Chapter 122C.

Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985.

Article 1.

General Provisions.

§ 122C-1. Short title.

This Chapter may be cited as the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985. (1985, c. 589, s. 2; 1989, c. 625, ss. 1, 2.)

§ 122C-2. Policy.

The policy of the State is to assist individuals with needs for mental health, developmental disabilities, and substance abuse services in ways consistent with the dignity, rights, and responsibilities of all North Carolina citizens. Within available resources it is the obligation of State and local government to provide mental health, developmental disabilities, and substance abuse services through a delivery system designed to meet the needs of clients in the least restrictive, therapeutically most appropriate setting available and to maximize their quality of life. It is further the obligation of State and local government to provide community-based services when such services are appropriate, unopposed by the affected individuals, and can be reasonably accommodated within available resources and taking into account the needs of other persons for mental health, developmental disabilities, and substance abuse services.

State and local governments shall develop and maintain a unified system of services centered in area authorities or county programs. The public service system will strive to provide a continuum of services for clients while considering the availability of services in the private sector. Within available resources, State and local government shall ensure that the following core services are available:

(1) Screening, assessment, and referral.
(2) Emergency services.
(3) Service coordination.
(4) Consultation, prevention, and education.

Within available resources, the State shall provide funding to support services to targeted populations, except that the State and counties shall provide matching funds for entitlement program services as required by law.

As used in this Chapter, the phrase "within available resources" means State funds appropriated and non-State funds and other resources appropriated, allocated or otherwise made available for mental health, developmental disabilities, and substance abuse services.

The furnishing of services to implement the policy of this section requires the cooperation and financial assistance of counties, the State, and the federal government. (1977, c. 568, s. 1; 1979, c. 358, s. 1; 1983, c. 383, s. 1; 1985, c. 589, s. 2; c. 771; 1989, c. 625, s. 2; 2001-437, s. 1.1.)

§ 122C-3. Definitions.

The following definitions apply in this Chapter:

(1) Area authority. – The area mental health, developmental disabilities, and substance abuse authority.
(2) Area board. – The area mental health, developmental disabilities, and substance abuse board.

(2a) Area director. – The administrative head of the area authority program appointed pursuant to G.S. 122C-121.

(2b) Behavioral health and intellectual/developmental disabilities tailored plan or BH IDD tailored plan. – As defined in G.S. 108D-1.

(2c) Board of county commissioners. – Includes the participating boards of county commissioners for multicounty area authorities and multicounty programs.

(3) Camp Butner reservation. – The original Camp Butner reservation as may be designated by the Secretary as having been acquired by the State and includes not only areas which are owned and occupied by the State but also those which may have been leased or otherwise disposed of by the State, and also includes those areas within the municipal boundaries of the Town of Butner and that portion of the extraterritorial jurisdiction of the Town of Butner consisting of lands not owned by the State of North Carolina.

(4) Catchment area. – The geographic part of the State served by a specific area authority or county program.

(4a) Children and families specialty plan or CAF specialty plan. – As defined in G.S. 108D-1.

(5) City. – As defined in G.S. 153A-1(1).

(6) Client. – An individual who is admitted to and receiving service from, or who in the past had been admitted to and received services from, a facility.

(7) Client advocate. – A person whose role is to monitor the protection of client rights or to act as an individual advocate on behalf of a particular client in a facility.

(8) Commission. – The Commission for Mental Health, Developmental Disabilities, and Substance Use Services, established under Part 4 of Article 3 of Chapter 143B of the General Statutes.

(8a) Commitment examiner. – A physician, an eligible psychologist, or any health professional or mental health professional who is certified under G.S. 122C-263.1 to perform the first examination for involuntary commitment described in G.S. 122C-263(c) or G.S. 122C-283(c) as required by Parts 7 and 8 of this Article.

(9) Confidential information. – Any information, whether recorded or not, relating to an individual served by a facility that was received in connection with the performance of any function of the facility. "Confidential information" does not include statistical information from reports and records or information regarding treatment or services which is shared for training, treatment, habilitation, or monitoring purposes that does not identify clients either directly or by reference to publicly known or available information.

(9a) Core services. – Services that are necessary for the basic foundation of any service delivery system. Core services are of two types: front-end service capacity such as screening, assessment, and emergency triage, and indirect services such as prevention, education, and consultation at a community level.

(10) County of residence. – The county of a client's domicile at the time of his or her admission or commitment to a facility. A county of residence is not changed because an individual is temporarily out of his or her county in a facility or otherwise.

(10a) County program. – A mental health, developmental disabilities, and substance abuse services program established, operated, and governed by a county pursuant to G.S. 122C-115.1.

(11) Dangerous to self or others.

a. Dangerous to self. – Within the relevant past, the individual has done any of the following:

1. The individual has acted in such a way as to show all of the following:

I. The individual would be unable, without care, supervision, and the continued assistance of others not otherwise available, to exercise self-control, judgment, and discretion in the conduct of the individual's daily responsibilities and social relations, or to satisfy the individual's need for nourishment, personal or medical care, shelter, or self-protection and safety.

II. There is a reasonable probability of the individual's suffering serious physical debilitation within the near future unless adequate treatment is given pursuant to this Chapter. A showing of behavior that is grossly irrational, of actions that the individual is unable to control, of behavior that is grossly inappropriate to the situation, or of other evidence of severely impaired insight and judgment shall create a prima facie inference that the individual is unable to care for himself or herself.

2. The individual has attempted suicide or threatened suicide and that there is a reasonable probability of suicide unless adequate treatment is given pursuant to this Chapter.

3. The individual has mutilated himself or herself or has attempted to mutilate himself or herself and that there is a reasonable probability of serious self-mutilation unless adequate treatment is given pursuant to this Chapter.

Previous episodes of dangerousness to self, when applicable, may be considered when determining reasonable probability of physical debilitation, suicide, or self-mutilation.

b. Dangerous to others. – Within the relevant past, the individual has inflicted or attempted to inflict or threatened to inflict serious bodily harm on another, or has acted in such a way as to create a substantial risk of serious bodily harm to another, or has engaged in extreme destruction of property; and that there is a reasonable probability that this conduct will be repeated. Previous episodes of dangerousness to others, when applicable, may be considered when determining reasonable probability of future dangerous conduct. Clear, cogent, and convincing evidence that an individual has committed a homicide in the relevant past is prima facie evidence of dangerousness to others.

(11a) Day/night service. – A service provided on a regular basis, in a structured environment that is offered to the same individual for a period of three or more hours within a 24-hour period.

(12) Department. – The North Carolina Department of Health and Human Services.

(12a) Developmental disability. – A severe, chronic disability of a person that satisfies all of the following:

a. Is attributable to a mental or physical impairment or combination of mental and physical impairments.

b. Is manifested before the person attains age 22, unless the disability is caused by a traumatic brain injury, in which case the disability may be manifested after attaining age 22.

c. Is likely to continue indefinitely.

d. Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, capacity for independent living, learning, mobility, self-direction, and economic self-sufficiency.

e. Reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services that are of a lifelong or extended duration and are individually planned and coordinated; or when applied to children from birth through age four, may be evidenced as a developmental delay.

f. Repealed by Session Laws 2019-76, s. 1, effective October 1, 2019, and applicable to proceedings commenced or services rendered on or after that date.

(13) Division. – The Division of Mental Health, Developmental Disabilities, and Substance Use Services of the Department.

(13a) Repealed by Session Laws 2000-67, s. 11.21(c), effective July 1, 2000.

(13a1) Recodified as subdivision (13c).

(13b) Recodified as subdivision (13d).

(13c) Eligible infants and toddlers. – Children with or at risk for developmental delays or atypical development until all of the following have occurred:

a. They have reached their third birthday.

b. Their parents have requested to have them receive services in the preschool program for children with disabilities established under Article 9 of Chapter 115C of the General Statutes.

c. They have been placed in the program by the local educational agency.

In no event shall a child be considered an eligible toddler after the beginning of the school year immediately following the child's third birthday, unless the Secretary and the State Board enter into an agreement under G.S. 115C-107.1(c).

The early intervention services that may be provided for these children and their families include early identification and screening, multidisciplinary evaluations, case management services, family training, counseling and home visits, psychological services, speech pathology and audiology, and occupational and physical therapy. All evaluations performed as part of early

intervention services shall be appropriate to the individual child's age and development.

(13d) Eligible psychologist. – A licensed psychologist who has at least two years' clinical experience. After January 1, 1995, "eligible psychologist" means a licensed psychologist who holds permanent licensure and certification as a health services provider psychologist issued by the North Carolina Psychology Board.

(14) **(Effective until contingency met – see note)** Facility. – Any person at one location whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of individuals with mental illnesses or intellectual or other developmental disabilities or substance abusers, and includes all of the following:

a. An "area facility," which is a facility that is operated by or under contract with the area authority or county program. For the purposes of this subparagraph, a contract is a contract, memorandum of understanding, or other written agreement whereby the facility agrees to provide services to one or more clients of the area authority or county program. Area facilities may also be licensable facilities in accordance with Article 2 of this Chapter. A State facility is not an area facility.

b. A "licensable facility," which is a facility for one or more minors or for two or more adults that provides services to individuals who have mental illnesses or intellectual or other developmental disabilities or are substance abusers. These services shall be day services offered to the same individual for a period of three hours or more during a 24-hour period, or residential services provided for 24 consecutive hours or more. Facilities for individuals who are substance abusers include chemical dependency facilities.

c. A "private facility," which is a facility that is either a licensable facility or a special unit of a general hospital or a part of either in which the specific service provided is not covered under the terms of a contract with an area authority.

d. The psychiatric service of the University of North Carolina Hospitals at Chapel Hill.

e. A "residential facility," which is a 24-hour facility that is not a hospital, including a group home.

f. A "State facility", which is a facility that is operated by the Secretary.

g. A "24-hour facility," which is a facility that provides a structured living environment and services for a period of 24 consecutive hours or more and includes hospitals that are facilities under this Chapter.

h. A Veterans Administration facility or part thereof that provides services for the care, treatment, habilitation, or rehabilitation of individuals with mental illnesses or intellectual or other developmental disabilities or substance abusers.

(14) **(Effective once contingency met – see note)** Facility. – Any person at one location, or in the case of an opioid treatment program facility licensed to operate an opioid treatment program medication unit, an opioid treatment

program mobile unit, or both, any person at one or more locations, whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of individuals with mental illnesses or intellectual or other developmental disabilities or substance abusers, and includes all of the following:

a. An "area facility," which is a facility that is operated by or under contract with the area authority or county program. For the purposes of this subparagraph, a contract is a contract, memorandum of understanding, or other written agreement whereby the facility agrees to provide services to one or more clients of the area authority or county program. Area facilities may also be licensable facilities in accordance with Article 2 of this Chapter. A State facility is not an area facility.

b. A "licensable facility," which is a facility for one or more minors or for two or more adults that provides services to individuals who have mental illnesses or intellectual or other developmental disabilities or are substance abusers. These services shall be day services offered to the same individual for a period of three hours or more during a 24-hour period, or residential services provided for 24 consecutive hours or more. Facilities for individuals who are substance abusers include chemical dependency facilities.

c. A "private facility," which is a facility that is either a licensable facility or a special unit of a general hospital or a part of either in which the specific service provided is not covered under the terms of a contract with an area authority.

d. The psychiatric service of the University of North Carolina Hospitals at Chapel Hill.

e. A "residential facility," which is a 24-hour facility that is not a hospital, including a group home.

f. A "State facility", which is a facility that is operated by the Secretary.

g. A "24-hour facility," which is a facility that provides a structured living environment and services for a period of 24 consecutive hours or more and includes hospitals that are facilities under this Chapter.

h. A Veterans Administration facility or part thereof that provides services for the care, treatment, habilitation, or rehabilitation of individuals with mental illnesses or intellectual or other developmental disabilities or substance abusers.

i. An opioid treatment program facility licensed to operate an opioid treatment program medication unit, an opioid treatment program mobile unit, or both.

(15) Guardian. – A person appointed as a guardian of the person or general guardian by the court under Chapters 7A or 35A or former Chapters 33 or 35 of the General Statutes.

(16) Habilitation. – Training, care, and specialized therapies undertaken to assist a client in maintaining his current level of functioning or in achieving progress in developmental skills areas.

(16a) Health screening. – An appropriate screening suitable for the symptoms presented and within the capability of the entity, including ancillary services routinely available to the entity, to determine whether or not an emergency medical condition exists. An emergency medical condition exists if an individual has acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(16b) Incapable. – With respect to an individual, as defined in G.S. 122C-72(4). An adult individual who is incapable is not the same as an incompetent adult unless the adult individual has been adjudicated incompetent under Chapter 35A of the General Statutes.

(17) Incompetent adult. – An adult individual who has been adjudicated incompetent under Chapter 35A of the General Statutes.

(17a) Intellectual disability. – A developmental disability characterized by significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested before age 22.

(18) Intoxicated. – The condition of an individual whose mental or physical functioning is presently substantially impaired as a result of the use of alcohol or other substance.

(19) Law enforcement officer. – Sheriff, deputy sheriff, police officer, State highway patrolman, or an officer employed by a city or county under G.S. 122C-302.

(20) "Legally responsible person" means: (i) when applied to an adult, who has been adjudicated incompetent, a guardian, subject to the limitations of G.S. 35A-1241(3); (ii) when applied to a minor, a parent, guardian, a person standing in loco parentis, or a legal custodian other than a parent who has been granted specific authority by law or in a custody order to consent for medical care, including psychiatric treatment; or (iii) when applied to an adult who has a health care power of attorney and who is incapable as defined in G.S. 122C-72(4) a health care agent named pursuant to a valid health care power of attorney unless the adult is adjudicated incompetent following the execution of the health care power of attorney and the health care agent's authority is suspended pursuant to G.S. 32A-22 and G.S. 35A-1208; provided that if an incapable adult does not have a health care agent or guardian, "legally responsible person" means one of the persons specified in subdivisions (3) through (7) of subsection (c) of G.S. 90-21.13, to be selected based on the priority indicated in said subdivisions (3) through (7).

(20a) Local funds. – Fees from services, including client payments, Medicare and the local and federal share of Medicaid receipts, fees from agencies under contract, gifts and donations, and county and municipal funds, and any other funds not administered by the Division.

(20b) Local management entity (LME). – An area authority.

(20c) Local management entity/managed care organization (LME/MCO). – A local management entity that is under contract with the Department to operate the combined Medicaid Waiver program authorized under Section 1915(b) and

Section 1915(c) of the Social Security Act or to operate a capitated PHP contract under Article 4 of Chapter 108D of the General Statutes.

(21) Mental illness. – The following:

a. When applied to an adult, an illness which so lessens the capacity of the individual to use self-control, judgment, and discretion in the conduct of the individual's affairs and social relations as to make it necessary or advisable for the individual to be under treatment, care, supervision, guidance, or control.

b. When applied to a minor, a mental condition, other than an intellectual disability alone, that so impairs the minor's capacity to exercise age adequate self-control or judgment in the conduct of the minor's activities and social relationships so that the minor is in need of treatment.

(22), (23) Repealed by Session Laws 2019-76, s. 1, effective October 1, 2019, and applicable to proceedings commenced or services rendered on or after that date.

(23a) Minimally adequate services. – A level of service required for compliance with all applicable State and federal laws, rules, regulations, and policies and with generally accepted professional standards and principles.

(23b) **(Effective once contingency met – see note)** Mobile unit. – A motor vehicle that operates with more than three wheels in contact with the ground that may lawfully be used on the public streets, roads, or highways and from which opioid treatment program mobile unit services are provided at one or more locations.

(24) Next of kin. – The individual designated in writing by the client or the client's legally responsible person upon the client's acceptance at a facility. If no such designation has been made, "next of kin" means the client's spouse or nearest blood relation in accordance with G.S. 104A-1.

(25) Operating costs. – Expenditures made by an area authority in the delivery of services for mental health, developmental disabilities, and substance abuse as provided in this Chapter and includes the employment of legal counsel on a temporary basis to represent the interests of the area authority.

(25a) **(Effective once contingency met – see note)** Opioid treatment program. – A facility with a current and valid registration under 21 U.S.C. § 823(g)(1) that meets all of the following criteria:

a. Is engaged in dispensing and administering treatment medication approved by the Food and Drug Administration for the treatment of individuals with opioid use disorders.

b. Has been licensed as an opioid treatment program facility by the Division of Health Service Regulation.

(25b) **(Effective once contingency met – see note)** Opioid treatment program medication unit. – A unit established as part of an opioid treatment program facility that meets all of the following criteria:

a. Operates at a geographically separate location from the opioid treatment program facility.

b. Is a site at which treatment medication approved by the Food and Drug Administration for the treatment of opioid use disorder is dispensed or administered and samples are collected for drug testing or analysis.

c. Is a site where intake or initial psychosocial and appropriate medical assessments may be conducted with a full physical examination to be completed or provided within 14 days of admission and the site provides appropriate privacy and adequate space for quality patient care, where treatment with medication approved by the Food and Drug Administration may be initiated after an appropriate medical assessment has been performed, and where other opioid treatment program services, such as counseling, may be provided directly, or when permissible, through the use of telehealth services and the site provides appropriate privacy and adequate space for quality patient care.

(25c) **(Effective once contingency met – see note)** Opioid treatment program mobile unit. – A mobile unit established as a mobile component of an opioid treatment program facility that meets all of the following criteria:

a. Operates at one or more geographically separate, predetermined locations from the opioid treatment program facility.

b. Is a site at which treatment medication approved by the Food and Drug Administration for treatment of opioid use disorder is dispensed or administered and samples are collected for drug testing or analysis.

c. Is a site where intake or initial psychosocial and appropriate medical assessments may be conducted with a full physical examination to be completed or provided within 14 days of admission and the site provides appropriate privacy and adequate space for quality patient care, where treatment with medication approved by the Food and Drug Administration may be initiated after an appropriate medical assessment has been performed, and where other opioid treatment program services, such as counseling, may be provided directly or, when permissible, through the use of telehealth services and the site provides appropriate privacy and adequate space for quality patient care.

(26) Repealed by Session Laws 1987, c. 345, s. 1.

(26a) Other recipient. – An individual who is not admitted to a facility but who receives a service other than care, treatment, or rehabilitation services. The services that the "other recipient" may receive include consultative, preventative, educational, and assessment services.

(27) Outpatient treatment. – As used in Part 7 of Article 5 of this Chapter, means treatment in an outpatient setting and may include medication, individual or group therapy, day or partial day programming activities, services and training including educational and vocational activities, supervision of living arrangements, and any other services prescribed either to alleviate the individual's illness or disability, to maintain semi-independent functioning, or to prevent further deterioration that may reasonably be predicted to result in the need for inpatient commitment to a 24-hour facility.

(27a) Outpatient treatment physician or center. – As used in Part 7 of Article 5 of this Chapter, a physician or center that provides treatment services directly to the outpatient commitment respondent. An LME/MCO that contracts with an outpatient treatment physician or center to provide outpatient treatment services to a respondent is not an outpatient treatment physician or center. Each

LME/MCO is responsible for contracting with qualified providers of services in accordance with G.S. 122C-141, 122C-142(a), and 122C-115.4(b)(2) to ensure the availability of qualified providers of outpatient commitment services to clients of LME/MCOs who are respondents to outpatient commitment proceedings and meet the criteria for outpatient commitment. A contracted provider with an LME/MCO shall not be designated as an outpatient treatment physician or center on an outpatient commitment order unless the respondent enrolled with an LME/MCO or is eligible for services through an LME/MCO, or the respondent otherwise qualifies for the provision of services offered by the provider.

(28) Person. – Any individual, firm, partnership, corporation, company, association, joint stock association, agency, or area authority.

(29) Physician. – An individual licensed to practice medicine in North Carolina under Chapter 90 of the General Statutes or a licensed medical doctor employed by the Veterans Administration.

(29a) Repealed by Session Laws 2018-33, s. 1, effective October 1, 2019.

(29b) Prepaid health plan. – As defined in G.S. 108D-1.

(30) Provider of support services. – A person that provides to a facility support services such as data processing, dosage preparation, laboratory analyses, or legal, medical, accounting, or other professional services, including human services.

(30a) Psychologist. – An individual licensed to practice psychology under Chapter 90 of the General Statutes. The term "eligible psychologist" is defined in subdivision (13d) of this section.

(30b) Public services. – Publicly funded mental health, developmental disabilities, and substance abuse services, whether provided by public or private providers.

(31) Qualified professional. – Any individual with appropriate training or experience as specified by the General Statutes or by rule of the Commission in the fields of mental health or developmental disabilities or substance abuse treatment or habilitation, including physicians, psychologists, psychological associates, educators, social workers, registered nurses, certified fee-based practicing pastoral counselors, and certified counselors.

(32) Responsible professional. – An individual within a facility who is designated by the facility director to be responsible for the care, treatment, habilitation, or rehabilitation of a specific client and who is eligible to provide care, treatment, habilitation, or rehabilitation relative to the client's disability.

(32a) Secretary. – The Secretary of the Department of Health and Human Services.

(32b) Security recordings. – Any films, videos, or electronic or other media recordings of a common area in a State facility that are produced for the purpose of maintaining or enhancing the health and safety of clients, residents, staff, or visitors of that State facility. The term does not include recordings of a client's clinical sessions or any other recordings that are part of a client's confidential records or information.

(33) Renumbered as subdivision (32a).

(33a) Severe and persistent mental illness. –A mental disorder suffered by persons of 18 years of age or older that leads these persons to exhibit emotional or

behavioral functioning that is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long term or indefinite duration. This disorder is a severe and persistent mental disability, resulting in a long-term limitation of functional capacities for the primary activities of daily living, such as interpersonal relations, homemaking, self-care, employment, and recreation.

(34) Repealed by Session Laws 2001-437, s. 1.2(c), effective July 1, 2002.

(35) Repealed by Session Laws 2001-437, s. 1.2(c), effective July 1, 2002.

(35a) Renumbered as subdivision (35e).

(35b) Specialty services. – Services that are provided to consumers from low-incidence populations.

(35c) Repealed by Session Laws 2023-65, s. 5.1(c), effective June 29, 2023.

(35d) Standard benefit plan. – As defined in G.S. 108D-1.

(35e) State Plan. – The State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services.

(35f) State resources. – State and federal funds and other receipts administered by the Division.

(36) Substance abuse. – The pathological use or abuse of alcohol or other drugs in a way or to a degree that produces an impairment in personal, social, or occupational functioning. "Substance abuse" may include a pattern of tolerance and withdrawal.

(37) Substance abuser. – An individual who engages in substance abuse.

(38) Targeted population. – Those individuals who are given service priority under the State Plan.

(38a) Traumatic brain injury. – An injury to the brain caused by an external physical force resulting in total or partial functional disability, psychosocial impairment, or both, and meets all of the following criteria:

a. Involves an open or closed head injury.

b. Resulted from a single event, or resulted from a series of events which may include multiple concussions.

c. Occurs with or without a loss of consciousness at the time of injury.

d. Results in impairments in one or more areas of the following functions: cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem-solving; sensory, perceptual, and motor abilities; psychosocial behavior; physical functions; information processing; and speech.

e. Does not include brain injuries that are congenital or degenerative.

(39) Uniform portal process. – A standardized process and procedures used to ensure consumer access to, and exit from, public services in accordance with the State Plan. (1899, c. 1, s. 28; Rev., s. 4574; C.S., s. 6189; 1945, c. 952, s. 18; 1947, c. 537, s. 12; 1949, c. 71, s. 3; 1955, c. 887, s. 1; 1957, c. 1232, s. 13; 1959, c. 1028, s. 4; 1963, c. 1166, ss. 2, 10; c. 1184, s. 1; 1965, c. 933; 1973, c. 475, s. 2; c. 476, s. 133; c. 726, s. 1; c. 1408, ss. 1, 3; 1977, c. 400, ss. 2, 12; c. 568, s. 1; c. 679, s. 7; 1977, 2nd Sess., c. 1134, s. 2; 1979, c. 164, ss. 3, 4; c. 171, s. 2; c. 358, ss. 2, 26; c. 915, s. 1; c. 751, s. 28; 1981, c. 51, ss. 2-4; c. 539, s. 1; 1983, c. 280; c. 383, s. 2; c. 638, s. 2; c. 718, s. 1; c. 864, s. 4; 1983 (Reg. Sess., 1984), c. 1110, s. 4;

1985, c. 589, s. 2; c. 695, s. 1; c. 777, s. 2; 1985 (Reg. Sess., 1986), c. 863, s. 7; 1987, c. 345, s. 1; c. 830, ss. 47(a), (b); 1989, c. 141, s. 8; c. 223; c. 486, s. 2; c. 625, s. 2; 1989 (Reg. Sess., 1990), c. 823, s. 11; c. 1003, s. 2; c. 1024, s. 26(a); 1993, c. 321, s. 220(a)-(c); c. 375, s. 6; c. 396, ss. 1, 2; 1995, c. 249, s. 1; c. 406, s. 5; 1997-443, s. 11A.118(a); 1997-456, s. 27; 1998-198, s. 3; 1998-202, s. 4(r); 1999-186, s. 1; 2000-67, s. 11.21(c); 2001-437, ss. 1.2(b), 1.2(c); 2001-437, s. 1.2(a); 2003-313, s. 1; 2006-69, s. 3(n); 2006-142, ss. 4(a), 7; 2007-269, s. 3.1; 2007-502, s. 15(a); 2008-107, s. 10.15(dd); 2013-85, s. 1; 2018-33, s. 1; 2019-76, s. 1; 2019-81, s. 9; 2019-240, ss. 20(a), 22, 26(a); 2021-77, s. 1; 2023-65, ss. 5.1(c), 5.2(b), 10.1; 2023-134, ss. 9E.22(*l*), 9G.7A(a2).)

§ 122C-4. Use of phrase "client or the legally responsible person".

(a) Except as otherwise provided by law, whenever in this Chapter the phrase "client or the legally responsible person" is used, and the client is a minor or an incompetent adult, the duty or right involved shall be exercised not by the client, but by the legally responsible person.

(b) Except as otherwise provided by law, whenever in this Chapter the phrase "client or the legally responsible person" is used, and the client is an incapable adult, the duty or right involved shall be exercised by a health care agent named pursuant to a valid health care power of attorney, if one exists, or by the client as expressed in a valid advance instruction for mental health treatment, if one exists. If no health care power of attorney or advance instruction for mental health treatment exists, the legally responsible person for an incapable adult who has not been adjudicated incompetent under Chapter 35A of the General Statutes shall be one of the persons listed in subdivisions (3) through (7) of subsection (c) of G.S. 90-21.13, to be selected based on the priority order indicated in said subdivisions (3) through (7). (1985, c. 589, s. 2; 2018-33, s. 2; 2019-240, s. 26(b).)

§ 122C-5. Report on restraint and seclusion.

The Secretary shall report annually on October 1 to the Joint Legislative Oversight Committee on Health and Human Services on the following for the immediately preceding fiscal year:

(1) The level of compliance of each facility with applicable State and federal laws, rules, and regulations governing the use of restraints and seclusion. The information shall indicate areas of highest and lowest levels of compliance.

(2) The total number of facilities that reported deaths under G.S. 122C-31, the number of deaths reported by each facility, the number of deaths investigated pursuant to G.S. 122C-31, and the number found by the investigation to be related to the use of restraint or seclusion. (2000-129, s. 3(b); 2003-58, s. 1; 2011-291, s. 2.40.)

§ 122C-6. Smoking prohibited; penalty.

(a) Smoking is prohibited inside facilities licensed under this Chapter. As used in this section, "smoking" means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product. As used in this section, "inside" means a fully enclosed area.

(b) The person who owns, manages, operates, or otherwise controls a facility subject to this section shall:

(1) Conspicuously post signs clearly stating that smoking is prohibited inside the facility. The signs may include the international "No Smoking" symbol, which

consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it.

(2) Direct any person who is smoking inside the facility to extinguish the lighted smoking product.

(3) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(c) The Department may impose an administrative penalty not to exceed two hundred dollars ($200.00) for each violation on any person who owns, manages, operates, or otherwise controls a facility licensed under this Chapter and fails to comply with subsection (b) of this section. A violation of this section constitutes a civil offense only and is not a crime.

(d) This section does not apply to State psychiatric hospitals. (2007-459, s. 3.)

§ 122C-7. Reserved for future codification purposes.

§ 122C-8. Reserved for future codification purposes.

§ 122C-9. Reserved for future codification purposes.

Article 1A.

MH/DD/SA Consumer Advocacy Program.

(This article has a contingent effective date)

§ 122C-10. (This article has a contingent effective date – see note) MH/DD/SA Consumer Advocacy Program.

The General Assembly finds that many consumers of mental health, developmental disabilities, and substance abuse services are uncertain about their rights and responsibilities and how to access the public service system to obtain appropriate care and treatment. The General Assembly recognizes the importance of ensuring that consumers have information about the availability of services and access to resources to obtain timely quality care. There is established the MH/DD/SA Consumer Advocacy Program. The purpose of this Program is to provide consumers, their families, and providers with the information and advocacy needed to locate appropriate services, resolve complaints, or address common concerns and promote community involvement. It is further the intent of the General Assembly that the Department, within available resources and pursuant to its duties under this Chapter, ensure that the performance of the mental health care system in this State is closely monitored, reviews are conducted, findings and recommendations and reports are made, and that local and systemic problems are identified and corrected when necessary to promote the rights and interests of all consumers of mental health, developmental disabilities, and substance abuse services. (2001-437, s. 2; 2002-126, s. 10.30; 2003-284, s. 10.10; 2005-276, s. 10.27.)

§ 122C-11. (This article has a contingent effective date – see notes) MH/DD/SA Consumer Advocacy Program/definitions.

Unless the context clearly requires otherwise, as used in this Article:

(1) "MH/DD/SA" means mental health, developmental disabilities, and substance abuse.

(2) "State Consumer Advocate" means the individual charged with the duties and functions of the State MH/DD/SA Consumer Advocacy Program established under this Article.
(3) "State Consumer Advocacy Program" means the State MH/DD/SA Consumer Advocacy Program.
(4) "Local Consumer Advocate" means an individual employed and certified by the State Consumer Advocate to perform the duties and functions of the MH/DD/SA Local Consumer Advocacy Program in accordance with this Article.
(5) "Local Consumer Advocacy Program" means a local MH/DD/SA Local Consumer Advocacy Program.
(6) "Consumer" means an individual who is a client or a potential client of public services from a State or area facility. (2001-437, s. 2; 2002-126, s. 10.30; 2003-284, s. 10.10; 2005-276, s. 10.27.)

§ 122C-12. (This article has a contingent effective date – see note) State MH/DD/SA Consumer Advocacy Program.

The Secretary shall establish a State MH/DD/SA Consumer Advocacy Program office in the Office of the Secretary of Health and Human Services. The Secretary shall appoint a State Consumer Advocate. In selecting the State Consumer Advocate, the Secretary shall consider candidates recommended by citizens' organizations representing the interest of individuals with needs for mental health, developmental disabilities, and substance abuse services. The State Consumer Advocate may hire individuals to assist in executing the State Consumer Advocacy Program and to act on the State Consumer Advocate's behalf. The State Consumer Advocate shall have expertise and experience in MH/DD/SA, including expertise and experience in advocacy. The Attorney General shall provide legal staff and advice to the State Consumer Advocate. (2001-437, s. 2; 2002-126, s. 10.30; 2003-284, s. 10.10; 2005-276, s. 10.27.)

§ 122C-13. (This article has a contingent effective date – see note) State Consumer Advocate duties.

The State Consumer Advocate shall:

(1) Establish Local Quality Care Consumer Advocacy Programs described in G.S. 122C-14 and appoint the Local Consumer Advocates.
(2) Establish certification criteria and minimum training requirements for Local Consumer Advocates.
(3) Certify Local Consumer Advocates. The certification requirements shall include completion of the minimum training requirements established by the State Consumer Advocate.
(4) Provide training and technical Advocacy to Local Consumer Advocates.
(5) Establish procedures for processing and resolving complaints both at the State and local levels.
(6) Establish procedures for coordinating complaints with local human rights committees and the State protection and advocacy agency.
(7) Establish procedures for appropriate access by the State and Local Consumer Advocates to State, area authority, and county program facilities and records to ensure MH/DD/SA. The procedures shall include, but not be limited to,

interviews of owners, consumers, and employees of State, area authority, and county program facilities, and on-site monitoring of conditions and services. The procedures shall ensure the confidentiality of these records and that the identity of any complainant or consumer will not be disclosed except as otherwise provided by law.

(8) Provide information to the public about available MH/DD/SA services, complaint procedures, and dispute resolution processes.

(9) Analyze and monitor the development and implementation of federal, State, and local laws, regulations, and policies relating to consumers and recommend changes as considered necessary to the Secretary.

(10) Analyze and monitor data relating to complaints or concerns about access and issues to identify significant local or systemic problems, as well as opportunities for improvement, and advise and assist the Secretary in developing policies, plans, and programs for ensuring that the quality of services provided to consumers is of a uniformly high standard.

(11) Submit a report annually to the Secretary, the Joint Legislative Oversight Committee on Health and Human Services, and the Joint Legislative Health Care Oversight Committee containing data and findings regarding the types of problems experienced and complaints reported by or on behalf of providers, consumers, and employees of providers, as well as recommendations to resolve identified issues and to improve the administration of MH/DD/SA facilities and the delivery of MH/DD/SA services throughout the State. (2001-437, s. 2; 2002-126, s. 10.30; 2003-284, s. 10.10; 2005-276, s. 10.27; 2011-291, s. 2.41.)

§ 122C-14. (This article has a contingent effective date – see note) Local Consumer Advocate; duties.

(a) The State Consumer Advocate shall establish a Local MH/DD/SA Consumer Advocacy Program in locations in the State to be designated by the Secretary. In determining where to locate the Local Consumer Advocacy Programs, the Secretary shall ensure reasonable consumer accessibility to the Local Consumer Advocates. Local Consumer Advocates shall administer the Local Consumer Advocacy Programs. The State Consumer Advocate shall appoint a Local Consumer Advocate for each of the Local Consumer Advocacy Programs. The State Consumer Advocate shall supervise the Local Consumer Advocates.

(b) Pursuant to policies and procedures established by the State Consumer Advocate, the Local Consumer Advocate shall:

(1) Assist consumers and their families with information, referral, and advocacy in obtaining appropriate services.

(2) Assist consumers and their families in understanding their rights and remedies available to them from the public service system.

(3) Serve as a liaison between consumers and their families and facility personnel and administration.

(4) Promote the development of consumer and citizen involvement in addressing issues relating to MH/DD/SA.

(5) Visit the State, area authority, or county program facilities to review and evaluate the quality of care provided to consumers and submit findings to the State Consumer Advocate.

(6) Work with providers and consumers and their families or advocates to resolve issues of common concern.
(7) Participate in regular Local Consumer Advocate training established by the State Consumer Advocate.
(8) Report regularly to area authorities and county programs, county and area authority boards, and boards of county commissioners about the Local Consumer Advocate's activities, including the findings made pursuant to subdivision (5) of this subsection.
(9) Provide training and technical assistance to counties, area authority boards, and providers concerning responding to consumers, evaluating quality of care, and determining availability of services and access to resources.
(10) Coordinate activities with local human rights committees based on procedures developed by the State Consumer Advocate.
(11) Provide information to the public on MH/DD/SA issues.
(12) Perform any other related duties as directed by the State Consumer Advocate. (2001-437, s. 2; 2002-126, s. 10.30; 2003-284, s. 10.10; 2005-276, s. 10.27.)

§ 122C-15. (This Article has a contingent effective date – see note) State/Local Consumer Advocate; authority to enter; communication with residents, clients, patients; review of records.

(a) For purposes of this section, G.S. 122C-16 and G.S. 122C-17, "Consumer Advocate" means either the State Consumer Advocate or any Local Consumer Advocate.

(b) In performing the Consumer Advocate's duties, a Consumer Advocate shall have access at all times to any State or area facility and shall have reasonable access to any consumer or to an employee of a State or area facility. Entry and access to any consumer or to an employee shall be conducted in a manner that will not significantly disrupt the provision of services. If a facility requires visitor registration, then the Consumer Advocate shall register.

(c) In performing the Consumer Advocate's duties, a Consumer Advocate may communicate privately and confidentially with a consumer. A consumer shall not be compelled to communicate with a Consumer Advocate. When initiating communication, a Consumer Advocate shall inform the consumer of the Consumer Advocate's purpose and that a consumer may refuse to communicate with the Consumer Advocate. A Consumer Advocate also may communicate privately and confidentially with State and area facility employees in performing the Consumer Advocate's duties.

