertise and modifications introduced in service of that implementation will continue to serve the larger system by continuing to find efficient and cost-effective ways to support persons with challenging disabilities in their communities. As practicable, these innovations may be

adapted for use in the larger service delivery system when opportunities to do so naturally present themselves. One opportunity for building on the TS success in deinstitutionalizing adults from the State's hospitals emerges as the State considers the number of other adults with similar needs who have become long term residents in our State psychiatric hospitals.

How Will the Transition Occur?

1. Rather than focus on the legal parameters established by the federal court, the Section will expand support availability to the larger group eligible for funding via the TS Special Provision, thus offering services and supports for persons with challenging and multiple disabilities that cross traditional disability lines.

   Whereas persons with challenging and multiple disabilities are generally viewed as outliers within other disability-specific service delivery systems, these individuals are the primary population for this service delivery system. The existence of the 1988 Thomas S. Court Order is testimony to the fact that the existing service delivery system was primarily configured to serve and support persons who present themselves in discreet disability categories and benefit from traditional program models available. The system does not always know where to refer individuals who do not fit into one disability category or another. This not only may result in administrative redundancy, as persons with multiple disabilities are shuffled among discreet disability systems to address the individual disabilities, but more significantly, the system finds itself less able to address the individual's overall needs which issue from the interaction of the disabilities.

2. Seek ways to develop cost-effective community-based services for persons who historically have been significant utilizers of public services and supports.

   Cost of services has already been addressed by the Thomas S. Section through the 1997 *Thomas S. Cost Containment Special Provision*, in which the Thomas S. Section was directed to examine ways to develop and implement cost containment measures to reduce the cost of direct services to Thomas S. class members through:
   - ✓ Positive client outcomes through long-term managed supports;
   - ✓ Identification and ultimate elimination of redundant, inefficient or unnecessary process oriented tasks;
   - ✓ Single stream funding from all available sources;
   - ✓ The application of waivers of federal requirements; and
   - ✓ The review and possible repeal of rules that conflict or interfere with cost containment measures.

3. Seek to develop Medicaid Waivers and suggest modifications of existing Medicaid Waivers that will allow more flexible funding options for persons in need of long term support.

   The health care, or "medical" model for managing services and supports assumes that, with preventative and intense short term clinical care, people will need less long term remedial care. **It is not a model that has ever had to look at supporting non-clinical needs to prevent utilization of high-cost services.** In managing costs of services and supports for people with long-term disabilities it is documented that the provision of supports in the community will minimize expensive, in-patient (institutional) care. At present, though all

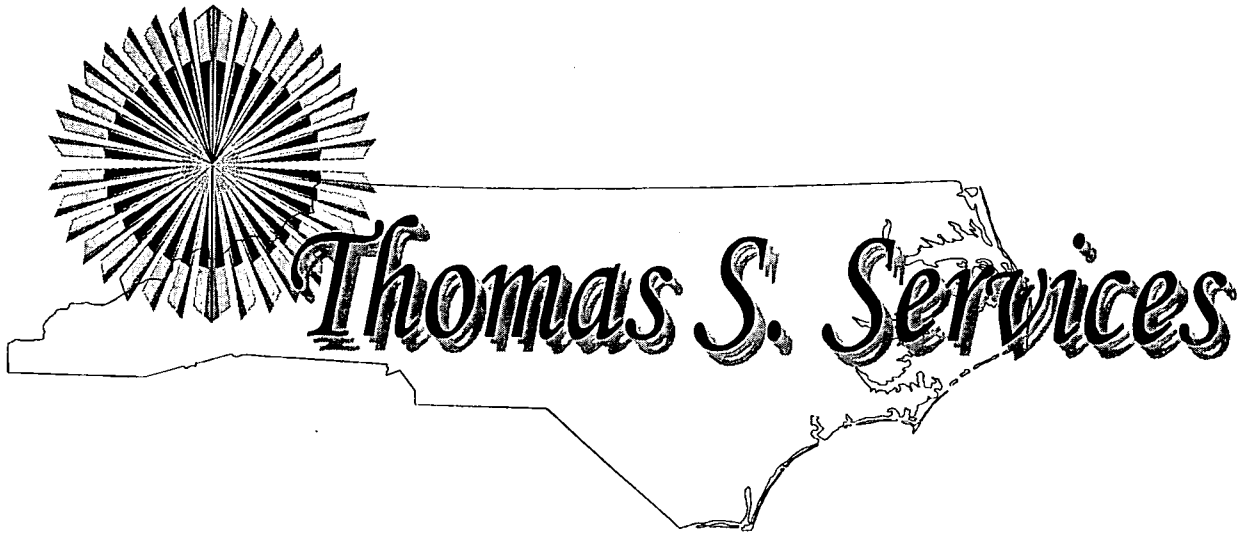
Thomas S. class members resided at some time in the state psychiatric hospitals, 95% of Thomas S. class members present costs to the system less than the average cost of services for persons residing in state psychiatric hospitals. Unlike the acute health care model, however, lower cost community supports will be an on-going expenditure probably over the span of a lifetime. The lesson from Thomas S. is that without available community supports, higher cost services will be necessary and will not necessarily provide adequate treatment. Nationally, Home and Community-Based Medicaid Waivers are allowing states to create more flexible options for long-term supports and, in turn, reducing overall costs per person.

4. Implement principles of Self-Determination in Service of Individual Empowerment and Cost-Containment.

Self-Determination is a national movement centering in over three hundred Robert Wood Johnson Foundation Self-Determination Projects. The principles and findings of these projects are distributed for adaptation and implementation where they will serve to foster the Self-Determination principles of freedom, authority, supports and responsibility for persons needing/receiving long term supports. When empowered to select their own supports and services, people tend to use only those supports and services they need and will routinely choose less than professionals would prescribe, allowing for cost-containment along with self-determination.

5. Facilitate the transition from court oversight to individual, family and community responsibility and involvement in the lives and futures of people with very serious disabilities.

Throughout 1998-1999 local area programs have been replacing the scheduled Thomas S. Special Master's Status Reviews with community forums. The use of the funds allocated by the General Assembly for this population is reviewed and reported to area boards and followed by community forums and feedback sessions with citizens, neighbors, class members, family members, as well as representatives from other involved agencies. This facilitates critical progress toward individual and local ownership and responsibility for all members of a community.



a court ordered deinstitutionalization program

SMOOTH

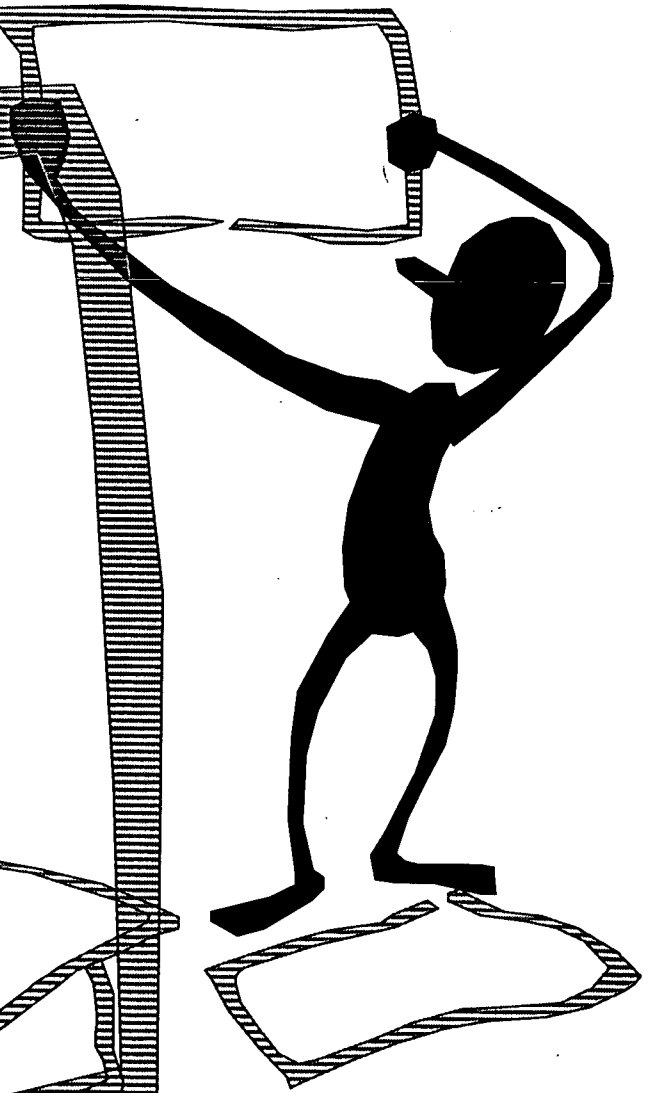
A Cross-Disability, Community-Based System of Specialized Supports

a mechanism for specialized long term support in the community.

Thomas S.!

A Cross-Disability, Community-Based System of Specialized Supports

A BRIEF HISTORY OF THE THOMAS S. CASE



Thomas S.:

A Cross-Disability, Community-Based System of Specialized Supports

Thomas S. Is a real person.

July 7, 1982: Original Court Action Filed.

On that date, Thomas S. was 19 years old.

By that date, Thomas had been...

- Given up for adoption at birth
- Diagnosed with schizophrenia and borderline mental retardation
- Placed in 40 different foster homes and institutions
- Declared incompetent, assigned a guardian, and moved to Broughton Hospital

July 7, 1982: Suit brought to secure appropriate Community Placement for Thomas.

- ✓ Federal issue: Thomas denied due process (14th amendment)
- ✓ State issues: guardianship and continuity of care statutes
- ✓ Defendants: Secretary, DHR; Thomas' guardian, county DSS, local MH/DD/SAS

March 26, 1983: Consent Judgement: Local agencies to secure appropriate placement. Case declared inactive.

March 22, 1984: One year after case declared inactive:

- ✓ Four others move to intervene as plaintiffs (Case becomes *Thomas S. et. al.)*
- ✓ Court finds that in the year since the consent order, Thomas has moved three times
- ✓ State claims dropped. Case becomes Denial of Due Process (14th Amendment)

December 4, 1984: Court requires requiring State to provide appropriate treatment for Thomas. State appeals.

August 19, 1986: Court orders evidentiary hearing.

March 5, 6 and May 5, 1987: Case heard.

November 21, 1988: Decision for Plaintiffs. *State Appeals.*

October 29, 1990: Writ of Certiorari denied by U. S. Supreme Court.

January, 1991: Judge appoints Special Master and Independent Evaluator.

February 4, 1994: **Focus Class Agreement:** ***Limits class size, defines Prospective/Confirmed class membership.***

December 21, 1995: **State files petition for relief from Court Oversight.**

January 26, 1998: **Court grants petition for Relief from Court Oversight:** ***removal of Special Master, Plaintiff's Attorneys.***

Thomas S.:

A Cross-Disability, Community-Based System of Specialized Supports

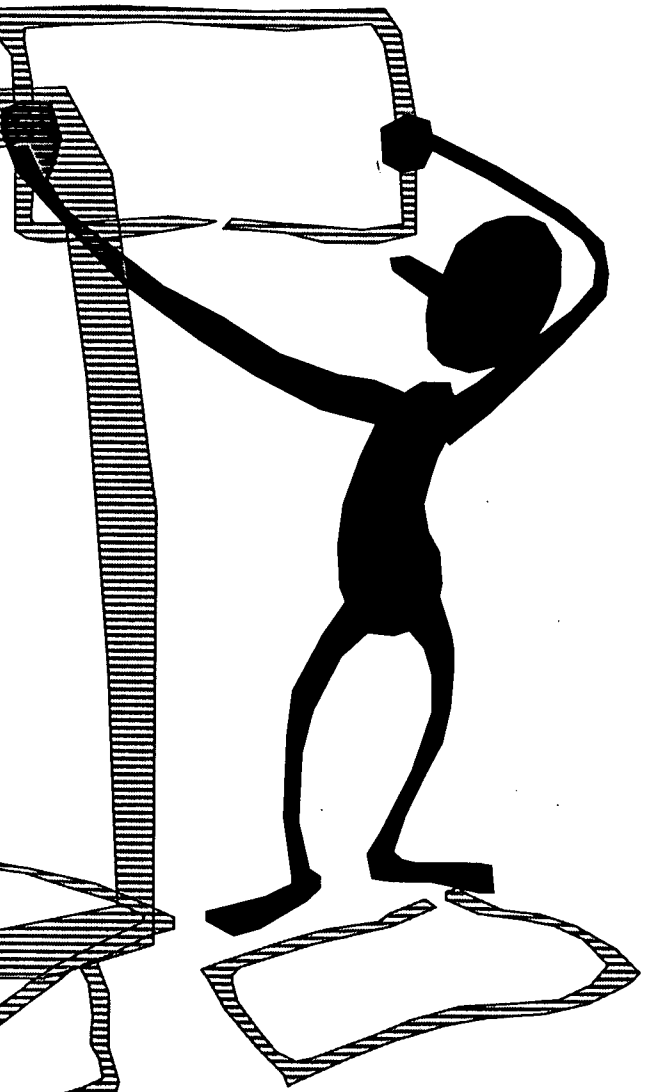
What The 1988 Court Decision Required:

- ✓ Safety, protection from harm, treatment under safe conditions
- ✓ Freedom from undue restraint
- ✓ Habilitation which reduces the likelihood of aggression or self-abuse, or prolonged isolation from home community
- ✓ Any treatment necessary to remedy injuries caused by constitutionally inappropriate treatment in the past.

Thomas S.:

A Cross-Disability, Community-Based System of Specialized Supports

OVERVIEW OF THE TRANSITION



Thomas S.:

A Cross-Disability, Community-Based System of Specialized Supports

Goals for the Transition:

- ✓ Maintaining the services and supports which were the basis for the 1998 dismissal;
- ✓ Expanding the positive practices and lessons learned in the Thomas S. lawsuit to the larger service delivery system;
- ✓ Increasing cost effectiveness by expanding the number of persons served and supported through this specialized service system.