(d) Notwithstanding G.S. 8-53, G.S. 8-53.3, or any other law relating to confidentiality of communications involving a consumer, in the course of performing the Consumer Advocate's duties, the Consumer Advocate may access any information, whether recorded or not, concerning the admission, discharge, medication, treatment, medical condition, or history of any consumer to the extent permitted by federal law and regulations. Notwithstanding any State law pertaining to the privacy of personnel records, in the course of the Consumer Advocate's duties, the Consumer Advocate shall have access to personnel records of employees of State, area authority, or county program facilities. (2001-437, s. 2; 2002-126, s. 10.30; 2003-284, s. 10.10; 2005-276, s. 10.27.)

§ 122C-16. (This Article has a contingent effective date – see note) State/Local Consumer Advocate; resolution of complaints.

(a) Following receipt of a complaint, a Consumer Advocate shall attempt to resolve the complaint using, whenever possible, informal mediation, conciliation, and persuasion.

(b) If a complaint concerns a particular consumer, the consumer may participate in determining what course of action the Consumer Advocate should take on the consumer's behalf. If the consumer has an opinion concerning a course of action, the Consumer Advocate shall consider the consumer's opinion.

(c) Following receipt of a complaint, a Consumer Advocate shall contact the service provider to allow the service provider the opportunity to respond, provide additional information, or initiate action to resolve the complaint.

(d) Complaints or conditions adversely affecting consumers that cannot be resolved in the manner described in subsection (a) of this section shall be referred by the Consumer Advocate to the appropriate licensing agency under Article 2 of this Chapter. (2001-437, s. 2; 2002-126, s. 10.30; 2003-284, s. 10.10; 2005-276, s. 10.27.)

§ 122C-17. (This Article has a contingent effective date – see note) State/Local Consumer Advocate; confidentiality.

(a) Except as required by law, a Consumer Advocate shall not disclose the following:

(1) Any confidential or privileged information obtained pursuant to G.S. 122C-15 unless the affected individual authorizes disclosure in writing; or

(2) The name of anyone who has furnished information to a Consumer Advocate unless the individual authorizes disclosure in writing.

(b) Violation of this section is a Class 3 misdemeanor, punishable only by a fine not to exceed five hundred dollars ($500.00).

(c) All confidential or privileged information obtained under this section and the names of persons providing information to a Consumer Advocate are exempt from disclosure pursuant to Chapter 132 of the General Statutes. Access to substance abuse records and redisclosure of protected information shall be in compliance with federal confidentiality laws protecting medical records. (2001-437, s. 2; 2002-126, s. 10.30; 2003-284, s. 10.10; 2005-276, s. 10.27.)

§ 122C-18. (This Article has a contingent effective date – see note) State/Local Consumer Advocate; retaliation prohibited.

No one shall discriminate or retaliate against any person, provider, or facility because the person, provider, or facility in good faith complained or provided information to a Consumer Advocate. (2001-437, s. 2; 2002-126, s. 10.30; 2003-284, s. 10.10; 2005-276, s. 10.27.)

§ 122C-19. (This Article has a contingent effective date – see note) State/Local Consumer Advocate; immunity from liability.

(a) The State and Local Consumer Advocate shall be immune from liability for the good faith performance of official Consumer Advocate duties.

(b) A State or area facility, its employees, and any other individual interviewed by a Consumer Advocate are immune from liability for damages resulting from disclosure of any information or documents to a Consumer Advocate pursuant to this Article. (2001-437, s. 2; 2002-126, s. 10.30; 2003-284, s. 10.10; 2005-276, s. 10.27.)

§ 122C-20. (This Article has a contingent effective date – see note) State/Local Consumer Advocate; penalty for willful interference.

Willful interference by an individual other than the consumer or the consumer's representative with the State or a Local Consumer Advocate in the performance of the Consumer Advocate's official duties is a Class 1 misdemeanor. (2001-437, s. 2; 2002-126, s. 10.30; 2003-284, s. 10.10; 2005-276, s. 10.27.)

§ 122C-20.1: Reserved for future codification purposes.

§ 122C-20.2: Reserved for future codification purposes.

§ 122C-20.3: Reserved for future codification purposes.

§ 122C-20.4: Reserved for future codification purposes.

Article 1B.

Transitions to Community Living.

Part 1. North Carolina Supportive Housing Program.

§ 122C-20.5. Definitions.

The following definitions apply in this Article:

(1) Individual with serious and persistent mental illness or SPMI. – A person who is 18 years of age or older who meets one of the following criteria:
   a. Has a mental illness or disorder that is so severe and chronic that it prevents or erodes development of functional capacities in primary aspects of daily life such as personal hygiene and self-care, decision making, interpersonal relationships, social transactions, learning, and recreational activities.
   b. Is receiving Supplemental Security Income or Social Security Disability Income due to mental illness.

(2) Individual with serious mental illness or SMI. – An individual who is 18 years of age or older with a mental illness or disorder that is described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, that impairs or impedes functioning in one or more major areas of living and is unlikely to improve without treatment, services, supports, or all three. The term does not include a primary diagnosis of Alzheimer's disease or dementia. (2013-397, s. 6(a).)

§ 122C-20.6. Department to establish statewide supportive housing program for individuals transitioning into community living; purpose.

The Department of Health and Human Services, in consultation with the North Carolina Housing Finance Agency, shall establish and administer a tenant-based rental assistance program known as the North Carolina Supportive Housing Program. The purpose of the program is to transition individuals diagnosed with serious mental illness or serious and persistent mental illness from institutional settings to more integrated community-based settings appropriate to meet their needs. Under the program, the Department, in consultation with the North Carolina Housing Finance Agency and LME/MCOs, shall arrange for program participants to be transitioned to housing slots available through the program with all the rights and obligations created by a landlord-tenant relationship. (2013-397, s. 6(a).)

§ 122C-20.7. Administration of housing subsidies for supportive housing.

The Department may enter into a contract with a private vendor to serve as the housing subsidy administrator for the North Carolina Supportive Housing Program with responsibility for distributing rental vouchers and community living vouchers to program participants based on a formula developed by the Department. (2013-397, s. 6(a).)

§ 122C-20.8. Eligibility requirements for NC Supportive Housing Program.

The Division of Aging and Adult Services shall adopt rules to establish eligibility requirements for the program. The eligibility requirements shall, at a minimum, include income eligibility requirements and requirements to give priority for program participation and transition services to individuals diagnosed with serious mental illness or serious and persistent mental illness who are currently residing in institutional settings. The Division may adopt temporary rules necessary to implement this Article. (2013-397, s. 6(a).)

§ 122C-20.9. In-reach activities for supportive housing.

The Department shall have ongoing responsibility for developing and distributing a list of potentially eligible program participants for each LME/MCO by catchment area. Upon receipt of this information, each LME/MCO shall have ongoing responsibility for prioritizing the list of individuals to whom it will provide in-reach activities in order to (i) arrange an in-person meeting with potentially eligible participants to determine their eligibility and level of interest and (ii) report back to the Department on the LME/MCO's recommended list of program participants on a daily basis. Upon receipt of an LME/MCO's recommended list of program participants, the Department shall make a final determination of eligibility. (2013-397, s. 6(a).)

§ 122C-20.10. Allocation of supportive housing slots to LME/MCOs.

The Department shall annually determine the number of housing slots to be allocated to each LME/MCO as follows:

(1) Each year, the Department shall distribute at least fifty percent (50%) of the housing slots available through this program equally among all LME/MCOs.

(2) The Department shall award additional housing slots to LME/MCOs based on local need, as determined by the information provided by LME/MCOs to the Department in accordance with G.S. 122C-20.9. (2013-397, s. 6(a).)

§ 122C-20.11. Transition of program participants into housing slots.

The LME/MCO shall develop a written transition plan for each individual determined to be eligible and interested in participating in the North Carolina Supportive Housing Program. The transition plan for the approved housing slot shall identify at least all of the following:

(1) Available housing units that meet the individual's needs.

(2) Any transition services that will be necessary for the individual, including, but not limited to, a one-time transition stability payment, not to exceed two thousand dollars ($2,000) per individual, for up-front move-in costs approved by the Department or the housing subsidy administrator.

(3) Solutions to potential barriers to the individual's successful transition to community-based supported housing.

(4) Any other information the Department deems necessary for the individual program participant's successful transition into community-based supported housing. (2013-397, s. 6(a).)

§ 122C-20.12. Transition services.

LME/MCOs shall provide individualized transition services to program participants within their respective catchment areas for the 90-day period following the individual's transition into a housing slot provided through the program. (2013-397, s. 6(a).)

§ 122C-20.13. Tenancy support services.

The Department or the housing subsidy administrator shall provide ongoing tenancy support services to program participants. (2013-397, s. 6(a).)

§ 122C-20.14. Approval of landlords and housing units.

The Department shall develop an application process for owners of housing units seeking to participate in the program as landlords. The application process shall, at a minimum, include an inspection of the owners' selected housing units and a requirement that owners receive educational information from the Department about the North Carolina Supportive Housing Program prior to being approved as landlords. (2013-397, s. 6(a).)

§ 122C-20.15. Annual reporting on NC Supportive Housing Program.

Annually on October 1, the Department shall report to the Joint Legislative Oversight Committee on Health and Human Services of the General Assembly on the number of individuals within each LME/MCO catchment area who transitioned into housing slots available through the North Carolina Supportive Housing Program during the preceding calendar year. The report shall include a breakdown of all funds expended by each LME/MCO for transitioning these individuals into the housing slots. (2013-397, s. 6(a).)

§ 122C-20.16. NC Supportive Housing Program not an entitlement.

The Department shall not be required to provide housing slots to individuals beyond the number that can be supported by funds appropriated by the General Assembly for this purpose. The supportive housing program established under this Part, whether administered by the Department or a private entity, is not an entitlement, and nothing in this Part shall create any property right. (2013-397, s. 6(a).)

Article 2.

Licensure of Facilities for Individuals With Mental Health Disorders, Developmental Disabilities, and Substance Use Disorders.

§ 122C-21. Purpose.

The purpose of this Article is to provide for licensure of facilities for the individuals with mental health disorders, developmental disabilities, and substance use disorders by the development, establishment, and enforcement of basic rules governing both of the following:

(1) The provision of services to individuals who receive services from licensable facilities as defined by this Chapter.

(2) The construction, maintenance, and operation of these licensable facilities that in the light of existing knowledge will ensure safe and adequate treatment of

these individuals. The Department shall ensure that licensable facilities are inspected every two years to determine compliance with physical plant and life-safety requirements. (1983, c. 718, s. 1; 1985, c. 589, s. 2; 1989, c. 625, s. 4; 2005-276, s. 10.40A(c); 2021-77, s. 7.4(b).)

§ 122C-22. Exclusions from licensure; deemed status.

(a) All of the following are excluded from the provisions of this Article and are not required to obtain licensure under this Article:

(1) Physicians and psychologists engaged in private office practice.
(2) General hospitals licensed under Article 5 of Chapter 131E of the General Statutes, that operate special units for patients with a mental health disorder diagnosis, one or more developmental disabilities, or a substance use disorder.
(3) State and federally operated facilities.
(4) Adult care homes licensed under Chapter 131D of the General Statutes.
(5) Developmental child care centers licensed under Article 7 of Chapter 110 of the General Statutes.
(6) Persons subject to licensure under rules of the Social Services Commission.
(7) Persons subject to rules and regulations of the Division of Employment and Independence for People with Disabilities.
(8) Facilities that provide occasional respite care for not more than two individuals at a time; provided that the primary purpose of the facility is other than as defined in G.S. 122C-3(14).
(9) Twenty-four-hour nonprofit facilities established for the purposes of shelter care and recovery from alcohol or other substance use disorder through a 12-step, self-help, peer role modeling, and self-governance approach.
(10) Inpatient chemical dependency or substance abuse facilities that provide services exclusively to inmates of the Department of Adult Correction, as described in G.S. 148-19.1.
(11) A charitable, nonprofit, faith-based, adult residential treatment facility that does not receive any federal or State funding and is a religious organization exempt from federal income tax under section 501(a) of the Internal Revenue Code.
(12) A home in which up to three adults, two or more having a disability, co-own or co-rent a home in which the persons with disabilities are receiving three or more hours of day services in the home or up to 24 hours of residential services in the home. The individuals who have disabilities cannot be required to move if the individuals change services, change service providers, or discontinue services.

(b) The Commission may adopt rules establishing a procedure whereby a facility that would otherwise require licensure under this Article that is certified by a nationally recognized agency, such as the Joint Commission on Accreditation of Hospitals, may be deemed licensed under this Article by the Secretary. Any facility licensed under the provisions of this subsection shall continue to be subject to inspection by the Secretary. The Secretary shall collaborate with relevant agencies to ensure that any facilities deemed licensed under this Article maintain the required certification. (1983, c. 718, s. 1; 1983 (Reg. Sess., 1984), c. 1110, s. 5; 1985, c. 589, s. 2; c. 695, s. 13; 1987, c. 345, s. 2; 1989, c. 625, s. 5; 1995, c. 535, s. 7; 1997-506, s. 43; 2000-67, s. 11.25A; 2001-424, s. 25.19(b); 2004-199, s. 32; 2011-145, s. 19.1(h); 2011-202, s. 1; 2012-15, s. 1; 2013-410, s. 11; 2017-186, s. 2(jjjjj); 2021-77, s. 7.3(a); 2021-180, s. 19C.9(ooo); 2023-65, s. 8.3.)

§ 122C-23. Licensure.

(a) No person shall establish, maintain, or operate a licensable facility for individuals with mental illnesses, individuals with intellectual or other developmental disabilities, or substance abusers without a current license issued by the Secretary.

(b) Each license is issued to the person only for the premises named in the application and is not transferrable or assignable except with prior written approval of the Secretary.

(c) Any person that intends to establish, maintain, or operate a licensable facility shall apply to the Secretary for a license. The Secretary shall prescribe by rule the contents of the application forms.

(d) The Secretary shall issue a license if the Secretary finds that the person complies with this Article and the rules of the Commission and Secretary.

(e) Initial licenses issued under this section are valid for not more than 15 months. Licenses shall be renewed annually thereafter and shall expire at the end of the calendar year. The expiration date of a license shall be specified on the license when issued. Renewal of a regular license is contingent upon receipt of information required by the Secretary for renewal and continued compliance with this Article and the rules of the Commission and the Secretary. Licenses for facilities that have not served any clients during the previous 12 months are not eligible for renewal.

The Secretary may issue a provisional license for a period up to six months to a person obtaining the initial license for a facility. The licensee must demonstrate substantial compliance prior to being issued a full license.

A provisional license for a period not to exceed six months may be granted by the Secretary to a person that is temporarily unable to comply with a rule when the noncompliance does not present an immediate threat to the health and safety of the individuals in the licensable facility. During this period the licensable facility shall correct the noncompliance based on a plan submitted to and approved by the Secretary. A provisional license for an additional period of time to meet the noncompliance shall not be issued.

(e1) Except as provided in subsection (e2) of this section, the Secretary shall not (i) enroll as a new provider in the North Carolina Medicaid program, (ii) revalidate as an enrolled provider in the Medicaid program during the period of the license revocation or suspension, or (iii) issue a license for a new facility or a new service to any applicant meeting any of the following criteria:

(1) The applicant was the owner, principal, or affiliate of a licensable facility under Chapter 122C, Chapter 131D, or Article 7 of Chapter 110 of the General Statutes that had its license revoked until 60 months after the date of the revocation.

(2) The applicant is the owner, principal, or affiliate of a licensable facility that was assessed a penalty for a Type A or Type B violation under Article 3 of this Chapter, or any combination thereof, and any one of the following conditions exist:

a. A single violation has been assessed in the six months prior to the application.

b. Two violations have been assessed in the 18 months prior to the application and 18 months have not passed from the date of the most recent violation.

c. Three violations have been assessed in the 36 months prior to the application and 36 months have not passed from the date of the most recent violation.

d. Four or more violations have been assessed in the 60 months prior to application and 60 months have not passed from the date of the most recent violation.

(3) The applicant is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under G.S. 122C-24.1(a) until 60 months after the date of reinstatement or restoration of the license.

(4) The applicant is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under Article 1A of Chapter 131D of the General Statutes until 60 months after the date of reinstatement or restoration of the license.

(e2) The Secretary may enroll a provider described in subsection (e1) of this section if any of the following circumstances apply:

(1) The applicant is an area program or county program providing services under G.S. 122C-141, and there is no other provider of the service in the catchment area.

(2) The Secretary finds that the area program or county program has shown good cause by clear and convincing evidence why the enrollment should be allowed.

(e3) Licensure or enrollment shall be denied if an applicant's history as a provider under Chapter 131D, Chapter 122C, or Article 7 of Chapter 110 of the General Statutes is such that the Secretary has concluded the applicant will likely be unable to comply with licensing or enrollment statutes, rules, or regulations. In the event the Secretary denies licensure or enrollment under this subsection, the reasons for the denial and appeal rights pursuant to Article 3 of Chapter 150B shall be given to the provider in writing.

(f) Upon written application and in accordance with rules of the Commission, the Secretary may for good cause waive any of the rules implementing this Article, so long as those rules do not affect the health, safety, or welfare of the individuals within the licensable facility. Decisions made pursuant to this subsection may be appealed by filing a contested case under Article 3 of Chapter 150B of the General Statutes.

(g) The Secretary may suspend the admission of any new clients to a facility licensed under this Article where the conditions of the facility are detrimental to the health or safety of the clients. This suspension shall be for the period determined by the Secretary and shall remain in effect until the Secretary is satisfied that conditions or circumstances merit removal of the suspension. In suspending admissions under this subsection, the Secretary shall consider the following factors:

(1) The degree of sanctions necessary to ensure compliance with this section and rules adopted to implement this subsection.

(2) The character and degree of impact of the conditions at the facility on the health or safety of its clients.

A facility may contest a suspension of admissions under this subsection in accordance with Chapter 150B of the General Statutes. In contesting the suspension of admissions, the facility must file a petition for a contested case within 20 days after the Department mails notice of suspension of admissions to the licensee.

(h) The Department shall charge facilities licensed under this Chapter a nonrefundable annual base license fee plus a nonrefundable annual per-bed fee as follows:

Type of Facility	Number of Beds	Base Fee	Per Bed Fee
Facilities (non ICF/IID):	0 beds	$215.00	$0
	1 to 6 beds	$305.00	$0
	More than 6 beds	$475.00	$17.50
ICF/IID Only:	1 to 6 beds	$845.00	$0
	More than 6 beds	$800.00	$17.50

(i) A social setting detoxification facility or medical detoxification facility subject to licensure under this Chapter shall not deny admission or treatment to an individual based solely on the individual's inability to pay. (1899, c. 1, s. 60; Rev., s. 4600; C.S., s. 6219; 1945, c. 952, s. 41; 1957, c. 100, ss. 1, 4; 1963, c. 813, s. 1; c. 1166, s. 7; 1965, c. 1178, ss. 1-3; 1969, c. 954; 1973, c. 476, ss. 133, 152; 1977, c. 679, s. 7; 1981, c. 51, s. 3; 1983, c. 718, ss. 1, 4; 1985, c. 589, s. 2; 1985 (Reg. Sess., 1986), c. 863, s. 8; 1987, c. 345, ss. 3, 4; 1989, c. 625, s. 6; 2000-55, s. 3; 2002-164, s. 4.1; 2003-284, s. 34.8(a); 2003-294, s. 2; 2003-390, s. 3; 2005-276, ss. 41.2(h), 10.40A(d); 2006-66, s. 10.23; 2009-451, s. 10.76(f); 2021-77, ss. 2, 7.1(b); 2021-88, s. 9(h); 2022-74, s. 9D.15(z); 2023-11, s. 3.2(h).)

§ 122C-23.1. Licensure of residential treatment facilities.

(a) The General Assembly finds:

(1) That much of the care for residential treatment facility residents is paid by the State and the counties;

(2) That the cost to the State for care for residents of residential treatment facilities is substantial, and high vacancy rates in residential treatment facilities further increase the cost of care;

(3) That the proliferation of residential treatment facilities results in costly duplication and underuse of facilities and may result in lower quality service;

(4) There is currently no ongoing relationship between some applicants for licensure and local management entities (LMEs) that are responsible for the placement of children and adults in residential treatment facilities; and

(5) That it is necessary to protect the general welfare and lives, health, and property of the people of the State for the local management entity (LME) to verify that additional beds are needed in the LME's catchment area before new residential treatment facilities are licensed. This process is established to ensure that unnecessary costs to the State do not result, residential treatment facility beds are available where needed, and that individuals who need care in residential treatment facilities may have access to quality care.

Based on these findings, the Department of Health and Human Services may license new residential treatment facilities if the applicant for licensure submits with the application a letter of support obtained from the local management entity in whose catchment area the facility will be located. The letter of support shall be submitted to the Department of Health and Human Services, Division of Health Service Regulation and Division of Mental Health, Developmental Disabilities,

and Substance Use Services, and shall specify the number of existing beds in the same type of facility in the catchment area and the projected need for additional beds of the same type of facility.

(b) All private psychiatric residential treatment facilities (PRTFs), as defined in G.S. 122C-450(a)(3), that serve children eligible to attend the public schools in accordance with G.S. 115C-366, including a student who has been suspended or expelled but otherwise meets the requirements of that statute, shall have a facility-based school as a condition of licensure. Subject to the time limits of subsection (c) of this section, the school shall meet all the requirements of a qualified nonpublic school under Article 39 of Chapter 115C of the General Statutes and of a Nonpublic Exceptional Children's Program as defined in G.S. 122C-450(a)(2). The requirements of this subsection and subsection (c) of this section do not apply to PRTFs that are approved charter schools pursuant to Article 14A of Chapter 115C of the General Statutes.

(c) The Department of Health and Human Services may issue an initial license to a PRTF that meets all licensure requirements except for the approval of the facility-based school as a Nonpublic Exceptional Children's Program by the Department of Public Instruction. This initial license is valid for a period of six months, during which time the PRTF shall obtain approval of its facility-based school as a Nonpublic Exceptional Children's Program by the Department of Public Instruction. If such approval is not obtained before the expiration of the initial license, the Department of Health and Human Services shall review the PRTF's license for appropriate action. If the PRTF obtains approval as a Nonpublic Exceptional Children's Program, the Department of Health and Human Services may issue a license for the remainder of the calendar year, and the facility is eligible for annual renewal thereafter.

(d) At any time upon receipt of a written notice from the Department of Public Instruction that a PRTF has not provided or is not providing educational services, or is not reasonably cooperating with the Department of Public Instruction to ensure those services are provided and that compliance with State and federal law is assured, the Department of Health and Human Services shall review the PRTF's license for appropriate action. The Department of Health and Human Services may issue sanctions including (i) requiring a refund of all State funds disbursed for the provision of educational services for the current fiscal year, (ii) barring future funding for the provision of educational services for the current or following year, or (iii) suspending or revoking the PRTF's license.

(e) As used in this section, "residential treatment facility" means a "residential facility" as defined in and licensed under this Chapter, but not subject to Certificate of Need requirements under Article 9 of Chapter 131E of the General Statutes. (2005-276, s. 10.40(a); 2007-182, s. 1; 2014-100, s. 8.39(c); 2014-101, s. 7; 2023-65, s. 5.2(b).)

§ 122C-24. Adverse action on a license.

(a) The Secretary may deny, suspend, amend, or revoke a license in any case in which the Secretary finds that there has been a substantial failure to comply with any provision of this Article or other applicable statutes or any applicable rule adopted pursuant to these statutes. Actions under this section and appeals of those actions shall be in accordance with rules of the Commission and Chapter 150B of the General Statutes.

(b) Repealed by Session Laws 2025-25, s. 24(h), effective June 26, 2025. (1983, c. 718, s. 1; 1985, c. 589, s. 2; 1985 (Reg. Sess., 1986), c. 863, ss. 8-10; 1987, c. 345, s. 5; 2025-25, s. 24(h).)

§ 122C-24.1. Penalties; remedies.

(a) Violation Classification and Penalties. – The Department of Health and Human Services shall impose an administrative penalty in accordance with provisions of this Article on any facility licensed under this Article which is found to be in violation of Article 2 or 3 of this Chapter or applicable State and federal laws and regulations. Citations for violations shall be classified and penalties assessed according to the nature of the violation as follows:

(1) "Type A1 Violation" means a violation by a facility of the regulations, standards, and requirements set forth in Article 2 or 3 of this Chapter or applicable State or federal laws and regulations governing the licensure or certification of a facility which results in death or serious physical harm, abuse, neglect, or exploitation. The person making the findings shall do the following:

a. Orally and immediately inform the facility of the Type A1 Violation and the specific findings.

a1. Require a written plan of protection regarding how the facility will immediately abate the Type A1 Violation in order to protect clients from further risk or additional harm.

b. Within 15 working days of the investigation, send a report of the findings to the facility.

c. Require a plan of correction to be submitted to the Department, based on a written report of the findings, that describes steps the facility will take to achieve and maintain compliance.

The Department shall impose a civil penalty in an amount not less than five hundred dollars ($500.00) nor more than ten thousand dollars ($10,000) for each Type Al Violation in facilities or programs that serve six or fewer persons. The Department shall impose a civil penalty in an amount not less than one thousand dollars ($1,000) nor more than twenty thousand dollars ($20,000) for each Type A1 Violation in facilities or programs that serve seven or more persons. Where a facility has failed to correct a Type A1 Violation, the Department shall access the facility a civil penalty in the amount of up to one thousand dollars ($1,000) for each day that the violation continues beyond the time specified for correction. The Department or its authorized representative shall determine whether the violation has been corrected.

(1a) "Type A2 Violation" means a violation by a facility of the regulations, standards, and requirements set forth in Article 2 or 3 of this Chapter or applicable State or federal laws and regulations governing the licensure or certification of a facility which results in substantial risk that death or serious physical harm, abuse, neglect, or exploitation will occur. The person making the findings shall do the following:

a. Orally and immediately inform the facility of the Type A2 Violation and the specific findings.

b. Require a written plan of protection regarding how the facility will immediately abate the Type A2 Violation in order to protect clients or residents from further risk or additional harm.

c. Within 15 working days of the investigation, send a report of the findings to the facility.

d. Require a plan of correction to be submitted to the Department, based on the written report of the findings, that describes steps the facility will take to achieve and maintain compliance.

The violation or violations shall be corrected within the time specified for correction by the Department or its authorized representative. The Department may or may not assess a penalty taking into consideration the compliance history, preventative measures, and response to previous violations by the facility. Where a facility has failed to correct a Type A2 Violation, the Department shall assess the facility a civil penalty in the amount of up to one thousand dollars ($1,000) for each day that the deficiency continues beyond the time specified for correction by the Department or its authorized representative. The Department or its authorized representative shall determine whether the violation has been corrected.

(1b) Repealed by Session Laws 2016-50, s. 1, effective June 30, 2016.

(2) "Type B Violation" means a violation by a facility of the regulations, standards, and requirements set forth in Article 2 or 3 of this Chapter or applicable State or federal laws and regulations governing the licensure or certification of a facility which is detrimental to the health, safety, or welfare of any client or patient, but which does not result in substantial risk that death or serious physical harm, abuse, neglect, or exploitation will occur. The person making the findings shall do the following:

a. Orally and immediately inform the facility of the Type B Violation and the specific findings.
b. Require a written plan of protection regarding how the facility will immediately abate the Type B Violation in order to protect clients or residents from further risk or additional harm.
c. Within 15 working days of the investigation, send a report of the findings to the facility.
d. Require a plan of correction to be submitted to the Department, based on the written report of the findings, that describes steps the facility will take to achieve and maintain compliance.

Where a facility has failed to correct a Type B Violation within the time specified for correction by the Department or its authorized representative, the Department shall assess the facility a civil penalty in the amount of up to four hundred dollars ($400.00) for each day that the violation continues beyond the date specified for correction without just reason for the failure. The Department or its authorized representative shall ensure that the violation has been corrected.

(2a) A Type A1, Type A2, or Type B Violation as defined above shall not include a violation by a facility of the regulations, standards, and requirements set forth in Article 2 or 3 of this Chapter or applicable State or federal laws and regulations governing the licensure or certification of a facility if all of the following criteria are met:

a. The violation was discovered by the facility.
b. The Department determines that the violation was abated immediately.
c. The violation was corrected prior to inspection by the Department.

d. The Department determines that reasonable preventative measures were in place prior to the violation.

e. The Department determines that subsequent to the violation, the facility implemented corrective measures to achieve and maintain compliance.

(2b) As used in this section, "substantial risk" shall mean the risk of an outcome that is substantially certain to materialize if immediate action is not taken.

(3) Repeat Violations. – The Department shall impose a civil penalty which is treble the amount assessed under this subsection when a facility under the same management or ownership has received a citation during the previous 12 months for which the appeal rights are exhausted and penalty payment is expected or has occurred, and the current violation is for the same specific provision of a statute or regulation for which it received a violation during the previous 12 months.

(b) Repealed by Session Laws 2011-249, s. 1, effective June 23, 2011.

(c) Factors to Be Considered in Determining Amount of Initial Penalty. – In determining the amount of the initial penalty to be imposed under this section, the Department shall consider the following factors:

(1) There is substantial risk that serious physical harm, abuse, neglect, or exploitation will occur, and this has not been corrected within the time specified by the Department or its authorized representative;

(2) Serious physical harm, abuse, neglect, or exploitation, without substantial risk for client death, did occur;

(3) Serious physical harm, abuse, neglect, or exploitation, with substantial risk for client death, did occur;

(3a) A client died;

(3b) A client died and there is substantial risk to others for serious physical harm, abuse, neglect, or exploitation;

(3c) A client died and there is substantial risk for further client death;

(4) The reasonable diligence exercised by the licensee to comply with G.S. 131E-256 and other applicable State and federal laws and regulations;

(5) Efforts by the licensee to correct violations;

(6) The number and type of previous violations committed by the licensee within the past 36 months; and

(7) Repealed by Session Laws 2011-249, s. 1, effective June 23, 2011.

(8) The number of clients or patients put at risk by the violation.

(d) The facts found to support the factors in subsection (c) of this section shall be the basis in determining the amount of the penalty. The Department shall document the findings in written record and shall make the written record available to all affected parties including:

(1) The licensee involved;

(2) The clients or patients affected; and

(3) The family members or guardians of the clients or patients affected.

(e) The Department shall impose a civil penalty of fifty dollars ($50.00) per day on any facility which refuses to allow an authorized representative of the Department to inspect the premises and records of the facility.

(f) Any facility wishing to contest a penalty shall be entitled to an administrative hearing as provided in Chapter 150B of the General Statutes. A petition for a contested case shall be filed

within 30 days after the Department mails a notice of penalty to a licensee. At least the following specific issues shall be addressed at the administrative hearing:

(1) The reasonableness of the amount of any civil penalty assessed, and

(2) The degree to which each factor has been evaluated pursuant to subsection (c) of this section to be considered in determining the amount of an initial penalty.

If a civil penalty is found to be unreasonable or if the evaluation of each factor is found to be incomplete, the hearing officer may recommend that the penalty be adjusted accordingly.

(g) Any penalty imposed by the Department of Health and Human Services under this section shall commence on the date of the letter of notification of the penalty amount.

(h) The Secretary may bring a civil action in the superior court of the county where the violation occurred to recover the amount of the administrative penalty if either of the following applies to a facility:

(1) The facility has not requested an administrative hearing and fails to pay the penalty within 60 days after being notified of the penalty.

(2) The facility has requested an administrative hearing and fails to pay the penalty within 60 days after the Office of Administrative Hearings forwards a written copy of the decision as provided in G.S. 150B-34.

(i) In lieu of assessing all or some of the administrative penalty, the Secretary may order a facility to provide staff training, or consider the approval of training completed by the facility after the violation, if all of the following criteria are met:

(1) The training is determined by the Department to be specific to the violation.

(2) The training is approved by the Department.

(3) The training is taught by someone approved by the Department.

(4) The facility has corrected the violation and continues to remain in compliance with the regulation.

(j) The clear proceeds of civil penalties provided for in this section shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2.

(k) In considering renewal of a license, the Department shall not renew a license if outstanding fines and penalties imposed by the Department against the facility or program have not been paid. Fines and penalties for which an appeal is pending are exempt from consideration for nonrenewal under this subsection. (2000-55, s. 4; 2005-276, ss. 10.40A(e), 10.40A(f); 2011-249, s. 1; 2011-398, s. 39; 2016-50, s. 1; 2025-25, s. 24(i).)

§ 122C-24.2. Regulatory oversight reporting.

(a) The Division of Health Service Regulation (DHSR) shall establish a quality dashboard that addresses mental health, intellectual and developmental disabilities, and substance use services (MH/IDD/SUS) agency performance and identifies trends and outcomes of DHSR reviews.

(b) DHSR shall post the following data to its website on a monthly basis beginning January 31, 2024:

(1) The number of MH/IDD/SUS facility licenses granted by licensure type or licensure category, whichever shall apply.

(2) Any identified trends regarding violations of review.

(3) The 10 most frequently violated rules.

(4) The 10 most frequently violated rules for each program type.

(5) Top core cited rule areas.

(6) The number of general citations issued requiring a corrective action plan.
(7) The number of Type B violations cited.
(8) The number of Type A2 violations cited.
(9) The number of Type A1 violations cited.
(10) The number of suspensions of admissions issued.
(11) The number of revocations issued.
(12) The number of summary suspensions issued.
(13) The number and amount of monetary penalties issued.

(c) DHSR shall post the following data to its website on a quarterly basis beginning January 31, 2024:

(1) A statement on how well it is complying with the statutory requirement of G.S. 122C-24.1 that reports of violations be sent to facilities within 15 working days of the investigation.
(2) The number of informal appeals and number of contested cases filed pursuant to the provisions of Chapter 150B of the General Statutes.
(3) The number of contested cases dismissed, number of contested cases upholding agency action, number of contested cases overturning agency action, and number of contested cases where agency action was upheld in part and overturned in part.

(d) DHSR shall make the following regulatory changes to promote transparency and enhanced communication with providers:

(1) DHSR shall establish a workgroup in collaboration with providers to address ongoing concerns identified by DHSR and providers. These discussions may include clarification of clear rules of engagement and standard operating procedures.
(2) DHSR shall make available annual training to providers and shall solicit feedback from providers and provider associations regarding topics and the scheduling of the annual training as identified by the workgroup.
(3) DHSR shall align its review processes to reflect technology in electronic health records and accept documentation presented through the electronic health record. DHSR may also request that it be provided with a printed copy of portions of the electronic health record or that it be provided with electronic copies of the electronic health record. Both shall be provided as requested. (2023-80, ss. 1, 2.)

§ 122C-25. Inspections; confidentiality.

(a) The Secretary shall make or cause to be made inspections that the Secretary considers necessary. Facilities licensed under this Article shall be subject to inspection at all times by the Secretary. All residential facilities as defined in G.S. 122C-3(14)e. shall be inspected on an annual basis.

(b) Notwithstanding G.S. 8-53, G.S. 8-53.3 or any other law relating to confidentiality of communications involving a patient or client, in the course of an inspection conducted under this section, representatives of the Secretary may review any writing or other record concerning the admission, discharge, medication, treatment, medical condition, or history of any individual who is or has been a patient, resident, or client of a licensable facility and the personnel records of those individuals employed by the licensable facility.

A licensable facility, its employees, and any other individual interviewed in the course of an inspection are immune from liability for damages resulting from disclosure of any information to the Secretary.

Except as required by law, it is unlawful for the Secretary or an employee of the Department to disclose the following information to someone not authorized to receive the information:

(1) Any confidential or privileged information obtained under this section unless the client or his legally responsible person authorizes disclosure in writing; or

(2) The name of anyone who has furnished information concerning a licensable facility without the individual's consent.

Violation of this subsection is a Class 3 misdemeanor punishable only by a fine, not to exceed five hundred dollars ($500.00).

All confidential or privileged information obtained under this section and the names of persons providing this information are exempt from Chapter 132 of the General Statutes.

(c) The Secretary shall adopt rules regarding inspections, that, at a minimum, provide for:

(1) A general administrative schedule for inspections; and

(2) An unscheduled inspection without notice, if there is a complaint alleging the violation of any licensing rule adopted under this Article.

(d) All residential facilities, as defined in G.S. 122C-3(14)e., shall ensure that the Division of Health Service Regulation complaint hotline number is posted conspicuously in a public place in the facility. (1983, c. 718, s. 1; 1985, c. 589, s. 2; 1993, c. 539, s. 918; 1994, Ex. Sess., c. 24, s. 14(c); 2005-276, ss. 10.40A(g), 10.40A(h); 2007-182, s. 1.)

§ 122C-26. Powers of the Commission.

In addition to other powers and duties, the Commission shall exercise the following powers and duties:

(1) Adopt, amend, and repeal rules consistent with the laws of this State and the laws and regulations of the federal government to implement the provisions and purposes of this Article;

(2) Issue declaratory rulings needed to implement the provisions and purposes of this Article;

(3) Adopt rules governing appeals of decisions to approve or deny licensure under this Article;

(4) Adopt rules for the waiver of rules adopted under this Article; and

(5) Adopt rules applicable to facilities licensed under this Article that do the following:

a. Establishing personnel requirements of staff employed in facilities.

b. Establishing qualifications of facility administrators or directors.

c. Establishing requirements for death reporting including confidentiality provisions related to death reporting.

d. Establishing requirements for patient advocates.

e. Requiring facility personnel who refer clients to provider agencies to disclose any pecuniary interest the referring person has in the provider agency, or other interest that may give rise to the appearance of impropriety.

f. Establishing standardized procedures for facilities in training and record keeping of the measures taken to inform employees and volunteers of the duties imposed by G.S. 122C-66.

(6) Adopt rules providing for the licensure and accreditation of residential treatment facilities that provide services to persons with traumatic brain injury. (1983, c. 718, s. 1; 1985, c. 589, s. 2; 2000-55, s. 5; 2005-276, s. 10.33; 2009-361, s. 1; 2015-36, s. 1.)

§ 122C-27. Powers of the Secretary.

The Secretary shall have the power to do all of the following:

(1) Administer and enforce the provisions, rules, and decisions pursuant to this Article.
(2) Appoint hearing officers to conduct appeals under this Article.
(3) Prescribe by rule the contents of the application for licensure and renewal.
(4) Inspect facilities and records of each facility to be licensed under this Article under the rules and decisions pursuant to this Article.
(5) Issue a license upon a finding that the applicant and facility comply with the provisions of this Article and the rules of the Commission and the Secretary.
(6) Define by rule procedures for submission of periodic reports by facilities licensed under this Article.
(7) Grant, deny, suspend, or revoke a license under this Article.
(7a) Issue orders directing facilities not licensed under this Article that are providing services requiring a license under this Article to cease and desist from engaging in any act or practice in violation of the provisions of this Article.
(8) In accordance with rules of the Commission, make final agency decisions for appeals from the denial, suspension, or revocation of a license in accordance with G.S. 122C-24.
(9) In accordance with rules of the Commission, grant waiver for good cause of any rules implementing this Article that do not affect the health, safety, or welfare of individuals within a licensable facility. (1983, c. 718, s. 1; 1985, c. 589, s. 2; 2021-77, s. 7.1(c).)

§ 122C-27.5. Waiver of rules and increase in bed capacity during an emergency.

In the event of a declaration of a state of emergency by the Governor in accordance with Article 1A of Chapter 166A of the General Statutes, a declaration of a national emergency by the President of the United States, a declaration of a public health emergency by the Secretary of the United States Department of Health and Human Services; or to the extent necessary to allow for consistency with any temporary waiver or modification issued by the Secretary of the United States Department of Health and Human Services or the Centers for Medicare and Medicaid Services under section 1135 or 1812(f) of the Social Security Act; or when the Division of Health Service Regulation determines the existence of an emergency that poses a risk to the health or safety of clients, the Division of Health Service Regulation may do either or both of the following:

(1) Temporarily waive any rules adopted to implement this Article.
(2) Allow a facility licensed under this Article to temporarily increase its bed capacity. (2022-74, s. 9E.2(a).)

§ 122C-28. Penalties.

Operating a licensable facility without a license is a Class H felony, including a fine of one thousand dollars ($1,000) per day that the facility is in operation in violation of this Article. (1983, c. 718, s. 1; 1985, c. 589, s. 2; 1993, c. 539, s. 919; 1994, Ex. Sess., c. 24, s. 14(c); 2021-77, s. 7.2(a).)

§ 122C-28.1. Facilities in violation of this Article.

(a) If the Department has directed a facility not licensed under this Article that is providing services requiring a license under this Article to cease and desist from engaging in any act or practice in violation of this Article, then the Department shall conduct a follow-up visit to determine if the Secretary may issue a cease and desist order pursuant to G.S. 122C-27, unless a cease and desist order has already been issued.

(b) The district attorney's office with jurisdiction over the facility shall collect information on the total amount of fines collected pursuant to G.S. 122C-28 and report that information to the Department. (2021-77, s. 7.1(a).)

§ 122C-29. Injunction.

(a) Notwithstanding the existence or pursuit of any other remedy, the Secretary may, in the way provided by law, maintain an action in the name of the State for injunction or other process against any person to restrain or prevent the establishment, conduct, management, or operation of a licensable facility operating without a license or in a way that threatens the health, safety, or welfare of the individuals in the licensable facility.

(b) If any individual interferes with the proper performance or duty of the Secretary in carrying out this Article, the Secretary may institute an action in the superior court of the county in which the interference occurred for injunctive relief against the continued interference, irrespective of all other remedies at law. (1983, c. 718, s. 1; 1985, c. 589, s. 2.)

§ 122C-30. Peer review committee; immunity from liability; confidentiality.

For purposes of peer review functions of a facility licensed under the provisions of this Chapter:

(1) A member of a duly appointed peer review committee or quality assurance committee who acts without malice or fraud shall not be subject to liability for damages in any civil action on account of any act, statement, or proceeding undertaken, made, or performed within the scope of the functions of the committee; and

(2) Proceedings of a peer review or quality assurance committee, the records and materials it produces, and the material it considers shall be confidential and not considered public records within the meaning of G.S. 132-1, "Public records' defined," and shall not be subject to discovery or introduction into evidence in any civil action against a facility or a provider of professional health services that results from matters which are the subject of evaluation and review by the committee. No person who was in attendance at a meeting of the committee shall be required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of the committee or as to any findings, recommendations, evaluations, opinions, or other actions of the committee or its members. However, information, documents or records

otherwise available are not immune from discovery or use in a civil action merely because they were presented during proceedings of the committee, and nothing herein shall prevent a provider of professional health services from using such otherwise available information, documents or records in connection with an administrative hearing or civil suit relating to the medical staff membership, clinical privileges or employment of the provider. Documents otherwise available as public records within the meaning of G.S. 132-1 do not lose their status as public records merely because they were presented or considered during proceedings of the committee. A member of the committee or a person who testifies before the committee may be subpoenaed and be required to testify in a civil action as to events of which the person has knowledge independent of the peer review or quality assurance process, but cannot be asked about the person's testimony before the committee for impeachment or other purposes or about any opinions formed as a result of the committee hearings. (1989 (Reg. Sess., 1990), c. 1053, s. 2; 2004-149, s. 2.8.)

§ 122C-31. Report required upon death of client.

(a) A facility shall notify the Secretary immediately upon the death of any client of the facility that occurs within seven days of physical restraint or seclusion of the client, and shall notify the Secretary within three days of the death of any client of the facility resulting from violence, accident, suicide, or homicide. The Secretary may assess a civil penalty of not less than five hundred dollars ($500.00) and not more than one thousand dollars ($1,000) against a facility that fails to notify the Secretary of a death and the circumstances surrounding the death known to the facility. Chapter 150B of the General Statutes governs the assessment of a penalty under this section. A civil penalty owed under this section may be recovered in a civil action brought by the Secretary or the Attorney General. The clear proceeds of the penalty shall be remitted to the State Treasurer for deposit in accordance with State law.

(b) Upon receipt of notification from a facility in accordance with subsection (a) of this section, the Secretary shall notify the State protection and advocacy agency designated under the Developmental Disabilities Assistance and Bill of Rights Act 2000, 42 U.S.C. § 15001, et seq., that a person with a disability has died. The Secretary shall provide the agency access to the information about each death reported pursuant to subsection (a) of this section, including information resulting from any investigation of the death by the Department and from reports received from the Chief Medical Examiner pursuant to G.S. 130A-385. The agency shall use the information in accordance with its powers and duties under applicable State and federal law and regulations.

(c) If the death of a client of a facility occurs within seven days of the use of physical restraint or seclusion, then the Secretary shall initiate immediately an investigation of the death.

(d) An inpatient psychiatric unit of a hospital licensed under Chapter 131E of the General Statutes shall comply with this section.

(e) Nothing in this section abrogates State or federal law or requirements pertaining to the confidentiality, privilege, or other prohibition against disclosure of information provided to the Secretary or the agency. In carrying out the requirements of this section, the Secretary and the agency shall adhere to State and federal requirements of confidentiality, privilege, and other prohibitions against disclosure and release applicable to the information received under this

section. A facility or provider that makes available confidential information in accordance with this section and with State and federal law is not liable for the release of the information.

(f) The Secretary shall establish a standard reporting format for reporting deaths pursuant to this section and shall provide to facilities subject to this section a form for the facility's use in complying with this section.

(g) In addition to the reporting requirements specified in subsections (a) through (e) of this section, and pursuant to G.S. 130A-383, every State facility shall report, without redactions other than to protect confidential personnel information, the death of any client of the facility, and, if known, the death of any former client of a facility who dies within 14 days of release from the facility, regardless of the manner of death:

(1) To the medical examiner of the county in which the body of the deceased is found; and

(2) To the State protection and advocacy agency designated under the Developmental Disabilities Assistance and Bill of Rights Act 2000, 42 U.S.C. § 15001, et seq. The State protection and advocacy agency shall use the information in accordance with its powers and duties under applicable State or federal law and regulations.

(h) Notwithstanding G.S. 122C-52, and unless otherwise prohibited by State or federal law or requirements, in order to provide for greater transparency in connection with the reporting requirements specified in subsections (a) through (g) of this section, the following information in reports made pursuant to this section shall be public records within the meaning of G.S. 132-1 when reported by a State facility:

(1) The name, sex, age, and date of birth of the deceased.

(2) The name of the facility providing the report.

(3) The date, time, and location of the death.

(4) A brief description of the circumstances of death, including the manner of death, if known.

(5) A list of all entities to whom the event was reported.

(i) Notwithstanding G.S. 122C-22, all facilities, as defined in G.S. 122C-3(14), shall comply with this section. (2000-129, s. 3(a); 2007-323, ss. 19.1(e), (f); 2008-131, s. 1; 2009-299, ss. 1-4.)

§ 122C-32. Patient visitation rights for residents of residential treatment facilities.

(a) Any facility licensed under this Chapter shall allow clients to receive visitors of their choice to the fullest extent permitted under the infection and prevention control program of the facility and applicable guidelines or orders issued by the Centers for Disease Control and Prevention, the Department, local health departments, or any other government public health agency.

(b) In the event the Department finds a facility has violated any rule, regulation, guidance, directive, or law relating to a client's visitation rights, the Department may issue a warning to the facility about the violation and give the facility not more than 24 hours to allow visitation. If visitation is not allowed after the 24-hour warning period, the Department shall impose a civil penalty in an amount not less than five hundred dollars ($500.00) for each instance on each day the facility was found to have a violation. This civil penalty shall be in addition to any licensure action, fine, or civil penalty that the Department may impose pursuant to this Chapter.

(c) Notwithstanding the provisions of subsection (b) of this section, in the event that circumstances require the complete closure of a facility to visitors, the facility shall use its best efforts to develop alternate visitation protocols that would allow visitation to the greatest extent safely possible. If those alternate protocols are found by the Department, the local health departments, or any other government public health agency to violate any rule, regulation, guidance, or federal law relating to a client's visitation rights, the Department may impose a civil penalty in an amount not less than five hundred dollars ($500.00) for each instance on each day the facility was found to have a violation. This civil penalty shall be in addition to any fine or civil penalty that the Centers for Medicare and Medicaid Services or other federal agency may choose to impose and any licensure action, fine, or civil penalty that the Department may impose pursuant to this Chapter.

(d) Each facility shall provide notice of the client visitation rights in this act to clients and, when possible, family members of clients. The required notice shall also include the contact information for the agency or individuals tasked with investigating violations of facility client visitation.

(e) Subject to, and to the fullest extent permitted by, any rules, regulations, or guidelines adopted by either the Centers for Medicare and Medicaid Services or the Centers for Disease Control and Prevention or any federal law, each facility shall allow compassionate care visits. The facility may require compassionate care visitors to submit to health screenings necessary to prevent the spread of infectious diseases, and, notwithstanding anything to the contrary in this section, the facility may restrict a compassionate care visitor who does not pass a health screening requirement or who has tested positive for an infectious disease. The facility may require compassionate care visitors to adhere to infection control procedures, including wearing personal protective equipment. Compassionate care situations that require visits include, but are not limited to, the following:

(1) End-of-life situations.

(2) A resident who was living with his or her family before recently being admitted to the facility is struggling with the change in environment and lack of physical family support.

(3) A resident who is grieving after a friend or family member recently passed away.

(4) A resident who needs cueing and encouragement with eating or drinking, previously provided by family or caregivers, is experiencing weight loss or dehydration.

(5) A resident, who used to talk and interact with others, is experiencing emotional distress, seldom speaking, or crying more frequently when the resident had rarely cried in the past. (2021-171, s. 6; 2021-181, s. 2(f).)

§ 122C-33: Reserved for future codification purposes.

§ 122C-34: Reserved for future codification purposes.

§ 122C-35. (Effective once contingency met – see note) Licensure of opioid treatment program medication units and opioid treatment program mobile units.

(a) Any licensed opioid treatment program facility that intends to establish, maintain, or operate an opioid treatment program medication unit or opioid treatment program mobile unit shall

apply to the Division of Health Service Regulation on forms prescribed by the Department for certified services provided from an opioid treatment program medication unit or opioid treatment program mobile unit to be added to its license. The Commission shall adopt rules establishing the requirements for obtaining such licensure, which shall include a requirement that each opioid treatment program medication unit and each opioid treatment program mobile unit seeking to operate in this State must demonstrate satisfactory proof to the Secretary that it has (i) obtained approval from the State Opioid Treatment Authority and (ii) registered with the Department's Drug Control Unit and the federal Drug Enforcement Agency.

(b) An opioid treatment program facility shall not submit a license application to the Division of Health Service Regulation to provide certified services at an opioid treatment program facility medication unit or opioid treatment program mobile unit prior to receiving approval from the State Opioid Treatment Authority or prior to receiving confirmation of registration with the Department's Drug Control Unit and the federal Drug Enforcement Agency.

(c) The Department may issue a license to an opioid treatment program facility to provide certified services at an opioid treatment program medication unit or an opioid treatment program mobile unit if the Secretary finds that the program is in compliance with all rules adopted by the Commission regarding opioid treatment programs. The Secretary may approve or deny an application for a license to provide certified services based upon consideration of all of the following criteria:

(1) The applicant's capacity, qualifications, and experience with regard to providing treatment and operating an opioid treatment program medication unit in compliance with applicable federal and State laws, regulations, and accepted clinical standards of practice.

(2) Any history of adverse regulatory actions involving the applicant in North Carolina or another state.

(3) Any history of suspension or revocation of, or other adverse regulatory action against, any professional licenses or narcotic licenses of persons proposed to be employed in the opioid treatment program medication unit or opioid treatment program mobile unit, in North Carolina or in another state, or any adverse regulatory action against the license of the opioid treatment program facility within the 12-month period preceding the application for licensure.

(4) Any additional criteria or standards established in rules adopted by the Commission regarding opioid treatment programs.

(d) An opioid treatment program facility shall not establish, maintain, or operate an opioid treatment program medication unit or opioid treatment program mobile unit without a current license from the Secretary that includes and covers that specific medication unit or mobile unit and without first obtaining certification from the Substance Abuse and Mental Health Services Administration.

(e) An opioid treatment program mobile unit or opioid treatment program medication unit added to an opioid treatment program facility license shall be deemed part of the opioid treatment program facility license and may be subject to inspections the Department deems necessary to validate compliance with the requirements set forth in this section, applicable rules adopted by the Commission, and all applicable federal laws and regulations, including, without limitation, Substance Abuse and Mental Health Services Administration regulations in Parts 8 and 21 of Title 42 of the Code of Federal Regulations governing opioid treatment programs, and federal Drug Enforcement Agency regulations in Parts 1300, 1301, and 1304 of Title 21 of the Code of Federal

Regulations, including 21 C.F.R. § 1301.13(e), governing controlled substances, dispensers of controlled substances, mobile narcotic treatment programs, and federal Drug Enforcement Agency restraints. Substantial failure to comply with the requirements of this section, applicable rules adopted by the Commission, and applicable federal laws and regulations may result in an adverse action on a license under G.S. 122C-24 and administrative penalties under G.S. 122C-24.1. Any required services not provided in an opioid treatment program mobile unit or opioid treatment program medication unit must be conducted at the opioid treatment program facility, including medical, counseling, vocational, educational, and other assessment and treatment services.

(f) Each license issued under this section to an opioid treatment program facility to provide certified services at an opioid treatment program mobile unit or an opioid treatment program medication unit shall expire on December 31 of the year for which it was issued and shall be renewed annually by filing with the Division of Health Service Regulation on or after December 1 an application for license renewal on forms prescribed by the Department, accompanied by the required fee. License renewal shall be contingent upon (i) the applicant providing all information required by the Secretary for renewal and (ii) continued compliance with this Article and any applicable rules adopted by the Commission regarding opioid treatment programs. The Department shall charge an opioid treatment program facility a nonrefundable annual license fee plus a nonrefundable annual per-unit fee of two hundred sixty-five dollars ($265.00) for each opioid treatment program medication unit or opioid treatment program mobile unit.

(g) The opioid treatment program facility is responsible for ensuring that opioid treatment program medication units and opioid treatment program mobile medication units adhere to all State and federal requirements for opioid treatment programs.

(h) Notwithstanding G.S. 122C-25(a), an opioid treatment program facility with no previous violations of State or federal requirements for opioid treatment programs may be subject to inspection once every other year, excluding any complaint investigation. An opioid treatment program facility with either an opioid treatment program medication unit or an opioid treatment program mobile unit may be subject to annual inspections.

(i) The Commission shall adopt emergency, temporary, or permanent rules for the licensure, inspection, and operation of opioid treatment program medication units and opioid treatment program mobile units, including rules concerning any of the following:

(1) Compliance with all applicable Substance Abuse and Mental Health Services Administration and federal Drug Enforcement Agency regulations governing opioid treatment program mobile units and opioid treatment program medication units.
(2) Identification of the location of opioid treatment program medication units and opioid treatment program mobile units.
(3) Schedules for the days and hours of operation to meet client needs.
(4) Maintenance and location of records.
(5) Requisite clinical staff and staffing ratios to meet immediate client needs at each opioid treatment program medication unit or opioid treatment program mobile unit, including client needs for nursing, counseling, and medical care.
(6) Emergency staffing requirements to ensure service delivery.
(7) Criteria for policies and procedures for a clinical and individualized assessment of individuals to receive services at an opioid treatment medication unit or opioid treatment mobile unit that consider medical and clinical appropriateness and accessibility to individuals served.

(8) Number of clients allowed per opioid treatment program medication unit and opioid treatment program mobile unit, based on staffing ratios.
(9) Criteria to ensure the opioid treatment program facility is providing the required counseling to individuals receiving services at an opioid treatment program medication unit or opioid treatment program mobile unit.
(10) Criteria for the opioid treatment program facility to ensure that individuals receiving services at an opioid treatment program medication unit or opioid treatment program mobile unit receive medical interventions when necessary. (2023-65, s. 10.2.)

§ 122C-36: Reserved for future codification purposes.

§ 122C-37: Reserved for future codification purposes.

§ 122C-38: Reserved for future codification purposes.

§ 122C-39: Reserved for future codification purposes.

§ 122C-40: Reserved for future codification purposes.

§ 122C-41: Reserved for future codification purposes.

§ 122C-42: Reserved for future codification purposes.

§ 122C-43: Reserved for future codification purposes.

§ 122C-44: Reserved for future codification purposes.

§ 122C-45: Reserved for future codification purposes.

§ 122C-46: Reserved for future codification purposes.

§ 122C-47: Reserved for future codification purposes.

§ 122C-48: Reserved for future codification purposes.

§ 122C-49: Reserved for future codification purposes.

§ 122C-50: Reserved for future codification purposes.

Article 3.

Clients' Rights and Advance Instruction.

Part 1. Client's Rights.

§ 122C-51. Declaration of policy on clients' rights.

It is the policy of the State to assure basic human rights to each client of a facility. These rights include the right to dignity, privacy, humane care, and freedom from mental and physical abuse,

neglect, and exploitation. Each facility shall assure to each client the right to live as normally as possible while receiving care and treatment.

It is further the policy of this State that each client who is admitted to and is receiving services from a facility has the right to treatment, including access to medical care and habilitation, regardless of age or degree of mental illness, developmental disabilities, or substance abuse. Each client has the right to an individualized written treatment or habilitation plan setting forth a program to maximize the development or restoration of his capabilities. (1973, c. 475, s. 1; c. 1436, ss. 1, 8; 1985, c. 589, s. 2; 1989, c. 625, s. 7; 1997-442, s. 1.)

§ 122C-52. Right to confidentiality.

(a) Except as provided in G.S. 132-5 and G.S. 122C-31(h), confidential information acquired in attending or treating a client is not a public record under Chapter 132 of the General Statutes.

(b) Except as authorized by G.S. 122C-53 through G.S. 122C-56, no individual having access to confidential information may disclose this information, provided, however, a HIPAA covered entity or business associate receiving confidential information that has been disclosed pursuant to G.S. 122C-53 through G.S. 122C-56 may use and disclose such information as permitted or required under 45 Code of Federal Regulations Part 164, Subpart E.

(c) Except as provided by G.S. 122C-53 through G.S. 122C-56, each client has the right that no confidential information acquired be disclosed by the facility.

(d) No provision of G.S. 122C-205 and G.S. 122C-53 through G.S. 122C-56 permitting disclosure of confidential information may apply to the records of a client when federal statutes or regulations applicable to that client prohibit the disclosure of this information.

(e) Except as required or permitted by law, disclosure of confidential information to someone not authorized to receive the information is a Class 3 misdemeanor and is punishable only by a fine, not to exceed five hundred dollars ($500.00). (1955, c. 887, s. 12; 1963, c. 1166, s. 10; 1965, c. 800, s. 4; 1973, c. 47, s. 2; c. 476, s. 133; c. 673, s. 5; c. 1408, s. 2; 1979, c. 147; 1983, c. 383, s. 10; c. 491; c. 638, s. 22; c. 864, s. 4; 1985, c. 589, s. 2; 1985 (Reg. Sess., 1986), c. 863, s. 11; 1987, c. 749, s. 2; 1993, c. 539, s. 920; 1994, Ex. Sess., c. 24, s. 14(c); 2009-299, s. 5; 2011-314, s. 2(a).)

§ 122C-53. Exceptions; client.

(a) A facility may disclose confidential information regarding a client if the client or the legally responsible person consents in writing to the release of the information which is subject to revocation by the consenting individual. A written release that contains the core elements for authorizations as set forth in Subpart E of Part 164 of Title 45 of the Code of Federal Regulations shall be valid for the purposes of this subsection.

(b) A facility may disclose (i) the fact of admission or discharge of a client and (ii) the time and location of admission or discharge to the client's next of kin whenever the responsible professional determines that the disclosure is in the best interest of the client.

(c) Upon request a client shall have access to confidential information in the client's record except information that would be injurious to the client's physical or mental well-being as determined by the attending physician or, if there is none, by the facility director or the facility director's designee. If the attending physician or, if there is none, the facility director or the facility director's designee has refused to provide confidential information to a client, the client may

request that the information be sent to a physician or psychologist of the client's choice, and in this event the information shall be so provided.

(d) Except as provided by G.S. 90-21.4(b), upon request the legally responsible person of a client shall have access to confidential information in the client's record; except information that would be injurious to the client's physical or mental well-being as determined by the attending physician or, if there is none, by the facility director or the facility director's designee. If the attending physician or, if there is none, the facility director or the facility director's designee has refused to provide confidential information to the legally responsible person, the legally responsible person may request that the information be sent to a physician or psychologist of the legally responsible person's choice, and in this event the information shall be so provided.

(e) A client advocate's access to confidential information and the client's responsibility for safeguarding this information are as provided by subsection (g) of this section.

(f) As used in subsection (g) of this section, the following terms have the meanings specified:

(1) "Internal client advocate" means a client advocate who is employed by the facility or has a written contractual agreement with the Department or with the facility to provide monitoring and advocacy services to clients in the facility in which the client is receiving services.

(2) "External client advocate" means a client advocate acting on behalf of a particular client with the written consent and authorization under either of the following circumstances:

a. In the case of a client who is an adult and who has not been adjudicated incompetent under Chapter 35A or former Chapters 33 or 35 of the General Statutes, of the client.

b. In the case of any other client, of the client and the legally responsible person.

(g) An internal client advocate shall be granted, without the consent of the client or the legally responsible person, access to routine reports and other confidential information necessary to fulfill monitoring and advocacy functions. In this role, the internal client advocate may disclose confidential information received to the client involved, to the legally responsible person, to the director of the facility or the director's designee, to other individuals within the facility who are involved in the treatment or habilitation of the client, or to the Secretary in accordance with the rules of the Commission. Any further disclosure shall require the written consent of the client and the legally responsible person. An external client advocate shall have access to confidential information only upon the written consent of the client and his legally responsible person. In this role, the external client advocate may use the information only as authorized by the client and his legally responsible person.

(h) In accordance with G.S. 122C-205, the facility shall notify the appropriate individuals upon the escape from and subsequent return of clients to a 24-hour facility.

(i) Upon the request of (i) a client who is an adult and who has not been adjudicated incompetent under Chapter 35A or former Chapters 33 or 35 of the General Statutes, or (ii) the legally responsible person for any other client, a facility shall disclose to an attorney confidential information relating to that client. (1973, c. 475, s. 1; c. 1436, ss. 2-5; 1985, c. 589, s. 2; 1989 (Reg. Sess., 1990), c. 1024, s. 26(d); 1995, c. 507, s. 23.4; 2018-33, s. 3; 2023-95, s. 1.)

§ 122C-54. Exceptions; abuse reports and court proceedings.

(a) A facility shall disclose confidential information if a court of competent jurisdiction issues an order compelling disclosure.

(a1) Upon a determination by the facility director or the facility director's designee that disclosure is in the best interests of the client, a facility may disclose confidential information for purposes of filing a petition for involuntary commitment of a client pursuant to Article 5 of this Chapter or for purposes of filing a petition for the adjudication of incompetency of the client and the appointment of a guardian or an interim guardian under Chapter 35A of the General Statutes.

(b) If an individual is a defendant in a criminal case and a mental examination of the defendant has been ordered by the court as provided in G.S. 15A-1002, the facility shall send the results or the report of the mental examination to the clerk of court, to the district attorney or prosecuting officer, and to the attorney of record for the defendant as provided in G.S. 15A-1002(d). The report shall contain a treatment recommendation, if any, and an opinion as to whether there is a likelihood that the defendant will gain the capacity to proceed.

(c) When an individual is held at a facility under involuntary commitment or voluntary admission proceedings that require district court hearings or rehearings pursuant to Article 5 of this Chapter, certified copies of written results of examinations, gathered during the course of the current commitment or admission, shall be furnished by the facility to the client's counsel, the attorney representing the State's interest, and the court. Upon request, the facility shall disclose to respondent's counsel, the attorney representing the State's interest, and the court confidential information collected, maintained, or used in attending or treating the respondent during the proceeding for voluntary admission or involuntary commitment. Other medical records shall be furnished only upon court order. The confidentiality of client information shall be preserved in all matters except those pertaining to the necessity for admission or continued stay in the facility or commitment under review.

(d) Except as otherwise provided in this section, any individual seeking confidential information contained in the court files or the court records of a proceeding made pursuant to Article 5 of this Chapter may file a written motion in the cause setting out why the information is needed. A district court judge may issue an order to disclose the confidential information sought if he finds the order is appropriate under the circumstances and if he finds that it is in the best interest of the individual admitted or committed or of the public to have the information disclosed.

Counsel for the respondent and counsel for the State in the commitment hearing may receive access to the court file without filing a motion or obtaining a court order. A judge presiding over a criminal case that initiated the Article 5 proceeding may have access to the file without filing a motion.

Judicial officials determining whether a criminal defendant may be released before trial pursuant to G.S. 15A-533 may have access to the defendant's records of proceedings made pursuant to Article 5 of this Chapter for the purposes of determining whether a criminal defendant has been involuntarily committed within the previous three years.

(d1) Repealed by Session Laws 2015-195, s. 11(a), effective January 1, 2016.

(d2) Repealed by Session Laws 2023-8, s. 2(c), effective March 29, 2023, and applicable to pistols sold, given away, transferred, purchased, or received on or after that date.

(d3) The following persons may obtain a court file number of an involuntary commitment proceeding upon request to the clerk's office:

(1) A commitment examiner and their administrative support staff for the purpose of filing subsequent documentation into a court file.

(2) A person desiring to petition pursuant to G.S. 14-409.42 for the purpose of providing complete information in the petition.

(e) Upon the request of the legally responsible person or the minor admitted or committed, and after that minor has both been released and reached adulthood, the court records of that minor made in proceedings pursuant to Article 5 of this Chapter may be expunged from the files of the court. The minor and the minor's legally responsible person shall be informed in writing by the court of the right provided by this subsection at the time that the application for admission is filed with the court.

(f) A State facility and the psychiatric service of the University of North Carolina Hospitals at Chapel Hill may disclose confidential information to staff attorneys of the Attorney General's office whenever the information is necessary to the performance of the statutory responsibilities of the Attorney General's office or to its performance when acting as attorney for a State facility or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill.

(g) A facility may disclose confidential information to an attorney who represents either the facility or an employee of the facility, if such information is relevant to litigation, to the operations of the facility, or to the provision of services by the facility. An employee may discuss confidential information with the employee's attorney or with an attorney representing the facility in which the employee is employed.

(h) A facility shall disclose confidential information for purposes of complying with Article 3 of Chapter 7B of the General Statutes and Article 6 of Chapter 108A of the General Statutes, or as required by other State or federal law.

(i) G.S. 132-1.4 shall apply to the records of criminal investigations conducted by any law enforcement unit of a State facility, and information described in G.S. 132-1.4(c) that is collected by the State facility law enforcement unit shall be public records within the meaning of G.S. 132-1.

(j) Notwithstanding any other provision of this Chapter, the Secretary may inform any person of any incident or event involving the welfare of a client or former client when the Secretary determines that the release of the information is essential to maintaining the integrity of the Department. However, the release shall not include information that identifies the client directly, or information for which disclosure is prohibited by State or federal law or requirements, or information for which, in the Secretary's judgment, by reference to publicly known or available information, there is a reasonable basis to believe the client will be identified. (1955, c. 887, s. 12; 1963, c. 1166, s. 10; 1973, c. 47, s. 2; c. 476, s. 133; c. 673, s. 5; c. 1408, s. 2; 1977, c. 696, s. 1; 1979, c. 147; c. 915, s. 20; 1983, c. 383, s. 10; c. 491; c. 638, s. 22; c. 864, s. 4; 1985, c. 589, s. 2; 1987, c. 638, ss. 1, 3.1; 1989, c. 141, s. 9; 1993, c. 516, s. 12; 1998-202, s. 13(dd); 2003-313, s. 2; 2008-210, s. 1; 2009-299, s. 6; 2013-18, s. 7; 2013-369, ss. 7, 8; 2015-195, s. 11(a), (e); 2018-33, s. 4; 2023-8, s. 2(c); 2024-33, s. 15; 2025-93, s. 1(f).)

§ 122C-54.1: Recodified as G.S. 14-409.42 by Session Laws 2015-195, s. 11(b), effective August 5, 2015.

§ 122C-55. Exceptions; care and treatment.

(a) Any facility may share confidential information regarding any client of that facility with any other facility when necessary to coordinate appropriate and effective care, treatment, or habilitation of the client. For the purposes of this section, the following definitions apply:

(1) "Client" includes an enrollee as defined in G.S. 108D-1.

(1a) Coordinate. – The provision, coordination, or management of mental health, developmental disabilities, and substance abuse services and other health or related services by one or more facilities and includes the referral of a client from one facility to another.

(2) Facility or area facility. – Include[s] an area authority or a prepaid health plan.

(3) Secretary. – Includes any primary care case management programs that contract with the Department to provide a primary care case management program for recipients of publicly funded health and related services.

(a1) Any facility may share confidential information regarding any client of that facility with the Secretary, and the Secretary may share confidential information regarding any client with a facility when necessary to conduct quality assessment and improvement activities or to coordinate appropriate and effective care, treatment, or habilitation of the client. For purposes of this subsection, subsection (a6), and subsection (a7) of this section, the purposes or activities for which confidential information may be disclosed include, but are not limited to, case management and care coordination, disease management, outcomes evaluation, the development of clinical guidelines and protocols, the development of care management plans and systems, population-based activities relating to improving or reducing health care costs, and the provision, coordination, or management of mental health, developmental disabilities, and substance abuse services and other health or related services.

(a2) Any facility or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill may share confidential information regarding any client of that facility with any other area facility or State facility or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill when necessary to conduct payment activities relating to an individual served by the facility. Payment activities are activities undertaken by a facility to obtain payment or receive reimbursement for the provision of services and may include, but are not limited to, determinations of eligibility or coverage, coordination of benefits, determinations of cost-sharing amounts, claims management, claims processing, claims adjudication, claims appeals, billing and collection activities, medical necessity reviews, utilization management and review, precertification and preauthorization of services, concurrent and retrospective review of services, and appeals related to utilization management and review.

(a3) Whenever there is reason to believe that a client is eligible for benefits through a Department program, any facility or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill may share confidential information regarding any client of that facility with the Secretary, and the Secretary may share confidential information regarding any client with an area facility or State facility or the psychiatric services of the University of North Carolina Hospitals at Chapel Hill. Disclosure is limited to that information necessary to establish initial eligibility for benefits, determine continued eligibility over time, and obtain reimbursement for the costs of services provided to the client.

(a4) An area authority or prepaid health plan may share confidential information regarding any client with any area facility, and any area facility may share confidential information regarding any client of that facility with the area authority or prepaid health plan, when the area authority or prepaid health plan determines the disclosure is necessary to develop, manage, monitor, or evaluate the area authority's or prepaid health plan's network of qualified providers as provided in G.S. 122C-141(a), Article 3 of Chapter 108D of the General Statutes, the State Plan, rules of the Secretary, and contracts between the facility and the Department. For the purposes of this subsection, the purposes or activities for which confidential information may be disclosed include,

but are not limited to, quality assessment and improvement activities, provider accreditation and staff credentialing, developing contracts and negotiating rates, investigating and responding to client grievances and complaints, evaluating practitioner and provider performance, auditing functions, on-site monitoring, conducting consumer satisfaction studies, and collecting and analyzing performance data.

(a5) Any area facility may share confidential information with any other area facility regarding an applicant when necessary to determine whether the applicant is eligible for area facility services. For the purpose of this subsection, the term "applicant" means an individual who contacts an area facility for services.

(a6) When necessary to conduct quality assessment and improvement activities or to coordinate appropriate and effective care, treatment, or habilitation of the client, the Department's Community Care of North Carolina Program, or other primary care case management program, may disclose confidential information acquired pursuant to subsection (a1) of this section to a health care provider or other entity that has entered into a written agreement with the Community Care of North Carolina Program, or other primary care case management program, to participate in the care management support network and systems developed and maintained by the primary care case manager for the purpose of coordinating and improving the quality of care for recipients of publicly funded health and related services. Health care providers and other entities receiving confidential information that has been disclosed pursuant to this subsection may use and disclose the information as permitted or required under 45 Code of Federal Regulations Part 164, Subpart E.

(a7) A facility may share confidential information with one or more HIPAA covered entities or business associates for the same purposes set forth in subsection (a1) of this section. Before making disclosures under this subsection, the facility shall inform the client or the client's legally responsible person that the facility may make the disclosures unless the client or the client's legally responsible person objects in writing or signs a non-disclosure form that shall be supplied by the facility. If the client or the client's legally responsible person objects in writing or signs a non-disclosure form, the disclosures otherwise permitted by this subsection are prohibited. A covered entity or business associate receiving confidential information that has been disclosed by a facility pursuant to this subsection may use and disclose the information as permitted or required under 45 Code of Federal Regulations Part 164, Subpart E. This confidential information, however, shall not be used or disclosed for discriminatory purposes including, without limitation, employment discrimination, medical insurance coverage or rate discrimination, or discrimination by law enforcement officers.

(b) A facility, physician, or other individual responsible for evaluation, management, supervision, or treatment of respondents examined or committed for outpatient treatment under the provisions of Article 5 of this Chapter may request, receive, and disclose confidential information to the extent necessary to fulfill the facility's, physician's, or individual's responsibilities.

(c) A facility may furnish confidential information in its possession to the Division of Prisons of the Department of Adult Correction when requested by that department regarding any client of that facility when the inmate has been determined by the Division of Prisons of the Department of Adult Correction to be in need of treatment for mental illness, developmental disabilities, or substance abuse. The Division of Prisons of the Department of Adult Correction may furnish to a facility confidential information in its possession about treatment for mental illness, developmental disabilities, or substance abuse that the Division of Prisons of the Department of Adult Correction has provided to any present or former inmate if the inmate is presently seeking treatment from the requesting facility or if the inmate has been involuntarily

committed to the requesting facility for inpatient or outpatient treatment. Under the circumstances described in this subsection, the consent of the client or inmate is not required in order for this information to be furnished, and the information shall be furnished despite objection by the client or inmate. Confidential information disclosed pursuant to this subsection is restricted from further disclosure.