Thomas S.:

A Cross-Disability, Community-Based System of Specialized Supports

Results for the Transition:

- ✓ Maintain good faith with the 1998 court action;
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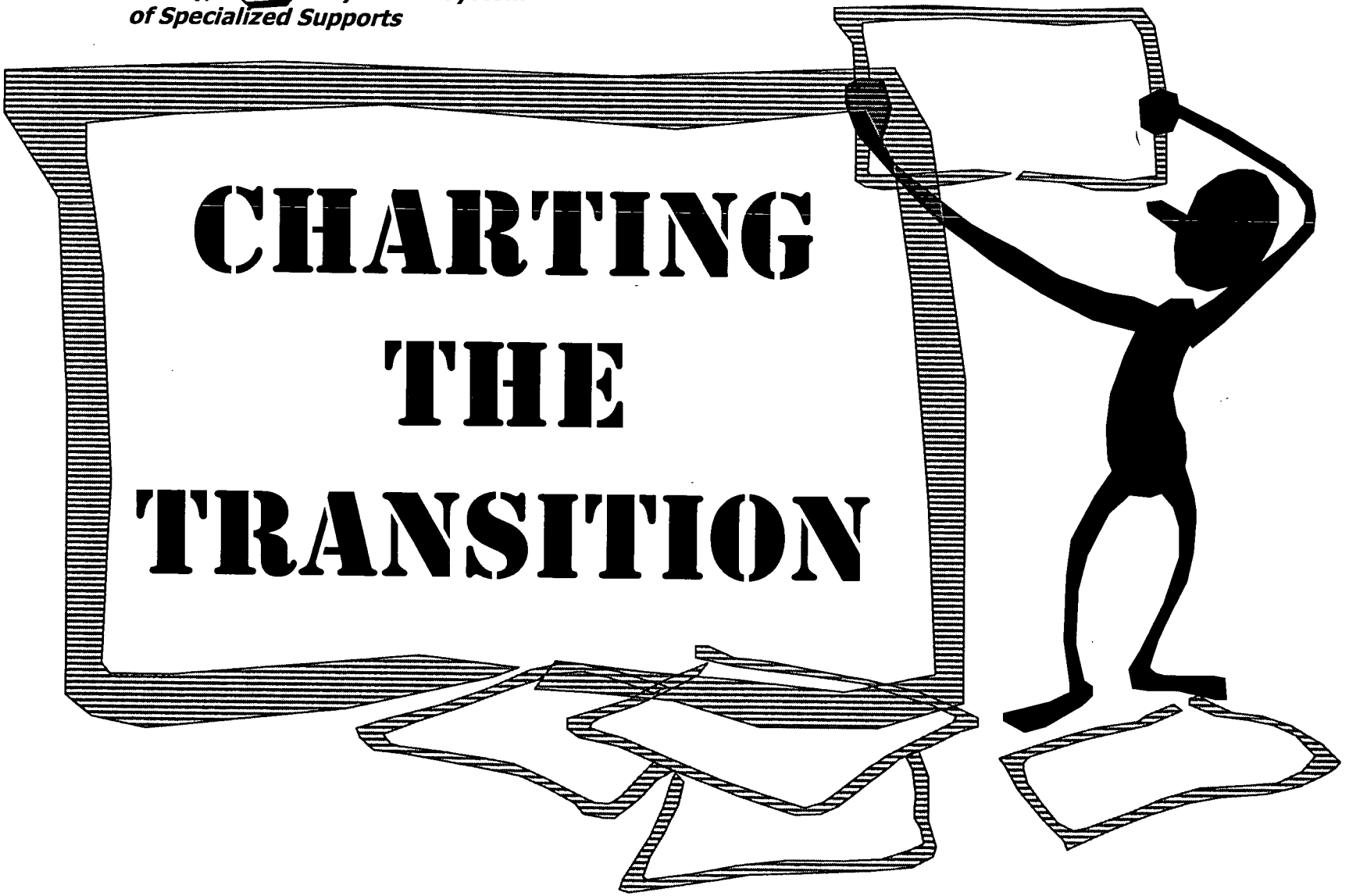
Thomas S.:

A Cross-Disability, Community-Based System of Specialized Supports



1 Maintaining a Good Faith Effort to Provide Community-Based Alternatives to Institutionalization

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"...at the time of the 1988 decree, the State had no system in place," [to serve this population]

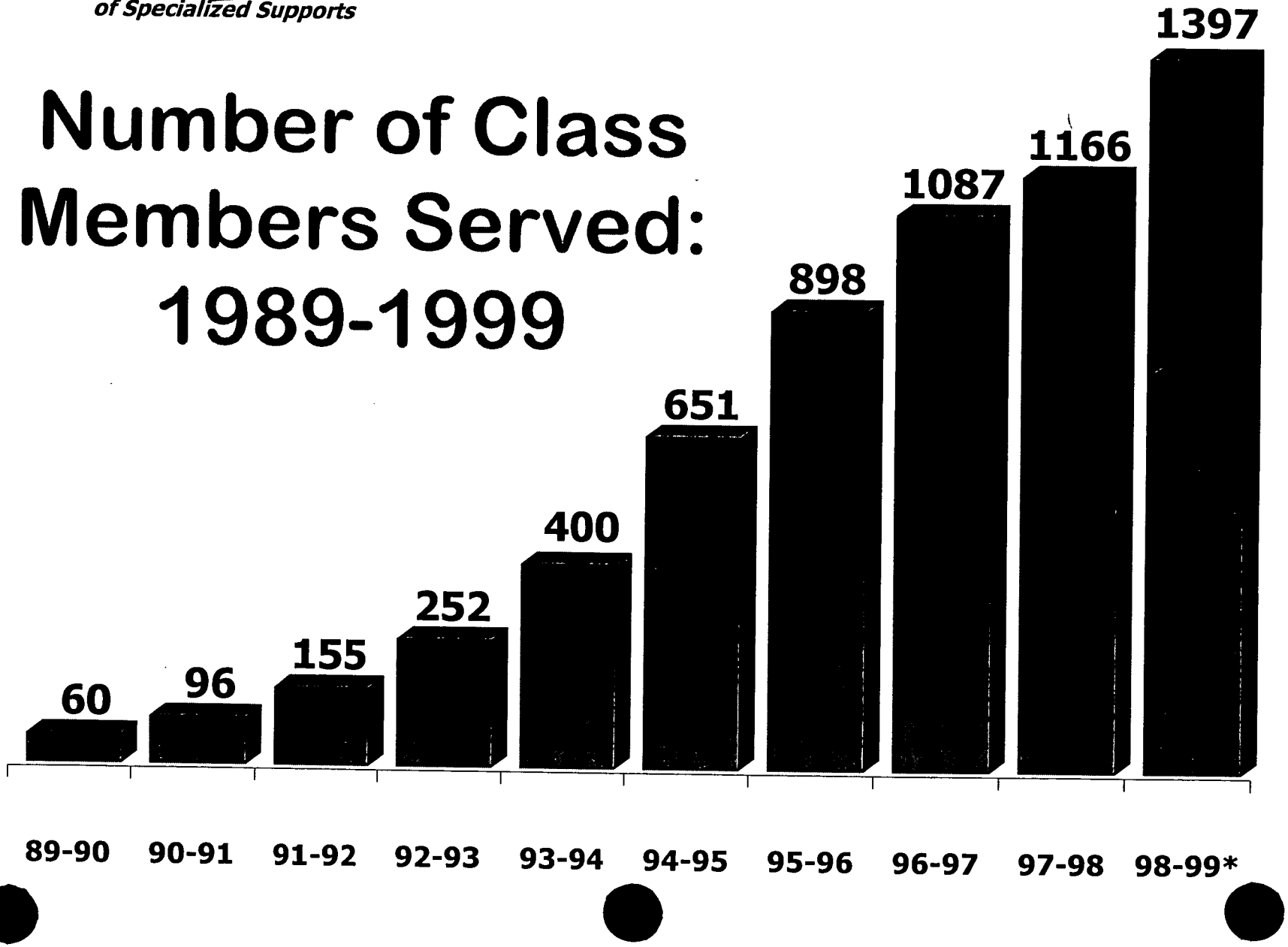
"but...the picture almost ten years later is radically different."

-- 1998 Decision, p. 21

Thomas S.:

A Cross-Disability, Community-Based System of Specialized Supports

Number of Class Members Served: 1989-1999



Thomas S.:
A Cross-Disability, Community-Based System of Specialized Supports

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Specifically, the components of that system which commend dismissal of the 1988 action are that the State:

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Thomas S.:
A Cross-Disability, Community-Based System of Specialized Supports

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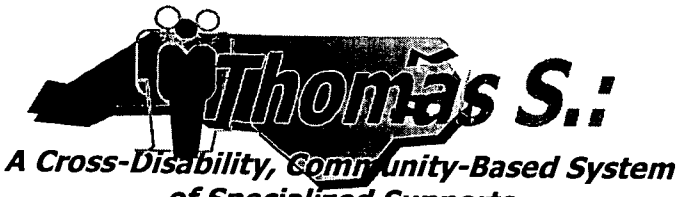
Thomas S.:

A Cross-Disability, Community-Based System of Specialized Supports

2 Support Individuals with Challenging and Multiple Disabilities in Ways that Minimize the Possibility of Inappropriate Institutionalization.

The original Thomas S. action was taken because the partnership of State and local service systems was not able to provide appropriate, stable, long-term community-based supports for persons with challenging and multiple disabilities.



2 Support Individuals with Challenging and Multiple Disabilities in Ways that Minimize the Possibility of Inappropriate Institutionalization.

According to the 1998 Court Decision ...

In 1988, There was no coordinated system of services for persons with mental retardation and co-existing diagnoses (p. 24), as evidenced by:

- 400 Persons with MR in state psychiatric hospitals
- 50% of the 400 with no MI diagnosis
- 47% with only a single MR diagnosis

Thomas S.:

A Cross-Disability, Community-Based System of Specialized Supports

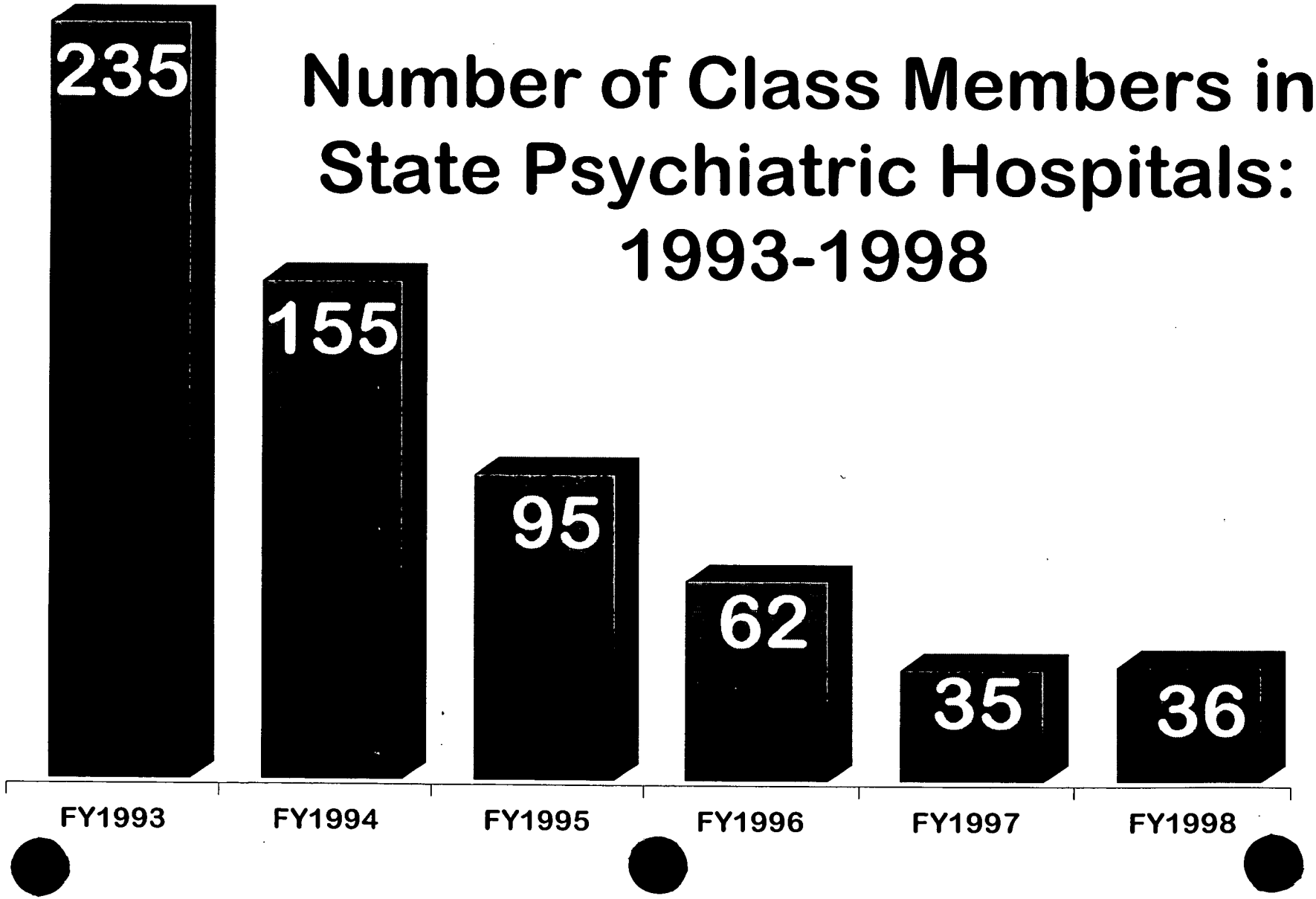
2 Support Individuals with Challenging and Multiple Disabilities in Ways that Minimize the Possibility of Inappropriate Institutionalization.

For many such individuals, this scarcity of alternatives to community-based natural settings creates a dependence on State institutions and State oversight that is both costly and restrictive.

Thomas S.!

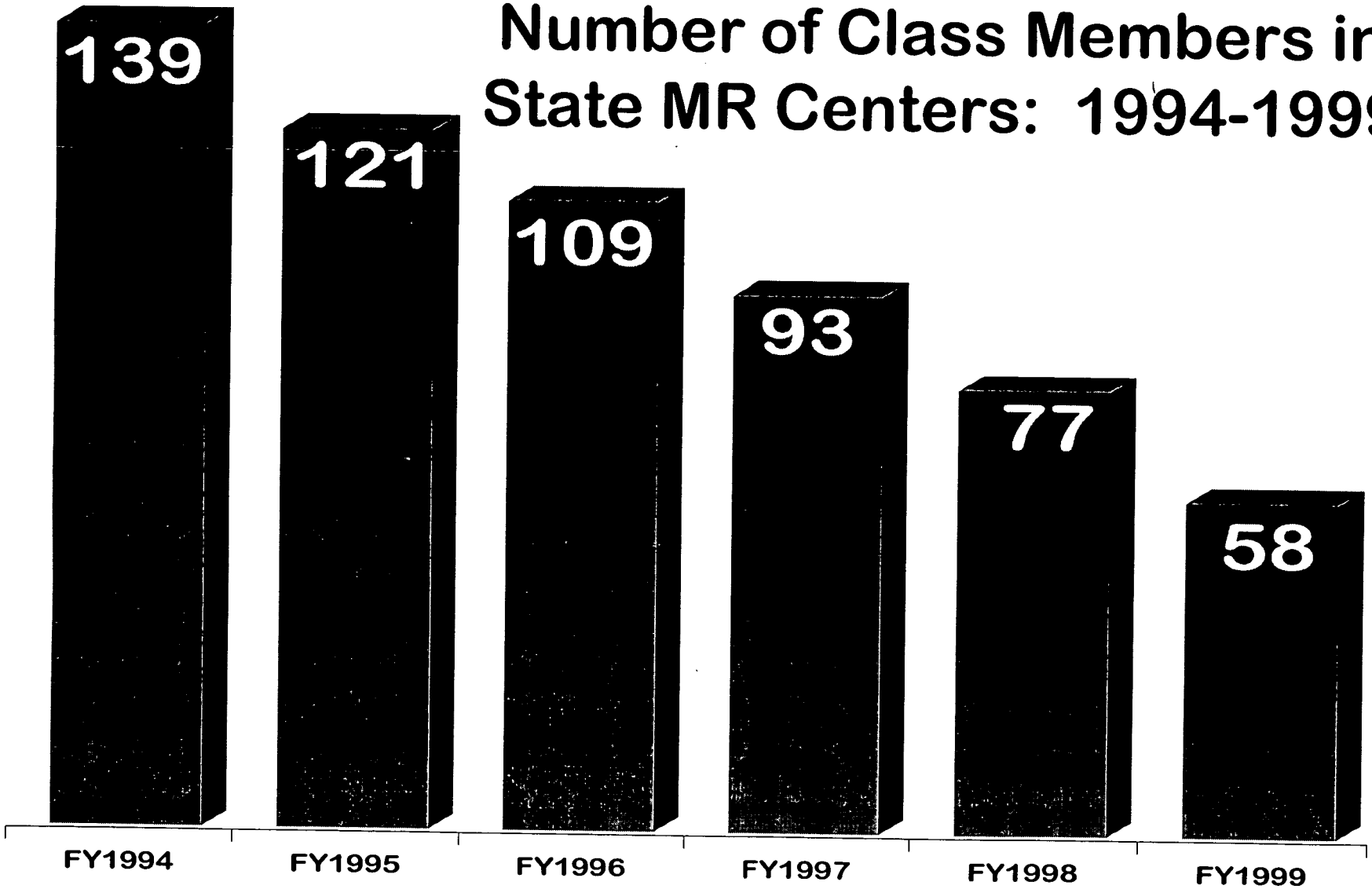
A Cross-Disability, Community-Based System of Specialized Supports