(c1) **(See editor's note for effective date information)** A facility may furnish confidential information in its possession to the sheriff of any county when requested by the sheriff regarding any client of that facility who is confined in the county's jail or jail annex when the inmate has been determined by the county jail medical unit to be in need of treatment for mental illness, developmental disabilities, or substance abuse. The sheriff may furnish to a facility confidential information in its possession about treatment for mental illness, developmental disabilities, or substance abuse that the county jail medical unit has provided to any present or former inmate if the inmate is presently seeking treatment from the requesting facility or if the inmate has been involuntarily committed to the requesting facility for inpatient or outpatient treatment. Under the circumstances described in this subsection, the consent of the client or inmate is not required in order for this information to be furnished, and the information shall be furnished despite objection by the client or inmate. Confidential information disclosed pursuant to this subsection is restricted from further disclosure.

(d) A responsible professional may disclose confidential information when in the responsible professional's opinion there is an imminent danger to the health or safety of the client or another individual or there is a likelihood of the commission of a felony or violent misdemeanor.

(e) A responsible professional may exchange confidential information with a physician or other health care provider that is providing emergency medical services to a client. Disclosure of the information is limited to that necessary to meet the emergency as determined by the responsible professional.

(e1) A State facility may furnish client identifying information to the Department for the purpose of maintaining an index of clients served in State facilities that may be used by State facilities only if that information is necessary for the appropriate and effective evaluation, care, and treatment of the client.

(e2) A responsible professional may disclose an advance instruction for mental health treatment or confidential information from an advance instruction to a physician, psychologist, or other qualified professional when the responsible professional determines that disclosure is necessary to give effect to or provide treatment in accordance with the advance instruction.

(f) A facility may disclose confidential information to a provider of support services whenever the facility has entered into a written agreement with a person to provide support services and the agreement includes a provision in which the provider of support services acknowledges that in receiving, storing, processing, or otherwise dealing with any confidential information, the provider of support services will safeguard and not further disclose the information.

(g) Whenever there is reason to believe that the client is eligible for financial benefits through a governmental agency, a facility may disclose confidential information to State, local, or federal government agencies. Except as provided in subsections (a3) and (g1) of this section, disclosure is limited to that confidential information necessary to establish financial benefits for a client. Except as provided in subsection (g1) of this section, after establishment of these benefits, the consent of the client or the client's legally responsible person is required for further release of confidential information under this subsection.

(g1) A State facility operated under the authority of G.S. 122C-181 may disclose confidential information for the purpose of collecting payment due the facility for the cost of care, treatment, or habilitation.

(g2) Whenever there is reason to believe that the client is eligible for educational services through a governmental agency, a facility shall disclose client identifying information to the Department of Public Instruction. Disclosure is limited to that information necessary to establish, coordinate, or maintain educational services. The Department of Public Instruction may further disclose client identifying information to a local school administrative unit as necessary.

(h) Within a facility, employees, students, consultants, or volunteers involved in the care, treatment, or habilitation of a client may exchange confidential information as needed for the purpose of carrying out their responsibility in serving the client.

(i) Upon specific request, a responsible professional may release confidential information to a physician or psychologist who referred the client to the facility.

(j) Upon request of the next of kin or other family member who has a legitimate role in the therapeutic services offered, or other person designated by the client or the client's legally responsible person, the responsible professional shall provide the next of kin or other family member or the designee with notification of the client's diagnosis, the prognosis, the medications prescribed, the dosage of the medications prescribed, the side effects of the medications prescribed, if any, and the progress of the client, if the client or the client's legally responsible person has consented in writing, or the client has consented orally in the presence of a witness selected by the client, prior to the release of this information. Both the client's or the legally responsible person's consent and the release of this information shall be documented in the client's medical record. This consent shall be valid for a specified length of time only and is subject to revocation by the consenting individual.

(k) Notwithstanding G.S. 122C-53(b) or G.S. 122C-206, upon request of the next of kin or other family member who has a legitimate role in the therapeutic services offered, or other person designated by the client or the client's legally responsible person, the responsible professional shall provide the next of kin, the family member, or the designee, notification of the client's admission to the facility, transfer to another facility, decision to leave the facility against medical advice, discharge from the facility, and referrals and appointment information for treatment after discharge, after notification to the client that this information has been requested.

(*l*) In response to a written request of the next of kin or other family member who has a legitimate role in the therapeutic services offered, or other person designated by the client, for additional information not provided for in subsections (j) and (k) of this section, and when the written request identifies the intended use for this information, the responsible professional shall, in a timely manner, do one or more of the following:

(1) Provide the information requested based upon the responsible professional's determination that providing this information will be to the client's therapeutic benefit, if the client or the client's legally responsible person has consented in writing to the release of the information requested.

(2) Refuse to provide the information requested based upon the responsible professional's determination that providing this information will be detrimental to the therapeutic relationship between client and professional.

(3) Refuse to provide the information requested based upon the responsible professional's determination that the next of kin or family member or designee does not have a legitimate need for the information requested.

(m) The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services shall adopt rules specifically to define the legitimate role referred to in subsections (j), (k), and (*l*) of this section. (1955, c. 887, s. 12; 1963, c. 1166, s. 10; 1973, c. 47, s. 2; c. 476, s. 133; c. 673, s. 5; c. 1408, s. 2; 1979, c. 147; 1983, c. 383, s. 10; c. 491; c. 638, s. 22; c. 864, s. 4; 1985, c. 589, s. 2; c. 695, s. 15; 1987, c. 638, ss. 2, 3; 1989, c. 141, s. 10; c. 438; c. 625, s. 8; 1989 (Reg. Sess., 1990), c. 1024, s. 27; 1991, c. 359, s. 1; c. 544, s. 1; 1998-198, s. 4; 2003-313, s. 3; 2009-65, s. 1(a), (b); 2009-487, s. 5; 2009-570, s. 43; 2011-102, ss. 3, 4; 2011-145, ss. 10.14, 19.1(h); 2011-314, s. 2(b); 2011-391, s. 23; 2014-100, s. 8.39(d); 2017-186, s. 2(kkkkk); 2018-33, s. 5; 2019-81, s. 9A; 2019-177, s. 6.1(a), (b); 2019-240, s. 26(c); 2021-180, s. 19C.9(p); 2023-134, s. 9G.7A(a3).)

§ 122C-56. Exceptions; research and planning.

(a) The Secretary may require information that does not identify clients from State and area facilities for purposes of preparing statistical reports of activities and services and for planning and study. The Secretary may also receive confidential information from State and area facilities when specifically required by other State or federal law.

(b) The Secretary may have access to confidential information from private or public agencies or agents for purposes of research and evaluation in the areas of mental health, developmental disabilities, and substance abuse. No confidential information shall be further disclosed.

(c) A facility may disclose confidential information to persons responsible for conducting general research or clinical, financial, or administrative audits if there is a justifiable documented need for this information. A person receiving the information may not directly or indirectly identify any client in any report of the research or audit or otherwise disclose client identity in any way. (1965, c. 800, s. 4; 1973, c. 476, s. 133; 1985, c. 589, s. 2; 1989, c. 625, s. 9.)

§ 122C-56.1. Exceptions; security recordings.

(a) Security recordings are not a public record under Chapter 132 of the General Statutes and are confidential information under this Chapter.

(b) A State facility is not required to disclose its security recordings unless required under federal law or compelled by a court of competent jurisdiction.

(c) A State facility shall allow viewing of security recordings by an internal client advocate.

(d) A State facility may allow viewing of a security recording by a client or their legally responsible person if, in the opinion of the responsible professional, it is determined to be in the best interest of the client. (2019-240, s. 20(b).)

§ 122C-57. Right to treatment and consent to treatment.

(a) Each client who is admitted to and is receiving services from a facility has the right to receive age-appropriate treatment for a mental illness, an intellectual or other developmental disability, substance abuse, or a combination thereof. Each client within 30 days of admission to a facility shall have an individual written treatment or habilitation plan implemented by the facility. The client and the client's legally responsible person shall be informed in advance of the potential risks and alleged benefits of the treatment choices.

(b) Each client has the right to be free from unnecessary or excessive medication. Medication shall not be used for punishment, discipline, or staff convenience.

(c) Medication shall be administered in accordance with accepted medical standards and only upon the order of a physician as documented in the client's record.

(d) Each voluntarily admitted client or the client's legally responsible person (including a health care agent named pursuant to a valid health care power of attorney) has the right to consent to or refuse any treatment offered by the facility. Consent may be withdrawn at any time by the person who gave the consent. If treatment is refused, the qualified professional shall determine whether treatment in some other modality is possible. If all appropriate treatment modalities are refused, the voluntarily admitted client may be discharged. In an emergency, a voluntarily admitted client may be administered treatment or medication, other than those specified in subsection (f) of this section, despite the refusal of the client or the client's legally responsible person, even if the client's refusal is expressed in a valid advance instruction for mental health treatment. The Commission may adopt rules to provide a procedure to be followed when a voluntarily admitted client refuses treatment.

(d1) Except as provided in G.S. 90-21.4, discharge of a voluntarily admitted minor from treatment shall include notice to and consultation with the minor's legally responsible person and in no event shall a minor be discharged from treatment upon the minor's request alone.

(e) In the case of an involuntarily committed client, treatment measures other than those requiring express written consent as specified in subsection (f) of this section may be given despite the refusal of the client, the client's legally responsible person, a health care agent named pursuant to a valid health care power of attorney, or the client's refusal expressed in a valid advance instruction for mental health treatment in the event of an emergency or when consideration of side effects related to the specific treatment measure is given and in the professional judgment, as documented in the client's record, of the treating physician and a second physician, who is either the director of clinical services of the facility, or the director's designee, that any of the following is true:

(1) The client, without the benefit of the specific treatment measure, is incapable of participating in any available treatment plan which will give the client a realistic opportunity of improving the client's condition.

(2) There is, without the benefit of the specific treatment measure, a significant possibility that the client will harm self or others before improvement of the client's condition is realized.

(f) Treatment involving electroshock therapy, the use of experimental drugs or procedures, or surgery other than emergency surgery may not be given without the express and informed written consent of the client, the client's legally responsible person, a health care agent named pursuant to a valid health care power of attorney, or the client's consent expressed in a valid advance instruction for mental health treatment. This consent may be withdrawn at any time by the person who gave the consent. The Commission may adopt rules specifying other therapeutic and diagnostic procedures that require the express and informed written consent of the client, the client's legally responsible person, or a health care agent named pursuant to a valid health care power of attorney. (1973, c. 475, s. 1; c. 1436, ss. 6, 7; 1981, c. 328, ss. 1, 2; 1985, c. 589, s. 2; 1995, c. 336, s. 1; 1997-442, s. 3; 1998-198, s. 5; 1998-217, s. 53(a)(4); 1999-456, s. 4; 2007-502, s. 15(b); 2019-76, s. 2.)

§ 122C-58. Civil rights and civil remedies.

Except as otherwise provided in this Chapter, each adult client of a facility keeps the same right as any other citizen of North Carolina to exercise all civil rights, including the right to dispose of

property, execute instruments, make purchases, enter into contractual relationships, register and vote, bring civil actions, and marry and get a divorce, unless the exercise of a civil right has been precluded by an unrevoked adjudication of incompetency. This section shall not be construed as validating the act of any client who was in fact incompetent at the time he performed the act. (1973, c. 475, s. 1; c. 1436, ss. 2-5; 1985, c. 589, s. 2.)

§ 122C-59. Use of corporal punishment.

Corporal punishment may not be inflicted upon any client. (1973, c. 475, s. 1; 1985, c. 589, s. 2.)

§ 122C-60. Use of physical restraints or seclusion.

(a) Physical restraint or seclusion of a client shall be employed only when there is imminent danger of abuse or injury to the client or others, when substantial property damage is occurring, or when the restraint or seclusion is necessary as a measure of therapeutic treatment. For purposes of this section, a technique to reenact the birthing process as defined by G.S. 14-401.21 is not a measure of therapeutic treatment. All instances of restraint or seclusion and the detailed reasons for such action shall be documented in the client's record. Each client who is restrained or secluded shall be observed frequently, and a written notation of the observation shall be made in the client's record.

(a1) A facility that employs physical restraint or seclusion of a client shall collect data on the use of the restraints and seclusion. The data shall reflect for each incidence, the type of procedure used, the length of time employed, alternatives considered or employed, and the effectiveness of the procedure or alternative employed. The facility shall analyze the data on at least a quarterly basis to monitor effectiveness, determine trends, and take corrective action where necessary. The facility shall make the data available to the Secretary upon request. Nothing in this subsection abrogates State or federal law or requirements pertaining to the confidentiality, privilege, or other prohibition against disclosure of information provided to the Secretary under this subsection. In reviewing data requested under this subsection, the Secretary shall adhere to State and federal requirements of confidentiality, privilege, and other prohibitions against disclosure and release applicable to the information received under this subsection.

(a2) Facilities shall implement policies and practices that emphasize the use of alternatives to physical restraint and seclusion. Physical restraint and seclusion may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually.

(b) The Commission shall adopt rules to implement this section. In adopting rules, the Commission shall take into consideration federal regulations and national accreditation standards. Rules adopted by the Commission shall include:

(1) Staff training and competence in:
   a. The use of positive behavioral supports.
   b. Communication strategies for defusing and deescalating potentially dangerous behavior.
   c. Monitoring vital indicators.
   d. Administration of CPR.
   e. Debriefing with client and staff.

f. Methods for determining staff competence, including qualifications of trainers and training curricula.

g. Other areas to ensure the safe and appropriate use of restraints and seclusion.

(2) Other matters relating to the use of physical restraint or seclusion of clients necessary to ensure the safety of clients and others.

The Department may investigate complaints and inspect a facility at any time to ensure compliance with this section. (1973, c. 475, s. 1; 1985, c. 589, s. 2; 2000-129, s. 1; 2003-205, s. 2.)

§ 122C-61. Treatment rights in 24-hour facilities.

In addition to the rights set forth in G.S. 122C-57, each client who is receiving services at a 24-hour facility has the following rights:

(1) The right to receive necessary treatment for and prevention of physical ailments based upon the client's condition and projected length of stay. The facility may seek to collect appropriate reimbursement for its costs in providing the treatment and prevention; and

(2) The right to have, as soon as practical during treatment or habilitation but not later than the time of discharge, an individualized written discharge plan containing recommendations for further services designed to enable the client to live as normally as possible. A discharge plan may not be required when it is not feasible because of an unanticipated discontinuation of a client's treatment. With the consent of the client or his legally responsible person, the professionals responsible for the plans shall contact appropriate agencies at the client's destination or in his home community before formulating the recommendations. A copy of the plan shall be furnished to the client or to his legally responsible person and, with the consent of the client, to the client's next of kin. (1973, c. 475, s. 1; c. 1436, ss. 6, 7; 1981, c. 328, ss. 1, 2; 1985, c. 589, s. 2.)

§ 122C-62. Additional rights in 24-hour facilities.

(a) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-61, each adult client who is receiving treatment or habilitation in a 24-hour facility keeps the right to:

(1) Send and receive sealed mail and have access to writing material, postage, and staff assistance when necessary;

(2) Contact and consult with, at his own expense and at no cost to the facility, legal counsel, private physicians, and private mental health, developmental disabilities, or substance abuse professionals of his choice; and

(3) Contact and consult with a client advocate if there is a client advocate.

The rights specified in this subsection may not be restricted by the facility and each adult client may exercise these rights at all reasonable times.

(b) Except as provided in subsections (e) and (h) of this section, each adult client who is receiving treatment or habilitation in a 24-hour facility at all times keeps the right to:

(1) Make and receive confidential telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party;

(2) Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over therapies;
(3) Communicate and meet under appropriate supervision with individuals of his own choice upon the consent of the individuals;
(4) Make visits outside the custody of the facility unless:
a. Commitment proceedings were initiated as the result of the client's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found not guilty by reason of insanity or incapable of proceeding;
b. The client was voluntarily admitted or committed to the facility while under order of commitment to a correctional facility of the Division of Prisons of the Department of Adult Correction; or
c. The client is being held to determine capacity to proceed pursuant to G.S. 15A-1002;

A court order may expressly authorize visits otherwise prohibited by the existence of the conditions prescribed by this subdivision;
(5) Be out of doors daily and have access to facilities and equipment for physical exercise several times a week;
(6) Except as prohibited by law, keep and use personal clothing and possessions, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002;
(7) Participate in religious worship;
(8) Keep and spend a reasonable sum of his own money;
(9) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes; and
(10) Have access to individual storage space for his private use.

(c) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-57 and G.S. 122C-59 through G.S. 122C-61, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to have access to proper adult supervision and guidance. In recognition of the minor's status as a developing individual, the minor shall be provided opportunities to enable him to mature physically, emotionally, intellectually, socially, and vocationally. In view of the physical, emotional, and intellectual immaturity of the minor, the 24-hour facility shall provide appropriate structure, supervision and control consistent with the rights given to the minor pursuant to this Part. The facility shall also, where practical, make reasonable efforts to ensure that each minor client receives treatment apart and separate from adult clients unless the treatment needs of the minor client dictate otherwise.

Each minor client who is receiving treatment or habilitation from a 24-hour facility has the right to:

(1) Communicate and consult with his parents or guardian or the agency or individual having legal custody of him;
(2) Contact and consult with, at his own expense or that of his legally responsible person and at no cost to the facility, legal counsel, private physicians, private mental health, developmental disabilities, or substance abuse professionals, of his or his legally responsible person's choice; and
(3) Contact and consult with a client advocate, if there is a client advocate.

The rights specified in this subsection may not be restricted by the facility and each minor client may exercise these rights at all reasonable times.

(d) Except as provided in subsections (e) and (h) of this section, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to:

(1) Make and receive telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party;

(2) Send and receive mail and have access to writing materials, postage, and staff assistance when necessary;

(3) Under appropriate supervision, receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over school or therapies;

(4) Receive special education and vocational training in accordance with federal and State law;

(5) Be out of doors daily and participate in play, recreation, and physical exercise on a regular basis in accordance with his needs;

(6) Except as prohibited by law, keep and use personal clothing and possessions under appropriate supervision, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002;

(7) Participate in religious worship;

(8) Have access to individual storage space for the safekeeping of personal belongings;

(9) Have access to and spend a reasonable sum of his own money; and

(10) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes.

(e) No right enumerated in subsections (b) or (d) of this section may be limited or restricted except by the qualified professional responsible for the formulation of the client's treatment or habilitation plan. A written statement shall be placed in the client's record that indicates the detailed reason for the restriction. The restriction shall be reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional at least every seven days, at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's record. Restrictions on rights may be renewed only by a written statement entered by the qualified professional in the client's record that states the reason for the renewal of the restriction. In the case of an adult client who has not been adjudicated incompetent, in each instance of an initial restriction or renewal of a restriction of rights, an individual designated by the client shall, upon the consent of the client, be notified of the restriction and of the reason for it. In the case of a minor client or an incompetent adult client, the legally responsible person shall be notified of each instance of an initial restriction or renewal of a restriction of rights and of the reason for it. Notification of the designated individual or legally responsible person shall be documented in writing in the client's record.

(f) The Commission may adopt rules to implement subsection (e) of this section.

(g) With regard to clients being held to determine capacity to proceed pursuant to G.S. 15A-1002 or clients in a facility for substance abuse, and notwithstanding the prior provisions of this section, the Commission may adopt rules restricting the rights set forth under (b)(2), (b)(3),

and (d)(3) of this section if restrictions are necessary and reasonable in order to protect the health, safety, and welfare of the client involved or other clients.

(h) The rights stated in subdivisions (b)(2), (b)(4), (b)(5), (b)(10), (d)(3), (d)(5) and (d)(8) may be modified in a general hospital by that hospital to be the same as for other patients in that hospital; provided that any restriction of a specific client's rights shall be done in accordance with the provisions of subsection (e) of this section. (1973, c. 475, s. 1; c. 1436, ss. 2-5, 8; 1985, c. 589, s. 2; 1989, c. 625, s. 10; 1995, c. 299, s. 2; 1997-456, s. 27; 2011-145, s. 19.1(h); 2017-186, s. 2(*llll*); 2021-180, s. 19C.9(p).)

§ 122C-63. Assurance for continuity of care for individuals with intellectual disabilities.

(a) Any individual with an intellectual disability admitted for residential care or treatment for other than respite or emergency care to any residential facility operated under the authority of this Chapter and supported all or in part by State-appropriated funds has the right to residential placement in an alternative facility if the client is in need of placement and if the original facility can no longer provide the necessary care or treatment.

(b) The operator of a residential facility providing residential care or treatment, for other than respite or emergency care, for individuals with intellectual disabilities shall notify the area authority serving the client's county of residence of the operator's intent to close a facility or to discharge a client who may be in need of continuing care at least 60 days prior to the closing or discharge.

The operator's notification to the area authority of intent to close a facility or to discharge a client who may be in need of continuing care constitutes the operator's acknowledgement of the obligation to continue to serve the client until whichever of the following occurs first:

(1) The area authority determines that the client is not in need of continuing care.
(2) The client is moved to an alternative residential placement.
(3) Sixty days have elapsed.

In cases in which the safety of the client who may be in need of continuing care, of other clients, of the staff of the residential facility, or of the general public, is concerned, this 60-day notification period may be waived by securing an emergency placement in a more secure and safe facility. The operator of the residential facility shall notify the area authority that an emergency placement has been arranged within 24 hours of the placement. The area authority and the Secretary shall retain their respective responsibilities upon receipt of this notice.

(c) An individual who may be in need of continuing care may be discharged from a residential facility without further claim for continuing care against the area authority or the State if any of the following is true:

(1) After the parent or guardian, if the client is a minor or an adjudicated incompetent adult, or the client, if an adult not adjudicated incompetent, has entered into a contract with the operator upon the client's admission to the original residential facility, the parent, guardian, or client who entered into the contract refuses to carry out the contract.
(2) After an alternative placement for a client in need of continuing care is located, the parent or guardian who admitted the client to the residential facility, if the client is a minor or an adjudicated incompetent adult, or the client, if the client is an adult not adjudicated incompetent, refuses the alternative placement.

(d) Decisions made by the area authority regarding the need for continued placement or regarding the availability of an alternative placement of a client may be appealed pursuant to the

appeals process of the area authority and subsequently to the Secretary or the Commission under their rules. If the appeal process extends beyond the operator's 60-day obligation to continue to serve the client, the Secretary shall arrange a temporary placement in a State developmental center pending the outcome of the appeal.

(e) The area authority that serves the county of residence of the client is responsible for assessing the need for continuity of care and for the coordination of the placement among available public and private facilities whenever the authority is notified that a client may be in need of continuing care. If an alternative placement is not available beyond the operator's 60-day obligation to continue to serve the client, the Secretary shall arrange for a temporary placement in a State developmental center. The area authority shall retain responsibility for coordination of placement during a temporary placement in a State developmental center.

(f) The Secretary is responsible for coordinative and financial assistance to the area authority in the performing of its duties to coordinate placement so as to assure continuity of care and for assuring a continuity of care placement beyond the operator's 60-day obligation period.

(g) The area authority's financial responsibility, through local and allocated State resources, is limited to the following:

(1) Costs relating to the identification and coordination of alternative placements.

(2) If the original facility is an area facility, maintenance of the client in the original facility for up to 60 days.

(3) Release of allocated categorical State funds used to support the care or treatment of the specific client at the time of alternative placement if the Secretary requires the release.

(h) In accordance with G.S. 143B-147(a)(1) the Commission shall develop programmatic rules to implement this section, and, in accordance with G.S. 122C-112(a)(6), the Secretary shall adopt budgetary rules to implement this section. (1981, c. 1012; 1985, c. 589, s. 2; 2019-76, s. 3.)

§ 122C-64. Client rights and human rights committees.

Client rights and human rights committees responsible for protecting the rights of clients shall be established at each State facility, for each local management entity, and provider agency. The Commission shall adopt rules for the establishment, composition, and duties of the committees and procedures for appointment and coordination with the State and Local Consumer Advocacy programs. The membership of the client rights and human rights committee for a multicounty program or local management entity shall include a representative from each of the participating counties. (1985-589, s. 2; 2001-437, s. 1.3; 2009-190, s. 1.)

§ 122C-65. Offenses relating to clients.

(a) For the protection of clients receiving treatment or habilitation in a 24-hour facility, it is unlawful for any individual who is not a developmentally disabled client in a facility:

(1) To assist, advise, or solicit, or to offer to assist, advise, or solicit a client of a facility to leave without authority;

(2) To transport or to offer to transport a client of a facility to or from any place without the facility's authority;

(3) To receive or to offer to receive a minor client of a facility into any place, structure, building, or conveyance for the purpose of engaging in any act that would constitute a sex offense, or to solicit a minor client of a facility to engage in any act that would constitute a sex offense;

(4) To hide an individual who has left a facility without authority; or

(5) To engage in, or offer to engage in an act with a client of a facility that would constitute a sex offense.

(b) Violation of this section is a Class 1 misdemeanor. (1899, c. 1, s. 53; Rev., s. 3694; C.S., s. 6171; 1963, c. 1184, ss. 1, 6; 1985, c. 589, s. 2; 1989, c. 625, s. 11; 1993, c. 539, s. 921; 1994, Ex. Sess., c. 24, s. 14(c).)

§ 122C-66. Protection from abuse and exploitation; reporting.

(a) An employee of or a volunteer at a facility who, other than as a part of generally accepted medical or therapeutic procedure, knowingly causes pain or injury to a client is guilty of a Class A1 misdemeanor. Any employee or volunteer who uses reasonable force to carry out the provisions of G.S. 122C-60 or to protect himself or others from a violent client does not violate this subsection.

(a1) An employee of or a volunteer at a facility who borrows or takes personal property from a client is guilty of a Class 1 misdemeanor. Any employee or volunteer who uses reasonable force to carry out the provisions of G.S. 122C-60 or to protect himself or others from a violent client does not violate this subsection.

(b) An employee of or a volunteer at a facility who witnesses or has knowledge of a violation of subsection (a), subsection (a1), or of an accidental injury to a client shall report the violation or accidental injury to authorized personnel designated by the facility. No employee making a report may be threatened or harassed by any other employee or volunteer on account of the report. Violation of this subsection is a Class 1 misdemeanor.

(b1) The employee of or a volunteer at a facility who witnesses a client become a victim of a violation of Article 7A or Article 26 of Chapter 14 of the General Statutes shall report the allegations within 24 hours after witnessing the violation to one of the following: (i) the department of social services in the county where the facility serves the client; (ii) the district attorney in the district where the facility serves the client; or (iii) the appropriate local law enforcement agency in the city or county where the facility serves the client. A violation of this section is a Class A1 misdemeanor. No employee making a report may be threatened or harassed by any other employee or volunteer on account of the report.

(c) The identity of an individual who makes a report under this section or who cooperates in an ensuing investigation may not be disclosed without the reporting individual's consent, except to persons authorized by the facility or by State or federal law to investigate or prosecute these incidents, or in a grievance or personnel hearing or civil or criminal action in which the reporting individual is testifying, or when disclosure is legally compelled or authorized by judicial discovery. This subsection shall not be interpreted to require the disclosure of the identity of an individual where it is otherwise prohibited by law.

(d) An employee who makes a report in good faith under this section is immune from any civil liability that might otherwise occur for the report. In any case involving liability, making of a report under this section is prima facie evidence that the maker acted in good faith.

(e) The duty imposed by this section is in addition to any duty imposed by G.S. 7B-301 or G.S. 108A-102.

(f) Except for reports made pursuant to subsection (b1) of this section, the facility shall investigate or provide for the investigation of all reports made under the provisions of this section.

(g) The county department of social services and the district attorney to whom a report is made under subsection (b1) of this section shall investigate or provide for the investigation of each

such report. (1985, c. 589, s. 2; 1993, c. 539, ss. 922, 923; 1994, Ex. Sess., c. 24, s. 14(c); 1998-202, s. 13(ee); 2015-36, s. 2.)

§ 122C-67. Other rules regarding abuse, exploitation, neglect not prohibited.

G.S. 122C-66 does not prohibit the Commission from adopting rules for State and area facilities and does not prohibit other facilities from issuing policies regarding other forms of prohibited abuse, exploitation, or neglect. (1985, c. 589, s. 2.)

§ 122C-68. Reserved for future codification purposes.

§ 122C-69. Reserved for future codification purposes.

§ 122C-70. Reserved for future codification purposes.

Part 2. Advance Instruction for Mental Health Treatment.

§ 122C-71. Purpose.

(a) The General Assembly recognizes as a matter of public policy the fundamental right of an individual to control the decisions relating to the individual's mental health care.

(b) The purpose of this Part is to establish an additional, nonexclusive method for an individual to exercise the right to consent to or refuse mental health treatment when the individual lacks sufficient understanding or capacity to make or communicate mental health treatment decisions.

(c) This Part is intended and shall be construed to be consistent with the provisions of Article 3 of Chapter 32A of the General Statutes, provided that in the event of a conflict between the provisions of this Part and Article 3 of Chapter 32A, the provisions of this Part control. (1997-442, s. 2; 1998-198, s. 2.)

§ 122C-72. Definitions.

As used in this Part, unless the context clearly requires otherwise, the following terms have the meanings specified:

(1) "Advance instruction for mental health treatment" or "advance instruction" means a written instrument, signed in the presence of two qualified witnesses who believe the principal to be of sound mind at the time of the signing, and acknowledged before a notary public, pursuant to which the principal makes a declaration of instructions, information, and preferences regarding the principal's mental health treatment and states that the principal is aware that the advance instruction authorizes a mental health treatment provider to act according to the instruction. It may also state the principal's instructions regarding, but not limited to, consent to or refusal of mental health treatment when the principal is incapable.

(2) "Attending physician" means the physician who has primary responsibility for the care and treatment of the principal.

(3) Repealed by Session Laws 1998-198, s. 2.

(4) "Incapable" means that, in the opinion of a physician or eligible psychologist, the person currently lacks sufficient understanding or capacity to make and

communicate mental health treatment decisions. As used in this Part, the term "eligible psychologist" has the meaning given in G.S. 122C-3(13d).

(5) "Mental health treatment" means the process of providing for the physical, emotional, psychological, and social needs of the principal for the principal's mental illness. "Mental health treatment" includes, but is not limited to, electroconvulsive treatment (ECT), commonly referred to as "shock treatment", treatment of mental illness with psychotropic medication, and admission to and retention in a facility for care or treatment of mental illness.

(6) "Principal" means the person making the advance instruction.

(7) "Qualified witness" means a witness who affirms that the principal is personally known to the witness, that the principal signed or acknowledged the principal's signature on the advance instruction in the presence of the witness, that the witness believes the principal to be of sound mind and not to be under duress, fraud, or undue influence, and that the witness is not:

a. The attending physician or mental health service provider or an employee of the physician or mental health treatment provider;

b. An owner, operator, or employee of an owner or operator of a health care facility in which the principal is a patient or resident; or

c. Related within the third degree to the principal or to the principal's spouse. (1997-442, s. 2; 1998-198, s. 2.)

§ 122C-73. Scope, use, and authority of advance instruction for mental health treatment.

(a) Any adult of sound mind may make an advance instruction regarding mental health treatment. The advance instruction may include consent to or refusal of mental health treatment.

(b) An advance instruction may include, but is not limited to, the names and telephone numbers of individuals to be contacted in case of a mental health crisis, situations that may cause the principal to experience a mental health crisis, responses that may assist the principal to remain in the principal's home during a mental health crisis, the types of assistance that may help stabilize the principal if it becomes necessary to enter a facility, and medications that the principal is taking or has taken in the past and the effects of those medications.

(c) An individual shall not be required to execute or to refrain from executing an advance instruction as a condition for insurance coverage, as a condition for receiving mental or physical health services, as a condition for receiving privileges while in a facility, or as a condition of discharge from a facility.

(c1) A principal, through an advance instruction, may grant or withhold authority for mental health treatment, including, but not limited to, the use of psychotropic medication, electroconvulsive treatment, and admission to and retention in a facility for the care or treatment of mental illness.

(d) A principal may nominate, by advance instruction for mental health treatment, the guardian of the person of the principal if a guardianship proceeding is thereafter commenced. The court shall make its appointment in accordance with the principal's most recent nomination in an unrevoked advance instruction for mental health treatment, except for good cause shown.

(e) If, following the execution of an advance instruction for mental health treatment, a court of competent jurisdiction appoints a guardian of the person of the principal, or a general guardian with powers over the person of the principal, the guardian shall follow the advance instruction consistent with G.S. 35A-1201(a)(5).

(f) An advance instruction for mental health treatment may be combined with a health care power of attorney or general power of attorney that is executed in accordance with the requirements of Chapter 32A or Chapter 32C of the General Statutes so long as each form shall be executed in accordance with its own statute. (1997-442, s. 2; 1998-198, s. 2; 2017-153, s. 2.7.)

§ 122C-74. Effectiveness and duration; revocation.

(a) A validly executed advance instruction becomes effective upon its proper execution and remains valid unless revoked.

(b) The attending physician or other mental health treatment provider may consider valid and rely upon an advance instruction, or a copy of that advance instruction that is obtained from the Advance Health Care Directive Registry maintained by the Secretary of State pursuant to Article 21 of Chapter 130A of the General Statutes, in the absence of actual knowledge of its revocation or invalidity.

(c) An attending physician or other mental health treatment provider may presume that a person who executed an advance instruction in accordance with this Part was of sound mind and acted voluntarily when he or she executed the advance instruction.

(d) An attending physician or other mental health treatment provider shall act in accordance with an advance instruction when the principal has been determined to be incapable. If a patient is incapable, an advance instruction executed in accordance with this Article is presumed to be valid.

(e) The attending physician or mental health treatment provider shall continue to obtain the principal's informed consent to all mental health treatment decisions when the principal is capable of providing informed consent or refusal, as required by G.S. 122C-57. Unless the principal is deemed incapable by the attending physician or eligible psychologist, the instructions of the principal at the time of treatment shall supersede the declarations expressed in the principal's advance instruction.

(f) The fact of a principal's having executed an advance instruction shall not be considered an indication of a principal's capacity to make or communicate mental health treatment decisions at such times as those decisions are required.

(g) Upon being presented with an advance instruction, an attending physician or other mental health treatment provider shall make the advance instruction a part of the principal's medical record. When acting under authority of an advance instruction, an attending physician or other mental health treatment provider shall comply with the advance instruction unless:

(1) Compliance, in the opinion of the attending physician or other mental health treatment provider, is not consistent with generally accepted community practice standards of treatment to benefit the principal;
(2) Compliance is not consistent with the availability of treatments requested;
(3) Compliance is not consistent with applicable law;
(4) The principal is committed to a 24-hour facility pursuant to Article 5 of Chapter 122C of the General Statutes, and treatment is authorized in compliance with G.S. 122C-57 and rules adopted pursuant to it; or
(5) Compliance, in the opinion of the attending physician or other mental health treatment provider, is not consistent with appropriate treatment in case of an emergency endangering life or health.

In the event that one part of the advance instruction is unable to be followed because of one or more of the above, all other parts of the advance instruction shall nonetheless be followed.

(h) If the attending physician or other mental health treatment provider is unwilling at any time to comply with any part or parts of an advance instruction for one or more of the reasons set out in subdivisions (1) through (5) of subsection (g), the attending physician or other mental health care treatment provider shall promptly notify the principal and, if applicable, the health care agent and shall document the reason for not complying with the advance instruction and shall document the notification in the principal's medical record.

(i) An advance instruction does not limit any authority provided in Article 5 of G.S. 122C either to take a person into custody, or to admit, retain, or treat a person in a facility.

(j) An advance instruction may be revoked at any time by the principal so long as the principal is not incapable. The principal may exercise this right of revocation in any manner by which the principal is able to communicate an intent to revoke and by notifying the revocation to the treating physician or other mental health treatment provider. The attending physician or other mental health treatment provider shall note the revocation as part of the principal's medical record. (1997-442, s. 2; 1998-198, s. 2; 2001-455, s. 5; 2001-513, s. 30(b).)

§ 122C-75. Reliance on advance instruction for mental health treatment.

(a) An attending physician or eligible psychologist who in good faith determines that the principal is or is not incapable for the purpose of deciding whether to proceed or not to proceed according to an advance instruction, is not subject to criminal prosecution, civil liability, or professional disciplinary action for making and acting upon that determination.

(b) In the absence of actual knowledge of the revocation of an advance instruction, no attending physician or other mental health treatment provider shall be subject to criminal prosecution or civil liability or be deemed to have engaged in unprofessional conduct as a result of the provision of treatment to a principal in accordance with this Part unless the absence of actual knowledge resulted from the negligence of the attending physician or mental health treatment provider.

(c) An attending physician or mental health treatment provider who administers or does not administer mental health treatment according to and in good faith reliance upon the validity of an advance instruction is not subject to criminal prosecution, civil liability, or professional disciplinary action resulting from a subsequent finding of an advance instruction's invalidity.

(d) No attending physician or mental health treatment provider who administers or does not administer treatment under authorization obtained pursuant to this Part shall incur liability arising out of a claim to the extent that the claim is based on lack of informed consent or authorization for this action.

(e) This section shall not be construed as affecting or limiting any liability that arises out of a negligent act or omission in connection with the medical diagnosis, care, or treatment of a principal under an advance instruction or that arises out of any deviation from reasonable medical standards. (1997-442, s. 2; 1998-198, s. 2.)

§ 122C-76. Penalty.

It is a Class 2 misdemeanor for a person, without authorization of the principal, willfully to alter, forge, conceal, or destroy an instrument, the reinstatement or revocation of an instrument, or any other evidence or document reflecting the principal's desires and interests, with the intent or effect of affecting a mental health treatment decision. (1997-442, s. 2.)

§ 122C-77. Statutory form for advance instruction for mental health treatment.

(a) This Part shall not be construed to invalidate an advance instruction for mental health treatment that was executed and was otherwise valid.

(b) The use of the following or similar form after the effective date of this Part in the creation of an advance instruction for mental health treatment is lawful, and, when used, it shall specifically meet the requirements and be construed in accordance with the provisions of this Part.

"ADVANCE INSTRUCTION FOR MENTAL HEALTH TREATMENT

I, _____, being an adult of sound mind, willfully and voluntarily make this advance instruction for mental health treatment to be followed if it is determined by a physician or eligible psychologist that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment. "Mental health treatment" means the process of providing for the physical, emotional, psychological, and social needs of the principal. "Mental health treatment" includes electroconvulsive treatment (ECT), commonly referred to as "shock treatment", treatment of mental illness with psychotropic medication, and admission to and retention in a facility for care or treatment of mental illness.

I understand that under G.S. 122C-57, other than for specific exceptions stated there, mental health treatment may not be administered without my express and informed written consent or, if I am incapable of giving my informed consent, the express and informed consent of my legally responsible person, my health care agent named pursuant to a valid health care power of attorney, or my consent expressed in this advance instruction for mental health treatment. I understand that I may become incapable of giving or withholding informed consent for mental health treatment due to the symptoms of a diagnosed mental disorder. These symptoms may include:

PSYCHOACTIVE MEDICATIONS

If I become incapable of giving or withholding informed consent for mental health treatment, my instructions regarding psychoactive medications are as follows: (Place initials beside choice.)

_____ I consent to the administration of the following medications:

_____ I do not consent to the administration of the following medications:

_____

_____

Conditions or limitations:_____

_____

_____

ADMISSION TO AND RETENTION IN FACILITY

If I become incapable of giving or withholding informed consent for mental health treatment, my instructions regarding admission to and retention in a health care facility for mental health treatment are as follows: (Place initials beside choice.)

_____ I consent to being admitted to a health care facility for mental health treatment.

My facility preference is_____
_____ I do not consent to being admitted to a health care facility for mental health treatment.
This advance instruction cannot, by law, provide consent to retain me in a facility for more than 15 days.
Conditions or limitations_____
_____

ADDITIONAL INSTRUCTIONS

These instructions shall apply during the entire length of my incapacity.
In case of mental health crisis, please contact:

1. Name:_____
   Home Address:_____
   Home Telephone Number:_____
   Work Telephone Number:_____
   Relationship to Me:_____
2. Name:_____
   Home Address:_____
   Home Telephone Number:_____
   Work Telephone Number:_____
   Relationship to Me:_____
3. My Physician:
   Name:_____
   Telephone Number:_____
4. My Therapist:
   Name:_____
   Telephone Number:_____

The following may cause me to experience a mental health crisis:
_____
_____
The following may help me avoid a hospitalization:_____
_____
_____
I generally react to being hospitalized as follows:_____
_____
_____
Staff of the hospital or crisis unit can help me by doing the following:
_____
_____
_____
I give permission for the following person or people to visit me:
_____
_____
_____

Instructions concerning any other medical interventions, such as electroconvulsive (ECT) treatment (commonly referred to as "shock treatment"):

_____
_____
_____
_____

Other instructions:_____
_____
_____
_____
_____

_____ I have attached an additional sheet of instructions to be followed and considered part of this advance instruction.

SHARING OF INFORMATION BY PROVIDERS

I understand that the information in this document may be shared by my mental health treatment provider with any other mental health treatment provider who may serve me when necessary to provide treatment in accordance with this advance instruction.
Other instructions about sharing of information:

_____
_____

SIGNATURE OF PRINCIPAL

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full impact of having made this advance instruction for mental health treatment.

_____

Signature of Principal Date

NATURE OF WITNESSES

I hereby state that the principal is personally known to me, that the principal signed or acknowledged the principal's signature on this advance instruction for mental health treatment in my presence, that the principal appears to be of sound mind and not under duress, fraud, or undue influence, and that I am not:

a. The attending physician or mental health service provider or an employee of the physician or mental health treatment provider;
b. An owner, operator, or employee of an owner or operator of a health care facility in which the principal is a patient or resident; or
c. Related within the third degree to the principal or to the principal's spouse.

AFFIRMATION OF WITNESSES

We affirm that the principal is personally known to us, that the principal signed or acknowledged the principal's signature on this advance instruction for mental health treatment in our presence, that the principal appears to be of sound mind and not under duress, fraud, or undue influence, and that neither of us is:

A person appointed as an attorney-in-fact by this document;

The principal's attending physician or mental health service provider or a relative of the physician or provider;

The owner, operator, or relative of an owner or operator of a facility in which the principal is a patient or resident; or

A person related to the principal by blood, marriage, or adoption.

Witnessed by:

Witness:_____ Date:_____

Witness:_____ Date:_____

STATE OF NORTH CAROLINA

COUNTY OF_____

CERTIFICATION OF NOTARY PUBLIC

STATE OF NORTH CAROLINA

COUNTY OF

I, _____, a Notary Public for the County cited above in the State of North Carolina, hereby certify that _____ appeared before me and swore or affirmed to me and to the witnesses in my presence that this instrument is an advance instruction for mental health treatment, and that he/she willingly and voluntarily made and executed it as his/her free act and deed for the purposes expressed in it.

I further certify that _____and _____, witnesses, appeared before me and swore or affirmed that they witnessed _____ sign the attached advance instruction for mental health treatment, believing him/her to be of sound mind; and also swore that at the time they witnessed the signing they were not (i) the attending physician or mental health treatment provider or an employee of the physician or mental health treatment provider and (ii) they were not an owner, operator, or employee of an owner or operator of a health care facility in which the principal is a patient or resident, and (iii) they were not related within the third degree to the principal or to the principal's spouse. I further certify that I am satisfied as to the genuineness and due execution of the instrument.

This is the _____ day of_____,_____

_____

Notary Public

My Commission expires:

NOTICE TO PERSON MAKING AN INSTRUCTION FOR MENTAL HEALTH TREATMENT

This is an important legal document. It creates an instruction for mental health treatment. Before signing this document you should know these important facts:

This document allows you to make decisions in advance about certain types of mental health treatment. The instructions you include in this declaration will be followed if a physician or eligible psychologist determines that you are incapable of making and communicating treatment decisions. Otherwise you will be considered capable to give or withhold consent for the treatments. Your instructions may be overridden if you are being held in accordance with civil commitment

law. Under the Health Care Power of Attorney you may also appoint a person as your health care agent to make treatment decisions for you if you become incapable. You have the right to revoke this document at any time you have not been determined to be incapable. YOU MAY NOT REVOKE THIS ADVANCE INSTRUCTION WHEN YOU ARE FOUND INCAPABLE BY A PHYSICIAN OR OTHER AUTHORIZED MENTAL HEALTH TREATMENT PROVIDER. A revocation is effective when it is communicated to your attending physician or other provider. The physician or other provider shall note the revocation in your medical record. To be valid, this advance instruction must be signed by two qualified witnesses, personally known to you, who are present when you sign or acknowledge your signature. It must also be acknowledged before a notary public.

NOTICE TO PHYSICIAN OR OTHER MENTAL HEALTH TREATMENT PROVIDER

Under North Carolina law, a person may use this advance instruction to provide consent for future mental health treatment if the person later becomes incapable of making those decisions. Under the Health Care Power of Attorney the person may also appoint a health care agent to make mental health treatment decisions for the person when incapable. A person is "incapable" when in the opinion of a physician or eligible psychologist the person currently lacks sufficient understanding or capacity to make and communicate mental health treatment decisions. This document becomes effective upon its proper execution and remains valid unless revoked. Upon being presented with this advance instruction, the physician or other provider must make it a part of the person's medical record. The attending physician or other mental health treatment provider must act in accordance with the statements expressed in the advance instruction when the person is determined to be incapable, unless compliance is not consistent with G.S. 122C-74(g). The physician or other mental health treatment provider shall promptly notify the principal and, if applicable, the health care agent, and document noncompliance with any part of an advance instruction in the principal's medical record. The physician or other mental health treatment provider may rely upon the authority of a signed, witnessed, dated, and notarized advance instruction, as provided in G.S. 122C-75."

(1997-442, s. 2; 1998-198, s. 2; 1998-217, s. 53(a)(5); 2019-240, s. 26(d).)

§ 122C-78. Reserved for future codification purposes.

§ 122C-79. Reserved for future codification purposes.

Article 3A.

Miscellaneous Provisions.

§ 122C-80. Criminal history record check required for certain applicants for employment.

(a) Definition. – As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter.

(b) Requirement. – An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on

consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the State Bureau of Investigation under G.S. 143B-1209.20 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 143B-1209.20, the State Bureau of Investigation shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the State Bureau of Investigation data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the State Bureau of Investigation. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency.

(c) Action. – If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant:

(1) The level and seriousness of the crime.
(2) The date of the crime.
(3) The age of the person at the time of the conviction.
(4) The circumstances surrounding the commission of the crime, if known.
(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.
(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.
(7) The subsequent commission by the person of a relevant offense.

The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.

(d) Limited Immunity. – A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for:

(1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual.

(2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section.

(e) Relevant Offense. – As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7B, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots, Civil Disorders, and Emergencies; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.

(f) Penalty for Furnishing False Information. – Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor.

(g) Conditional Employment. – A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met:

(1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 143B-1209.20.

(2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3; 2012-12, s. 2(tt); 2014-100, s. 17.1(q), (ddd); 2015-181, s. 47; 2023-134, s. 19F.4(q).)

§ 122C-81. National accreditation benchmarks.

(a) As used in this section, the term:

(1) "National accreditation" applies to accreditation by an entity approved by the Secretary that accredits mental health, developmental disabilities, and substance abuse services.

(2) "Provider" applies to only those providers of services, including facilities, requiring national accreditation, which services are designated by the Secretary pursuant to subsection (b) of this section.

(b) The Secretary, through the Medicaid State Plan, Medicaid waiver, or rules adopted by the Secretary, shall designate the mental health, developmental disabilities, and substance abuse services that require national accreditation. In accordance with rules of the Commission, the Secretary may exempt a provider that is accredited under this section and in good standing with the national accrediting agency from undergoing any routine monitoring that is duplicative of the oversight by the national accrediting agency.

(c) Providers enrolled with the Medicaid program prior to July 1, 2008, and providing services that require national accreditation approved by the Secretary pursuant to subsection (b) of this section, shall successfully complete national accreditation requirements within three years of enrollment with the Medicaid program. Providers shall meet the following benchmarks to ensure continuity of care for consumers in the event the provider does not make sufficient progress in achieving national accreditation in a timely manner:

(1) Nine months prior to the accreditation deadline – Formal selection of an accrediting agency as documented by a letter from the agency to the provider acknowledging the provider's selection of that accrediting agency. A provider failing to meet this benchmark shall be prohibited from admitting new clients to service. If a provider fails to meet this benchmark, then the LMEs shall work with the provider to transfer all the provider's entire case load to another provider within four months of the date of the provider's failure to meet the benchmark. The transfer of the case load shall be in increments such that not fewer than twenty-five percent (25%) of the provider's total caseload shall be transferred per month. The Department shall terminate the provider's enrollment in the Medicaid program within four months of the provider's failure to meet the benchmark.

(2) Six months prior to the accreditation deadline – An on-site accreditation review scheduled by the accrediting agency as documented by a letter from the agency to the facility. A provider failing to meet this benchmark will be prohibited from admitting new clients to service. If a provider fails to meet this benchmark, then the LMEs shall work with the provider to transfer the provider's entire case load to another provider within three months of the date of the provider's failure to meet the benchmark. The transfer of the case load shall be in increments such that not fewer than thirty-three percent (33%) of the provider's total caseload shall be transferred per month. The Department shall terminate the provider's enrollment in the Medicaid program within three months of the provider's failure to meet the benchmark.

(3) Three months prior to the accreditation deadline – Completion of an on-site accreditation review, receipt of initial feedback from accrediting agency, and submission of a Plan of Correction for any deficiencies noted by the accrediting agency. A provider failing to meet this benchmark shall be prohibited from admitting new clients to service. If a provider fails to meet this benchmark, then the LMEs shall work with the provider to transfer the provider's entire case load to another provider within two months of the date of the provider's failure to meet the benchmark. The transfer of the case load shall be in increments such

that not fewer than fifty percent (50%) of the provider's total caseload shall be transferred per month. The Department shall terminate the provider's enrollment in the Medicaid program within two months of the provider's failure to meet the benchmark.

(4) Accreditation deadline – Approval as fully accredited by the national accrediting agency. A provider failing to meet this requirement shall be prohibited from admitting new clients to service. The LMEs will work with a provider failing to meet this deadline to transition clients currently receiving service to other providers within 60 days. The Department shall terminate the provider's enrollment in the Medicaid program within 60 days of the provider's failure to meet the benchmark.

(5) A provider that has its enrollment terminated in the Medicaid program as a result of failure to meet benchmarks for national accreditation or failure to continue to be nationally accredited may not apply for re-enrollment in the Medicaid program for at least one year following its enrollment termination.

(d) Providers enrolled in the Medicaid program or contracting for State-funded services on or after July 1, 2008, and providing services which require national accreditation shall successfully complete all accreditation requirements and be awarded national accreditation within one year of enrollment in the Medicaid program or within two years following the provider's first contract to deliver a State-funded service requiring national accreditation. Providers providing services that require national accreditation shall be required to discontinue service delivery and shall have their Medicaid enrollment and any service contracts terminated if they do not meet the following benchmarks for demonstrating sufficient progress in achieving national accreditation following the date of enrollment in the Medicaid program or initial contract for State-funded services:

(1) Three months – On-site accreditation review scheduled by accrediting agency as documented by a letter from the agency to the provider and completion of self-study and self-evaluation protocols distributed by the selected accrediting agency.

(2) Six months – On-site accreditation review scheduled by accrediting agency as documented by a letter from the agency to the provider.

(3) Nine months – Completion of on-site accreditation review, receipt of initial feedback from accrediting agency, plan to address any deficiencies identified developed.

(4) If a provider's Medicaid enrollment or service delivery contracts are terminated as a result of failure to meet accreditation benchmarks or failure to continue to be nationally accredited, the provider will work with the LME to transition consumers served by the provider to other service providers in an orderly fashion within 60 days of notification by the LME of such failure.

(5) A provider that has its Medicaid enrollment or service delivery contracts terminated as a result of failure to meet accreditation benchmarks or failure to continue to be nationally accredited may not reapply for enrollment in the Medicaid program or enter into any new service delivery contracts for at least one year following enrollment or contract termination.

(e) The Commission may adopt rules establishing a procedure by which a provider that is accredited under this section and in good standing with the national accrediting agency may be exempt from undergoing any routine monitoring that is duplicative of the oversight by the national

accrediting agency. Any provider shall continue to be subject to inspection by the Secretary, provided the inspection is not duplicative of inspections required by the national accrediting agency. Rules adopted under this subsection may not waive any requirements that may be imposed under federal law. (2008-107, s. 10.15A(c); 2015-286, s. 3.7.)

Article 4.

Organization and System for Delivery of Mental Health, Developmental Disabilities, and Substance Abuse Services.

Part 1. Policy.

§ 122C-101. Policy.

Within the public system of mental health, developmental disabilities, and substance abuse services, there are area, county, and State facilities. An area authority or county program is the locus of coordination among public services for clients of its catchment area. (1985, c. 589, s. 2; 1989, c. 625, s. 13; 1993, c. 396, s. 3; 2001-437, s. 1.4.)

§ 122C-102. State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services; system performance measures.

(a) Purpose of State Plan. – The Department shall develop and implement a State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services. The purpose of the State Plan is to provide a strategic template regarding how State and local resources shall be organized and used to provide services. The State Plan shall be issued every three years beginning July 1, 2007. It shall identify specific goals to be achieved by the Department, area authorities, and county programs over a three-year period of time and benchmarks for determining whether progress is being made towards those goals. It shall also identify data that will be used to measure progress towards the specified goals. In order to increase the ability of the State, area authorities, county programs, private providers, and consumers to successfully implement the goals of the State Plan, the Department shall not adopt or implement policies that are inconsistent with the State Plan without first consulting with the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(b) Content of State Plan. – The State Plan shall include the following:

(1) Vision and mission of the State Mental Health, Developmental Disabilities, and Substance Abuse Services system.

(2) Repealed by Session Laws 2006-142, s. 2(a), effective July 19, 2006.

(3) Protection of client rights and consumer involvement in planning and management of system services.

(4) Provision of services to targeted populations, including criteria for identifying targeted populations.

(5) Compliance with federal mandates in establishing service priorities in mental health, developmental disabilities, and substance abuse.

(6) Description of the core services that are available to all individuals in order to improve consumer access to mental health, developmental disabilities, and substance abuse services at the local level.

(7) Service standards for the mental health, developmental disabilities, and substance abuse services system.

(8) Implementation of the uniform portal process.

(9) Strategies and schedules for implementing the service plan, including consultation on Medicaid policy with area and county programs, qualified providers, and others as designated by the Secretary, intersystem collaboration, promotion of best practices, technical assistance, outcome-based monitoring, and evaluation.

(10) A plan for coordination of the State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services with the Medicaid State Plan.

(11) A business plan to demonstrate efficient and effective resource management of the mental health, developmental disabilities, and substance abuse services system, including strategies for accountability for non-Medicaid and Medicaid services.

(12) Strategies and schedules for implementing a phased in plan to eliminate disparities in the allocation of State funding across county programs and area authorities by January 1, 2007, including methods to identify service gaps and to ensure equitable use of State funds to fill those gaps among all counties.

(c) Repealed by Session Laws 2013-360, s. 12A.8(c), effective July 1, 2013. (2001-437, s. 1.5; 2006-142, s. 2(a); 2011-291, s. 2.42; 2013-360, s. 12A.8(c); 2022-74, s. 9D.15(z).)

§§ 122C-103 through 122C-110. Reserved for future codification purposes.

Part 2. State, County and Area Authority.

§ 122C-111. Administration.

The Secretary shall administer and enforce the provisions of this Chapter and the rules of the Commission and shall operate State facilities. An area director shall enforce applicable State laws, rules of the Commission, and rules of the Secretary. The Secretary in cooperation with area directors and State facility directors shall provide for the coordination of public services between area authorities and State facilities. An area authority shall monitor the provision of mental health, developmental disabilities, and substance use disorder services for compliance with the law, which monitoring and management shall not supersede or duplicate the regulatory authority or functions of agencies of the Department. (1963, c. 1166, s. 3; 1973, c. 476, s. 133; 1985, c. 589, s. 2; 2001-437, s. 1.6; 2002-164, s. 4.2; 2006-142, s. 4(b); 2023-134, s. 9G.7A(a4).)

§ 122C-112: Repealed by Session Laws 2001-437, s. 1.7(a), effective July 1, 2002.

§ 122C-112.1. Powers and duties of the Secretary.

(a) The Secretary shall do all of the following:

(1) Oversee development and implementation of the State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services.

(2) Enforce the provisions of this Chapter and the rules of the Commission and the Secretary.

(3) through (5) Repealed by Session Laws 2023-134, s. 9G.7A(a5), effective October 3, 2023.

(6) Establish comprehensive, cohesive oversight and monitoring procedures and processes to ensure continuous compliance by area authorities, third-party contractors of area authorities, and all providers of public services with State and federal policy, law, and standards. The procedures shall include the

development and use of critical performance measures and report cards for each area authority.

(7) Conduct regularly scheduled monitoring and oversight of area authorities and all providers of public services. Monitoring and oversight shall be used to assess implementation of core LME functions. Monitoring shall also include the examination of LME and provider performance on outcome measures including adherence to best practices, the assessment of consumer satisfaction, and the review of client rights complaints.

(8) Make findings and recommendations based on information and data collected pursuant to subdivision (7) of this subsection and submit these findings and recommendations to the applicable area authority board, board of county commissioners, providers of public services, and to the Local Consumer Advocacy Office.

(9) Provide ongoing and focused technical assistance to area authorities in the implementation of the LME functions and the establishment and operation of community-based programs. The Secretary shall include in the State Plan a mechanism for monitoring the Department's success in implementing this duty and the progress of area authorities in achieving these functions.

(10) Operate State facilities and adopt rules pertaining to their operation.

(11) Develop a unified system of services provided at the community level, by State facilities, and by providers enrolled or under a contract with the State and an area authority.

(12) Adopt rules governing the expenditure of all funds for mental health, developmental disabilities, and substance abuse programs and services.

(13) Adopt rules to implement the appeal procedure authorized by G.S. 122C-151.2.

(14) Implement the uniform portal process developed under rules adopted by the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services in accordance with G.S. 122C-114.

(15) Except as provided in G.S. 122C-26(4), adopt rules establishing procedures for waiver of rules adopted by the Secretary under this Chapter.

(16) Notify the clerks of superior court of changes in the designation of State facility regions and of facilities designated under G.S. 122C-252.

(17) Promote public awareness and understanding of mental health, mental illness, developmental disabilities, and substance abuse.

(18) Administer and enforce rules that are conditions of participation for federal or State financial aid.

(19) Carry out G.S. 122C-361.

(20) Monitor the fiscal and administrative practices of area authorities to ensure that the area authorities are accountable to the State for the management and use of federal and State funds allocated for mental health, developmental disabilities, and substance use disorder services. The Secretary shall ensure maximum accountability by area authorities for rate-setting methodologies, reimbursement procedures, billing procedures, provider contracting procedures, record keeping, documentation, and other matters pertaining to financial management and fiscal accountability. The Secretary shall further

ensure that the practices are consistent with professionally accepted accounting and management principles.

(21) Provide technical assistance, including conflict resolution, to counties as requested by the county.

(22) Develop a methodology to be used for calculating county resources to reflect cash and in-kind contributions of the county.

(23) Adopt rules establishing program evaluation and management of mental health, developmental disabilities, and substance abuse services.

(24) Adopt rules regarding the requirements of the federal government for grants-in-aid for mental health, developmental disabilities, or substance use disorder programs which may be made available to area authorities or the State. This section shall be liberally construed in order that the State and its citizens may benefit from the grants-in-aid.

(25) Repealed by Session Laws 2023-134, s. 9G.7A(a5), effective October 3, 2023.

(26) Establish a process for approving area authorities to provide services directly in accordance with G.S. 122C-141.

(27) Sponsor training opportunities in the fields of mental health, developmental disabilities, and substance use disorder.

(28) Enforce the protection of the rights of clients served by State facilities, area authorities, and providers of public services.

(29) Adopt rules for the enforcement of the protection of the rights of clients being served by State facilities, area authorities, and providers of public services.

(30) Prior to requesting approval to close a State facility under G.S. 122C-181(b):

a. Notify the Joint Legislative Commission on Governmental Operations, the Joint Legislative Oversight Committee on Health and Human Services, and members of the General Assembly who represent catchment areas affected by the closure; and

b. Present a plan for the closure to the members of the Joint Legislative Oversight Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Senate Appropriations Committee on Health and Human Services for their review, advice, and recommendations. The plan shall address specifically how patients will be cared for after closure, how support services to community-based agencies and outreach services will be continued, and the impact on remaining State facilities. In implementing the plan, the Secretary shall take into consideration the comments and recommendations of the committees to which the plan is presented under this subdivision.

(31) Ensure that the State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services is coordinated with the Medicaid State Plan.

(32) Implement standard forms, quality measures, contracts, processes, and procedures to be used by all area authorities with other public and private service providers. The Secretary shall consult with LMEs, CFACs, counties, and qualified providers regarding the development of any forms, processes, and procedures required under this subdivision. Any document, process, or procedure developed under this subdivision shall place an obligation upon

providers to transmit to LMEs timely client information and outcome data. The Secretary shall also adopt rules regarding what constitutes a clean claim for purposes of billing.

When implementing this subdivision, the Secretary shall balance the need for LMEs to exercise discretion in the discharge of their LME functions with the need of qualified providers for a uniform system of doing business with public entities.

(33) Develop and implement critical performance indicators to be used to hold LMEs accountable for managing the mental health, developmental disabilities, and substance use disorder services system. The performance system indicators shall be implemented no later than July 1, 2007.

(34) Adopt a copayment schedule for behavioral health services, intellectual and developmental disabilities services, and substance use disorder services based on the Medicaid copayments for those services to be used by LMEs and by contractual provider agencies under G.S. 122C-146. The copayment schedule adopted under this subdivision shall require a copayment for services identified by the Secretary. Families whose family income is three hundred percent (300%) or greater of the federal poverty level are eligible for services with the applicable copayment.

(35) Develop and adopt rules governing a statewide data system containing waiting list information obtained annually from each LME as required under G.S. 122C-115.4(b)(8). The rules adopted shall establish standardized criteria to be used by LMEs to ensure that the waiting list data are consistent across LMEs. The Department shall use data collected from LMEs under G.S. 122C-115.4(b)(8) for statewide planning and needs projections. The creation of the statewide waiting list data system does not create an entitlement to services for individuals on the waiting list. The Department shall report annually to the Joint Legislative Oversight Committee on Health and Human Services its recommendations based on data obtained annually from each LME. The report shall indicate the services that are most needed throughout the State, plans to address unmet needs, and any cost projections for providing needed services.

(36) The Department shall ensure that developmental disability services funded from State appropriations to or allocations from the Division of Mental Health, Developmental Disabilities, and Substance Use Services, including CAP-MRDD are authorized on a quarterly, semiannual, or annual basis, in accordance with guidelines issued by the Department, unless a change in the individual's person-centered plan indicates a different authorization frequency.

(37) The Department shall develop new developmental disability service definitions for developmental disability services funded from State appropriations to or allocations from the Division of Mental Health, Developmental Disabilities, and Substance Use Services, including CAP-MRDD that allow for person-centered and self-directed supports.

(38) Repealed by Session Laws 2023-134, s. 9G.7A(a5), effective October 3, 2023.

(39) Develop and use a standard contract for all local management entity/managed care organizations for operation of the 1915(b)/(c) Medicaid Waiver that

requires compliance by each LME/MCO with all provisions of the contract to operate the 1915(b)/(c) Medicaid Waiver and with all applicable provisions of State and federal law.

(b) The Secretary may do the following:

(1) Acquire, by purchase or otherwise in the name of the Department, equipment, supplies, and other personal property necessary to carry out the mental health, developmental disabilities, and substance abuse programs.

(2) Promote and conduct research in the fields of mental health, developmental disabilities, and substance abuse; promote best practices.

(3) Receive donations of money, securities, equipment, supplies, or any other personal property of any kind or description that shall be used by the Secretary for the purpose of carrying out mental health, developmental disabilities, and substance abuse programs. Any donations shall be reported to the Office of State Budget and Management as determined by that office.

(4) Accept, allocate, and spend any federal funds for mental health, developmental disabilities, and substance abuse activities that may be made available to the State by the federal government. This Chapter shall be liberally construed in order that the State and its citizens may benefit fully from these funds. Any federal funds received shall be deposited with the Department of State Treasurer and shall be appropriated by the General Assembly for the mental health, developmental disabilities, or substance abuse purposes specified.

(5) Enter into agreements authorized by G.S. 122C-346.

(6) Notwithstanding G.S. 126-18, authorize funds for contracting with a person, firm, or corporation for aid or assistance in locating, recruiting, or arranging employment of health care professionals in any facility listed in G.S. 122C-181.

(7) Contract with one or more private providers or other public service agencies to serve clients of an area authority or county program and reallocate program funds to pay for services under the contract if the Secretary finds all of the following:

a. The area authority or county program refuses or has failed to provide the services to clients within its catchment area, or provide specialty services in another catchment area, in a manner that is at least adequate.

b. Clients within the area authority or county program catchment area will either not be served or will suffer an unreasonable hardship if required to obtain the services from another area authority or county program.

c. There is at least one private provider or public service agency within the area authority or county program catchment area, or within reasonable proximity to the catchment area, willing and able to provide services under contract.

Before contracting with a private provider as authorized under this subdivision, the Secretary shall provide written notification to the area authority or county program and to the applicable participating boards of county commissioners of the Secretary's intent to contract and shall provide the area authority or county program and the applicable participating boards of county commissioners an opportunity to be heard.

(8) Contract with one or more private providers or other public service agencies to serve clients from more than one area authority or county program and reallocate the funds of the applicable programs to pay for services under the contract if the Secretary finds either that there is no other area authority or county program available to act as the administrative entity under contract with the provider or that the area authority or county program refuses or has failed to properly manage and administer the contract with the contract provider, and clients will either not be served or will suffer unreasonable hardship if services are not provided under the contract. Before contracting with a private provider as authorized under this subdivision, the Secretary shall provide written notification to the area authority or county program and the applicable participating boards of county commissioners of the Secretary's intent to contract and shall provide the area authority or county program and the applicable participating boards of county commissioners an opportunity to be heard.

(9) Require reports of client characteristics, staffing patterns, agency policies or activities, services, or specific financial data of the area authority, county program, and providers of public services. The reports shall not identify individual clients of the area authority or county program unless specifically required by State law or by federal law or regulation or unless valid consent for the release has been given by the client or legally responsible person. (2001-437, s. 1.7(b); 2006-142, s. 4(m); 2007-410, s. 2; 2007-504, s. 2.2; 2009-186, s. 2; 2011-291, ss. 2.43, 2.44; 2012-151, s. 7(b); 2013-85, s. 3; 2021-77, s. 3; 2022-74, s. 9D.15(z); 2023-65, s. 5.2(b); 2023-134, s. 9G.7A(a5), (c1), (c2).)

§ 122C-113. Cooperation between Secretary and other agencies.

(a) The Secretary shall cooperate with other State agencies to coordinate services for the treatment and habilitation of individuals who are mentally ill, developmentally disabled, or substance abusers. The Secretary shall also coordinate with these agencies to provide public education to promote a better understanding of mental illness, developmental disabilities, and substance abuse.

(b) The Secretary shall promote cooperation among area facilities, State facilities, and local agencies to facilitate the provision of services to individuals who are mentally ill, developmentally disabled, or substance abusers.

(b1) The Secretary shall cooperate with the State Board of Education and the Division of Juvenile Justice of the Department of Public Safety in coordinating the responsibilities of the Department of Health and Human Services, the State Board of Education, the Division of Juvenile Justice of the Department of Public Safety, and the Department of Public Instruction for adolescent substance abuse programs. The Department of Health and Human Services, through its Division of Mental Health, Developmental Disabilities, and Substance Use Services and its Division of Child and Family Well-Being, in cooperation with the Division of Juvenile Justice of the Department of Public Safety, shall be responsible for intervention and treatment in non-school based programs. The State Board of Education and the Department of Public Instruction, in consultation with the Division of Juvenile Justice of the Department of Public Safety, shall have primary responsibility

for in-school education, identification, and intervention services, including student assistance programs.

(c) The Secretary shall adopt rules to assure this coordination. (1963, c. 1166, s. 3; 1973, c. 476, s. 133; 1977, c. 679, s. 7; 1981, c. 51, s. 3; 1985, c. 589, s. 2; 1987, c. 863, s. 1; 1989, c. 625, s. 14; 1993, c. 522, s. 9; 1997-443, s. 11A.118(a); 1998-202, s. 4(s); 2000-137, s. 4(v); 2011-145, s. 19.1(l); 2017-186, s. 2(mmmmm); 2021-180, s. 19C.9(z); 2023-65, ss. 3.3, 5.2(b).)

§ 122C-114. Powers and duties of the Commission.

(a) The Commission shall have authority as provided by this Chapter, Chapters 90 and 148 of the General Statutes, and by G.S. 143B-147.

(b) The Commission shall adopt rules regarding all of the following:

(1) The development of a process for screening, triage, and referral, including a uniform portal process, for implementation by the Secretary as required under G.S. 122C-112.1(14).

(2) LME monitoring of providers of mental health, developmental disabilities, and substance abuse services.

(3) LME provision of technical assistance to providers of mental health, developmental disabilities, and substance abuse services.

(4) The requirements of a qualified public or private provider as that term is used in G.S. 122C-141. In adopting rules under this subsection, the Commission shall take into account the need to ensure fair competition among providers. (C.S., s. 6153; 1929, c. 265, s. 1; 1933, c. 342, s. 1; 1943, cc. 32, 164; 1945, c. 952, s. 9; 1947, c. 537, s. 5; 1957, c. 1232, s. 1; 1959, c. 348, s. 3; c. 1002, s. 3; c. 1028, ss. 1, 2, 3, 5; 1963, c. 451, s. 1; c. 1166, s. 10; 1973, c. 476, s. 133; 1977, c. 679, s. 7; 1981, c. 51, s. 3; 1985, c. 589, s. 2; 2007-504, s. 2.3; 2012-66, s. 1.)

§ 122C-115. Duties of counties; appropriation and allocation of funds by counties and cities.

(a) A county shall provide mental health, developmental disabilities, and substance use disorder services in accordance with rules, policies, and guidelines adopted pursuant to statewide restructuring of the management responsibilities for the delivery of services for individuals with mental illness, intellectual or other developmental disabilities, and substance use disorders through an area authority. The catchment area of an area authority shall contain a minimum population of at least 1,500,000 based on the 2023 population estimate from the State Demographer of the Office of Budget and Management. To the extent this section conflicts with G.S. 153A-77, the provisions of this section control.

(a1) Repealed by Session Laws 2023-134, s. 9G.7A(a6), effective October 3, 2023.

(a2) Repealed by Session Laws 2023-134, s. 9G.7A(a6), effective October 3, 2023.

(a3) Repealed by Session Laws 2023-134, s. 9G.7A(a6), effective October 3, 2023.

(b) Counties shall and cities may appropriate funds for the support of programs that serve the catchment area, whether the programs are physically located within a single county or whether any facility housing a program is owned and operated by the city or county. Counties and cities may make appropriations for the purposes of this Chapter and may allocate for these purposes other revenues not restricted by law, and counties may fund them by levy of property taxes pursuant to G.S. 153A-149(c)(22).

(c) Within a catchment area, a board of county commissioners or two or more boards of county commissioners jointly shall establish an area authority with the approval of the Secretary.

(c1) Repealed by Session Laws 2023-134, s. 9G.7A(a6), effective October 3, 2023.

(d) Except as otherwise provided in this subsection, 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.

(e) Beginning July 1, 2021, LME/MCOs shall cease managing Medicaid services for all Medicaid recipients who are enrolled in a standard benefit plan.

(e1) Until BH IDD tailored plans become operational, all of the following shall occur:

(1) LME/MCOs shall continue to manage the Medicaid services that are covered by the LME/MCOs under the combined 1915(b) and (c) waivers for Medicaid recipients who are covered by the those waivers and who are not enrolled in a standard benefit plan.

(2) The Division of Health Benefits shall negotiate actuarially sound capitation rates directly with the LME/MCOs based on the change in composition of the population being served by the LME/MCOs.

(3) Capitation payments under contracts between the Division of Health Benefits and the LME/MCOs shall be made directly to the LME/MCO by the Division of Health Benefits.

(f) LME/MCOs operating the BH IDD tailored plans under G.S. 108D-60 may contract with the Department to continue to manage the behavioral health, intellectual and developmental disability, and traumatic brain injury services for any Medicaid recipients who are not enrolled in a BH IDD tailored plan or the CAF specialty plan. (1977, c. 568, s. 1; c. 679, s. 7; 1979, c. 358, ss. 5, 23; 1981, c. 51, s. 3; 1985, c. 589, s. 2; 1989, c. 625, s. 14; 1995 (Reg. Sess., 1996), c. 749, s. 1; 1999-202, s. 1; 2001-437, s. 1.8; 2004-124, s. 10.26(a); 2006-66, s. 10.32(c), (d); 2007-504, s. 1.3; 2011-264, s. 2; 2012-151, ss. 1, 6; 2013-85, s. 4(a)-(c); 2013-363, s. 4.12(a); 2013-378, s. 11; 2013-410, s. 23(a); 2015-245, s. 4; 2018-48, s. 1; 2019-81, ss. 12, 14(a)(8); 2020-88, s. 12(c); 2021-62, ss. 3.4A(b), 4.8(d); 2023-65, s. 5.1(a); 2023-134, ss. 9E.22(m), 9G.7A(a6); 2024-34, s. 12.2.)