Number of Class Members in State Psychiatric Hospitals: 1993-1998



Thomas S.:
A Cross-Disability, Community-Based System of Specialized Supports

Number of Class Members in State MR Centers: 1994-1999



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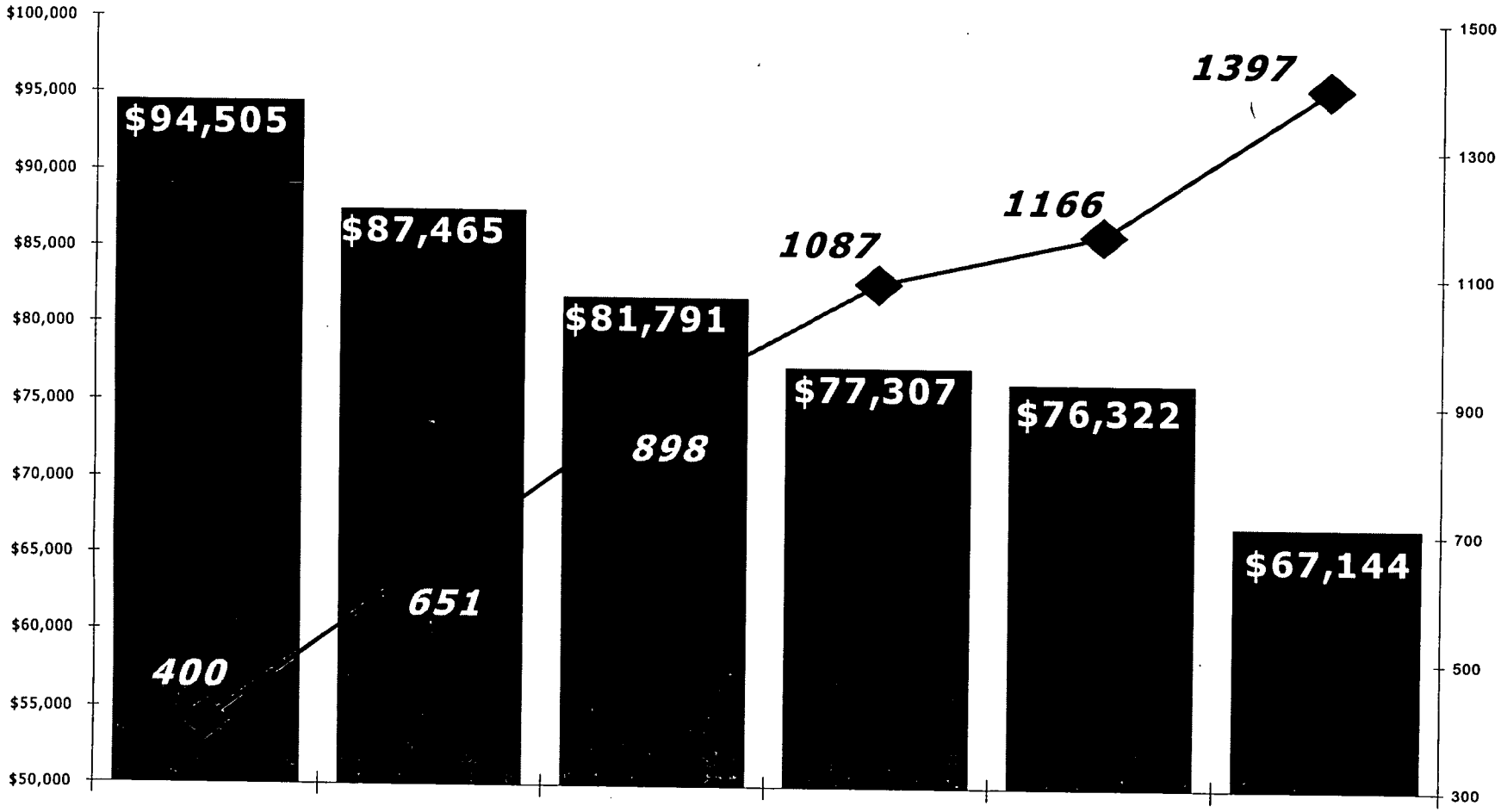
Thomas S.

A Cross-Disability, Community-Based System of Specialized Supports



Cost Per Class Member in Allocated State Dollars v. Number of Class Members In Services: 1993-1999

Thomas S.:
A Cross-Disability, Community-Based System of Specialized Supports

3 The Development of Person-Centered Service Delivery System Components is Beneficial to the Larger Service Delivery System.

Often the long-term benefits to a State in satisfying the requirements of a class action suit are in the changes to the system that the implementation of that suit requires. Some specific innovations and system enhancements that have come from the Thomas S. lawsuit include:

Thomas S.:
A Cross-Disability, Community-Based System of Specialized Supports

3 The Development of Person-Centered Service Delivery System Components is Beneficial to the Larger Service Delivery System.

- ✓ Individualized Information Systems;
- ✓ A Unit-Cost Reimbursement and Reporting System;
- ✓ Expansion of Service Provider Options;
- ✓ Person-Centered Planning;
- ✓ Expertise in Serving Persons with Co-Occurring Disabilities;
- ✓ Cost-Containment for High Utilizers of State-Funded Supports and Services.

Thomas S.:
A Cross-Disability, Community-Based System of Specialized Supports

4

During court oversight it was impractical to integrate all the important innovations of the lawsuit throughout the system; however, increased integration of the knowledge and best practices developed is the long term goal of the Division.

The expertise and modifications introduced in service of the implementation of the Thomas S. Court order will continue to serve the larger system by continuing to find efficient and cost-effective ways to support persons with challenging disabilities in their communities.

Thomas S.:
A Cross-Disability, Community-Based System of Specialized Supports

And what about Thomas?

Well, Thomas...

- Has had the same address for six years ...
- Is now purchasing his own home ...
- Has his own business ...
- Is tired of people coming around asking how he's doing ...

Thomas S.:

A Cross-Disability, Community-Based System of Specialized Supports

HOW WILL THE TRANSITION HAPPEN?

Thomas S.:
A Cross-Disability, Community-Based System of Specialized Supports

1 Help Integrate what Thomas S. has Learned in Implementing the 1988 Court Order Where it May Help the Larger Service Delivery System.

Some things we've learned:

- The existence of the 1988 Thomas S. Court Order is testimony to the fact that the existing service delivery system is primarily configured to serve persons who present themselves in discreet disability categories.

Thomas S.:
A Cross-Disability, Community-Based System of Specialized Supports

1 Help Integrate what Thomas S. has Learned in Implementing the 1988 Court Order Where it May Help the Larger Service Delivery System.

Some things we've learned:

- The system will not always know where to send these individuals and tends to want to categorize them into one disability or another.

Thomas S.:

A Cross-Disability, Community-Based System of Specialized Supports

1 Help Integrate what Thomas S. has Learned in Implementing the 1988 Court Order Where it May Help the Larger Service Delivery System.

Some things we've learned:

- This not only may result in administrative redundancy, as persons with multiple disabilities are shuffled among discreet disability systems to address the individual disabilities, but more significantly, the system finds itself less able to address the individual's overall needs which issue from the interaction of the disabilities.

Thomas S.:
A Cross-Disability, Community-Based System of Specialized Supports

2 Seek ways to develop Cost-Effective Community-Based Services for persons who historically have been significant Utilizers of public services and supports.

Cost of services has already been addressed by the Thomas S. Section through the 1997 *Thomas S. Cost Containment Special Provision*, in which the Thomas S. Section was directed to examine ways develop and implement cost containment measures to reduce the cost of direct services to Thomas S. class members through...

Thomas S.:

A Cross-Disability, Community-Based System of Specialized Supports

2 Seek ways to develop Cost-Effective Community-Based Services for persons who historically have been significant Utilizers of public services and supports.

- ✓ Positive client outcomes through long-term managed supports;
- ✓ Identification and ultimate elimination of redundant, inefficient or unnecessary process oriented tasks;
- ✓ Single stream funding from all available sources;
- ✓ The application of waivers of federal requirements;
- ✓ The review and possible repeal of rules that conflict or interfere with cost containment measures.

Thomas S.:

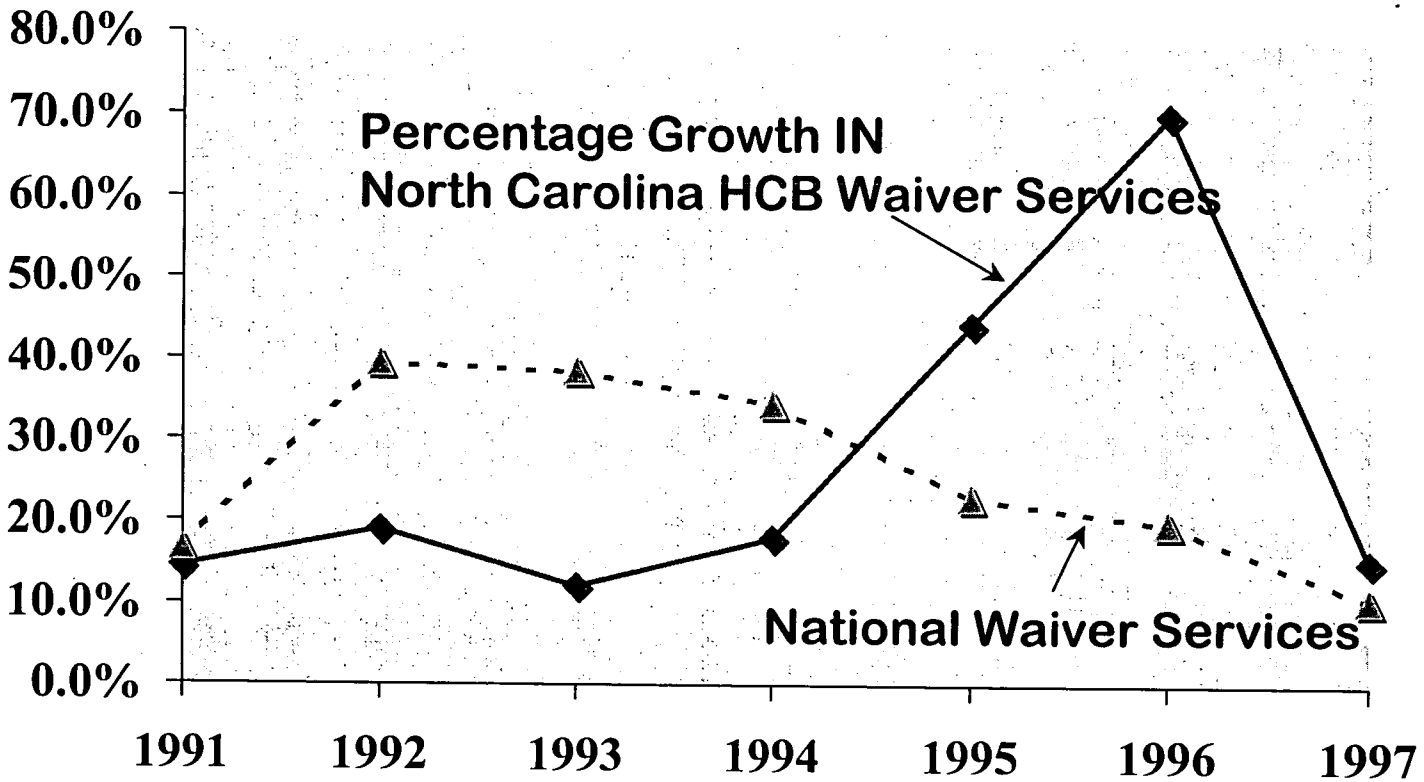
A Cross-Disability, Community-Based System of Specialized Supports

3 **Seek to develop Medicaid Waivers and Suggest Modifications of existing Waivers that will allow more flexible funding options for persons with Long-Term Disabilities.**

Nationally, Home and Community-Based Medicaid Waivers are allowing states to create more flexible options for long-term supports and, in turn, reducing overall costs per person.

Thomas S.:
A Cross-Disability, Community-Based System of Specialized Supports

A Comparison of Percentage Growth in Number of Persons Served Through HCB Waivers in North Carolina and Nationally: 1990-1997



3 Seek to develop Medicaid Waivers and Suggest Modifications of existing Waivers that will allow more flexible funding options for persons with Long-Term Disabilities.

The health care, or "medical model" for managing services and supports assumes that, with preventative and intense short term clinical care, people will need less long term remedial care. It is not a model that has ever had to look at supporting non-clinical needs to prevent utilization of high-cost services.

Thomas S.!

A Cross-Disability, Community-Based System of Specialized Supports

3 Seek to develop Medicaid Waivers and Suggest Modifications of existing Waivers that will allow more flexible funding options for persons with Long-Term Disabilities.

In managing costs of services and supports for people with long-term disabilities it is documented that the provision of supports in the community will minimize expensive, in-patient (institutional) care.

At present, though all Thomas S. class members resided at some time in the state psychiatric hospitals, 95% of Thomas S. class members present costs to the system less than the average cost of services for persons residing in state psychiatric hospitals.

4 Implement principles of Self-Determination in Service of Individual Empowerment and Cost-Containment.

Self-Determination is a national movement centering in over three hundred Robert Wood Johnson Foundation's self-determination projects. The principles and findings of these projects are distributed for adaptation and implementation where they will serve to foster the Self-Determination principles:

- ✓ **Freedom**
- ✓ **Responsibility**
- ✓ **Authority**
- ✓ **Support**

Thomas S.:

A Cross-Disability, Community-Based System of Specialized Supports

4 Implement principles of Self-Determination in Service of Individual Empowerment and Cost-Containment.

When empowered to select the supports and services they receive, people tend to use only those supports and services they need and will routinely choose less than professionals would prescribe, allowing for cost-containment along with self-determination.