§ 122C-115.1. County governance and operation of mental health, developmental disabilities, and substance abuse services program.

(a) A county may operate a county program for mental health, developmental disabilities, and substance abuse services as a single county or, pursuant to Article 20 of Chapter 160A of the General Statutes, may enter into an interlocal agreement with one or more other counties for the operation of a multicounty program. An interlocal agreement shall provide for the following:

(1) Adoption and administration of the program budget in accordance with Chapter 159 of the General Statutes.

(2) Appointment of a program director to carry out the provisions of G.S. 122C-111 and duties and responsibilities delegated by the county. Except when specifically waived by the Secretary, the program director shall meet all the following minimum qualifications:

a. Masters degree.

b. Related experience.

c. Management experience.

d. Any other qualifications required under G.S. 122C-120.1.

(3) Repealed by Session Laws 2006-66, s. 10.32(e), effective July 1, 2007.
(4) Compliance with the provisions of this Chapter and the rules of the Commission and the Secretary.
(5) Written notification to the Secretary prior to the termination of the interlocal agreement.
(6) Appointment of an advisory committee. The interlocal agreement shall designate a county manager to whom the advisory committee shall report. The interlocal agreement shall also designate the appointing authorities. The appointing authorities shall make appointments that take into account sufficient citizen participation, equitable representation of the disability groups, and equitable representation of participating counties. The membership shall conform to the requirements provided in G.S. 122C-118.1.

(b) Before establishing a county program pursuant to this section, a county board of commissioners shall hold a public hearing with notice published at least 10 days before the hearing.

(c) A county shall ensure that the county program and the services provided through the county program comply with the provisions of this Chapter and the rules adopted by the Commission and the Secretary.

(d) A county program shall submit on a quarterly basis to the Secretary and the board of county commissioners service delivery reports that assess the quality and availability of public services within the county program's catchment area. The service delivery reports shall include the types of services delivered, number of recipients served, and services requested but not delivered due to staffing, financial, or other constraints. In addition, at least annually, a progress report shall be submitted to the Secretary and the board of county commissioners. The progress report shall include an assessment of the progress in implementing local service plans, goals, and outcomes. All reports shall be in a format and shall contain any additional information required by the Secretary or board of county commissioners.

(e) Within 30 days of the end of each quarter of the fiscal year, the program director and finance officer of the county program shall present to each member of the board of county commissioners a budgetary statement and balance sheet that details the assets, liabilities, and fund balance of the county program. This information shall be read into the minutes of the meeting at which it is presented. The program director or finance officer of the county program shall provide to the board of county commissioners ad hoc reports as requested by the board of county commissioners.

(f) In a single-county program, the program director shall be appointed by the county manager. In a multicounty program, the program director shall be appointed in accordance with the terms of the interlocal agreement.

Except when specifically waived by the Secretary, the program director in a single county program shall meet all the following minimum qualifications:

(1) Masters degree.
(2) Related experience.
(3) Management experience.
(4) Any other qualifications required under G.S. 122C-120.1.

(g) In a single-county program, an advisory committee shall be appointed by the board of county commissioners and shall report to the county manager. The appointments shall take into account sufficient citizen participation, equitable representation of the disability groups, and equitable representation of participating counties. The membership shall conform to the

requirements in G.S. 122C-118.1. In a multicounty program, the advisory committee shall be appointed in accordance with the terms of the interlocal agreement.

(h) The county program may contract to provide services to governmental or private entities, including Employee Assistance Programs.

(i) Except as otherwise specifically provided, this Chapter applies to counties that provide mental health, developmental disabilities, and substance abuse services through a county program. As used in the applicable sections of this Article, the terms "area authority", "area program", and "area facility" shall be construed to include "county program". (2001-437, s. 1.9; 2006-66, s. 10.32(e); 2006-142, s. 4(f), (g), (i), (j); 2012-151, s. 2(b).)

§ 122C-115.2. Repealed by Session Laws 2023-134, s. 9G.7A(a7), effective October 3, 2023.

§ 122C-115.3. Repealed by Session Laws 2023-134, s. 9G.7A(a7), effective October 3, 2023.

§ 122C-115.4. Functions of local management entities.

(a) Local management entities are responsible for the management and oversight of the public system of services for people with serious mental illness, severe and persistent mental illness, intellectual and developmental disabilities, traumatic brain injuries, and severe substance use disorders at the community level. An LME shall plan, develop, implement, and monitor services within a specified geographic area to ensure expected outcomes for consumers within available resources.

(a1) Local management entities may perform services within their expertise and experience on a statewide basis or outside their specified geographic area pursuant to contracts or grants awarded to the local management entity.

(b) The primary functions of an LME are designated in this subsection and shall not be conducted by any other entity unless an LME voluntarily enters into a contract with that entity under subsection (c) of this section. The primary functions include all of the following:

(1) Access for all citizens to the core services and administrative functions described in G.S. 122C-2. In particular, this shall include the implementation of a 24-hour a day, seven-day a week screening, triage, and referral process and a uniform portal of entry into care.

(2) Provider monitoring, technical assistance, capacity development, and quality control. If at anytime the LME has reasonable cause to believe a violation of licensure rules has occurred, the LME shall make a referral to the Division of Health Service Regulation. If at anytime the LME has reasonable cause to believe the abuse, neglect, or exploitation of a client has occurred, the LME shall make a referral to the local Department of Social Services, Child Protective Services Program, or Adult Protective Services Program.

(3) Utilization management, utilization review, and determination of the appropriate level and intensity of services. An LME may participate in the development of person centered plans for any consumer and shall monitor the implementation of person centered plans. An LME shall review and approve person centered plans for consumers who receive State-funded services and shall conduct concurrent reviews of person centered plans for consumers in the LME's catchment area who receive Medicaid funded services.

(4) Authorization of the utilization of State psychiatric hospitals and other State facilities. Authorization of eligibility determination requests for recipients under a CAP-MR/DD waiver.

(5) Care coordination and quality management. This function involves individual client care decisions at critical treatment junctures to assure clients' care is coordinated, received when needed, likely to produce good outcomes, and is neither too little nor too much service to achieve the desired results. Care coordination is sometimes referred to as "care management." Care coordination shall be provided by clinically trained professionals with the authority and skills necessary to determine appropriate diagnosis and treatment, approve treatment and service plans, when necessary to link clients to higher levels of care quickly and efficiently, to facilitate the resolution of disagreements between providers and clinicians, and to consult with providers, clinicians, case managers, and utilization reviewers. Care coordination activities for high-risk/high-cost consumers or consumers at a critical treatment juncture include the following:

a. Assisting with the development of a single care plan for individual clients, including participating in child and family teams around the development of plans for children and adolescents.
b. Addressing difficult situations for clients or providers.
c. Consulting with providers regarding difficult or unusual care situations.
d. Ensuring that consumers are linked to primary care providers to address the consumer's physical health needs.
e. Coordinating client transitions from one service to another.
f. Conducting customer service interventions.
g. Assuring clients are given additional, fewer, or different services as client needs increase, lessen, or change.
h. Interfacing with utilization reviewers and case managers.
i. Providing leadership on the development and use of communication protocols.
j. Participating in the development of discharge plans for consumers being discharged from a State facility or other inpatient setting who have not been previously served in the community.

(6) Community collaboration and consumer affairs including a process to protect consumer rights, an appeals process, and support of an effective consumer and family advisory committee.

(7) Financial management and accountability for the use of State and local funds and information management for the delivery of publicly funded services.

(7a) Community crisis services planning in accordance with G.S. 122C-202.2.

(8) Each LME shall develop a waiting list of persons with intellectual or developmental disabilities that are waiting for specific services. The LME shall develop the list in accordance with rules adopted by the Secretary to ensure that waiting list data are collected consistently across LMEs. Each LME shall report this data annually to the Department. The data collected should include numbers of persons who are:

a. Waiting for residential services.
b. Potentially eligible for CAP-MRDD.

c. In need of other services and supports funded from State appropriations to or allocations from the Division of Mental Health, Developmental Disabilities, and Substance Use Services, including CAP-MRDD.

(9) Each LME/MCO shall receive referrals from school superintendents or designees in accordance with G.S. 115C-105.65(b)(3) related to students who are uninsured or are covered by Medicaid and not enrolled in a prepaid health plan residing in the LME/MCO's catchment area. Within 10 calendar days after receipt of a referral, the LME/MCO shall contact the student's parent or legal guardian using the information provided on the referral and shall provide assistance with identifying appropriate existing mental health resources available to the student. The assistance shall include identifying sources of funding to assist with the cost of mental health services as well as providing referrals to appropriate mental health service providers and mental health services.

Subject to all applicable State and federal laws and rules established by the Secretary and the Commission, nothing in this subsection shall be construed to preempt or supersede the regulatory or licensing authority of other State or local departments or divisions.

(c) Subject to subsection (b) of this section, all applicable State and federal laws and rules, and contractual requirements established by the Secretary, an LME may contract with a public or private entity for the implementation of LME functions designated under subsection (b) of this section. An LME shall direct its subcontractor to remove staff from, or cancel, any such contract when directed by the Secretary to achieve compliance with State and federal law, rule, policy, or standards, and contractual requirements.

(d) Repealed by Session Laws 2023-134, s. 9G.7A(c4), effective October 3, 2023.

(e) Repealed by Session Laws 2023-134, s. 9G.7A(c4), effective October 3, 2023.

(f) The Commission shall adopt rules regarding the following matters:

(1) The definition of a high risk consumer. Until such time as the Commission adopts a rule under this subdivision, a high risk consumer means a person who has been assessed as needing emergent crisis services three or more times in the previous 12 months.

(2) The definition of a high cost consumer. Until such time as the Commission adopts a rule under this subdivision, a high cost consumer means a person whose treatment plan is expected to incur costs in the top twenty percent (20%) of expenditures for all consumers in a disability group.

(3) Repealed by Session Laws 2023-134, s. 9G.7A(c5), effective October 3, 2023.

(g) The Commission shall adopt rules to ensure that the needs of members of the active and reserve components of the Armed Forces of the United States, veterans, and their family members are met by requiring:

(1) Each LME to have at least one trained care coordination person on staff to serve as the point of contact for TRICARE, the North Carolina National Guard's Integrated Behavioral Health System, the Army Reserve Department of Psychological Health, the United States Department of Veterans Affairs, the Division of Juvenile Justice, and related organizations to ensure that members of the active and reserve components of the Armed Forces of the United States, veterans, and their family members have access to State-funded services when

they are not eligible for federally funded mental health or substance abuse services.

(2) LME staff members who provide screening, triage, or referral services to receive training to enhance the services provided to members of the active or reserve components of the Armed Forces of the United States, veterans, and their families. The training required by this subdivision shall include training on at least all of the following:

a. The number of persons who serve or who have served in the active or reserve components of the Armed Forces of the United States in the LME's catchment area.

b. The types of mental health and substance abuse disorders that these service personnel and their families may have experienced, including traumatic brain injury, posttraumatic stress disorder, depression, substance use disorders, potential suicide risks, military sexual trauma, and domestic violence.

c. Appropriate resources to which these service personnel and their families may be referred as needed. (2006-142, s. 4(d); 2007-323, ss. 10.49(l), (hh); 2007-484, ss. 18, 43.7(a)-(c); 2007-504, s. 1.2; 2008-107, s. 10.15(cc); 2009-186, s. 1; 2009-189, s. 1; 2011-145, s. 19.1(h); 2011-185, s. 6; 2011-291, s. 2.45; 2012-66, s. 2; 2012-83, s. 43; 2017-186, s. 2(nnnnn); 2018-33, s. 6; 2021-180, s. 19C.9(z); 2023-65, s. 5.2(b); 2023-78, s. 2(c); 2023-134, ss. 9E.22(n), 9G.7A(c3)-(c5).)

§ 122C-115.5. Alignment of counties with an area authority.

(a) Reserved for future codification purposes.

(b) Reserved for future codification purposes.

(c) Area authorities may add one or more additional counties to their existing catchment area, including through the merger or consolidation of area authorities, upon the adoption of a resolution to that effect by a majority of the members of the area board and the approval of the Secretary.

(d) The Secretary shall direct the dissolution of an area authority upon any of the following:

(1) The termination of a BH IDD tailored plan contract with an area authority.

(2) The Secretary's delivery of a notice of noncompliance to an area authority under G.S. 122C-124.2(c) or G.S. 122C-124.2(d).

(e) When an area authority is dissolved at the direction of the Secretary, all of the following shall occur:

(1) The Secretary shall deliver a notice of dissolution to the board of county commissioners of each of the counties in the dissolved area authority.

(2) The area authority shall be dissolved on a time line established by the Secretary. The Secretary shall allow at least seven but no more than 30 calendar days for all of the following to occur:

a. The completion by the area authority being dissolved of negotiations for a merger or consolidation with one or more compliant area authorities.

b. The submission to the Secretary of any requests for consideration with regard to the realignment with another area authority by any county in the catchment area of the area authority being dissolved.

(3) The area authority being dissolved shall cooperate with the Secretary in order to ensure the uninterrupted provision of services to Medicaid recipients and the other individuals who received services through the area authority.

(4) The Secretary shall assign any contracts, as defined in G.S. 122C-124.2(g), of the area authority being dissolved to the one or more area authorities that (i) are under contract for the operation of a BH IDD tailored plan and (ii) are receiving at least one county from the area authority being dissolved. The Secretary may consult with the area directors and chairs of the area boards of (i) the area authority being dissolved and (ii) the remaining area authorities before assigning these contracts. The Secretary shall take into consideration the factors described in subsection (f) of this section in assigning these contracts.

(5) The Secretary shall assign the State-funded services contract between the area authority being dissolved and the Division of Mental Health, Developmental Disabilities, and Substance Use Services to the area authorities receiving the counties from the area authority being dissolved.

(6) The Secretary shall effectuate and oversee the orderly transfer of all management responsibilities, operations, and contracts of the area authority being dissolved, including the responsibility of paying providers for covered services that are subsequently rendered.

(7) The Secretary shall arrange for the providers of services to be reimbursed for proper, authorized, and valid claims for services rendered that were not previously paid by the area authority being dissolved. These reimbursements shall be made from the remaining fund balance or risk reserve of the area authority being dissolved, or from other funds of the Department if necessary. In the event there are insufficient assets to satisfy the liabilities of the area authority being dissolved, it shall be the responsibility of the Secretary to satisfy the liabilities of the area authority being dissolved.

(8) Effective until the date that BH IDD tailored plans begin operating, risk reserve funds of the area authority being dissolved may be used only to pay authorized and approved provider claims. Any funds remaining in the risk reserve transferred under this subdivision shall become part of the risk reserve of the area authorities receiving the realigned counties and shall be subject to the same restrictions on the use of the risk reserve applicable to those area authorities.

(9) The Secretary may assume control, in part or in full, of the financial affairs of the area authority and appoint an administrator to exercise the powers assumed by the Secretary. This assumption of control shall have the effect of divesting the area authority of its authority as to the powers assumed, including service delivery, adoption of budgets, expenditures of money, and all other financial powers conferred on the area authority by law.

(10) County funding of the area authority shall continue and shall not be reduced as a result of the dissolution. A county shall not withdraw funds previously obligated or appropriated to the area authority.

(11) Any fund balance or risk reserve available to an area authority at the time of its dissolution that is not utilized to pay liabilities shall be transferred to one or more area authorities contracted to operate the 1915(b)/(c) Medicaid Waiver or a BH IDD tailored plan in all or a portion of the catchment area of the dissolved area authority, as directed by the Department in accordance with G.S. 122C-115.6.

(12) Effective until the date that BH IDD tailored plans begin operating, if the fund balance transferred from the dissolved area authority under subdivision (11) of this subsection is insufficient to constitute fifteen percent (15%) of the anticipated operational expenses arising from assumption of responsibilities from the dissolved area authority, the Secretary shall guarantee the operational reserves for the area authority assuming the responsibilities under the 1915(b)/(c) Medicaid Waiver until the assuming area authority has reestablished fifteen percent (15%) operational reserves.

(f) In considering whether to approve any merger or consolidation of area authorities, or in determining how to assign any contracts, as defined in G.S. 122C-124.2(g), of an area authority following the termination of a BH IDD tailored plan contract under subsection (d) of this section, the Secretary may consider, at a minimum, all of the following factors:

(1) For any area authority receiving a county, the readiness of that area authority to operate the BH IDD tailored plan in the expanded catchment area.

(2) For any area authority receiving a county, the area authority's operational capacity and history of performance.

(3) Whether the distribution among area authorities of the population of individuals covered under BH IDD tailored plans will promote fiscal viability of BH IDD tailored plan contracts.

(4) Assurances of network adequacy and the alignment with existing hospitals and health systems of the area authorities involved in the merger or consolidation.

(5) For any area authority involved in the merger or consolidation, the area authority's experience with prior mergers and consolidations.

(6) Any input received by a county being realigned from one area authority to another.

(7) Geographic contiguity of counties within a catchment area.

(8) For any area authority receiving a county, the number of providers that will have to enter into new contracts with that area authority.

(9) Any input received from a provider or a Consumer and Family Advisory Committee established under G.S. 122C-170 or G.S. 122C-171.

(g) The Secretary's decision to approve or disapprove a merger or consolidation of area authorities is final, and there is no right to appeal the decision to the Office of Administrative Hearings, in accordance with G.S. 150B-1(e)(21), or any other forum. (2023-134, s. 9G.7A(a1).)

§ 122C-115.6. Transfer of area authority fund balance upon county realignment.

(a) When a county realigns with another area authority under G.S. 108D-46 or G.S. 122C-115.5, regardless of whether the realignment was due to the merger of area authorities, the consolidation of area authorities, or another process, a portion of the risk reserve and other funds of the area authority from which the county is disengaging shall be transferred to the area authority with which the county is realigning. The amount of risk reserve and other funds to be

transferred shall be determined by the Department in accordance with a formula or formulas developed in accordance with this section.

(b) Any formula developed by the Department under this section shall consider the stability of both the area authority from which the county is disengaging and the area authority with which the county is realigning. The formula shall support (i) the ability for each area authority to carry out its responsibilities under State law, (ii) the successful operation of the 1915(b)/(c) waivers, (iii) the capitated arrangements authorized by G.S. 108D-60(b), and (iv) the successful operation of BH IDD tailored plans under G.S. 108D-60. The formula shall assure that the area authority from which the county is disengaging retains sufficient funds to pay any outstanding liabilities to healthcare providers, staff-related expenses, and other liabilities.

(c) The area authority from which the county is disengaging and the area authority with which the county is realigning shall provide the Department with all financial information requested by the Department that is necessary to determine the amount of funds to be transferred using the formula or formulas developed under this section, upon any of the following:

(1) The Secretary's approval of a county realignment under G.S. 108D-46 or G.S. 122C-115.5.

(2) The Secretary's delivery of a notice of dissolution to the area authority under G.S. 122C-115.5(e)(1).

(d) Prior to finalizing any formula developed under this section, the Department shall post the proposed formula on its website and provide notice of the proposed formula to all area authorities, the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Medicaid, and the Fiscal Research Division. The Department shall accept public comment on the proposed formula. The Department shall post the final version of the formula on its website.

(e) The Department may amend the formula as needed to ensure the requirements of subsection (b) of this section are met. Prior to finalizing any amended formula developed under this section, the Department shall post the proposed amended formula on its website and provide notice of the proposed amended formula to all area authorities, the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Medicaid, and the Fiscal Research Division. The Department shall accept public comment on the proposed amended formula. The Department shall post the final version of the amended formula on its website.

(f) Beginning July 15, 2023, and quarterly thereafter, the Department shall report to the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Medicaid, and the Fiscal Research Division on any funds transferred as a result of county realignments during the previous quarter.

(g) The development, application, and amendment of the formula or formulas under this section shall be exempt from the rulemaking requirements and contested case provisions of Chapter 150B of the General Statutes, as provided in G.S. 150B-1(d)(34) and G.S. 150B-1(e)(27). (2023-134, s. 9G.7A(a1); 2024-1, s. 3.3(a), (b).)

§ 122C-115.7. Children and families specialty plan operation.

An area authority is authorized to operate the CAF specialty plan under a contract with the Department. For purposes of operating the CAF specialty plan only, all of the following apply:

(1) The area authority shall have a statewide catchment area.

(2) Counties are prohibited from withdrawing from or declining to participate in the statewide catchment area of the CAF specialty plan. (2023-134, s. 9E.22(o).)

§ 122C-116. Status of area authority; status of consolidated human services agency.

(a) An area authority is a local political subdivision of the State.

(b) A consolidated human services agency is a department of the county.

(c) One or more area authorities may jointly form a consortium, through an interlocal agreement, for the purpose of responding to requests for proposals issued by the Department and contracting with the Department. The consortium shall be considered a multicounty public authority and a local political subdivision of the State and shall establish, by interlocal agreement, an alternative governance structure that reports to the area boards of each participating area authority. The boards of each participating area authority shall have the option to appoint members of the multicounty public authority board in a manner or with a composition other than as required by G.S. 122C-118.1 by each participating area board adopting a resolution to that effect and receiving written approval from the Secretary.

(d) An area authority may, individually or in concert with other eligible entities such as other area authorities, entities licensed as a prepaid health plan under G.S. 58-93-5, or other permitted bidders, respond to requests for proposals issued by the Department to cover services on a statewide basis and contract with the Department to cover these services. An area authority may, through an interlocal agreement, be designated by other area authorities as the lead applicant to respond to requests for proposals issued by the Department and to contract with the Department to cover services on a statewide basis. (1977, c. 568, s. 1; c. 679, s. 7; 1979, c. 358, s. 2; 1981, c. 51, ss. 3, 4; c. 539, s. 1; 1983, c. 280; c. 383, s. 2; 1985, c. 589, s. 2; 1995 (Reg. Sess., 1996), c. 690, s. 10; 2012-151, s. 2(a); 2023-134, s. 9E.22(p).)

§ 122C-117. Powers and duties of the area authority.

(a) The area authority shall do all of the following:

(1) Engage in comprehensive planning, budgeting, implementing, and monitoring of community-based mental health, developmental disabilities, and substance abuse services.

(2) Ensure the provision of services to clients in the catchment area, including clients committed to the custody of the Division of Juvenile Justice of the Department of Public Safety.

(3) Determine the needs of the area authority's clients and coordinate with the Secretary and with the Division of Juvenile Justice of the Department of Public Safety the provision of services to clients through area and State facilities.

(4) Develop plans and budgets for the area authority subject to the approval of the Secretary. The area authority shall submit the approved budget to the board of county commissioners and the county manager and provide quarterly reports on the financial status of the program in accordance with subsection (c) of this section.

(5) Assure that the services provided by the county through the area authority meet the rules of the Commission and Secretary.

(6) Comply with federal requirements as a condition of receipt of federal grants.

(7) Appoint an area director in accordance with G.S. 122C-121(d).

(8) Repealed by Session Laws 2023-134, s. 9G.7A(a7), effective October 3, 2023.

(9) Perform public relations and community advocacy functions.

(10) Recommend to the board of county commissioners the creation of local program services.

(11) Submit to the Secretary and the board of county commissioners service delivery reports, on a quarterly basis, that assess the quality and availability of public services within the area authority's catchment area. The service delivery reports shall include the types of services delivered, number of recipients served, and services requested but not delivered due to staffing, financial, or other constraints. In addition, at least annually, a progress report shall be submitted to the Secretary and the board of county commissioners. The progress report shall include an assessment of the progress in implementing local service plans, goals, and outcomes. All reports shall be in a format and shall contain any additional information required by the Secretary or board of county commissioners.

(12) Repealed by Session Laws 2023-134, s. 9G.7A(a7), effective October 3, 2023.

(13) Coordinate with Treatment Accountability for Safer Communities for the provision of services to criminal justice clients.

(14) Maintain a 24-hour a day, seven day a week crisis response service. Crisis response shall include telephone and face-to-face capabilities. Crisis phone response shall include triage and referral to appropriate face-to-face crisis providers and shall be initiated within one hour of notification. Crisis services do not require prior authorization but shall be delivered in compliance with appropriate policies and procedures. Crisis services shall be designed for prevention, intervention, and resolution, not merely triage and transfer, and shall be provided in the least restrictive setting possible, consistent with individual and family need and community safety.

(15) An LME that utilizes single stream funding shall, on a biannual basis, report on the allocation of service dollars and allow for public comment at a regularly scheduled LME board of directors meeting.

(16) Before an LME proposes to reduce State funding to HUD group homes and HUD apartments below the original appropriation of State funds, the LME must:

a. Receive approval of the reduction in funding from the Department, and

b. Hold a public hearing at an open LME board meeting to receive comment on the reduction in funding.

(17) Have the authority to borrow money with the approval of the Local Government Commission.

(18) Develop and adopt community crisis services plans in accordance with G.S. 122C-202.2.

(a1) The area authority may contract to provide services to governmental or private entities, including Employee Assistance Programs.

(b) The governing unit of the area authority is the area board. All powers, duties, functions, rights, privileges, or immunities conferred on the area authority may be exercised by the area board.

(c) Within 30 days of the end of each quarter of the fiscal year, the area director and finance officer of the area authority shall provide the quarterly report of the area authority to the county finance officer. The county finance officer shall provide the quarterly report to the board of county

commissioners at the next regularly scheduled meeting of the board. The clerk of the board of commissioners shall notify the area director and the county finance officer if the quarterly report required by this subsection has not been submitted within the required period of time. This information shall be delivered to the county and, at the request of the board of county commissioners, may be presented in person by the area director or the director's designee.

(d) A multicounty area authority shall provide to each board of county commissioners of participating counties a copy of the area authority's annual audit. The audit findings shall be presented in a format prescribed by the county and shall be read into the minutes of the meeting at which the audit findings are presented. (1971, c. 470, s. 1; 1973, c. 476, s. 133; c. 661; 1977, c. 568, s. 1; c. 679, s. 7; 1979, c. 358, ss. 1, 3, 14, 23; 1981, c. 51, s. 3; 1983, c. 383, s. 1; 1985, c. 589, s. 2; 1987, c. 830, s. 47(d); 1989, c. 625, s. 14; 1991, c. 215, s. 1; 1995 (Reg. Sess., 1996), c. 749, s. 2; 1997-443, s. 11A.118(a); 1998-202, s. 4(t); 2000-137, s. 4(w); 2001-437, s. 1.10; 2001-487, s. 79.5; 2005-371, s. 2; 2006-142, s. 3(a); 2009-191, s. 1; 2011-145, s. 19.1(l); 2012-151, s. 9(a); 2017-186, s. 2(ooooo); 2018-33, s. 7; 2021-180, s. 19C.9(z); 2023-134, s. 9G.7A(a7).)

§ 122C-118: Repealed by Session Laws 2001-437, s. 1.11.

§ 122C-118.1. Structure of area board.

(a) An area board shall have no fewer than 11 and no more than 21 voting members. The board of county commissioners, or the boards of county commissioners within the area, shall appoint members consistent with the requirements provided in subsection (b) of this section. The process for appointing members shall ensure participation from each of the constituent counties of a multicounty area authority. If the board or boards fail to comply with the requirements of subsection (b) of this section, the Secretary shall appoint the unrepresented category. The boards of county commissioners within a multicounty area with a catchment population of at least 1,250,000 shall have the option to appoint members of the area board in a manner or with a composition other than as required by this section by each county adopting a resolution to that effect and receiving written approval from the Secretary. A member of the board may be removed with or without cause by the initial appointing authority. The area board may declare vacant the office of an appointed member who does not attend three consecutive scheduled meetings without justifiable excuse. The chair of the area board shall notify the appropriate appointing authority of any vacancy. Vacancies on the board shall be filled by the initial appointing authority before the end of the term of the vacated seat or within 90 days of the vacancy, whichever occurs first, and the appointments shall be for the remainder of the unexpired term.

(b) Within the maximum membership provided in subsection (a) of this section, the membership of the area board shall reside within the catchment area and be composed as follows:

(1) At least one member who is a current county commissioner.

(2) The chair of the local Consumer and Family Advisory Committee (CFAC) or the chair's designee.

(3) At least one family member of the local CFAC, as recommended by the local CFAC, representing the interests of the following:

a. Individuals with mental illness.

b. Individuals in recovery from addiction.

c. Individuals with intellectual or other developmental disabilities.

(4) At least one openly declared consumer member of the local CFAC, as recommended by the local CFAC, representing the interests of the following:

a. Individuals with mental illness.
b. Individuals with intellectual or other developmental disabilities.
c. Individuals in recovery from addiction.

(5) An individual with health care expertise and experience in the fields of mental health, intellectual or other developmental disabilities, or substance abuse services.

(6) An individual with health care administration expertise consistent with the scale and nature of the managed care organization.

(7) An individual with financial expertise consistent with the scale and nature of the managed care organization.

(8) An individual with insurance expertise consistent with the scale and nature of the managed care organization.

(9) An individual with social services expertise and experience in the fields of mental health, intellectual or other developmental disabilities, or substance abuse services.

(10) An attorney with health care expertise.

(11) A member who represents the general public and who is not employed by or affiliated with the Department of Health and Human Services, as appointed by the Secretary.

(12) The President of the LME/MCO Provider Council or the President's designee to serve as a nonvoting member who shall participate only in Board activities that are open to the public.

(13) An administrator of a hospital providing mental health, developmental disabilities, and substance abuse emergency services to serve as a nonvoting member who shall participate only in Board activities that are open to the public.

Except as provided in subdivisions (12) and (13) of this subsection, an individual that contracts with a local management entity (LME) for the delivery of mental health, developmental disabilities, and substance abuse services may not serve on the board of the LME for the period during which the contract for services is in effect. No person registered as a lobbyist under Chapter 120C of the General Statutes shall be appointed to or serve on an area authority board. Of the members described in subdivisions (2) through (4) of this subsection, the boards of county commissioners shall ensure there is at least one member representing the interest of each of the following: (i) individuals with mental illness, (ii) individuals with intellectual or other developmental disabilities, and (iii) individuals in recovery from addiction.

(c) The board of county commissioners may elect to appoint a member of the area authority board to fill concurrently no more than two categories of membership if the member has the qualifications or attributes of the two categories of membership.

(d) Any member of an area board who is a county commissioner serves on the board in an ex officio capacity at the pleasure of the initial appointing authority, for a term not to exceed the earlier of three years or the member's service as a county commissioner. Any member of an area board who is a county manager serves on the board at the pleasure of the initial appointing authority, for a term not to exceed the earlier of three years or the duration of the member's employment as a county manager. The terms of members on the area board shall be for three years, except that upon the initial formation of an area board in compliance with subsection (a) of this

section, one-third shall be appointed for one year, one-third for two years, and all remaining members for three years. Members shall not be appointed for more than three consecutive terms.

(e) Upon request, the board shall provide information pertaining to the membership of the board that is a public record under Chapter 132 of the General Statutes.

(f) An area authority that adds one or more counties to its existing catchment area under G.S. 122C-115(c1) shall ensure that the expanded catchment area is represented through membership on the area board, with or without adding area board members under this section, as provided in G.S. 122C-118.1(a). (2001-437, s. 1.11(b); 2002-159, s. 40(a); 2006-142, s. 4(e); 2007-504, s. 1.4; 2010-31, s. 10.7; 2012-151, s. 3(a); 2013-85, ss. 6, 7; 2017-6, s. 3; 2018-146, ss. 3.1(a), (b), 6.1.)

§ 122C-118.2. Establishment of county commissioner advisory board.

(a) There is established a county commissioner advisory board for each catchment area, consisting of one county commissioner from each county in the catchment area, designated by the board of commissioners of each county. The county commissioner advisory board shall meet on a regular basis, and its duties shall include serving as the chief advisory board to the area authority and to the director of the area authority on matters pertaining to the delivery of services for individuals with mental illness, intellectual or other developmental disabilities, and substance abuse disorders in the catchment area. The county commissioner advisory board serves in an advisory capacity only to the area authority, and its duties do not include authority over budgeting, personnel matters, governance, or policymaking of the area authority.

(b) Each board of commissioners within the catchment area shall designate from its members the commissioner to serve on the county commissioner advisory board. Each board of commissioners may determine the manner of designation, the term of service, and the conditions under which its designee will serve on the county commissioner advisory board. (2013-85, s. 8.)

§ 122C-119. Organization of area board.

(a) The area board shall meet at least six times per year.

(b) Meetings shall be called by the area board chairman or by three or more members of the board after notifying the area board chairman in writing.

(c) Members of the area board elect the board's chairman. The term of office of the area board chairman shall be one year. A county commissioner area board member may serve as the area board chairman.

(d) The area board shall establish a finance committee that shall meet at least six times per year to review the financial strength of the area program. The finance committee shall have a minimum of three members, two of whom have expertise in budgeting and fiscal control. The member of the area board who is the county finance officer or individual with financial expertise shall serve as an ex officio member. All other finance officers of participating counties in a multicounty area authority may serve as ex officio members. If the area board so chooses, the entire area board may function as the finance committee; however, its required meetings as a finance committee shall be distinct from its meetings as an area board. (1971, c. 470, s. 1; 1973, c. 455; c. 476, s. 133; c. 1355; 1975, c. 400, ss. 1-4; 1977, c. 568, s. 1; 1979, c. 358, ss. 6, 23; c. 455; 1981, c. 52; 1983, c. 6; 1985, c. 589, s. 2; 1995 (Reg. Sess., 1996), c. 749, s. 4; 2001-437, s. 1.11(c).)

§ 122C-119.1. Area Authority board members' training.

All members of the governing body for an area authority shall receive initial orientation on board members' responsibilities and annual training provided by the Department which shall include fiscal management, budget development, and fiscal accountability. A member's refusal to be trained shall be grounds for removal from the board. (1995, c. 507, s. 23.3; 1995 (Reg. Sess., 1996), c. 749, s. 5; 2012-151, s. 4(a).)

§ 122C-120. Compensation of area board members.

(a) Area board members may receive as compensation for their services per diem and a subsistence allowance for each day during which they are engaged in the official business of the area board. The amount of the per diem and subsistence allowances shall be established by the area board. The amount of per diem allowance shall not exceed fifty dollars ($50.00). Reimbursement of subsistence expenses shall be at the rates allowed to State officers and employees under G.S. 138-6(a)(3).

(b) Area board members may be reimbursed for all necessary travel expenses and registration fees in amounts fixed by the board. (1979, c. 358, s. 28; 1985, c. 589, s. 2; 2000-67, s. 11.18.)

§ 122C-120.1. Repealed by Session Laws 2023-134, s. 9G.7A(d4), effective October 3, 2023.

§ 122C-121. Area director.

(a) The area director is an employee of the area board, shall serve at the pleasure of the board, and shall be appointed in accordance with G.S. 122C-117(a)(7). As used in this subsection, "employee" means an individual and does not include a corporation, a partnership, a limited liability corporation, or any other business association.

(a1) The area board shall establish the area director's salary under Article 3 of Chapter 126 of the General Statutes. Notwithstanding G.S. 126-9(b), an area director may be paid a salary that is in excess of the salary ranges established by the State Human Resources Commission. Any salary that is higher than the maximum of the applicable salary range shall be supported by documentation of comparable salaries in comparable operations within the region and shall also include the specific amount the board proposes to pay the director. The area board shall not authorize any salary adjustment that is above the normal allowable salary range without obtaining prior approval from the Director of the Office of State Human Resources.

(a2) The area board shall not provide the director with any benefits that are not also provided by the area board to all permanent employees of the area authority, except that the area board may, in its discretion, offer severance benefits, relocation expenses, or both, to an applicant for the position of director as an incentive for the applicant to accept an offer of employment. The director shall be reimbursed only for allowable employment-related expenses at the same rate and in the same manner as other employees of the area authority.

(b) The area board shall evaluate annually the area director for performance based on criteria established by the Secretary and the area board. In conducting the evaluation, the area board shall consider comments from the board of county commissioners.

(c) The area director is the administrative head of the area authority. In addition to the duties under G.S. 122C-111, the area director shall:

(1) Appoint, supervise, and terminate area authority staff.
(2) Administer area authority services.
(3) Develop the budget of the area authority for review by the area board.

(4) Provide information and advice to the board of county commissioners through the county manager.
(5) Act as liaison between the area authority and the Department.

(d) Except when specifically waived by the Secretary, the area director shall meet all the following minimum qualifications:

(1) Holds a master's, or higher, degree in business, healthcare administration, public health, finance, law, medicine, or a related field deemed acceptable by the area board.
(2) Has related experience.
(3) Has management experience.
(4) Meets any other qualifications required by any contracts, as defined in G.S. 122C-124.2(g). (1971, c. 470, s. 1; 1973, c. 476, s. 133; 1977, c. 568, s. 1; c. 679, s. 7; 1979, c. 358, s. 14; 1981, c. 51, s. 3; 1985, c. 589, s. 2; 2001-437, s. 1.12; 2006-142, s. 4(k); 2007-323, s. 6.20(a); 2012-151, s. 11(c); 2013-339, s. 1; 2013-382, s. 9.1(c); 2023-134, s. 9G.7A(d3).)