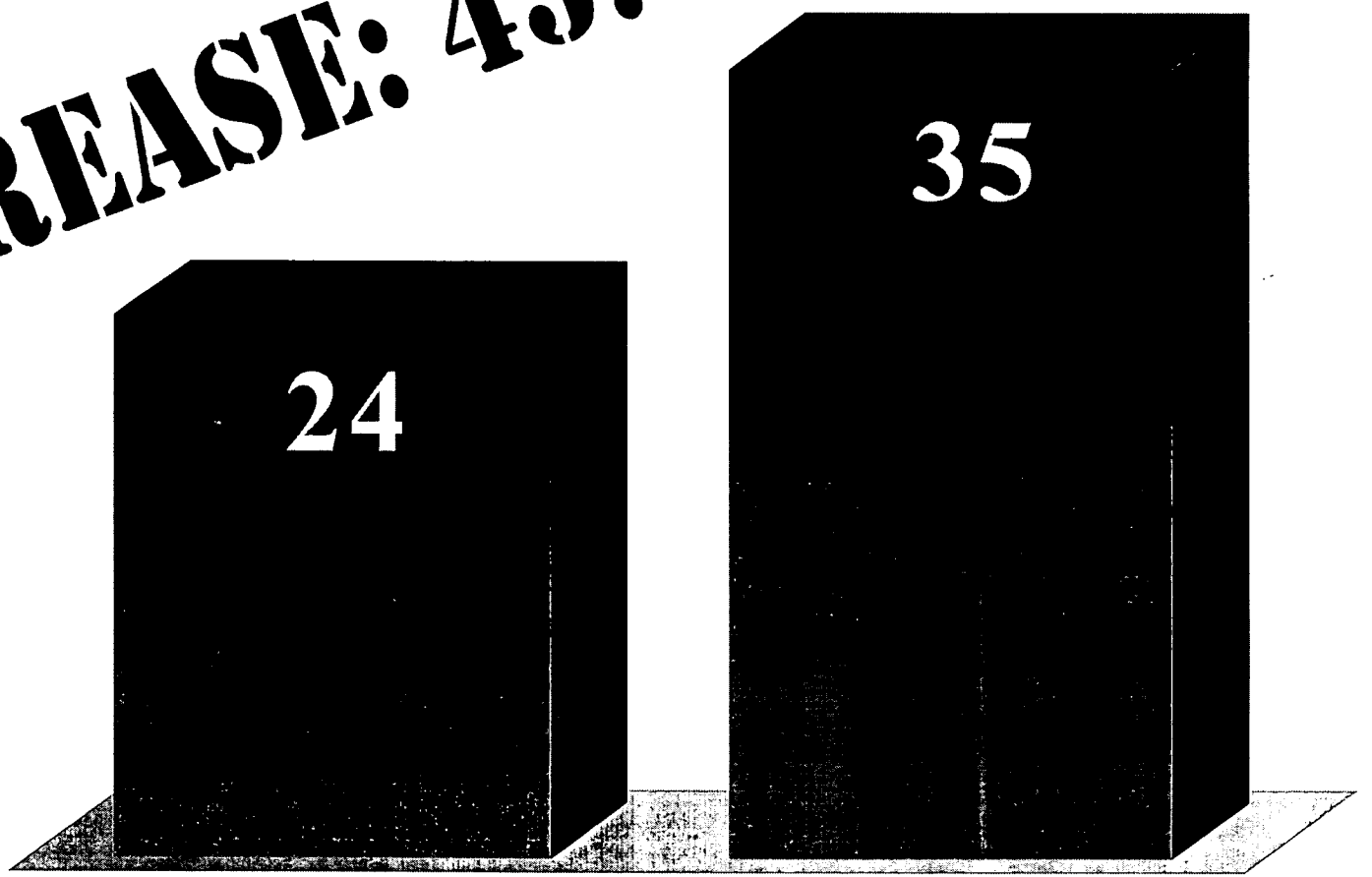
Tri-Alliance

Thomas S. Participant-Driven Managed Supports Self-Determination Project

Thomas S.:

A Cross-Disability, Community-Based System of Specialized Supports

INCREASE: 45.8%



Number of Persons Served: 1997-1998

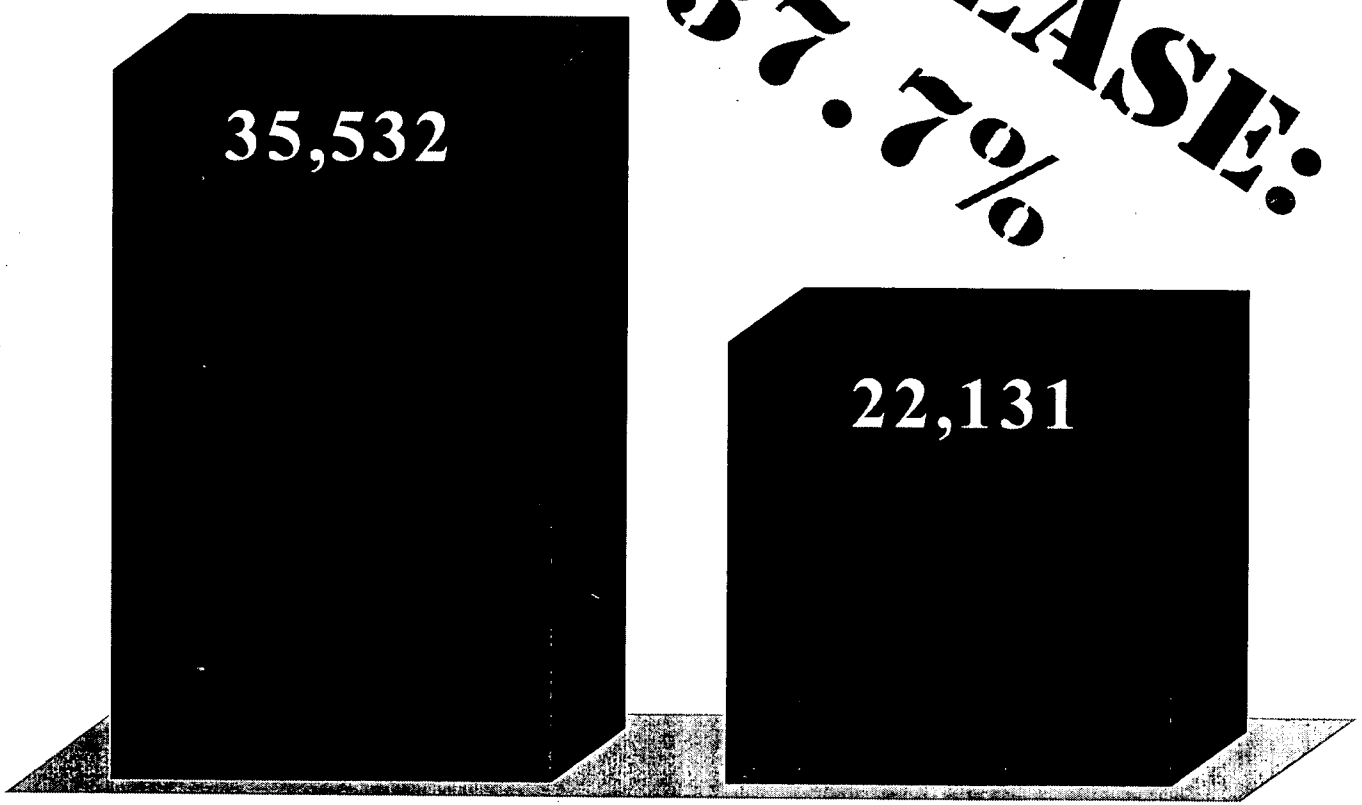
Tri-Alliance

Thomas S. Participant-Driven Managed Supports Self-Determination Project

Thomas S.:

A Cross-Disability, Community-Based System of Specialized Supports

DECREASE: 37.7%



Comparison of Numbers of Units Billed to UCR-TS: 1997-1998

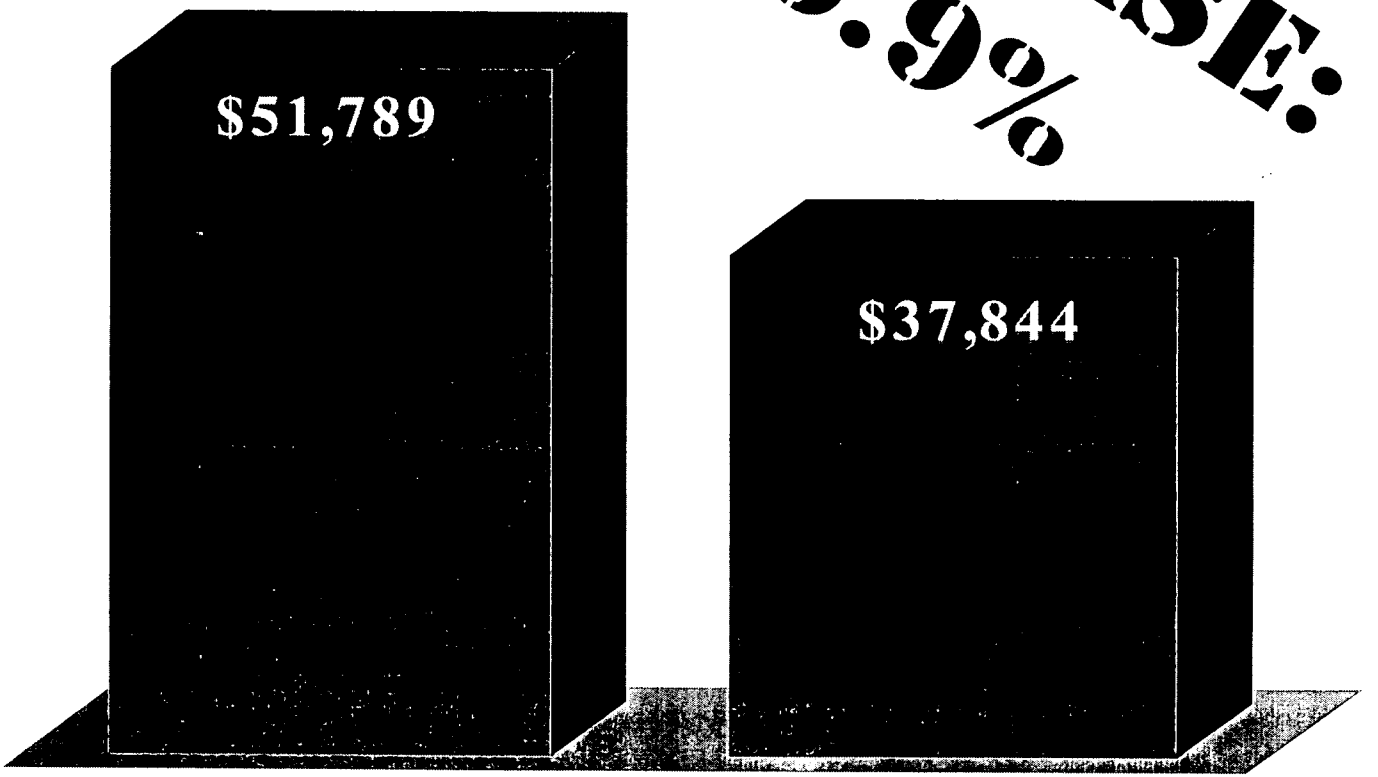
Tri-Alliance

Thomas S. Participant-Driven Managed Supports Self-Determination Project

Thomas S.:

A Cross-Disability, Community-Based System of Specialized Supports

DECREASE: 26.9%



Comparison of Net Cost Per Person Served: 1997-1998

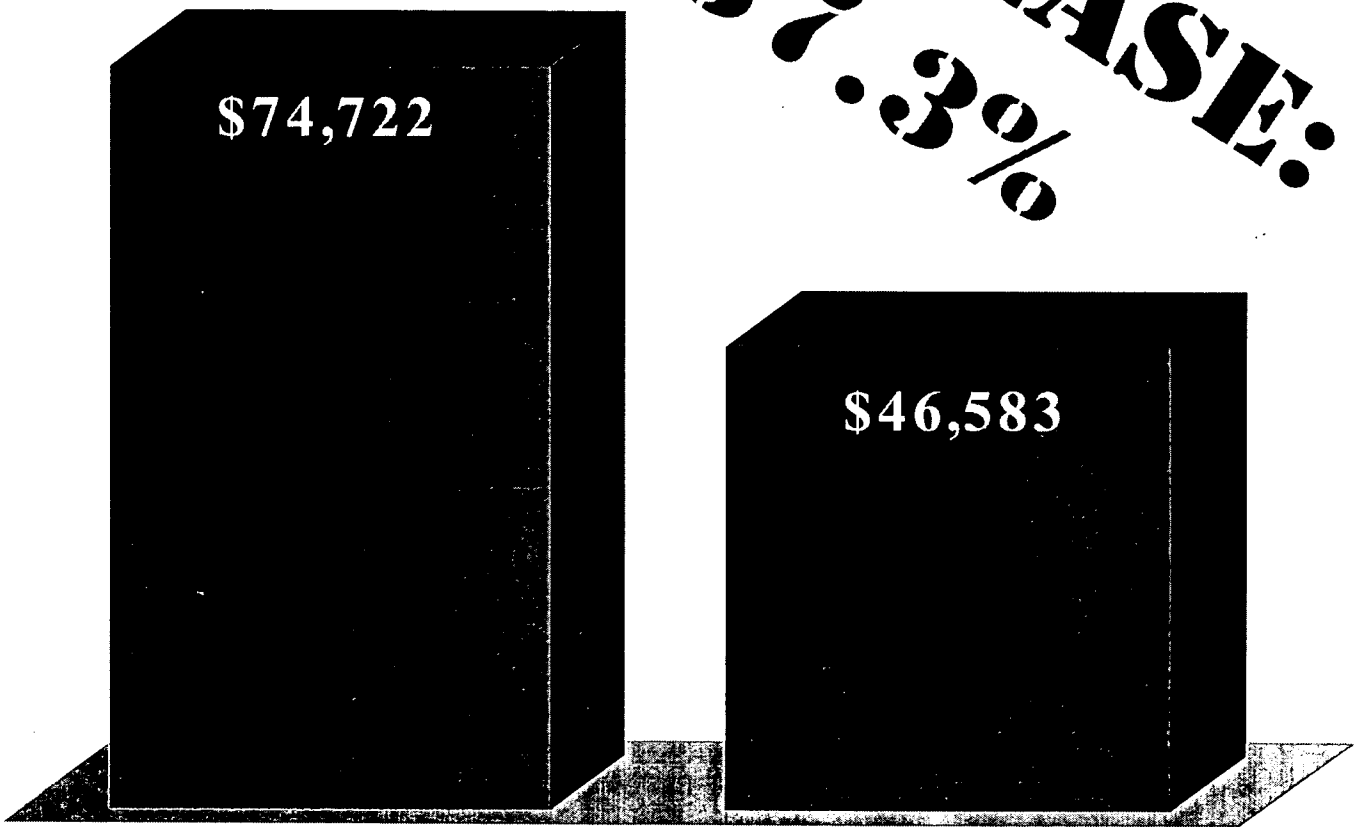
Tri-Alliance

Thomas S. Participant-Driven Managed Supports Self-Determination Project

Thomas S.:

A Cross-Disability, Community-Based System of Specialized Supports

DECREASE: 37.3%



Comparison of Gross Cost Per Person Served: 1997-1998

HOUSE COMMITTEE ON MENTAL HEALTH

May 25, 1999
10:00 a.m.
Room 415

AGENDA

Chair: Rep. Jim Crawford

INTRODUCTIONS

SB 1122 AREA MENTAL HEALTH/COUNTY APPROPRIATIONS

SPEAKERS Substance Abuse Services
Flo Stein, Chief

Adult Health Services
Don Willis

DISCUSSION

ADJOURNMENT

MINUTES
HOUSE COMMITTEE ON MENTAL HEALTH
MAY 25, 1999

The House Committee on Mental Health met on Tuesday, May 25, 1999 in Room 415 of the Legislative Office Building at 10:00 a.m. The following members were present: Chairman Jim Crawford, Representatives Cansler, Esposito, Gardner, Goodwin, Horn, Insko, Nye, Oldham, and Warwick. Linda Attarian and Kory Goldsmith, staff, attended. A visitor registration list is attached and made part of these minutes. Chairman Crawford introduced the pages for the day.