§ 122C-121.1. Area authority key personnel.

(a) As used in this section, key personnel means the key personnel designated by the Department in a contract, as defined in G.S. 122C-124.2(g), with the area authority.

(b) The Secretary may discharge an employee of an area authority who is in a position designated as key personnel if the employee has failed to substantially comply with the requirements of the applicable key personnel role description contained in the area authority's contract, as defined in G.S. 122C-124.2(g), with the Department.

(c) The Secretary's decision to discharge an employee of an area authority under subsection (b) of this section is not subject to appeal to the Office of Administrative Hearings, in accordance with G.S. 150B-1(e)(28). (2023-134, s. 9G.7A(d1).)

§ 122C-122: Repealed by Session Laws 2012-151, s. 12(a), effective July 12, 2012.

§ 122C-123. Other agency responsibility.

Notwithstanding the provisions of G.S. 122C-112(a)(10), G.S. 122C-117(a)(1), G.S. 122C-127, and G.S. 122C-131, other agencies of the Department, other State agencies, and other local agencies shall continue responsibility for services they provide for persons with developmental disabilities. (1987, c. 830, s. 47(e); 1989, c. 625, s. 14; 1995 (Reg. Sess., 1996), c. 690, s. 11.)

§ 122C-123.1. Area authority reimbursement to State for disallowed expenditures.

Any funds or part thereof of an area authority that are transferred by the area authority to any entity including a firm, partnership, corporation, company, association, joint stock association, agency, or nonprofit private foundation shall be subject to reimbursement by the area authority to the State when expenditures of the area authority are disallowed pursuant to a State or federal audit. (1999-237, s. 11.41.)

§ 122C-124: Repealed by Session Laws 2001-437, s. 1.13(a).

§ 122C-124.1. Repealed by Session Laws 2023-134, s. 9G.7A(a7), effective October 3, 2023.

§ 122C-124.2. Actions by the Secretary to ensure effective management of behavioral health services under the 1915(b)/(c) Medicaid Waiver.

(a) For all local management entity/managed care organizations, the Secretary shall certify whether the LME/MCO is in compliance or is not in compliance with all requirements of subdivisions (1) through (3) of subsection (b) of this section. The Secretary's certification shall be made every six months beginning August 1, 2013. In order to ensure accurate evaluation of administrative, operational, actuarial and financial components, and overall performance of the LME/MCO, the Secretary's certification shall be based upon an internal and external assessment made by an independent external review agency in accordance with applicable federal and State laws and regulations. Beginning on February 1, 2014, and for all subsequent assessments for certification, the independent review will be made by an External Quality Review Organization approved by the Centers for Medicare and Medicaid Services and in accordance with applicable federal and State laws and regulations.

(b) The Secretary's certification under subsection (a) of this section shall be in writing and signed by the Secretary and shall contain a clear and unequivocal statement that the Secretary has determined the local management entity/managed care organization to be in compliance with all of the following requirements:

(1) The LME/MCO has made adequate provision against the risk of insolvency and, in accordance with G.S. 122C-125.3, is either (i) not required to be under a corrective action plan or (ii) in compliance with a corrective action plan.

(2) The LME/MCO is making timely provider payments. The Secretary shall certify that an LME/MCO is making timely provider payments if there are no consecutive three-month periods during which the LME/MCO paid less than ninety percent (90%) of clean claims for covered services within the 30-day period following the LME/MCO's receipt of these claims during that three-month period. As used in this subdivision, a "clean claim" is a claim that can be processed without obtaining additional information from the provider of the service or from a third party. The term includes a claim with errors originating in the LME/MCO's claims system. The term does not include a claim from a provider who is under investigation by a governmental agency for fraud or abuse or a claim under review for medical necessity.

(3) The LME/MCO is exchanging billing, payment, and transaction information with the Department and providers in a manner that complies with all applicable federal standards, including all of the following:

a. Standards for information transactions and data elements specified in 42 U.S.C. § 1302d-2 of the Healthcare Insurance Portability and Accountability Act (HIPAA), as from time to time amended.

b. Standards for health care claims or equivalent encounter information transactions specified in HIPAA regulations in 45 C.F.R. § 162.1102, as from time to time amended.

c. Implementation specifications for Electronic Data Interchange standards published and maintained by the Accredited Standards Committee (ASC X12) and referenced in HIPAA regulations in 45 C.F.R. § 162.920, as from time to time amended.

(c) If the Secretary does not provide a local management entity/managed care organization with the certification of compliance required by this section based upon the LME/MCO's failure to comply with any of the requirements specified in subdivisions (1) through (3) of subsection (b) of this section, the Secretary shall direct the dissolution of the LME/MCO in accordance with G.S. 122C-115.5 after the Department fulfills any contractual obligations regarding the noncompliance.

(d) If, at any time, in the Secretary's determination, a local management entity/managed care organization is not in compliance with a requirement of the Contract other than those specified in subdivisions (1) through (3) of subsection (b) of this section, then the Secretary shall direct the dissolution of the LME/MCO in accordance with G.S. 122C-115.5 after the Department fulfills any contractual obligations regarding the noncompliance.

(e) Repealed by Session Laws 2023-134, s. 9G.7A(a8), effective October 3, 2023.

(f) The Secretary shall provide a copy of each written, signed certification of compliance or noncompliance completed in accordance with this section to the Senate Appropriations Committee on Health and Human Services, the House Appropriations Subcommittee on Health and Human Services, the Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division.

(g) As used in this section, the following terms mean:

(1) Compliant local management entity/managed care organization. – An LME/MCO that has undergone an independent external assessment and been determined by the Secretary to be operating successfully and to have the capability of expanding.

(2) Contract. – A contract between the Department of Health and Human Services and a local management entity for the operation of the 1915(b)/(c) Medicaid Waiver or a BH IDD tailored plan. (2013-85, s. 2; 2018-5, s. 11F.10(d); 2023-134, s. 9G.7A(a8).)

§ 122C-124.3. Actions by the Secretary in response to county concerns.

(a) A county that has concerns about the performance of the area authority with which it is aligned shall provide written notice of its concerns to the Secretary, the area director of the area authority, the chair of the area board, and the chairs of the Joint Legislative Oversight Committee on Health and Human Services.

(b) Upon the Secretary's receipt of a notice from a county under subsection (a) of this section, the Department shall evaluate the performance concerns to determine their validity. If the performance concerns are valid, then all of the following shall occur:

(1) The Secretary shall direct the area authority to promptly address and resolve the performance concerns raised by the county.

(2) If the concerns involve the area authority's performance under a contract, as defined in G.S. 122C-124.2(g), then (i) the Secretary shall take all actions necessary to ensure that the area authority complies with the terms of the contract and (ii) if the area authority does not come into compliance with the terms of the contract within the time frame contemplated in the contract, then the Secretary shall follow the processes specified in the contract and under 42 C.F.R. Part 438, Subpart I, which may include intermediate sanctions or termination of the contract. (2023-134, s. 9G.7A(b1).)

§ 122C-125. Repealed by Session Laws 2023-134, s. 9G.7A(a9), effective October 3, 2023.

§ 122C-125.1: Repealed by Session Laws 2001-437, s. 1.13.

§ 122C-125.2. Repealed by Session Laws 2023-134, s. 9G.7A(a10), effective October 3, 2023.

§ 122C-125.3. LME/MCO solvency; corrective action plan.

(a) In its contracts with LME/MCOs, the Department shall establish solvency standards based on industry-standard financial accounting measures such as the current ratio of assets to liabilities, defensive interval ratio of current assets to average monthly expenditure, capital reserves, and profit and loss. The contracts shall require the development of a corrective action plan when an LME/MCO does not meet the solvency standards specified in the contract.

(b) Each LME/MCO shall provide the Department with monthly financial reports containing the data needed to calculate the financial accounting measures and assess the LME/MCO's adherence to the solvency standards established in the contract.

(c) On a quarterly basis, beginning on April 1, 2024, the Department shall publish to its website a dashboard reporting all of the following information for each LME/MCO for the previous quarter:

(1) Each solvency standard applicable to the LME/MCO under its contracts with the Department, including any applicable minimum or maximum threshold.

(2) The financial position of the LME/MCO relative to each solvency standard applicable to the LME/MCO under its contracts with the Department.

(3) Whether the LME/MCO is under any corrective action plan related to the solvency standards applicable to the LME/MCO under its contracts with the Department, and whether the LME/MCO is in compliance with any such corrective action plan.

(d) The Department shall notify the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Medicaid, and the Fiscal Research Division when the information required under subsection (c) of this section has been published to the Department's website. (2023-134, s. 9G.7A(a11).)

§ 122C-125.4: Reserved for future codification purposes.

§ 122C-125.5: Reserved for future codification purposes.

§ 122C-126: Repealed by Session Laws 2001-437, s. 1.13.

§ 122C-126.1. Confidentiality of competitive health care information.

(a) For the purposes of this section, competitive health care information means information relating to competitive health care activities by or on behalf of the area authority. Competitive health care information shall be confidential and not a public record under Chapter 132 of the General Statutes; provided that any contract entered into by or on behalf of an area authority shall be a public record, unless otherwise exempted by law, or the contract contains competitive health care information, the determination of which shall be as provided in subsection (b) of this section.

(b) If an area authority is requested to disclose any contract that the area authority believes in good faith contains or constitutes competitive health care information, the area authority may

either redact the portions of the contract believed to constitute competitive health care information prior to disclosure or, if the entire contract constitutes competitive health care information, refuse disclosure of the contract. The person requesting disclosure of the contract may institute an action pursuant to G.S. 132-9 to compel disclosure of the contract or any redacted portion thereof. In any action brought under this subsection, the issue for decision by the court shall be whether the contract, or portions of the contract withheld, constitutes competitive health care information, and in making its determination, the court shall be guided by the procedures and standards applicable to protective orders requested under Rule 26(c)(7) of the Rules of Civil Procedure. Before rendering a decision, the court shall review the contract in camera and hear arguments from the parties. If the court finds that the contract constitutes or contains competitive health care information, the court may either deny disclosure or may make such other appropriate orders as are permitted under Rule 26(c) of the Rules of Civil Procedure.

(c) Nothing in this section shall be deemed to prevent the Attorney General, the State Auditor, or an elected public body, in closed session, which has responsibility for the area authority, from having access to this confidential information. The disclosure to any public entity does not affect the confidentiality of the information. Members of the public entity shall have a duty not to further disclose the confidential information. (2012-151, s. 10.)

Part 2A. Consolidated Human Services.

§ 122C-127. Consolidated human services board; human services director.

(a) Except as otherwise provided by this section and subject to any limitations that may be imposed by the board of county commissioners under G.S. 153A-77, a consolidated human services agency shall have the responsibility and authority set forth in G.S. 122C-117(a) to carry out the programs established in this Chapter in conformity with the rules and regulations of the Department and under the supervision of the Secretary in the same manner as an area authority. In addition to the powers conferred by G.S. 153A-77(d), a consolidated human services board shall have all the powers and duties of the governing unit of an area authority as provided by G.S. 122C-117(b), except that the consolidated human services board may not:

(1) Appoint the human services director.
(2) Transmit or present the budget for social services programs.
(3) Enter into contracts, including contracts to provide services to governmental or private entities, unless specifically authorized to do so by the board of county commissioners in accordance with county contracting policies and procedures.

(b) In addition to the powers conferred by G.S. 153A-77(e), a human services director shall have all the powers and duties of an area director as provided by G.S. 122C-121, except that the human services director may:

(1) Serve as the executive officer of the consolidated human services board only to the extent and in the manner authorized by the county manager.
(2) Appoint staff of the consolidated human services agency only upon the approval of the county manager.

The human services director is not an employee of the area board, but serves as an employee of the county under the direct supervision of the county manager. (1995 (Reg. Sess., 1996), c. 690, s. 12.)

§ 122C-128. Reserved for future codification purposes.

§ 122C-129. Reserved for future codification purposes.

§ 122C-130. Reserved for future codification purposes.

Part 3. Service Delivery System.

§ 122C-131. Composition of system.

Mental health, developmental disabilities, and substance abuse services of the public system in this State shall be delivered through area authorities and State facilities. (1985, c. 589, s. 2; 1989, c. 625, s. 15.)

§ 122C-132: Repealed by Session Laws 2001-437, s. 1.14.

§ 122C-132.1: Repealed by Session Laws 2001-437, s. 1.14.

§§ 122C-133 through 122C-140. Reserved for future codification purposes.

Part 4. Area Facilities.

§ 122C-141. Provision of services.

(a) An area authority shall contract with other qualified public or private providers, agencies, institutions, or resources for the provision of services, and, subject to the approval of the Secretary, is authorized to provide services directly. Unless an area authority requests a shorter time, any approval granted by the Secretary shall be for not less than one year. The Secretary shall develop criteria for the approval of direct service provision by area authorities in accordance with this section. For the purposes of this section, a qualified public or private provider is a provider that meets the provider qualifications as defined by rules adopted by the Secretary.

(b) All area authority services provided directly or under contract shall meet the requirements of applicable State statutes and the rules of the Commission and the Secretary. The Secretary may delay payments and, with written notification of cause, may reduce or deny payment of funds if an area authority fails to meet these requirements.

(c) The area authority may contract with a health maintenance organization, certified and operating in accordance with the provisions of Article 67 of Chapter 58 of the General Statutes for the area authority to provide mental health, developmental disabilities, or substance use disorder services to enrollees in a health care plan provided by the health maintenance organization. The terms of the contract must meet the requirements of all applicable State statutes and rules of the Commission and Secretary governing both the provision of services by an area authority and the general and fiscal operation of an area authority and the reimbursement rate for services rendered shall be based on the usual and customary charges paid by the health maintenance organization to similar providers. Any provision in conflict with a State statute or rule of the Commission or the Secretary shall be void; however, the presence of any void provision in that contract does not render void any other provision in that contract which is not in conflict with a State statute or rule of the Commission or the Secretary. Subject to approval by the Secretary and pending the timely reimbursement of the contractual charges, the area authority may expend funds for costs which may be incurred by the area authority as a result of providing the additional services under a contractual agreement with a health maintenance organization.

(d) If two or more counties enter into an interlocal agreement under Article 20 of Chapter 160A of the General Statutes to be a public provider of mental health, developmental disabilities,

or substance abuse services ("public provider"), before an LME may enter into a contract with the public provider, all of the following must apply:

(1) The public provider must meet all the provider qualifications as defined by rules adopted by the Commission. A county that satisfies its duties under G.S. 122C-115(a) through a consolidated human services agency may not be considered a qualified provider for purposes of this subdivision.

(2) The LME must adopt a conflict of interest policy that applies to all provider contracts.

(3) The interlocal agreement must provide that any liabilities of the public provider shall be paid from its unobligated surplus funds and that if those funds are not sufficient to satisfy the indebtedness, the remaining indebtedness shall be apportioned to the participating counties.

(e) When enforcing rules adopted by the Commission, the Secretary shall ensure that there is fair competition among providers. (1977, c. 568, s. 1; c. 679, s. 7; 1979, c. 358, ss. 7, 18; 1981, c. 51, s. 3; c. 539, ss. 3, 4; c. 614, s. 7; 1985, c. 589, s. 2; 1987, c. 839; 1989, c. 625, s. 16; 2001-437, s. 1.15; 2006-142, s. 4(l); 2007-504, s. 2.4(a); 2023-134, s. 9G.7A(a12).)

§ 122C-142. Contract for services.

(a) When the area authority contracts with persons for the provision of services, it shall use the standard contract adopted by the Secretary and shall assure that these contracted services meet the requirements of applicable State statutes and the rules of the Commission and the Secretary. However, an area authority may amend the contract to comply with any court-imposed duty or responsibility. An area authority that is operating under a Medicaid waiver may amend the contract subject to the approval of the Secretary. Terms of the standard contract shall require the area authority to monitor the contract to assure that rules and State statutes are met. It shall also place an obligation upon the entity providing services to provide to the area authority timely data regarding the clients being served, the services provided, and the client outcomes. The Secretary may also monitor contracted services to assure that rules and State statutes are met.

(b) When the area authority contracts for services, it may provide funds to purchase liability insurance, to provide legal representation, and to pay any claim with respect to liability for acts, omissions, or decisions by members of the boards or employees of the persons with whom the area authority contracts. These acts, omissions, and decisions shall be ones that arise out of the performance of the contract and may not result from actual fraud, corruption, or actual malice on the part of the board members or employees. (1977, c. 568, s. 1; c. 679, s. 7; 1979, c. 358, s. 18; 1981, c. 51, s. 3; c. 539, ss. 3, 4; 1985, c. 589, s. 2; 2006-142, s. 1; 2006-259, s. 23; 2013-85, s. 9.)

§ 122C-142.1. Substance abuse services for those convicted of driving while impaired or driving while less than 21 years old after consuming alcohol or drugs.

(a) Services. – An area authority shall provide, directly or by contract, the substance abuse services needed by a person to obtain a certificate of completion required under G.S. 20-17.6 as a condition for the restoration of a drivers license. A person may obtain the required services from an area facility, from a private facility authorized by the Department to provide this service, or, with the approval of the Department, from an agency that is located in another state.

(a1) Authorization of a Private Facility Provider. – The Department shall authorize a private facility located in this State to provide substance abuse services needed by a person to obtain a

certificate of completion if the private facility complies with all of the requirements of this subsection:

(1) Notifies both the designated area facility for the catchment area in which it is located and the Department of its intent to provide the services.

(2) Agrees to comply with the laws and rules concerning these services that apply to area facilities.

(3) Pays the Department the applicable fee for authorizing and monitoring the services of the facility. The initial fee is payable at the time the facility notifies the Department of its intent to provide the services and by July 1 of each year thereafter. Collected fees shall be used by the Division for program monitoring and quality assurance. The applicable fee is based upon the number of assessments completed during the prior fiscal year as set forth below:

Number of Assessments	Fee Amount
0-24	$250.00
25-99	$500.00
100 or more	$750.00.

(b) Assessments. – To conduct a substance abuse assessment, a facility shall give a client a standardized test approved by the Department to determine chemical dependency and shall conduct a clinical interview with the client. Based on the assessment, the facility shall recommend that the client either attend an alcohol and drug education traffic (ADET) school or obtain treatment. A recommendation shall be reviewed and signed by a certified alcoholism, drug abuse, or substance abuse counselor, as defined by the Commission, a Certified Substance Abuse Counselor, or by a physician certified by the American Society of Addiction Medicine (ASAM). The signature on the recommendation shall be the personal signature of the individual authorized to review the recommendation and not the signature of his or her agent. The signature shall reflect that the authorized individual has personally reviewed the recommendation and, with full knowledge of the contents of the recommendation, approved of the recommended treatment.

(b1) Persons Authorized to Conduct Assessments. – The following individuals are authorized to conduct a substance abuse assessment under subsection (b) of this section:

(1) A Certified Substance Abuse Counselor (CSAC), as defined by the Commission.

(2) A Licensed Clinical Addiction Specialist (LCAS), as defined by the Commission.

(3) Repealed by Session Laws 2004-197, s. 2, effective October 1, 2008, and applicable to substance abuse assessments conducted on or after that date.

(4) A person licensed by the North Carolina Medical Board or the North Carolina Psychology Board.

(5) A physician certified by the American Society of Addiction Medicine (ASAM).

(c) School or Treatment. – Attendance at an ADET school is required if none of the following applies and completion of a treatment program is required if any of the following applies:

(1) The person took a chemical test at the time of the offense that caused the person's license to be revoked and the test revealed that the person had an alcohol concentration at any relevant time after driving of at least 0.15.

(2) The person has a prior conviction of an offense involving impaired driving.

(3) The substance abuse assessment identifies a substance abuse disability.

(d) Standards. – An ADET school shall offer the curriculum established by the Commission and shall comply with the rules adopted by the Commission. A substance abuse treatment program offered to a person who needs the program to obtain a certificate of completion shall comply with the rules adopted by the Commission.

(d1) Persons Authorized to Provide Instruction. – Beginning January 1, 2009, individuals who provide ADET school instruction as a Department-authorized ADETS instructor must have at least one of the following qualifications:

(1) A Certified Substance Abuse Counselor (CSAC), as defined by the Commission.

(2) A Licensed Clinical Addictions Specialist (LCAS), as defined by the Commission.

(3) A Certified Substance Abuse Prevention Consultant (CSAPC), as defined by the Commission.

(e) Certificate of Completion. – Any facility that issues a certificate of completion shall forward the original certificate of completion to the Department. The Department shall review the certificate of completion for accuracy and completeness. If the Department finds the certificate of completion to be accurate and complete, the Department shall forward it to the Division of Motor Vehicles of the Department of Transportation. If the Department finds the certificate of completion is not accurate or complete, the Department shall return the certificate of completion to the area facility for appropriate action.

(f) Fees. – A person who has a substance abuse assessment conducted for the purpose of obtaining a certificate of completion shall pay to the assessing agency a fee of one hundred dollars ($100). A person shall pay to a school a fee of one hundred sixty dollars ($160.00). A person shall pay to a treatment facility a fee of seventy-five dollars ($75.00). If the defendant is treated by an area mental health facility, G.S. 122C-146 applies after receipt of the seventy-five dollar ($75.00) fee.

A facility that provides to a person who is required to obtain a certificate of completion a substance abuse assessment, an ADET school, or a substance abuse treatment program may require the person to pay a fee required by this subsection before it issues a certificate of completion. As stated in G.S. 122C-146, however, an area facility may not deny a service to a person because the person is unable to pay.

A facility shall remit to the Department ten percent (10%) of each fee paid to the facility under this subsection by a person who attends an ADET school conducted by the facility. The Department may use amounts remitted to it under this subsection only to support, evaluate, and administer ADET schools.

(f1) Multiple Assessments. – If a person has more than one offense for which a certificate of completion is required under G.S. 20-17.6, the person shall pay the assessment fee required under subsection (f) of this section for each certificate of completion required. However, the facility shall conduct only one substance abuse assessment and recommend only one ADET school or treatment program for all certificates of completion required at that time, and the person shall pay the fee required under subsection (f) of this section for only one school or treatment program.

If any of the criteria in subdivisions (c)(1), (c)(2), or (c)(3) of this section are present in any of the offenses for which the person needs a certificate of completion, completion of a treatment program shall be required pursuant to subsection (c) of this section.

The provisions of this subsection do not apply to subsequent assessments performed after a certificate of completion has already been issued for a previous assessment.

(g) Out-of-State Services. – A person may obtain a substance abuse service needed to obtain a certificate of completion from a provider located in another state if the service offered by that provider is substantially similar to the service offered by a provider located in this State. A person who obtains a service from a provider located in another state is responsible for paying any fees imposed by the provider.

(h) Rules. – The Commission may adopt rules to implement this section. In developing rules for determining when a person needs to be placed in a substance abuse treatment program, the Commission shall consider diagnostic criteria such as those contained in the most recent revision of the Diagnostic and Statistical Manual or used by the American Society of Addiction Medicine (ASAM).

(i) Report. – The Department shall submit an annual report on substance abuse assessments to the Joint Legislative Commission on Governmental Operations. The report is due by February 1. Each facility that provides services needed by a person to obtain a certificate of completion shall file an annual report with the Department by October 1 that contains the information the Department needs to compile the report the Department is required to submit under this section.

The report submitted to the Joint Legislative Commission on Governmental Operations shall include all of the following information and any other information requested by that Commission:

(1) The number of persons required to obtain a certificate of completion during the previous fiscal year as a condition of restoring the person's drivers license under G.S. 20-17.6.

(2) The number of substance abuse assessments conducted during the previous fiscal year for the purpose of obtaining a certificate of completion.

(3) Of the number of assessments reported under subdivision (2) of this subsection, the number recommending attendance at an ADET school, the number recommending treatment, and, for those recommending treatment, the level of treatment recommended.

(4) Of the number of persons recommended for an ADET school or treatment under subdivision (3) of this subsection, the number who completed the school or treatment.

(5) The number of substance abuse assessments conducted by each facility and, of these assessments, the number that recommended attendance at an ADET school and the number that recommended treatment.

(6) The fees paid to a facility for providing services for persons to obtain a certificate of completion and the facility's costs in providing those services.

(j) Repealed by Session Laws 2013-360, s. 12A.8(a), effective July 1, 2013. (1995, c. 496, ss. 10, 13; 2001-370, s. 9; 2003-396, ss. 1, 3, 4; 2004-197, ss. 1, 2, 3; 2005-312, ss. 1, 2, 4; 2008-130, ss. 7, 8; 2013-360, s. 12A.8(a).)

§ 122C-142.2. Presence at a hospital for mental health treatment; assessment and placement upon discharge of juvenile in department of social services custody.

(a) Definitions. – The following definitions apply in this section:

(1) Assessment. – A comprehensive clinical assessment, psychiatric evaluation, or a substantially equivalent assessment.

(2) Director. – The director of the county department of social services with custody of the juvenile, or the director's representative as authorized in G.S. 108A-14.
(3) Reserved for future codification purposes.
(4) Rapid Response Team. – A Department of Health and Human Services team of representatives from all of the following:
a. The Division of Child and Family Well-Being.
b. The Division of Health Benefits.
c. The Division of Mental Health, Developmental Disabilities, and Substance Use Services.
d. The Division of Social Services.

(b) If a juvenile (i) is in the custody of a department of social services, (ii) requires mental health treatment, and (iii) is present in the hospital by any means other than an involuntary commitment or voluntary admission order that is in effect, the hospital shall contact the director to notify the director of the juvenile's presence in the hospital. The director shall contact the appropriate LME/MCO or prepaid health plan as soon as practicable and, in any event, no later than 24 hours after the determination that the juvenile should not remain at the hospital and no appropriate placement is immediately available, to request an assessment.

(c) Consistent with the care coordination responsibilities under G.S. 122C-115.4(b)(5), the LME/MCO or prepaid health plan must, when applicable or required by their contract with the Department, arrange for an assessment to be performed by the juvenile's clinical home provider; the hospital, if able and willing; or other qualified licensed clinician within three business days following notification under subsection (b) of this section from the director. For purposes of this section, "business days" shall mean Monday through Friday, inclusive of holidays. The hospital shall reasonably cooperate with the LME/MCO or prepaid health plan to provide access to the juvenile during the juvenile's stay in the hospital.

(d) Based on the findings and recommendations of an assessment conducted pursuant to this section, all of the following must occur:
(1) If the comprehensive clinical assessment recommends a traditional foster home or a Level I group home, the director shall identify and provide the placement within five business days. The county department of social services shall be responsible for transporting the juvenile to the identified placement as soon as practicable but no later than five business days after the recommendation is made.
(2) If the assessment recommends a level of care requiring authorization by the LME/MCO or prepaid health plan, the LME/MCO or prepaid health plan shall authorize an appropriate level of care and identify appropriate providers within five business days and assign a care manager for the duration that the LME/MCO or prepaid health plan provides services to the juvenile. Once an appropriate level of care has been authorized and providers identified, the director shall place the juvenile in the appropriate placement as soon as practicable but no later than five business days after the recommendation is made. The county department of social services shall be responsible for transporting the juvenile to the identified placement.

(d1) The hospital shall not release the juvenile unless the juvenile meets hospital discharge criteria and at least one of the following conditions exists:

(1) The placement as recommended by the assessment is available.
(2) The consent of the individual or director authorized to consent to treatment pursuant to G.S. 7B-505.1.

(e) The county department of social services shall provide ongoing case management, virtually or in person, to address the juvenile's educational and social needs during the juvenile's stay in the hospital. The hospital shall cooperate with the county department of social services to provide access to the juvenile during the juvenile's stay in the hospital.

(f) The director, an LME/MCO, or a prepaid health plan shall notify the Rapid Response Team of any of the following circumstances:

(1) After completion of the assessment, the director under subdivision (d)(1) of this section or the LME/MCO or prepaid health plan under subdivision (d)(2) of this section anticipates being unable to identify an appropriate available placement or treatment provider for the juvenile.
(2) The assessment recommendations differ from the preferences of the individual or director authorized to consent to treatment pursuant to G.S. 7B-505.1 or from services readily available.
(3) There are delays in accessing needed behavioral health assessments.
(4) The juvenile has been released from the hospital in violation of subsection (d1) of this section.

(f1) The director, pursuant to G.S. 7B-302(a1)(1) and the LME/MCO, or the prepaid health plan, are authorized to disclose confidential information to the Rapid Response Team to ensure the juvenile is protected from abuse or neglect and for the provision of protective services to the juvenile. All confidential information disclosed to the Rapid Response Team shall remain confidential, shall not be further redisclosed unless authorized by State or federal law or regulations, and shall not be considered a public record. Notification to the Rapid Response Team does not relieve the director, LME/MCO, prepaid health plan, or any other entity from carrying out their responsibilities to the juvenile.

(g) Upon receipt of a notification made in accordance with subsection (f) of this section, the Rapid Response Team shall evaluate the information provided to determine if action from the Rapid Response Team is necessary to address the immediate needs of the juvenile. If action is necessary, the Rapid Response Team shall develop a plan with the county department of social services, LME/MCO or prepaid health plan, and hospital regarding the steps needed to meet the treatment needs of the juvenile. Any plan shall include the means by which to monitor the implementation of the plan.

(h) Meetings of the Rapid Response Team convened under this section shall be limited to members of the Rapid Response Team and individuals from the relevant county department of social services, LME/MCOs, prepaid health plans, and the hospital that are invited by the Rapid Response Team, or other individuals or providers only if invited by the Rapid Response Team. The meetings of the Rapid Response Team shall not be open to the public. Subsection (f1) of this section shall apply to any information gathered for the meeting. Information shared at the meeting or documents created during the course of the meetings or during the course of evaluating and developing any response in accordance with subsection (g) of this section shall not be public record and shall not be disclosed or redisclosed unless authorized under State or federal law.

(i) The LME/MCO or prepaid health plan shall notify monthly the Division of Social Services of the Department of Health and Human Services of all of the following information:

(1) The number of county department of social services notifications of assessments.
(2) The length of time to find placement for the juvenile.
(3) The number of recommendations at each level of care. (2021-132, s. 5(a); 2023-65, ss. 3.4, 5.2(b); 2025-16, s. 1.16(a).)

§ 122C-143: Repealed by Session Laws 1993, c. 321, s. 220(d).

§ 122C-143.1. Policy guidance.

(a) The General Assembly shall, as it considers necessary, endorse as policy guidance long-range plans for the broad age/disability categories of persons to be served and the services to be provided by area authorities.

(b) The Secretary shall develop a payment policy that designates, within broad age/disability categories, the priority populations, based on their disability level and the types of service to be supported by State resources. The Secretary shall review the Department's payment policy annually to assure that payments are made consistent with the State's long-range plans.

(c) The Secretary shall ensure that the payment policy provides incentives designated to target resources consistent with legislative policy and with the State's long-range plans and to promote equal accessibility to services for individuals regardless of their catchment area.

(d) Upon request of the Secretary, each area authority shall develop, revise, or amend its local long-range plans to be consistent with the policy guidance set forth in the State's long-range plans. Local service implementation plans shall be subject to the approval of the Secretary.

(e) The Secretary shall ensure that the Department's requests for expansion funds for area authorities are consistent with the State's long-range plans and include consideration of needs identified by the area authorities and their local plans. (1993, c. 321, s. 220(e).)

§ 122C-143.2: Repealed by Session Laws 2001-437, s. 1.16, effective July 1, 2002.

§ 122C-144: Repealed by Session Laws 1993, c. 321, s. 220(f).

§ 122C-144.1. Budget format and reports.

(a) The area authority shall maintain its budget in accordance with the requirements of Article 3 of Subchapter III of Chapter 159 of the General Statutes, the Local Government Budget and Fiscal Control Act.

(b) The Secretary may require periodic reports of receipts and expenditures for all area authority services provided directly or under contract according to a format prescribed by the Secretary.

(c) In accordance with G.S. 159-34, the area authority shall have an audit completed and submit it to the Local Government Commission.

(d) The Secretary may require reports of client characteristics, staffing patterns, agency policies or activities, services, or specific financial data of the area authority, but the reports shall not identify individual clients of the area authority unless specifically required by State statute or federal statute or regulation, or unless valid consent for the release has been given by the client or legally responsible person. (1993, c. 321, s. 220(g).)

§ 122C-145: Renumbered as G.S. 122C-151.2 by Session Laws 1993, c. 321, s. 220.

§ 122C-146. Uniform co-payment schedule.

(a) The LME and its contractual provider agencies shall implement the co-payment schedule based on family income adopted by the Secretary under G.S. 122C-112.1(a)(34). The LME is responsible for determining the applicability of the co-payment to individuals authorized by the LME to receive services. An LME that provides services and its contractual provider agencies shall also make every reasonable effort to collect appropriate reimbursement for costs in providing these services from individuals or entities able to pay, including insurance and third-party payments. However, no individual may be refused services because of an inability to pay.

(b) Individuals may not be charged for free services, as required in "The Amendments to the Education of the Handicapped Act", P.L. 99-457, provided to eligible infants and toddlers and their families. This exemption from charges does not exempt insurers or other third-party payors from being charged for payment for these services, if the person who is legally responsible for any eligible infant or toddler is first advised that the person may or may not grant permission for the insurer or other payor to be billed for the free services.

(c) All funds collected from co-payments for LME operated services shall be used to provide services to individuals in targeted populations.

The collection of co-payments by an LME that provides services may not be used as justification for reduction or replacement of the budgeted commitment of local tax revenue. All funds collected from co-payments by contractual provider agencies shall be used to provide services to individuals in targeted populations. (1977, c. 568, s. 1; 1979, c. 358, s. 16; 1985, c. 589, s. 2; 1989 (Reg. Sess., 1990), c. 1003, s. 4; 1991, c. 215, s. 2; 1993, c. 487, s. 3; c. 553, s. 36; 2007-410, s. 1.)

§ 122C-147. Financing and title of area authority property.

(a) Repealed by Session Laws 1993, c. 321, s. 220(i).

(b) Unless otherwise specified by the Secretary, State appropriations to area authorities shall be used exclusively for the operating costs of the area authority; provided however:

(1) The Secretary may specify that designated State funds may be used by area authorities (i) for the purchase, alteration, improvement, or rehabilitation of real estate to be used as a facility or (ii) in contracting with a private, nonprofit corporation or with another governmental entity that operates facilities for the mentally ill, developmentally disabled, or substance abusers and according to the terms of the contract between the area authority and the private, nonprofit corporation or with the governmental entity, for the purchase, alteration, improvement, rehabilitation of real estate or, to make a lump sum down payment or periodic payments on a real property mortgage in the name of the private, nonprofit corporation or governmental entity.

(2) Upon cessation of the use of the facility by the area authority, if operated by the area authority, or upon termination, default, or nonrenewal of the contract if operated by a contractual agency, the Department shall be reimbursed in accordance with rules adopted by the Secretary for the Department's participation in the purchase of the facility.

(c) All real property purchased for use by the area authority shall be provided by local or federal funds unless otherwise allowed under subsection (b) of this section or by specific capital

funds appropriated by the General Assembly. The title to this real property and the authority to acquire it is held by the area authority. Real property may not be acquired by means of an installment contract under G.S. 160A-20 unless the Local Government Commission has approved the acquisition. No deficiency judgment may be rendered against any unit of local government in any action for breach of a contractual obligation authorized by this subsection, and the taxing power of a unit of local government is not and may not be pledged directly or indirectly to secure any moneys due under a contract authorized by this subsection.

(d) The area authority may lease real property.

(e) Equipment necessary for the operation of the area authority may be obtained with local, State, federal, or donated funds, or a combination of these.

(f) The area authority may acquire or lease personal property. An acquisition may be accomplished by an installment contract under G.S. 160A-20 or by a lease-purchase agreement. An area authority may not acquire personal property by means of an installment contract under G.S. 160A-20 without the approval of the board or boards of commissioners of all the counties that comprise the area authority. The approval of a board of county commissioners shall be by resolution of the board and may have any necessary or proper conditions, including provisions for distribution of the proceeds in the event of disposition of the property by the area authority. The area authority may not acquire personal property by means of an installment contract under G.S. 160A-20 without the approval of the Local Government Commission, when required by that statute. No deficiency judgment may be rendered against any unit of local government in any action for breach of a contractual obligation authorized by this subsection, and the taxing power of a unit of local government is not and shall not be pledged directly or indirectly to secure any moneys due under a contract authorized by this subsection. Title to personal property may be held by the area authority.

(g) All area authority funds shall be spent in accordance with the rules of the Secretary. Failure to comply with the rules is grounds for the Secretary to stop participation in the funding of the particular program. The Secretary may withdraw funds from a specific program of services not being administered in accordance with an approved plan and budget after written notice and subject to an appeal as provided by G.S. 122C-145 and Chapter 150B of the General Statutes.