Chairman Crawford introduced Flo Stein, Chief, Substance Abuse Services to present an overview of services of the section. Ms. Stein talked about the section's mission and its current initiatives. The section is currently conducting a study to determine how many substance abusers are in need of treatment and how well their needs are being met. She provided two handouts that describe current services and statistics by county.

SB 1122 AREA MENTAL HEALTH/COUNTY APPROPRIATIONS. Senator Moore was introduced to explain the bill which would bring the statute in line with the practice of the department to allow counties to reduce appropriations by the amount previously appropriated by the county for one-time special needs of the area authority. Rep. Cansler submitted a committee substitute to make a technical correction and to address a concern by Rep. Nye that "special needs" would be misused by changing the wording to "special non-recurring needs." With no objection, Rep. Esposito moved for a favorable report as to committee substitute, unfavorable as to the original bill. The motion passed.

Chairman Crawford introduced Don Willis, Chief, Adult Mental Health Services, to give an overview of the services provided by the section. Mr. Willis gave an update on the new Dix hospital. He also provided information on the section's initiatives and how they are responding to the recommendations included in the study by MGT.

Chairman Crawford adjourned the meeting at 10:55.

Respectfully submitted,

Representative Jim Crawford
Chairman

Linda S. Winstead
Committee Assistant

VISITOR REGISTRATION SHEET

MENTAL HEALTH — Tuesday 25th, 1999

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Helen Wolskerwolmer	Division of MH/DD/SAS
[illegible]	DHR MH/DD/SAS
Don Willis	DMH DDSAS
Bob Hedrick	CNC
Missi Porter	Bone & Associates
Wayne Williams	State Budget office
Heidi Yates	Sen. Moore's office
Jim Tate	MHA/NC
Ken Moore	NC Senate
"	
Sandra Long	NCAPP

1999 COMMITTEE REPORT
HOUSE OF REPRESENTATIVES

The following report(s) from standing committee(s) is/are presented:
By Representative(s) **Crawford & Goodwin** for the Committee on **MENTAL HEALTH.**

☒ Committee Substitute for
S.B. 1122 A BILL TO BE ENTITLED AN ACT TO AMEND THE LAW TO ALLOW COUNTIES TO REDUCE CERTAIN COUNTY APPROPRIATIONS AND EXPENDITURES FOR AREA MENTAL HEALTH AUTHORITIES FOR FUTURE FISCAL YEARS.

☐ With a favorable report.

☐ With a favorable report and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report, as amended.

☐ With a favorable report, as amended, and recommendation that the bill be re-referred to the Committee on Appropriations ☐ Finance ☐ ☐.

☐ With a favorable report as to committee substitute bill (#), ☐ which changes the title, unfavorable as to (original bill) (Committee Substitute Bill #), (and recommendation that the committee substitute bill #) be re-referred to the Committee on .)

☒ With a favorable report as to House committee substitute bill, unfavorable as to Senate committee substitute bill.

☐ With an unfavorable report.

☐ With recommendation that the House concur.

☐ With recommendation that the House do not concur.

☐ With recommendation that the House do not concur; request conferees.

☐ With recommendation that the House concur; committee believes bill to be material.

☐ With an unfavorable report, with a Minority Report attached.

☐ Without prejudice.

☐ With an indefinite postponement report.

☐ With an indefinite postponement report, with a Minority Report attached.

☐ With recommendation that it be adopted. (HOUSE RESOLUTION ONLY)

2/24/99

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 1122
Health Care Committee Substitute Adopted 4/28/99
Proposed House Committee Substitute S1122-PCS4703-RM

Short Title: Area Mental Health/County Appropriations. (Public)

Sponsors:

Referred to:

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAW TO ALLOW COUNTIES TO REDUCE CERTAIN COUNTY APPROPRIATIONS AND EXPENDITURES FOR AREA MENTAL HEALTH AUTHORITIES FOR FUTURE FISCAL YEARS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 122C-115(d) reads as rewritten:

"(d) Except as otherwise provided in this subsection, ~~Counties~~ counties shall not reduce county appropriations and expenditures for current operations and ongoing programs and services of area authorities because of the availability of State-allocated funds, fees, capitation amounts, or fund balance to the area authority. Counties may reduce county appropriations by the amount previously appropriated by the county for one-time, nonrecurring special needs of the area authority."

Section 2. This act becomes effective July 1, 1999.

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may 25
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GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 2

SENATE BILL 1122
Health Care Committee Substitute Adopted 4/28/99

Short Title: Area Mental Health/County Appropriations. (Public)

Sponsors:

Referred to:

April 15, 1999

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Section 2. This act becomes effective July 1, 1999.

SENATE BILL 1122:
Area Mental Health/County Appropriations.

BILL ANALYSIS

Committee:	House Mental Health	**Introduced by:**	Sen. Moore
Date:	April 20, 1999	**Summary by:**	Linda Attarian
Version:	Second		Committee Counsel

SUMMARY: ***This bill would allow counties to reduce appropriations to area mental health authorities in future fiscal years by the amount previously appropriated by the county for one-time special needs of the area authority.***

CURRENT LAW: Under North Carolina law, the counties are responsible for the delivery of mental health, developmental disabilities, and substance abuse services through a network of local area authorities. Counties may not adjust their funding allocation to pay for the cost of providing services through the area authorities due to the availability of State-allocated funds, fees, capitation amounts or fund balance to the area authorities. However, current law does not specifically prevent counties from decreasing future appropriations to area authorities by amounts previously appropriated for one-time special projects, such as purchasing a building or computers, etc.

BILL ANALYSIS:

Section 1. Amends G.S. 122C-115(d) to provide that counties shall not reduce their appropriations to area authorities *for current operations and ongoing programs and services* because of the availability of State-allocated funds, but *may do so by amounts previously appropriated by the county for one-time special needs of the area authority.*

Section 2. If enacted, the bill becomes effective July 1, 1999

How to use this information

What are risk and protective factors?

Risk factors are characteristics of people, their families, and school and community environments, which are empirically associated with increases in substance abuse. Protective factors are those characteristics that appear to have a protective function in a community, i.e., they serve to reduce or moderate the influence of risk factors. Clearly some protective factors are hard to modify; for example, it would be hard to modify your genetic disposition. Research suggests that the pattern of risk and protection varies from county to county.

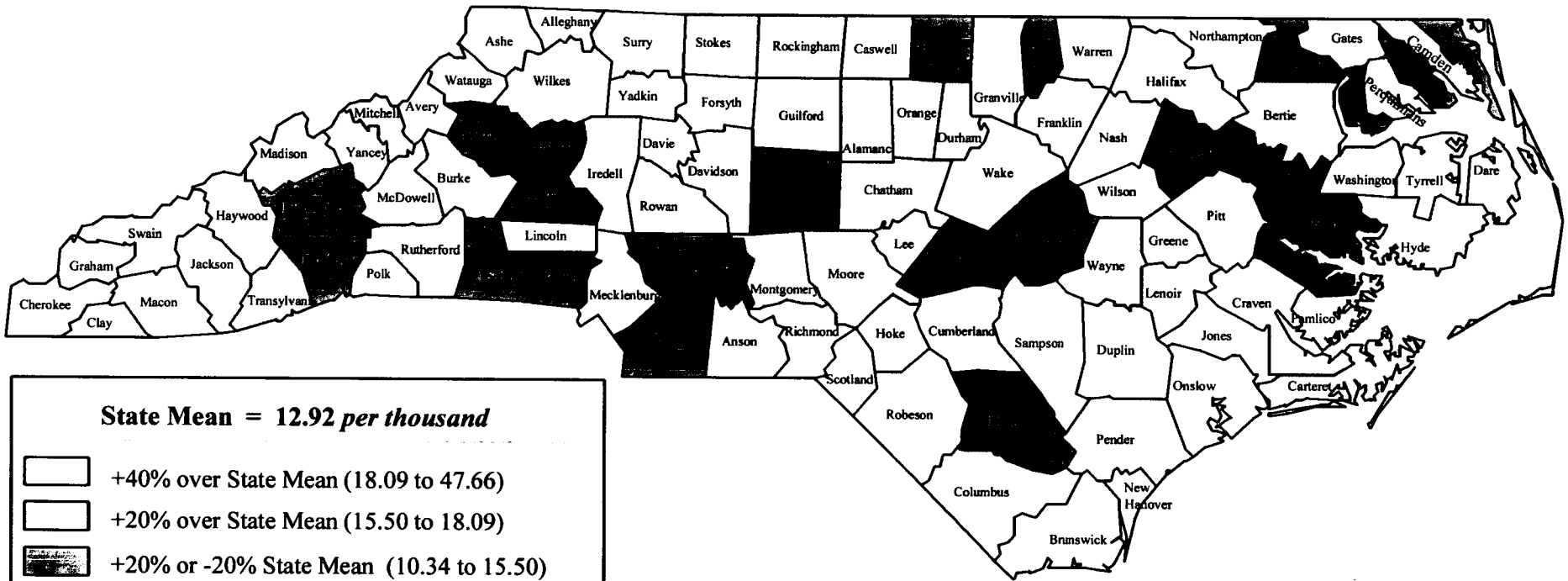
There is a large body of social indicator data routinely collected on risk factors. Such things as number or arrests for drug possession, alcohol related mortality rates, are collected each year by the state. As part of our Center for Substance Abuse Treatment (CSAT) Needs Assessment studies, we collected 5 years worth of social indicator data thought to be associated with substance use and abuse and averaged them so that oddities in data reporting or small numbers didn't distort the indicators. The bar graph entitled *NC Social Indicators, Years 1990-1995, Ranked by County* is our attempt to give you a 'snap shot' picture of where your county stands on a number of these indicators. In order to help you study risk factors that may be associated with substance abuse in your county, we have ranked counties from 1 to 100 in terms of amount of risk/severity. We then grouped the counties into groups of ten known as deciles. So if your county is in the first decile on a social indicator it means your county has lower risk on that particular indicator.

Because we thought that there might be regional influences at play, we have also created colored state maps for those indicators so you can quickly see how your county compares with its neighbors. On these maps the county rank is compared with the state mean. Those areas in red are counties with the greatest risk.

If you have any questions about the information presented, please call Carol Council at 919 733-0696.

NORTH CAROLINA STATE TREATMENT AND PREVENTION NEEDS ASSESSMENT STUDY

Level of Community Crime and Violence: *Juvenile Arrest Rate for Property Index Crimes* (aged 10-17)



State Mean = 12.92 *per thousand*

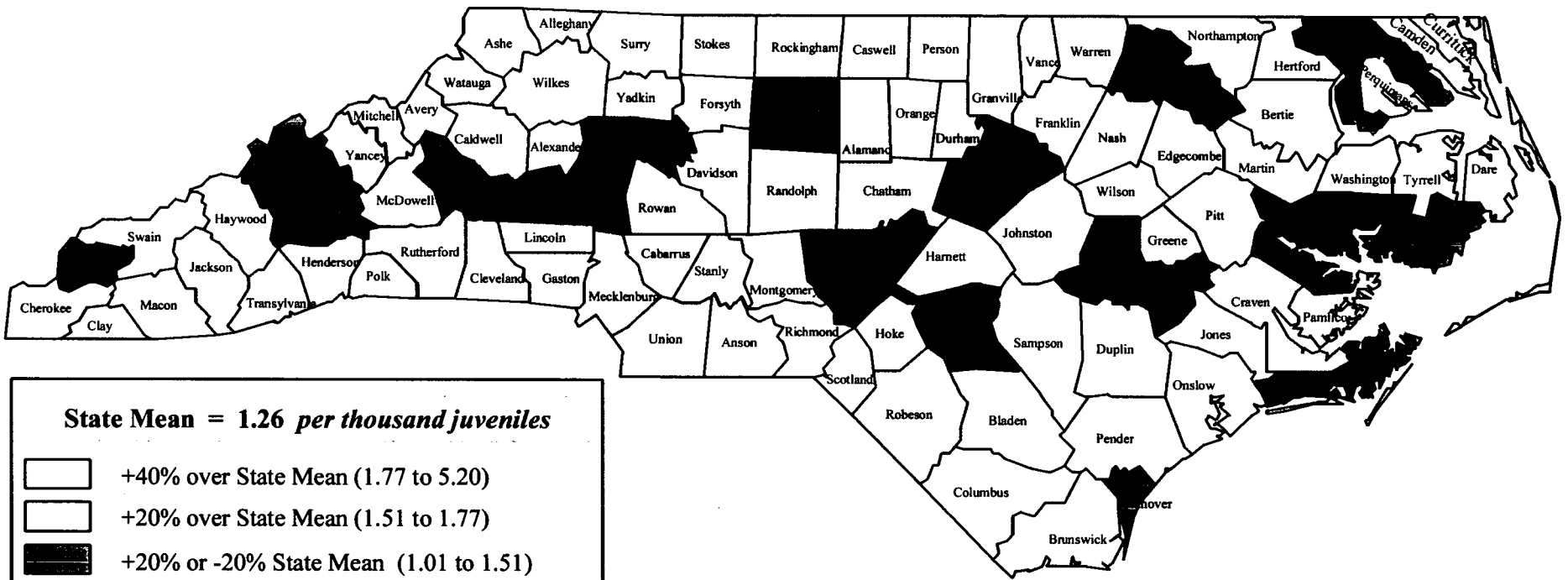
- +40% over State Mean (18.09 to 47.66)
- +20% over State Mean (15.50 to 18.09)
- +20% or -20% State Mean (10.34 to 15.50)
- -20% below the State Mean (7.75 to 10.34)
- -40% below the State Mean (0.00 to 7.75)

* Counties in white (Madison, Mitchell and Swain) reflect missing arrest records.
Property crimes are burglary, larceny and motor vehicle theft.
Source: North Carolina Social Indicator Study, 1995

Substance Abuse Services
Division of MH/DD/SAS
DHHS 5/19/99

NORTH CAROLINA STATE TREATMENT AND PREVENTION NEEDS ASSESSMENT STUDY

Alcohol and Drug Abuse Indicators: *Unduplicated Admission Rate to Publicly Funded Treatment Programs for Both Alcohol and Drugs Per 1,000 Juveniles (aged 10-17)*



State Mean = 1.26 ***per thousand juveniles***

- +40% over State Mean (1.77 to 5.20)
- +20% over State Mean (1.51 to 1.77)
- +20% or -20% State Mean (1.01 to 1.51)
- -20% below the State Mean (0.76 to 1.01)
- -40% below the State Mean (00.00 to 0.76)

Source: North Carolina Social Indicator Study: 1995

Substance Abuse Services Section

DMH / DD / SAS

NC DHHS, (JUN98

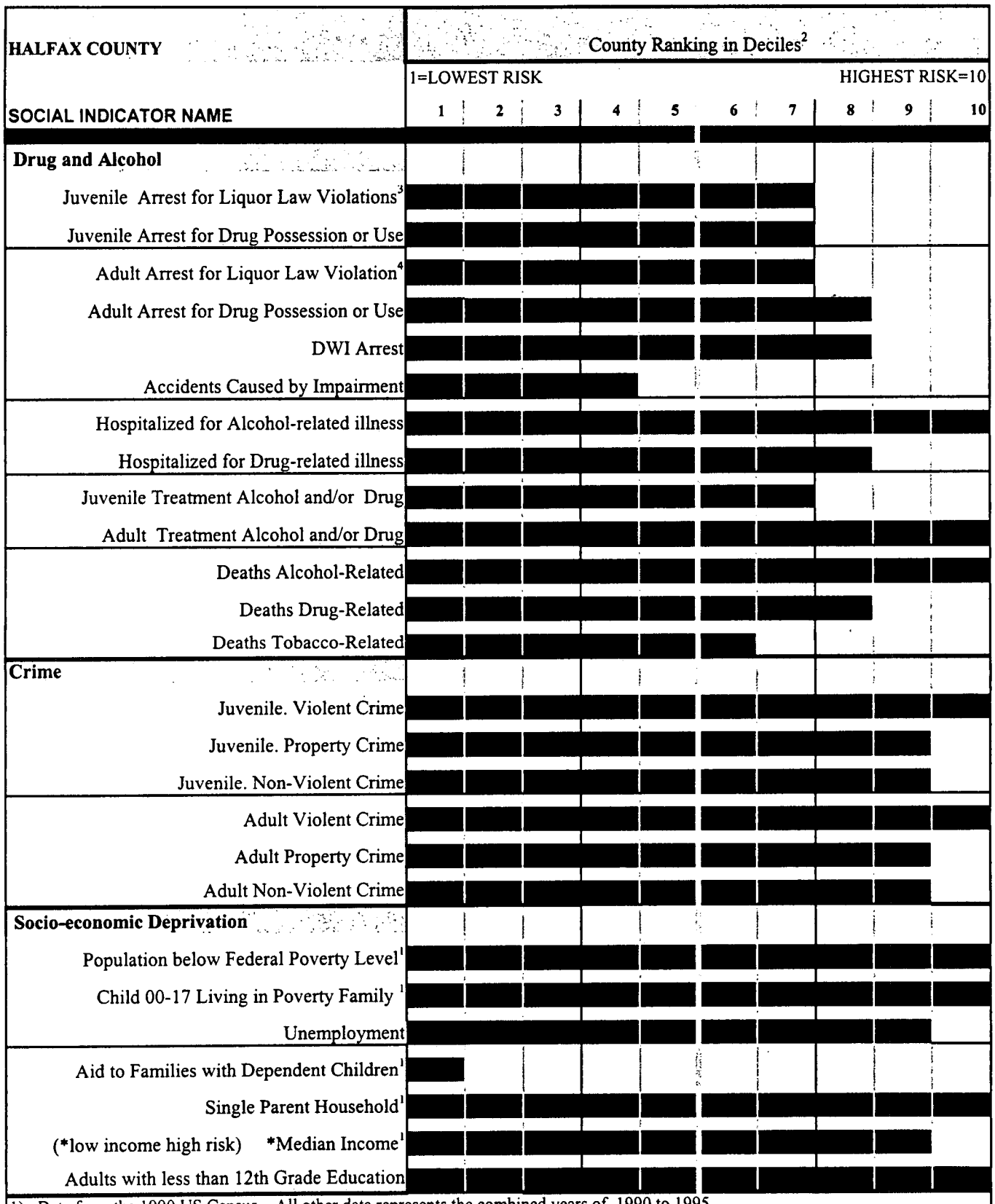
NC Social Indicators, Years 1990-1995, Ranked by County

CLAY COUNTY	County Ranking in Deciles[2]
	1=LOWEST RISK ... HIGHEST RISK=10
SOCIAL INDICATOR NAME	1 2 3 4 5 6 7 8 9 10
Drug and Alcohol	
Juvenile Arrest for Liquor Law Violations[3]	
Juvenile Arrest for Drug Possession or Use	
Adult Arrest for Liquor Law Violation[4]	
Adult Arrest for Drug Possession or Use	
DWI Arrest	
Accidents Caused by Impairment	
Hospitalized for Alcohol-related illness	
Hospitalized for Drug-related illness	
Juvenile Treatment Alcohol and/or Drug	
Adult Treatment Alcohol and/or Drug	
Deaths Alcohol-Related	
Deaths Drug-Related	
Deaths Tobacco-Related	
Crime	
Juvenile. Violent Crime	
Juvenile. Property Crime	
Juvenile. Non-Violent Crime	
Adult Violent Crime	
Adult Property Crime	
Adult Non-Violent Crime	
Socio-economic Deprivation	
Population below Federal Poverty Level[1]	
Child 00-17 Living in Poverty Family [1]	
Unemployment	
Aid to Families with Dependent Children[1]	
Single Parent Household[1]	
(*low income high risk) *Median Income[1]	
Adults with less than 12th Grade Education	

1) Data from the 1990 US Census. All other data represents the combined years of 1990 to 1995.
2) A decile is a group of ten counties. The ten counties at the highest risk for substance abuse problems within a large proportion of their population are given the rank of 10.
3) Juvenile Liquor Law Violations are DWI, Alcohol Law Violation, and Drunkenness.
4) Adult Liquor Law Violations are Alcohol Law Violation, and Drunkenness (except DWI).

Source: CSAT-1, NC Social Indicator Study, 1995

NC Social Indicators, Years 1990-1995, Ranked by County



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Source: CSAT-1, NC Social Indicator Study, 1995

DIVISION OF MENTAL HEALTH/DEVELOPMENTAL DISABILITIES/SUBSTANCE ABUSE SERVICES

SUBSTANCE ABUSE SERVICES

FISCAL RESEARCH DIVISION

MARCH 9, 1999

SUBSTANCE ABUSE IN NORTH CAROLINA

Prepared by
The Substance Abuse Services Section
MH/DD/SAS

Substance abuse is one of the State's greatest social and health problems. The morbidity and mortality from this abuse is staggering as are the direct and indirect costs.

Businesses lose millions of dollars each year in lost worker productivity as well as in increasing crime attributed to substance dependency. The cost to North Carolina includes violence, crime, overburdened social systems, higher insurance rates and higher health care costs. The cost of alcohol abuse and dependence in the United States was estimated at $116.9 billion dollars in 1983, of which 61 percent was attributed to lost employment and reduced productivity and 13 percent to health care costs. For example, we estimate that drunk driving costs about half a billion dollars each year in North Carolina (this estimate excludes lost quality of life.)

HOW MANY SUBSTANCE ABUSERS ARE THERE IN NORTH CAROLINA?

We are frequently asked how many substance abusers there are in North Carolina. This is a difficult question to answer because many people deny they have a problem or are able to hide it within the confines of their families. It is difficult to call people up and ask them if they use illegal substances because they may fear that disclosure will have detrimental consequences. The State is currently conducting a CSAT sponsored study to determine how many substance abusers there are in North Carolina who are in need of treatment and how well we are meeting their needs. Although the study will not be completed until 1998, we have information from a telephone survey randomly collected from 4700 households in North Carolina that provide us with a conservative estimate of substance use (excludes many high risk populations such as the homeless, those incarcerated, etc.). These figures indicate that:

- 343,000 North Carolinians are in need of comprehensive substance abuse treatment
- 784,000 are in need of some type of substance abuse services.
- Nearly 1 in 5 young males in North Carolina between the ages of 18 to 24 were in need of comprehensive treatment (8.9% of black males and 18.3% of white males).
- Marijuana is the most frequently abused illicit substance.
- 24% of those in need of comprehensive treatment in North Carolina report no health insurance coverage.
- 11.6 % of women pregnant within the past 12 months has used an illicit drug.
- 59.4% of those who reported being pregnant within the past 12 months had used alcohol in the same time period; 0.4% were past year heavy drinkers.

ALCOHOL-RELATED MORTALITY

We can look at our worst system failures -- mortality attributable to alcohol. In North Carolina, the unadjusted death rate for all alcohol-related causes of death is 51.1 per hundred thousand (U.S., 1986-1990). For the nation, the rate is 44 per hundred thousand.

IV DRUG USE

We estimate that here are 17,544 IV drug users in North Carolina. In 1995 we served 2,315 in our area programs.

CRIME

DWI

- 84,908 drivers were arrested for DWI in North Carolina during FY 1995/96. There are 5,138,594 licensed drivers in the State. That means we had 1.65 DWI arrests per hundred licensed drivers.

- In a UNC study of the 109,000 persons convicted of DWI in North Carolina, those completing assessment and treatment were 74% less likely to be rearrested than those who failed to comply.

- 27.4% of fatal crashes and 27.2% of persons killed on our highways were determined to be alcohol-related. In 1995, the investigating officer indicated in 7922 crashes that the driver had been drinking.

DRUG RELATED ARRESTS

- There were 34,132 drug related arrests in North Carolina during 1995.

ALCOHOL AND DRUG USE AMONG PREGNANT WOMEN

In a study of drug and alcohol use in pregnancy sponsored by our Section and the Department of Crime Control and Public Safety, (Sept. 1994.) researchers found that of the 2742 pregnant North Carolinian women in the sample, 7.4% had a positive urine toxicology for an illicit drug. Based on these estimates, researchers believe that approximately 7400 infants in the state are exposed to an illicit drug. This does not even count exposure to alcohol. Why does this matter? First, we have one of the highest infant mortality rates in the U.S. Second, many of these drugs have been shown to cause birth defects and many of these birth defects cost North Carolina millions of health care and custodial care costs each year.

Substance Abuse Problems Among Juveniles In North Carolina

With more and more juveniles coming into the justice system in North Carolina, it is crucial that we deal not only with the specific behaviors or circumstances that bring them to our attention, but also with their underlying substance abuse problems. Although the prevalence of substance abuse disorders among youth in the juvenile justice system is largely unknown, recent research suggests that these problems are significantly greater for juvenile delinquents than for other youth. (Cocozza, 1992)[1].

Research has also demonstrated that juvenile delinquents tend to have both mental health disorders and substance abuse problems, and a high percentage of them also have conduct disorders. Finally, research and experience demonstrate that the services available in the juvenile justice system to alleviate these problems are entirely inadequate. Four key steps by government and private organizations can help remedy this situation, namely:

1. **Learn more.**

2. **Assess juveniles when they first come in contact with the system**. Quality assessments can determine whether young offenders represent a risk to the community and also can form the basis for effective treatment plans that will reduce the likelihood of reoffending by addressing the issues that put the youth at risk for delinquency.

3. **Increase the number of quality treatment programs in the community and in juvenile institutions**. This step requires a significant commitment of resources and cross-training to improve the ability of juvenile justice and SA/mental health staff to deal with juvenile who have mental health and substance abuse problems. It also requires a determination to maintain a therapeutic environment in the juvenile justice system.

4. **Focus on juveniles who are at risk for delinquency rather than those already in the juvenile justice system.** Initiatives may be begun in elementary school to promote coping and competence among youth and reduce their risk for conduct problems, aggression, substance abuse, delinquency, violence, and school failure.

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[1] Cocozza, J., ed. 1992 (November). *Responding to the Mental Health Needs of Youth in the Juvenile Justice System.* Seattle, WA: The National Coalition for the Mentally Ill in the Criminal Justice System.

What we know:

SELF-REPORTED ALCOHOL AND DRUG USE IN OUR HIGH SCHOOLS[2]

- 69% of students had used alcohol for other than religious purposes, at least once by the age of 17.
- 40% drank alcohol within the past month.
- 23% consumed five or more drinks in a row during the past month.
- 10% are heavily using alcohol - 14% men and 6% women. (Heavy users are defined as using 5 or more drinks in a row on 3 or more occasions in the 30 day period before the survey.)
- 23% of high school students are risky drug users (defined as using marijuana or inhalants 10 or more times **and/or** cocaine, uppers, hallucinogens or crack at least once in their lifetime. In addition the students must have used drugs in the past 12 months.)
- 22% had used marijuana during the past month.
- 4.7% had used cocaine at least once in their lifetime
- 2.2% had used cocaine or crack in the past month.
- 1.7% had injected drugs at some point in their lives.

PROPORTION IN NEED OF SUBSTANCE ABUSE SERVICES

- 7.8% of high school students were in need of services for alcohol use-10% male, 5% female. Nearly twice as many whites as African Americans (9% vs 5%)
- 13% of high school students were in needs of services for illicit drugs use - 15% male and 11% female

This survey contrasts public high school students who needs some type of intervention for their alcohol use with those that don't. 27.9% of these students had carried a gun in the past 30 days compared with 5.6% of those not needing services. 61.2% had been in a fight during the past year compared with 25.1% of those not needing intervention.

Now we have the ability to map counties by their rates of arrest for juvenile crimes. While these figures are greatly influenced by level of law enforcement they do provide a useful method for focusing our efforts. (See attached figures). Four graphs are presented as transparencies. These permit the reader to superimpose maps to identify areas that appear to be at greatest risk for intervention. Please note we have included the school drop out rate because it provides a useful index of potential school problems.

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[2] Results from North Carolina's Substance Abuse Needs Assessment Studies supported by a federal CSAT contract). The work was undertaken by the Research Triangle Institute and added supplemental questions to the DPI Youth Behavior Risk Survey administered in a sample of public schools during May and June of 1995. It does not include those in private schools, those who have dropped out, those who have run away from home, or those who are in our institutions.

SUBSTANCE ABUSE SERVICES

North Carolina's Substance Abuse Services Are Grounded in Three Basic Beliefs

1. Addiction is Chronic and Life Threatening, Rooted in Genetic Susceptibility, Social Circumstances and Personal Behavior; Certain Drugs are Highly Addictive and Others Become Addictive Over Longer Periods of Time.

2. Substance Abuse Treatment is Provided in Many Settings (Outpatient and Inpatient With Different Levels of Intensity; In Many Different Ways (Short-Term Treatment and Therapeutic Communities); For Different Lengths of Time {Four General Phases Include 1) Detoxification, 2) Rehabilitation, 3) Continuing/Transitional Care, and 4) Relapse Prevention.}

3. Treatment Works.

SUBSTANCE ABUSE SERVICES

Mission: to provide leadership in the planning, development and organization of a statewide system of alcohol and other drug services; to coordinate and communicate policies and strategies that educate, encourage, and respond proactively to alcohol and other drug prevention, intervention, and treatment issues.

The Division Supports This Mission Through:

- Institutional Services
- Community Services
- Regulatory Unit
- DWI/Criminal Justice
- Employee Assistance Program
- Prevention Services

SUBSTANCE ABUSE SERVICES

- Institutional Services
  -Provides inpatient services through the State Alcohol and Drug Abuse Treatment Centers (ADATC).

- Community Services
  -Provide support to 40 Area Programs in the implementation of substance abuse plans; 2) Coordinate and develop programs to reduce HIV/AIDS; 3) Coordinate and develop programs and services to women, including TANF recipients and their families; and 4) Provide leadership and support for the development of a comprehensive system of prevention and treatment services for children and youth.

- Regulatory Unit
  -Prevents controlled substances into illicit markets

SUBSTANCE ABUSE SERVICES

- DWI/Criminal Justice
  -Provide leadership and support for services targeted at clients involved with the criminal justice system (e.g., Treatment Alternatives to Street Crime - TASC).

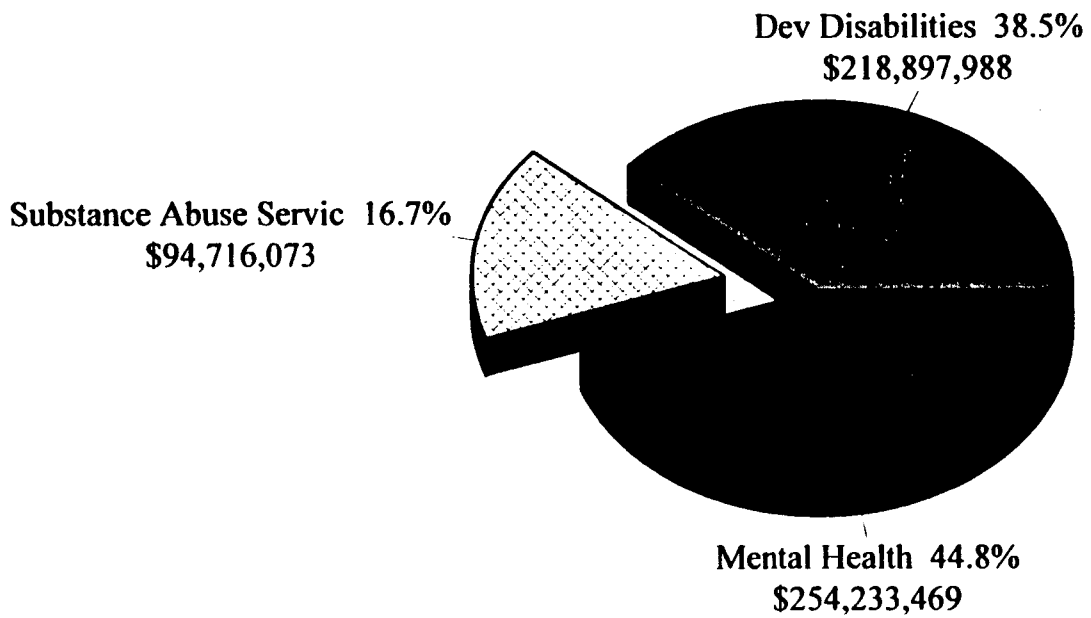
- Employee Assistance Program
  -Assist employees impaired by stress, substance abuse or other personal concerns; Develop of Enhance EAP to private employers and TANF recipients; provide technical assistance to Area Programs; and provides guidance for DHHS's Alcohol & Drug-Free Workplace Initiative.

- Prevention Services
  -Develop and coordinate prevention efforts statewide including the infusion of science-based prevention strategies into existing prevention programs.

SUBSTANCE ABUSE SERVICES

AREA MENTAL HEALTH PROGRAMS

ESTIMATED PROGRAM SERVICES BY DISABILITY (FY97/98)



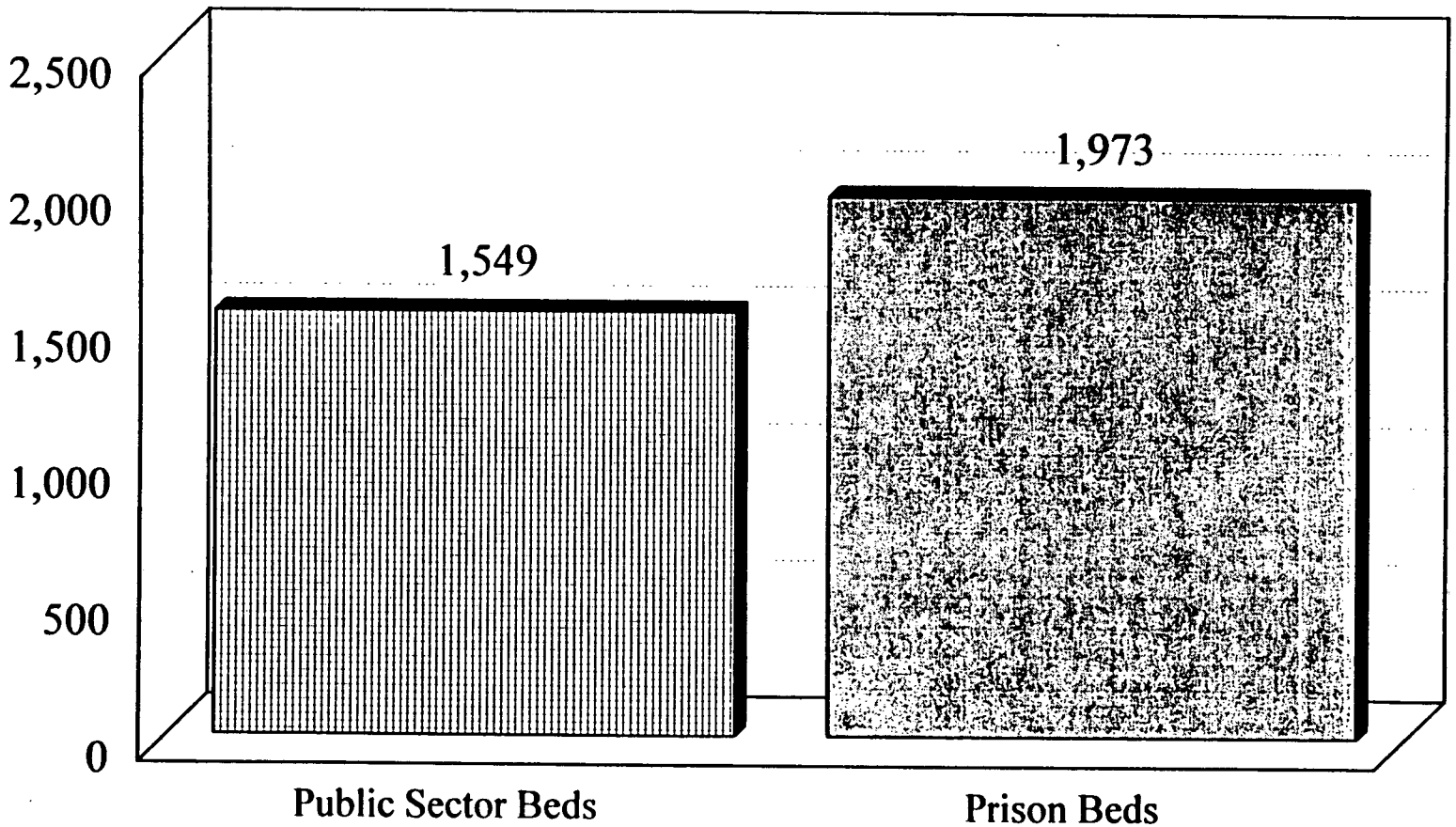
TOTAL: $567.8M
(excludes Willie M & Thomas S)

Area Programs - provide services in the areas of assessment, screening, education, half-way house, detoxification, inpatient and residential treatment, and day activity.

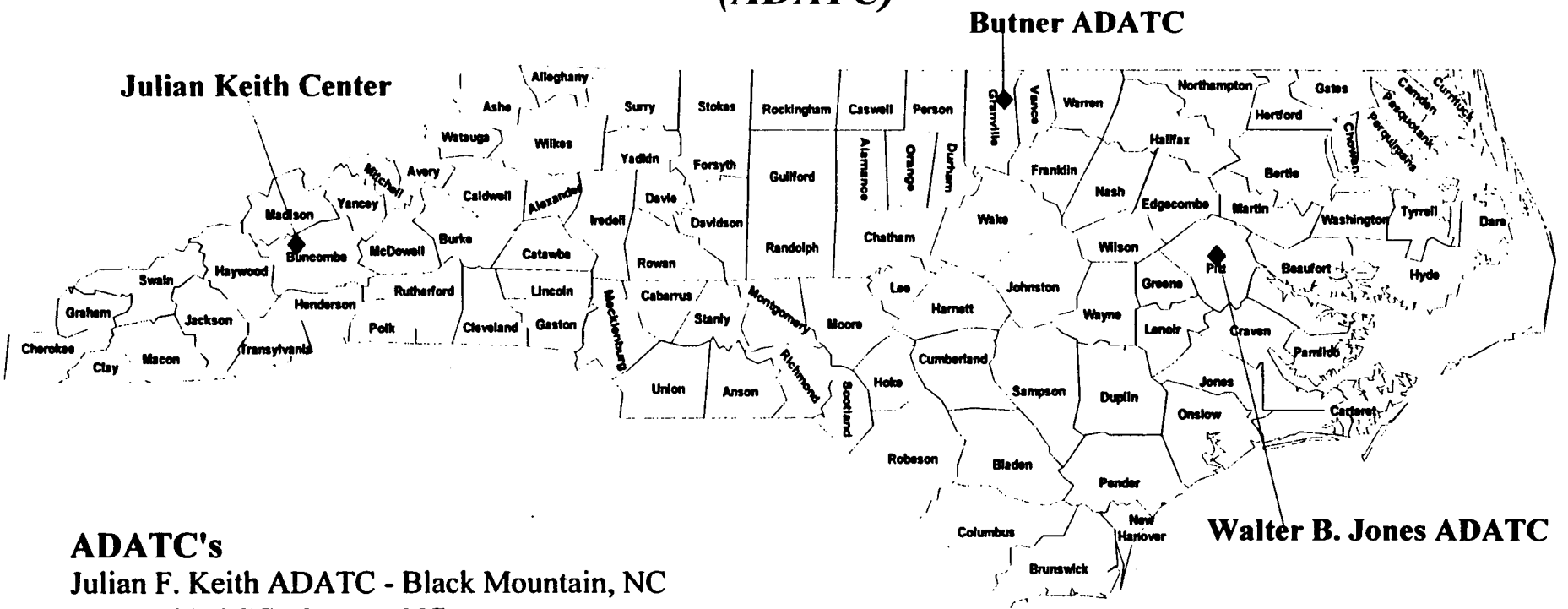
Residential Services in North Carolina

Service	Total Beds Available
Detoxification (Medical)	296
Social Setting Detoxification	112
Half-way House	376
Residential Treatment	284
Therapeutic Homes/TC	93
ADATC	236
TOTAL	1549

PUBLIC SECTOR TREATMENT BEDS



ALCOHOL AND DRUG ADDICTION TREATMENT CENTERS (ADATC)



ADATC's

Julian F. Keith ADATC - Black Mountain, NC

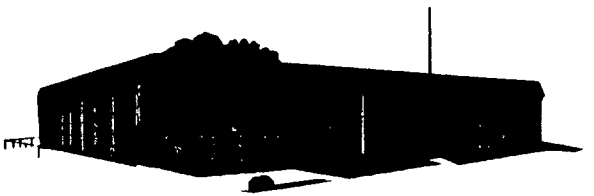
Butner ADATC - Butner, NC

Walter B. Jones ADATC - Greenville, NC

SUBSTANCE ABUSE SERVICES

STATE ALCOHOL & DRUG ABUSE TREATMENT CENTERS

Julian F. Keith ADATC



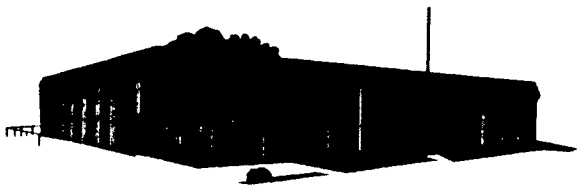
- Serves Western NC
- Bed Capacity: 100
- Persons Served FY97/98: 1,389
- Average Length of Stay: 26.2 Days
- Average Daily Population: 87
- FY97/98 Occupancy Rate: 89%
- Operating Budget FY98/99: $6.5M

Butner ADATC

- Serves Central NC
- Bed Capacity: 80 (temporarily at 60 due to construction)
- Persons Served FY97/98: 1,255
- Average Length of Stay: 14 days
- Average Daily Population: 63
- FY97/98 Occupancy Rate: 80%

STATE ALCOHOL & DRUG ABUSE TREATMENT CENTERS

Walter B. Jones ADATC



- Serves Eastern NC
- Bed Capacity: 76
- Persons Served FY97/98: 1,329
- Average Length of Stay: 19.9 Days
- Average Daily Population: 45
- FY97/98 Occupancy Rate: 76%
- Operating Budget FY98/99: $6.1M
- Unique Characteristics:
  -SA/Deaf Unit

SUBSTANCE ABUSE INITIATIVES

1. WORK FIRST/TANF SERVICES

- Initiative Targeted at Welfare Recipients Needing SAS
- Qualified Substance Abuse Professionals Provided for Each Area Program
- Applicants Screened & Referred For Assessment
- Child Care & Transportation Provided to Facilitate Treatment
- During 7-Month Period 2,225 TANF Applicants Screened for Substance Abuse
  -68% Were Assessed for SA
  -25% Were Admitted for Treatment
- Extensive Training for Area Programs and County Departments of Social Services
- Funding Source: Temporary Assistance for Needy Families (TANF) Block Grant

SUBSTANCE ABUSE INITIATIVES

2. MANAGING ACCESS FOR JUVENILE OFFENDER RESOURCES AND SERVICES (MAJORS)

- **Target Population:** 12-17 Year Old Juvenile Offienders **At Risk** for Placement in Residential Treatment or Juvenile Detention/Training Schools
- **Target Population:** 12-17 Year Olds **Returning to the Community** Following Placement in a Residential Treatment or Juvenile Detention/Training School
- Clinical Assessments Upon Referral from Court Counselor
- Substance Abuse Counselor/Care Coordinator Provides Case Management
- 10 Area Programs Will Begin Implementation FY98/99
- Funding: $2M (Social Services Block Grant, Governor's Crime Commission and State)

SUBSTANCE ABUSE INITIATIVES

3. "NEXT STEP FOR YOUTH"

- Directed by Office of Substance Abuse Policy
- Statewide Comprehensive Initiative to Prevent and Reduce the Use of Drugs and Alcohol by Youth
- Coordination of All Substance Abuse Prevention Funding Statewide
- Incorporate Scientifically-Based Prevention Programs in Existing Programs
- Evaluation Component Included
- Funding: $9M Three-Year Federal Grant & TANF Block Grant Funds

SUBSTANCE ABUSE INITIATIVES

4. ENHANCED EMPLOYEE ASSISTANCE PROGRAM

- Pilot/Initiative Which Provides Private Employers Enhanced EAP Services for Hiring Welfare Recipients
- Places Special Emphasis on Prevention, Intervention, Mentoring, Training and Case Monitoring of Clients
- Seven Area Programs Participating (Covering 11 Counties)
- Projected 1,000 Work First Participants
- Includes a Longitudinal Evaluation to Assess Effectiveness
- Funding: $1M Social Services Block Grant

SUBSTANCE ABUSE INITIATIVES

5. TREATMENT ALTERNATIVES TO STREET CRIME (TASC)

- Began in 1978
- Program Targets Offenders Whose Criminal Behavior is Driven by Drugs
- Based on the "Breaking the Cycle" Model Which Includes Frequent Drug Testing & Continuum of Sanctions and Treatment
- Includes Identification, Assessment, Treatment Matching, Referral & Treatment Management
- 23 Programs Serving 43 Judicial Districts
- During FY98, 7,433 Offenders Were Served
- Funding: $2.8M (State Appropriations and Substance Abuse Prevention and Treatment Block Grant)

HOUSE COMMITTEE ON MENTAL HEALTH

JUNE 1, 1999
10:00 AM
Room 415

AGENDA

Chair(s): Rep. Wayne Goodwin and Rep. Jim Crawford

INTRODUCTIONS

SPEAKERS Johnny Whitfield, Mental Health Research

DISCUSSION

ADJOURNMENT

MINUTES
HOUSE COMMITTEE ON MENTAL HEALTH
JUNE 1, 1999
RM. 415 LOB

The House Committee on Mental Health met on Tuesday, June 1, 1999 in Room 415 of the Legislative Office Building at 10:00 AM. The following members were present: Chairs- Representatives Crawford and Goodwin (Presiding), Representatives Horn and Nye. Committee staff Kory Goldsmith and Linda Attarian were also present. A visitor registration list is attached and made part of these minutes.

Rep. Goodwin introduced the pages for the day. No quorum was reached and the rest of the meeting was cancelled. Rep. Goodwin adjourned the meeting at 10:25.

Respectfully submitted,

Rep. Wayne Goodwin
Chairman

Kristen Younts
Committee Assistant

VISITOR REGISTRATION SHEET

Mental Health — Name of Committee

6-1-99 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sally Cameron	NCPA
[illegible]	NC Council
Marvin Swartz	Duke University
Richard Weisler MD	Richard Weisler MD PA
Rebecca H Whitfield	private citizen
Johnny Whitfield	private citizen

HOUSE COMMITTEE ON MENTAL HEALTH

June 8, 1999
10:00 a.m.
Room 415

AGENDA

Chair: Rep. Jim Crawford

INTRODUCTIONS

SPEAKERS Michelle Cotton and Tim Wildfire
Outcomes Report and Consumer Outcomes Initiative

DISCUSSION

ADJOURNMENT

MINUTES
HOUSE COMMITTEE ON MENTAL HEALTH
JUNE 8, 1999

The House Committee on Mental Health met on Tuesday, June 8, 1999 in Room 415 of the Legislative Office Building at 10:00 a.m. The following members were present: Chairman Jim Crawford, Representatives Cansler, Horn, McAllister, Nye, and Oldham. Kory Goldsmith, staff, attended. A visitor registration list is attached and made part of these minutes. Chairman Crawford introduced the pages for the day.

Chairman Crawford introduced Michelle Cotton with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services who presented a report on consumer outcomes (handout). The report provides background on consumer-focused research within the division and key characteristics of specific populations, and key characteristics of specific populations. It also provides a general description of programs and services and a summary of the findings of the 1996 consumer satisfaction survey. Rep. Cansler requested additional information on the increase of children with severe emotional disorders and the impact of broken homes.

Chairman Crawford introduced Tim Wildfire with the Division to discuss the consumer outcomes initiative (handout). The process was begun in March to assess progress of clients served. Clinicians will complete the inventory form for clients and return to the division which will compile the data for a quarterly report.

Chairman Crawford adjourned the meeting at 10:55.

Respectfully submitted,

Representative Jim Crawford
Chairman

Linda S. Winstead
Committee Assistant

VISITOR REGISTRATION SHEET

MENTAL HEALTH — June 8, 1999

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Janet Simonsen	NC Council
Kristen Guillory	Lt. Gov. office
Zach Holly [illegible]	NCADD
Flora Dunbar	NCAPP
Sandra Lee	NCAPP
Bob Hedrick	CMC
Sally Cameron	NCPA
Dan Nixon	NCPA
Gustavo Francisco	Div. of MH/DD/SAS
Tim Wildfire	Div. of MH/DD/SAS
Mary Eldridge	Div. of MH/DD/SAS
Bob Kuertz	Div. of MH/DD/SAS
Terry Stelle	DMHDDSAS

#1

North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

Enhancing the Quality of Life for Children and Adults Living with Mental Health, Developmental Disabilities, and Substance Abuse Problems

Report to the General Assembly
June, 1999

Division of MH/DD/SA Services
Consumer Outcomes Initiative

✓ Purpose

- Assess progress of clients from different sub-populations using a consistent method
- Provide information regarding eight different "Domains"

– Crisis Utilization – Functioning	*MH & SA*
– Criminal Justice Involvement	*MH & SA, DD*
– Residential Appropriateness – Employment/Education	*MH & SA, DD, EI*
– Choice – Participation and Inclusion – Access to Services	*DD and EI*

#2

Division of MH/DD/SA Services
Consumer Outcomes Initiative

✓ Purpose

- Collect baseline information about clients served
- Gain experience in developing appropriate measures in the above domains
- Develop expertise in collection and analysis of system-wide outcome measures based on repeated measures for the same client (*admission, 3 mo., 6 mo for new clients , annual assessments for all clients)*

✓ Progress Report

- MH & SA data collection began in March *(20% sample of clients)*
  - MH/SA Client Outcome Inventory (COI) form attached
  - Outcome data processing system implemented
- DD and Early Intervention (EI) forms have been developed
  - Field testing now in progress
  - Implementation planned for October 1999

NC Division of MH/DD/SA Client Outcome Inventory (COI)

Client Record Number

10 Substance Use
(in past three months)

a Tobacco Use ☐
b Heavy Alcohol Use (≥m5(f4) drinks per sitting) ☐
c Regular Alcohol Use (<m5(f4) drinks per sitting) ☐
d Marijuana or Hashish Use ☐
e Cocaine or Crack Use ☐
f Heroin or Other Opiate Use ☐
g Other Drug Use ☐☐ ☐
h Other Drug Use ☐☐ ☐
i NO USE AT ALL ☐

Frequency Codes
0- Not used
1- 1-3 times monthly or less
2- 1-2 times weekly
3- 3-6 times weekly
4- Daily

Drug Codes
05-Non-prescription Methadone
07- PCP
08- Other Hallucinogen
09- Methamphetamine
10-Other Amphetamine
11- Other Stimulant
12- Benzodiazepine
13- Other Tranquilizer
14- Barbiturate
15- Other Sedative or Hypnotic
16- Inhalant
17- Over the Counter

13 Current Employment Status *(enter one code from list)*

☐
0- Unemployed (seeking work)
1- Employed full time
2- Employed part time
3- Not in work force – student
4- Not in work force- retired
5- Not in work force-homemaker
6. Not in work force (not avail. for work)
7- Armed forces/ National Guard
8- Seasonal/migrant
9- Unknown

14 Expanded Employment Descriptors *(Mark all that apply)*

☐ a. Student
☐ b. Unpaid work/ Community Service
☐ c. Sheltered Employment (Less than minimum wage)
☐ d. Supported/transitional employment
☐ e. Same employer for Three months or more
☐ f. Retired
☐ g. Unable to work
☐ h. Institutionalized
☐ i. Incarcerated
☐ j. Vocational Rehabilitation

11 Current Living Arrangement *(select one code from list)*

☐☐
01- Private Residence (in own home, apartment, with parents or relatives)
02- Other Independent (in dormitory, rooming house, barracks, fraternity house, ship)
03- Homeless (street, shelter, vehicle)
04-Correctional facility (in prison, jail, training school, detention ctr.)
05- Institution (Psychiatric hospital, MR Ctr, secure nonmedical)
06- Residential Facility (in halfway house, group home, child caring institution, DDA Group Home)
07- Foster family, alternative family living
08- Nursing Home (ICF,SNF)
09- Adult Care Home - 7 or more beds (Rest Home)
10- Adult Care Home - 6 or fewer beds (Family Care home)
11-Community ICF-MR - 6 or fewer beds

15 Hours worked: *Enter the number of hours for the average week, in the past three months.*

☐☐ a Paid Hours
☐☐ b Unpaid Hours

TANF/Work First ONLY:
☐☐ c TANF Paid Hours
☐☐ d TANF Unpaid Hours

16. Academic/Vocational

16a Has the client received a grade promotion, diploma or GED as scheduled since the last COI (last 12 mo. for initial COI) *(enter one code from list)*
1- Yes, completed a program of study or promoted as scheduled.
2- Is still enrolled in the program of study
3- No, Did not complete program as scheduled (dropped out, failed, held back, etc.)
4- Not applicable (not enrolled since last COI)

☐

	(1)	(2)
12a Are those living with the client abusing substances at this time?	☐ Yes	☐ No
12b In the past three months, has the client been kicked, hit or slapped or otherwise physically hurt by spouse/partner or other adult in the home?	☐ Yes	☐ No
12c Has there been a Child or Adult protective Service report for this household since the last COI (last 12 mo. for initial COI)	☐ Yes	☐ No
12d Is the client currently living in substandard housing?	☐ Yes	☐ No

Complete 16b & c for students under 18yrs	(1)	(2)
16b In the past three months, has the student missed more than 5 days due to truancy?	☐ Yes	☐ No
16c In the past three months, has the student received out of school suspension or been expelled?	☐ Yes	☐ No

For clients in a vocational program:

16d Since the last COI, has the client completed a vocational program?	☐ Yes	☐ No

Confidentiality of SA client information is protected under Federal regulations 42 CFR Part 2. Approved use of this form is permitted under the audit or evaluation exception of 42 CFR Part 2.53 which allows disclosure of information without client consent. Redisclosure of information is explicitly prohibited except as provided in 42 CFR Part 2.

COI-1/1/1999 (Rev)

NC Division of MH/DD/SA Client Outcome Inventory (COI)

1a Client Record Number

1b Unique ID *(Required for Willie M. & Thomas S)*

1c Form B Admission Date ___ / ___ / ____

1d Date of Last Face to Face Contact ___ / ___ / ____

1e Date COI Completed ___ / ___ / ____

2a Facility Code

2b Report Unit/Cost Center

2c Project Code

2d Casemanager/Clinician ID

3a COI Type *(Select Code)*
1-Initial
2-Update
3-Discharge

3b Non-Completion Only
1-Client not seen
2-Other reason

3c Discharge Only
1- Achieved Service Goals
2- Left Before Completion
3- Discharged, non-compliant
9-Other

4. **Eligibility and Special Populations** *(Mark all that apply)*

- a. None
- b. TANF/ Work First
- c. Medicaid Recipient
- d. CAP MR/DD
- e. SSI/SSDI
- f. SED (Child)
- g. SPMI (Adult)
- h. TBI
- i. In DSS Custody (Child)
- j. Deaf/Hard of Hearing
- k. Non-English Speaking
- l. Youth w/ Sexually Aggressive Behavior
- m. Pregnant
- n. Maternal
- o.Juvenile/Criminal Justice
- p. Communicable Disease Risk

Global Assessment of Functioning (Child & Adult)

GAF Score

Child and Adolescent Functional Assessment (CAFAS)

a Role Performance | b Behavior Toward Others | c Moods/ Self Harm | d Substance Abuse | e Thinking

7a Is client actively engaged in treatment at this time? (1) Yes (2) Somewhat (3) No

7b If prescribed,does client currently take psychotropic medications as directed? Yes / No / None Prescribed

7c In past three months, has client participated in a self help, self advocacy or other community peer group? Yes / No

8a Since last COI, enter the number of admissions to an inpatient unit for a psychiatric problem. *(for initial COI, last 12 months)* # of Admissions

8b Since last COI, enter the number of admissions to an inpatient unit for a substance abuse problem. *(for initial COI, last 12 months)* # of Admissions

8c Since last COI, has client had more than one face to face MH/SA contact after regular clinic hours? (1) Yes (2) No

8d In past three months, has client had any arrests (including DWI), probation or parole violations? (exclude other traffic offenses). Yes / No

	(1) Yes	(2) No
9a Is the client currently living in housing arranged/supervised by area program? ***IF YES, answer 9b and 9c. IF NO, skip to #10***		
9b Is the client living in the residence of his/her choice?		
9c Is the client living in the least restrictive, appropriate setting?		

Confidentiality of SA client information is protected under Federal regulations 42 CFR Part 2. Approved use of this form is permitted under the audit or evaluation exception of 42 CFR Part 2.53 which allows disclosure of information without client consent. Redisclosure of information is explicitly prohibited except as provided in 42 CFR Part 2.

MINUTES
HOUSE COMMITTEE ON MENTAL HEALTH
JUNE 22, 1999

The House Committee on Mental Health met on Tuesday, June 22, 1999 in Room 415 of the Legislative Office Building at 10:00 a.m. The following members were present: Chairman Jim Crawford, Representatives Cansler, Esposito, Gardner, Horn, and Nye. Kory Goldsmith, staff, attended. A visitor registration list is attached and made part of these minutes. Chairman Crawford introduced the pages for the day.

Chairman Crawford introduced Johnny Whitfield from Oxford to address the committee on research needed on Mental Health. Mr. Whitfield spoke of his personal interest in mental health and the fact that current research is focused on collection of data of those receiving treatment. He asked that the committee consider funding during the next budget year research into the causes of mental health and cures rather than maintenance treatment.

Rep. Cansler asked what research is being done through the university system or at pharmaceutical companies in the Triangle and what is the focus of that research. Dr. Terry Stelle, Division of Mental Health, said that John Umstead Hospital is working with Duke University on research of medications being used for treatment. Also, UNC-Chapel Hill Department of Psychology partially staffs a self-contained unit at Dorothea Dix Hospital for research. Dr. Stelle will provide information to the members on the specific research conducted at these two facilities and any other that is ongoing. Rep. Gardner commented that we should begin research into cause and cure rather than just treatment and what is being done at the federal level. Rep. Horn suggested that this is an appropriate time to begin educating the public about recognizing the symptoms of mental health disorders. Chairman Crawford recommended the issue of research should be transmitted to the study commission for consideration and recommendation. Rep. Nye applauded Mr. Whitfield for bringing this issue to the committee for consideration.

Chairman Crawford adjourned the meeting at 10:45.

Respectfully submitted,

Representative Jim Crawford
Chairman

Linda S. Winstead
Committee Assistant

VISITOR REGISTRATION SHEET

MENTAL HEALTH — Name of Committee

6-22-99 — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bob Hedrick	CNC
Johnny Whitfield	114 Forest Ave. Oxford NC 27565
Fannie M.B. Williams	Duke LTC, STHL, SLC of AARP
Brian Bodtman	Pfizer Inc. Fayetteville
BRAD JULIAN	PFIZER INC ROCKY MOUNT
C Porter	Bone & Associates
Tommy Worth	Carolinas HealthCare Syst
[illegible]	NCPA
Jerry Gibson	Pfizer - Greenville
Gary Schott	Pfizer - Greensboro
Wayne Wellborn	Pfizer Raleigh
Hillary Macken	Pfizer - Charlotte