(h) Notwithstanding subsection (b) of this section and in addition to the purposes listed in that subsection, the funds allocated by the Secretary for services for members of the class identified in Willie M., et al. vs. Hunt, et al. (C-C-79-294, Western District) may be used for the purchase, alteration, improvement, or rehabilitation of real property owned or to be owned by a nonprofit corporation or by another governmental entity and used or to be used as a facility.

(i) Notwithstanding subsection (c) of this section and in addition to the purposes listed in that subsection, funds allocated by the Secretary for services for members of the class identified in Willie M., et al. vs. Hunt, et al. (C-C-79-294, Western District) may be used for the purchase, alteration, improvement, or rehabilitation of real property used by an area authority as long as the title to the real property is vested in the county where the property is located or is vested in another governmental entity. If the property ceases to be used in accordance with the annual plan, the unamortized part of funds spent under this subsection for the purchase, alteration, improvement, or rehabilitation of real property shall be returned to the Department, in accordance with the rules of the Secretary.

(j) Notwithstanding subsection (c) of this section the area authority, with the approval of the Secretary, may use local funds for the alteration, improvement, and rehabilitation of real property owned by a nonprofit corporation or by another governmental entity under contract with

the area authority and used or to be used as a facility. Prior to the use of county appropriated funds for this purpose, the area authority shall obtain consent of the board or boards of commissioners of all the counties that comprise the area authority. The consent shall be by resolution of the affected board or boards of county commissioners and may have any necessary or proper conditions, including provisions for distribution of the proceeds in the event of disposition of the property. (1973, c. 476, s. 133; c. 613; 1977, c. 568, s. 1; c. 679, s. 7; 1979, c. 358, s. 29; 1981, c. 51, s. 3; 1983, c. 5; c. 25; c. 402; 1985, c. 589, s. 2; 1987, c. 720, s. 3; c. 784; 1989, c. 625, s. 17; 1993, c. 321, s. 220(h), (i); 1993 (Reg. Sess., 1994), c. 592, s. 1; 1995, c. 305, s. 1; 2012-151, s. 8.)

§ 122C-147.1. Appropriations and allocations.

(a) Except as provided in subsection (b) of this section, funds shall be appropriated by the General Assembly in broad age/disability categories. The Secretary shall allocate and account for funds in broad age/disability categories so that the area authority may, with flexibility, earn funds in response to local needs that are identified within the payment policy developed in accordance with G.S. 122C-143.1(b).

(b) When the General Assembly determines that it is necessary to appropriate funds for a more specific purpose than the broad age/disability category, the Secretary shall determine whether expenditure accounting, special reporting within earning from a broad fund, the Memorandum of Agreement, or some other mechanism allows the best accounting for the funds.

(b1) Notwithstanding subsection (b) of this section, funds appropriated by the General Assembly for crisis services shall not be allocated in broad disability or age/disability categories. Subsection (c) of this section shall not apply to funds appropriated by the General Assembly for crisis services.

(c) Funds that have been appropriated by the General Assembly for a more specific purpose than specified in subsection (a) of this section shall be converted to a broad age/disability category at the beginning of the second biennium following the appropriation, unless otherwise acted upon by the General Assembly.

(d) The Secretary shall allocate funds to area programs:

(1) To be earned in a purchase of service basis, at negotiated reimbursement rates, for services that are included in the payment policy and delivered to mentally ill, developmentally disabled, and substance abuse clients and for services that are included in the payment policy to other recipients; or

(2) To be paid under a grant on the basis of agreed-upon expenditures, when the Secretary determines that it would be impractical to pay on a purchase of service basis.

(d1) Notwithstanding subsections (b) and (d) of this section, each area program shall determine whether to earn the funds for crisis services and funds for services to substance abuse clients in a purchase-for-service basis, under a grant, or some combination of the two. Area programs shall account for funds expended on a grant basis according to procedures required by the Secretary and in a manner that is similar to funds expended in a purchase-for-service basis.

(e) After the close of a fiscal year, final payments of funds shall be made:

(1) Under the purchase of service basis, on the earnings of the area authority for the delivery to individuals within each age/disability group, of any services that are consistent with the payment policy established in G.S. 122C-143.1(b), up to the final allocation amount; or

(2) When awarded on an expenditure basis, on allowable actual expenditures, up to the final allocation amount.

Under rules adopted by the Secretary, final payments shall be adjusted on the basis of the audit required in G.S. 122C-144.1(d). (1993, c. 321, s. 220(j); 2007-323, ss. 10.49(b), (q).)

§ 122C-147.2. Purchase of services and reimbursement rates.

(a) When funds are used to purchase services, the following provisions apply:

(1) Reimbursement rates for specific types of service shall be negotiated between the Secretary and the area authority. The negotiation shall begin with the rate determined by a standardized cost-finding and rate-setting procedure approved by the Secretary.

(2) The reimbursement rate used for the payment of services shall incorporate operating and administrative costs, including costs for property in accordance with G.S. 122C-147.

(b) To ensure uniformity in rates charged to area programs and funded with State-allocated resources, the Division of Mental Health, Developmental Disabilities, and Substance Use Services of the Department of Health and Human Services may require a private agency that provides services under contract with an area program or county program, except for hospital services that have an established Medicaid rate, to complete an agency-wide uniform cost finding in accordance with subsection (a) of this section. The resulting cost shall be the maximum included for the private agency in the contracting area program's unit cost finding. If a private agency fails to timely and accurately complete the required agency-wide uniform cost finding in a manner acceptable to the Department's controller's office, the Department may suspend all Department funding and payment to the private agency until such time as an acceptable cost finding has been completed by the private agency and approved by the Department's controller's office. (1993, c. 321, s. 220(j); 2005-276, s. 10.30; 2023-65, s. 5.2(b).)

§§ 122C-148 through 122C-150: Repealed by Session Laws 1993, c. 321, s. 220(k).

§ 122C-151. Responsibilities of those receiving appropriations.

(a) All resources allocated to and received by any area authority and used for programs of mental health, developmental disabilities, substance abuse or other related services are subject to the conditions specified in this Article and to the rules of the Commission and the Secretary and to the conditions of the Memorandum of Agreement specified in G.S. 122C-143.2.

(b) If an area authority fails to complete actions necessary for the development of a Memorandum of Agreement, fails to file required reports within the time limit set by the Secretary, or fails to comply with any other requirements specified in this Article, the Secretary may:

(1) Delay payments; and

(2) With written notification of cause and subject to an appeal as provided by G.S. 122C-151.2, reduce or deny payment of funds. Restoration of funds upon compliance is within the discretion of the Secretary. (1977, c. 568, s. 1; c. 679, s. 7; 1979, c. 358, s. 25; 1981, c. 51, s. 3; 1985, c. 589, s. 2; 1989, c. 625, s. 19; 1993, c. 321, s. 220(l).)

§ 122C-151.1: Repealed by Session Laws 1993, c. 321, s. 220(n), as amended by Session Laws 1993 (Regular Session, 1994), c. 591, s. 7.)

§ 122C-151.2. Appeal by area authorities and county programs.

(a) The area authority or county program may appeal to the Commission any action regarding rules under the jurisdiction of the Commission or rules under the joint jurisdiction of the Commission and the Secretary.

(b) The area authority or county program may appeal to the Secretary any action regarding rules under the jurisdiction of the Secretary.

(c) Appeals shall be conducted according to rules adopted by the Commission and Secretary and in accordance with Chapter 150B of the General Statutes. (1977, c. 568, s. 1; c. 679, s. 7; 1979, c. 358, ss. 7, 19; 1981, c. 51, s. 3; c. 614, s. 7; 1985, c. 589, s. 2; 1987, c. 720, s. 3; 1993, c. 321, s. 220(m); 2001-437, s. 1.17(a).)

§ 122C-151.3. Dispute with area authorities or county programs.

(a) An area authority or county program shall establish written procedures for resolving disputes over decisions of an area authority or county program that may be appealed to the State MH/DD/SA Appeals Panel under G.S. 122C-151.4. The procedures shall be informal and shall provide an opportunity for those who dispute the decision to present their position.

(b) This section does not apply to LME/MCOs, enrollees, applicants, providers of emergency services, or network providers subject to Chapter 108D of the General Statutes. (1993, c. 321, s. 220(o); 2001-437, s. 1.17(b); 2013-397, s. 2.)

§ 122C-151.4. Appeal to State MH/DD/SA Appeals Panel.

(a) Definitions. – The following definitions apply in this section:

(1) Repealed by Session Laws 2021-88, s. 16(d), effective July 22, 2021.

(1a) Client. – An individual who is admitted to or receiving public services from an area facility. The term includes the client's personal representative or designee.

(1b) Contract. – A contract with an area authority or county program to provide services, other than personal services, to clients and other recipients of services.

(2) Contractor. – A person that has a contract or that had a contract during the current fiscal year.

(3) Former contractor. – A person that had a contract during the previous fiscal year.

(4) Panel. – The State MH/DD/SA Appeals Panel established under this section.

(b) Appeals Panel. – The State MH/DD/SA Appeals Panel is established. The Panel shall consist of three members appointed by the Secretary. The Secretary shall determine the qualifications of the Panel members. Panel members serve at the pleasure of the Secretary.

(c) Persons That May Appeal. – The following persons may appeal to the Panel after having exhausted the appeals process at the appropriate area authority or county program:

(1) A contractor or a former contractor that claims that an area authority or county program is not acting or has not acted within applicable State law or rules in denying the contractor's application for endorsement or in imposing a particular requirement on the contractor on fulfillment of the contract.

(2) A contractor or a former contractor that claims that a requirement of the contract substantially compromises the ability of the contractor to fulfill the contract.

(3) A contractor or former contractor that claims that an area authority or county program has acted arbitrarily and capriciously in reducing funding for the type

of services provided or formerly provided by the contractor or former contractor.

(4) A client or a person who was a client in the previous fiscal year, who claims that an area authority or county program has acted arbitrarily and capriciously in reducing funding for the type of services provided or formerly provided to the client directly by the area authority or county program.

(5) A person that claims that an area authority or county program did not comply with a State law or a rule adopted by the Secretary or the Commission in developing the plans and budgets of the area authority or county program and that the failure to comply has adversely affected the ability of the person to participate in the development of the plans and budgets.

(d) Hearing. – All members of the Panel shall hear an appeal to the Panel. An appeal shall be filed with the Panel within the time required by the Secretary and shall be heard by the Panel within the time required by the Secretary. A hearing shall be conducted at the place determined in accordance with the rules adopted by the Secretary. A hearing before the Panel shall be informal; no sworn testimony shall be taken and the rules of evidence do not apply. The person that appeals to the Panel has the burden of proof. The Panel shall not stay a decision of an area authority during an appeal to the Panel.

(e) Decision. – The Panel shall make a written decision on each appeal to the Panel within the time set by the Secretary. A decision may direct a contractor, an area authority, or a county program to take an action or to refrain from taking an action, but it shall not require a party to the appeal to pay any amount except payment due under the contract. In making a decision, the Panel shall determine the course of action that best protects or benefits the clients of the area authority or county program. If a party to an appeal fails to comply with a decision of the Panel and the Secretary determines that the failure deprives clients of the area authority or county program of a type of needed service, the Secretary may use funds previously allocated to the area authority or county program to provide the service.

(f) Chapter 150B Appeal. – A person that is dissatisfied with a decision of the Panel may commence a contested case under Article 3 of Chapter 150B of the General Statutes. Notwithstanding G.S. 150B-2(1b), an area authority or county program is considered an agency for purposes of the limited appeal authorized by this section. If the need to first appeal to the Panel is waived by the Secretary, a contractor may appeal directly to the Office of Administrative Hearings after having exhausted the appeals process at the appropriate area authority or county program.

(g) Limitation of Applicability. – This section does not apply to LME/MCOs, enrollees, applicants, providers of emergency services, or network providers subject to Chapter 108D of the General Statutes. (1993, c. 321, s. 220(o); 2001-437, s. 1.17(c); 2008-107, s. 10.15A(h); 2011-398, s. 40; 2012-66, s. 3; 2013-397, s. 3; 2021-88, s. 16(d).)

§ 122C-152. Liability insurance and waiver of immunity as to torts of agents, employees, and board members.

(a) An area authority, by securing liability insurance as provided in this section, may waive its governmental immunity from liability for damage by reason of death or injury to person or property caused by the negligence or tort of any agent, employee, or board member of the area authority when acting within the scope of his authority or within the course of his duties or employment. Governmental immunity is waived by the act of obtaining this insurance, but it is

waived by only to the extent that the area authority is indemnified by insurance for the negligence or tort.

(b) Any contract of insurance purchased pursuant to this section shall be issued by a company or corporation licensed and authorized to execute insurance contracts in this State and shall by its terms adequately insure the area authority against any and all liability for any damages by reason of death or injury to a person or property proximately caused by the negligent acts or torts of the agents, employees, and board members of the area authority when acting within the course of their duties or employment. The area board shall determine the extent of the liability and what agents, employees by class, and board members are covered by any insurance purchased pursuant to this subsection. Any company or corporation that enters into a contract of insurance as described in this section with the authority, by this act waives any defense based upon the governmental immunity of the area authority.

(c) Any persons sustaining damages, or, in the case of death, his personal representative, may sue an area authority insured under this section for the recovery of damages in any court of competent jurisdiction in this State, but only in a county located within the geographic limits of the authority. It is no defense to any action that the negligence or tort complained of was in pursuance of a governmental or discretionary function of the area authority if, and to the extent that, the authority has insurance coverage as provided by this section.

(d) Except as expressly provided by subsection (c) of this section, nothing in this section deprives any area authority of any defense whatsoever to any action for damages or to restrict, limit, or otherwise affect any defense which the area authority may have at common law or by virtue of any statute. Nothing in this section relieves any person sustaining damages nor any personal representative of any decedent from any duty to give notice of a claim to the area authority or to commence any civil action for the recovery of damages within the applicable period of time prescribed or limited by statute.

(e) The area authority may incur liability pursuant to this section only with respect to a claim arising after the authority has procured liability insurance pursuant to this section and during the time when the insurance is in force.

(f) No part of the pleadings that relate to or allege facts as to a defendant's insurance against liability may be read or mentioned in the presence of the trial jury in any action brought pursuant to this section. This liability does not attach unless the plaintiff waives the right to have all issues of law or fact relating to insurance in the action determined by a jury. These issues shall be heard and determined by the judge, and the jury shall be absent during any motions, arguments, testimony, or announcement of findings of fact or conclusions of law with respect to insurance. (1981, c. 539, s. 2; 1985, c. 589, s. 2.)

§ 122C-153. Defense of agents, employees, and board members.

(a) Upon request made by or in behalf of any agent, employee, or board member or former agent, employee, or board member of the area authority, any area authority may provide for the defense of any civil or criminal action or proceeding brought against him either in his official or in his individual capacity, or both, on account of any act done or omission made, or any act allegedly done or omission allegedly made, in the scope and course of his duty as an agent, employee, or board member. The defense may be provided by the local board by employing counsel or by purchasing insurance that requires that the insurer provide the defense. Nothing in this section requires any area authority to provide for the defense of any action or proceeding of any nature.

(b) An area authority may budget funds for the purpose of paying all or part of the claim made or any civil judgment entered against any of its agents, employees, or board members or former agents, employees, or board members when a claim is made or judgment is rendered as damages on account of any act done or omission made, or any act allegedly done or omission allegedly made, in the scope and course of his duty as an agent, employee, or board member of the area authority. Nothing in this section shall authorize any area authority to budget funds for the purpose of paying any claim made or civil judgment against any of its agents, employees, or board members, or former agents, employees, or board members, if the authority finds that the agent, employee, or board member acted or failed to act because of actual fraud, corruption, or actual malice on his part. Any authority may budget for and purchase insurance coverage for payment of claims or judgments pursuant to this section. Nothing in this section requires any authority to pay any claim or judgment referred to, and the purchase of insurance coverage for payment of the claim or judgment may not be considered an assumption of any liability not covered by the insurance contract and may not be deemed an assumption of liability or payment of any claim or judgment in excess of the limits of coverage in the insurance contract.

(c) Subsection (b) of this section does not authorize an authority to pay all or part of a claim made or civil judgment entered or to provide a defense to a criminal charge unless (i) notice of the claim or litigation is given to the area authority before the time that the claim is settled or civil judgment is entered; and (ii) the area authority has adopted, and made available for public inspection, uniform standards under which claims made, civil judgments entered, or criminal charges against agents, employees, or board members or former agents, employees, or board members shall be defended or paid.

(d) The board or boards of county commissioners that establish the area authority and the Secretary may allocate funds not otherwise restricted by law, in addition to the funds allocated for the operation of the program, for the purpose of paying legal defense, judgments, and settlements under this section. (1981, c. 539, s. 2; 1985, c. 589, s. 2.)

§ 122C-154. Personnel.

Employees under the direct supervision of the area director are employees of the area authority. For the purpose of personnel administration, Chapter 126 of the General Statutes applies unless otherwise provided in this Article. Notwithstanding G.S. 126-9(b), an employee of an area authority may be paid a salary that is in excess of the salary ranges established by the State Human Resources Commission. Any salary that is higher than the maximum of the applicable salary range shall be supported by documentation of comparable salaries in comparable operations within the region and shall also include the specific amount the board proposes to pay the employee. The area board shall not authorize any salary adjustment that is above the normal allowable salary range without obtaining prior approval from the Director of the Office of State Human Resources. (1971, c. 470, s. 1; 1973, c. 476, s. 133; 1977, c. 568, s. 1; c. 679, s. 7; 1979, c. 358, s. 14; 1981, c. 51, s. 3; 1985, c. 589, s. 2; 2001-437, s. 1.18; 2012-151, s. 11(b); 2013-382, s. 9.1(c); 2023-134, s. 9G.7A(a13).)

§ 122C-155. Supervision of services.

Unless otherwise specified, client services are the responsibility of a qualified professional. Direct medical and psychiatric services shall be provided by a qualified psychiatrist or a physician with adequate training and experience acceptable to the Secretary. (1971, c. 470, s. 1; 1973, c. 476, s. 133; 1977, c. 568, s. 1; c. 679, s. 7; 1979, c. 358, s. 14; 1981, c. 51, s. 3; 1985, c. 589, s. 2.)

§ 122C-156. Salary plan for employees of the area authority.

(a) The area authority shall establish a salary plan which shall set the salaries for employees of the area authority. The salary plan shall be in compliance with Chapter 126 of the General Statutes. In a multi-county area, the salary plan shall not exceed the highest paying salary plan of any county in that area. In a single-county area, the salary plan shall not exceed the county's salary plan. The salary plan limitations set forth in this section may be exceeded only if the area authority and the board or boards of county commissioners, as the case may be, jointly agree to exceed these limitations.

(b) An area authority may purchase life insurance or health insurance or both for the benefit of all or any class of authority officers or employees as a part of its compensation. An area authority may provide other fringe benefits for authority officers and employees.

(c) An area authority that is providing health insurance under subsection (b) of this section may provide health insurance for all or any class of former officers and employees of the area authority who are receiving benefits under Article 3 of Chapter 128 of the General Statutes. Health insurance may be paid entirely by the area authority, partly by the area authority and former officer or employee, or entirely by the former officer or employee, at the option of the area board. (1977, c. 568, s. 1; 1979, c. 358, ss. 15, 23; 1985, c. 589, s. 2.)

§ 122C-157. Establishment of a professional reimbursement policy.

The area authority shall adopt and enforce a professional reimbursement policy. This policy shall (i) require that fees for the provision of services received directly under the supervision of the area authority shall be paid to the area authority, (ii) prohibit employees of the area authority from providing services on a private basis which require the use of the resources and facilities of the area authority, and (iii) provide that employees may not accept dual compensation and dual employment unless they have the written permission of the area authority. (1977, c. 568, s. 1; 1979, c. 358, s. 17; 1985, c. 589, s. 2.)

§ 122C-158. Privacy of personnel records.

(a) Notwithstanding the provisions of G.S. 132-6 or any other State statute concerning access to public records, personnel files of employees or applicants for employment maintained by an area authority are subject to inspection and may be disclosed only as provided by this section. For purposes of this section, an employee's personnel file consists of any information in any form gathered by the area authority with respect to that employee, including his application, selection or nonselection, performance, promotions, demotions, transfers, suspensions and other disciplinary actions, evaluation forms, leave, salary, and termination of employment. As used in this section, "employee" includes former employees of the area authority.

(b) The following information with respect to each employee is a matter of public record:

(1) Name.
(2) Age.
(3) Date of original employment or appointment to the area authority.
(4) The terms of any contract by which the employee is employed whether written or oral, past and current, to the extent that the agency has the written contract or a record of the oral contract in its possession.
(5) Current position.
(6) Title.

(7) Current salary.
(8) Date and amount of each increase or decrease in salary with that area authority.
(9) Date and type each promotion, demotion, transfer, suspension, separation, or other change in position classification with that area authority.
(10) Date and general description of the reasons for each promotion with that area authority.
(11) Date and type of each dismissal, suspension, or demotion for disciplinary reasons taken by the area authority. If the disciplinary action was a dismissal, a copy of the written notice of the final decision of the area authority setting forth the specific acts or omissions that are the basis of the dismissal.
(12) The office to which the employee is currently assigned.

(b1) For the purposes of this subsection, the term "salary" includes pay, benefits, incentives, bonuses, and deferred and all other forms of compensation paid by the employing entity.

(b2) The area authority shall determine in what form and by whom this information will be maintained. Any person may have access to this information for the purpose of inspection, examination, and copying during regular business hours, subject only to rules for the safekeeping of public records as the area authority may have adopted. Any person denied access to this information may apply to the appropriate division of the General Court of Justice for an order compelling disclosure, and the court shall have jurisdiction to issue these orders.

(c) All information contained in an employee's personnel file, other than the information made public by subsection (b) of this section, is confidential and is open to inspection only in the following instances:

(1) The employee or an authorized agent may examine portions of his personnel file except (i) letters of reference solicited before employment, and (ii) information concerning a medical disability, mental or physical, that a prudent physician would not divulge to a patient.
(2) A licensed physician designated in writing by the employee may examine the employee's medical record.
(3) An area authority employee having supervisory authority over the employee may examine all material in the employee's personnel file.
(4) By order of a court of competent jurisdiction, any person may examine the part of an employee's personnel file that is ordered by the court.
(5) An official of an agency of the State or federal government, or any political subdivision of the State, may inspect any part of a personnel file pursuant to G.S. 122C-25(b) or G.S. 122C-192(a) or when the inspection is considered by the official having custody of the records to be inspected to be necessary and essential to the pursuance of a proper function of the inspecting agency. No information may be divulged for the purpose of assisting in a criminal prosecution of the employee or for the purpose of assisting in an investigation of the employee's tax liability. However, the official having custody of the records may release the name, address, and telephone number from a personnel file for the purpose of assisting in a criminal investigation.
(6) An employee may sign a written release, to be placed with the employee's personnel file, that permits the person with custody of the file to provide, either in person, by telephone or by mail, information specified in the release to

prospective employers, educational institutions, or other persons specified in the release.

(7) The area authority may tell any person of the employment or nonemployment, promotion, demotion, suspension, or other disciplinary action, reinstatement, transfer, or termination of an employee and the reasons for that personnel action. Before releasing the information, the area authority shall determine in writing that the release is essential to maintaining public confidence in the administration of services or to maintaining the level and quality of services. This written determination shall be retained as a record for public inspection and shall become part of the employee's personnel file.

(d) Even if considered part of an employee's personnel file, the following information need not be disclosed to an employee nor to any other person:

(1) Testing or examination material used solely to determine individual qualifications for appointment, employment, or promotion in the area authority service, when disclosure would compromise the objectivity or the fairness of the testing or examination process.

(2) Investigative reports or memoranda and other information concerning the investigation of possible criminal action of an employee, until the investigation is completed and no criminal action taken, or until the criminal action is concluded.

(3) Information that might identify an undercover law-enforcement officer or a law-enforcement informer.

(4) Notes, preliminary drafts, and internal communications concerning an employee. In the event these materials are used for any official personnel decision, then the employee or an authorized agent has a right to inspect these materials.

(e) The area authority may permit access, subject to limitations it may impose, to selected personnel files by a professional representative of a training, research, or academic institution if that representative certifies that he will not release information identifying the employees whose files are opened and that the information will be used solely for statistical, research, or teaching purposes. This certification shall be retained by the area authority as long as each personnel file so examined is retained.

(f) The area authority that maintains personnel files containing information other than the information mentioned in subsection (b) of this section shall establish procedures whereby an employee who objects to material in the employee's file on grounds that it is inaccurate or misleading may seek to have the material removed from the file or may place in the file a statement relating to the material.

(g) Permitting access, other than that authorized by this section, to a personnel file of an employee of an area authority is a Class 3 misdemeanor and is punishable only by a fine, not to exceed five hundred dollars ($500.00).

(h) Anyone who, knowing that he is not authorized to do so, examines, removes, or copies information in a personnel file of an employee of an area authority is guilty of a Class 3 misdemeanor and is punishable only by a fine, not to exceed five hundred dollars ($500.00). (1983, c. 281; 1985, c. 589, s. 2; 1993, c. 539, ss. 924, 925; 1994, Ex. Sess., c. 24, s. 14(c); 2007-508, s. 3; 2010-169, s. 18(d).)

§§ 122C-159 through 122C-169. Reserved for future codification purposes.

Part 4A. Consumer and Family Advisory Committees.

§ 122C-170. Local Consumer and Family Advisory Committees.

(a) Area authorities shall establish committees made up of consumers and family members to be known as Consumer and Family Advisory Committees (CFACS). A local CFAC shall be a self-governing and a self-directed organization that advises the area authority in its catchment area on the planning and management of the local public mental health, intellectual and developmental disabilities, substance use disorder, and traumatic brain injury services system.

Each CFAC shall adopt bylaws to govern the selection and appointment of its members, their terms of service, the number of members, and other procedural matters. At the request of either the CFAC or the governing board of the area authority, the CFAC and the governing board shall execute an agreement that identifies the roles and responsibilities of each party, channels of communication between the parties, and a process for resolving disputes between the parties.

(b) Each of the disability groups shall be equally represented on the CFAC, and the CFAC shall reflect as closely as possible the racial and ethnic composition of the catchment area. The terms of members shall be three years, and no member may serve more than three consecutive terms. The CFAC shall be composed exclusively of:

(1) Adult consumers of mental health, intellectual and developmental disabilities, substance use disorder, and traumatic brain injury services.

(2) Family members of consumers of mental health, intellectual and development disabilities, substance use disorder, and traumatic brain injury services.

(c) The CFAC shall undertake all of the following:

(1) Review, comment on, and monitor the implementation of the contract deliverables between area authorities and the Department of Health and Human Services.

(2) Identify service gaps and underserved populations.

(3) Make recommendations regarding the service array and monitor the development of additional services.

(4) Review and comment on the area authority budget.

(5) Develop a collaborative and working relationship with the area authorities member advisory committees to obtain input related to service delivery and system change issues.

(6) Submit to the State Consumer and Family Advisory Committee findings and recommendations regarding ways to improve the delivery of mental health, intellectual and developmental disabilities, substance use disorder, and traumatic brain injury services, including Statewide issues.

(d) The director of the area authority shall provide sufficient staff to assist the CFAC in implementing its duties under subsection (c) of this section. The assistance shall include data for the identification of service gaps and underserved populations, training to review and comment on contract deliverables and budgets, procedures to allow participation in quality monitoring, and technical advice on rules of procedure and applicable laws. (2006-142, s. 5; 2012-151, s. 5; 2021-77, s. 8.1.)

§ 122C-171. State Consumer and Family Advisory Committee.

(a) There is established the State Consumer and Family Advisory Committee (State CFAC). The State CFAC shall be a self-governing and self-directed organization that advises the Department and the General Assembly on the planning and management of the State's public mental health, intellectual and developmental disabilities, substance use disorder, and traumatic brain injury services system.

(b) The State CFAC shall be composed of 21 members. The members shall be composed exclusively of adult consumers of mental health, intellectual and developmental disabilities, substance use disorder, and traumatic brain injury services and family members of consumers of mental health, intellectual and developmental disabilities, substance use disorder, and traumatic brain injury services. The terms of members shall be three years, and no member may serve more than two consecutive terms. Vacancies shall be filled by the appointing authority. The members shall be appointed as follows:

(1) Nine members appointed by the Secretary. The Secretary's appointments shall reflect each of the disability groups. The terms shall be staggered so that terms of three of the appointees expire each year.

(2) Four members appointed by the President Pro Tempore of the Senate as follows:
   a. One member from the eastern region of the State.
   b. One member from the central region of the State.
   c. Two members from the western region of the State.

   The terms of the appointees shall be staggered so that the term of one appointee expires every year.

(3) Four members appointed by the Speaker of the House of Representatives as follows:
   a. One member from the eastern region of the State.
   b. Two members from the central region of the State.
   c. One member from the western region of the State.

   The terms of the appointees shall be staggered so that the term of one appointee expires every year.

(4) Repealed by Session Laws 2021-77, s. 4(a), effective July 2, 2021, and applicable only to appointments to the Consumer and Family Advisory Committee made on or after that date.

(5) Four members appointed by the North Carolina Association of County Commissioners as follows:
   a. Two members from the eastern region of the State.
   b. One member from the central region of the State.
   c. One member from the western region of the State.

   The terms of the appointees shall be staggered so that the term of one appointee expires every year.

(c) The State CFAC shall undertake all of the following:

(1) Review, comment on, and monitor the implementation of the State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services.

(2) Identify service gaps and underserved populations.

(3) Make recommendations regarding the service array and monitor the development of additional services.

(4) Review and comment on the State budget for mental health, intellectual and developmental disabilities, substance use disorder, and traumatic brain injury services.
(5) Review and comment on contract deliverables and the process and outcomes of prepaid health plans in meeting these contract deliverables.
(6) Receive the findings and recommendations by local CFACs regarding ways to improve the delivery of mental health, intellectual and developmental disabilities, substance use disorder, and traumatic brain injury services, including Statewide issues.
(7) Develop a collaborative and working relationship with the prepaid health plan member advisory committees to obtain input related to service delivery and system change issues.

(d) The Secretary shall provide sufficient staff to assist the State CFAC in implementing its duties under subsection (c) of this section. The assistance shall include data for the identification of service gaps and underserved populations, training to review and comment on the State Plan and departmental budget, procedures to allow participation in quality monitoring, and technical advice on rules of procedure and applicable laws.

(e) State CFAC members shall receive the per diem and allowances prescribed by G.S. 138-5 for State boards and commissions. (2006-142, s. 5; 2009-50, s. 1; 2021-77, s. 4(a).)

§§ 122C-172 through 122C-180. Reserved for future codification purposes.

Part 5. State Facilities.

§ 122C-181. Secretary's jurisdiction over State facilities.

(a) Except as provided in subsection (b) of this section, the Secretary shall operate the following facilities:

(1) Psychiatric Hospitals:
  a. Cherry Hospital.
  a1. Central Regional Hospital.
  b., c. Repealed by Session Laws 2007-177, s. 2. See Editor's note.
  d. Broughton Hospital.
(2) Developmental Centers:
  a. Caswell Developmental Center.
  b. Repealed by Session Laws 2007-177, s. 1, effective July 5, 2007.
  b1. J. Iverson Riddle Developmental Center.
  c. Murdoch Developmental Center.
  d. through e. Repealed by Session Laws 2007-177, s. 1, effective July 5, 2007.
(3) Alcohol and Drug Treatment Centers:
  a. Walter B. Jones Alcohol and Drug Abuse Treatment Center.
  b. Repealed by Session Laws 2007-177, s. 1, effective July 5, 2007.
  c. Julian F. Keith Alcohol and Drug Abuse Treatment Center.
  d. Repealed by Session Laws 2023-3, s. 2, effective March 10, 2023.
(4) Neuro-Medical Treatment Centers:
  a. through c. Repealed by Session Laws 2007-177, s. 1, effective July 5, 2007.

d. Black Mountain Neuro-Medical Treatment Center.
e. O'Berry Neuro-Medical Treatment Center.
f. Longleaf Neuro-Medical Treatment Center.

(5) Residential Programs for Children:
a. Whitaker School.
b. Wright School.

(b) Subject to the requirements of subsection (c) of this section, the Secretary may, with the approval of the Governor and Council of State, close any State facility.

(c) Closure of a State facility under subsection (b) of this section becomes effective on the earlier of the 31st legislative day or the day of adjournment of the next regular session of the General Assembly that begins at least 10 days after the date the closure is approved, unless a different effective date applies under this subsection. If a bill that specifically disapproves the State facility closure is introduced in either house of the General Assembly before the thirty-first legislative day of that session, the closure becomes effective on the earlier of either the day an unfavorable final action is taken on the bill or the day that session of the General Assembly adjourns without ratifying a bill that specifically disapproves the State facility closure. If the Secretary specifies a later effective date for closure than the date that would otherwise apply under this subsection, the later date applies. Closure of a State facility does not become effective if the closure is specifically disapproved by a bill enacted into law before it becomes effective. Notwithstanding any rule of either house of the General Assembly, any member of the General Assembly may introduce a bill during the first 30 legislative days of any regular session to disapprove closure of a facility that has been approved by the Governor and Council of State as provided in subsection (b) of this section. Nothing in this subsection shall be construed to impair the Secretary's power or duty otherwise imposed by law to close a State facility temporarily for the protection of health and safety. (Code, ss. 2227, 2240; 1899, c. 1, s. 1; Rev., s. 4542; C.S., s. 6151; 1945, c. 952, s. 8; 1947, c. 537, s. 2; 1949, c. 1206, s. 1; 1955, c. 887, s. 1; 1959, c. 348, s. 1; c. 1002, s. 1; c. 1008; c. 1028, ss. 1-4; 1961, c. 513; c. 1173, ss. 1, 2, 4; 1963, c. 1166, ss. 2, 10, 12; c. 1184, s. 6; 1967, c. 151; 1969, c. 982; 1973, c. 476, ss. 128, 133, 138; 1975, c. 19, s. 41; 1977, c. 679, s. 7; 1981, c. 51, s. 3; c. 77; c. 412, s. 4; 1983, c. 383, s. 9; 1985, c. 589, s. 2; 1989, c. 145, s. 1; 1991, c. 689, s. 136; 2001-437, s. 1.19; 2001-487, s. 80(a); 2007-177, ss. 1, 2; 2023-3, s. 2.)

§ 122C-182. Authority to contract with area authorities.

To establish a coordinated system of services for its clients, a State facility shall contract with an area authority. Contracted services shall meet the rules of the Commission and the Secretary. (1985, c. 589, s. 2.)

§ 122C-183. Appointment of employees as police officers who may arrest without warrant.

The director of each State facility may appoint as special police officers the number of employees of their respective facilities they consider necessary. Within the grounds of the State facility the employees appointed as special police officers have all the powers of police officers of cities. The Secretary, or the Secretary's designee, may assign these special police officers to other State-operated facilities on a temporary basis to carry out the powers allowed under this section and as otherwise provided by laws relating to the specific joint security force to which they are assigned. Upon this temporary assignment, the special police officer will take the oath in G.S. 122C-184 for that specific facility. Following the oath, the police officer has the right to arrest without warrant individuals committing violations of the State law or the ordinances or rules of that

facility in their presence and to bring the offenders before a magistrate who shall proceed as in other criminal cases. (1899, c. 1, s. 55; 1901, c. 627; Rev., s. 4569; C.S., s. 6181; 1921, c. 207; 1957, c. 1232, s. 12; 1959, c. 1002, s. 12; 1973, c. 108, s. 73; c. 673, s. 12.1; 1981, c. 635, s. 5; 1985, c. 589, s. 2; 2019-240, s. 19(a).)

§ 122C-184. Oath of special police officers.

Before exercising the duties of a special police officer, the employees appointed under G.S. 122C-183 shall take an oath or affirmation of office before an officer empowered to administer oaths. The oath or affirmation shall be filed with the records of the Department. The oath or affirmation of office is:

State of North Carolina: _____County.

I, _____, do solemnly swear (or affirm) that I will well and truly execute the duties of office of special police officer in and for the State facility called_____, according to the best of my skill and ability and according to law; and that I will use my best endeavors to enforce all the ordinances of said facility, and to suppress nuisances, and to suppress and prevent disorderly conduct within these grounds. So help me, God.

Sworn and subscribed before me, this _____ day of_____, A.D. _____.

(1899, c. 1, s. 56; 1901, c. 627; Rev., s. 4570; C.S., s. 6182; 1963, c. 1166, s. 11; 1973, c. 108, s. 74; c. 476, s. 133; 1985, c. 589, s. 2.)

§ 122C-185. Application of funds belonging to State facilities.

(a) All moneys and proceeds of property donated to any State facility shall be deposited into the State treasury and accounted for in the appropriate fund as determined by the Secretary and approved by the Office of State Budget and Management. All moneys and proceeds of property donated in which there are special directions for their application and the interest earned on these funds shall be spent as the donor has directed and except as required for deposit with the State treasury, shall not be subject to the provisions of the State Budget Act except for capital improvements projects which shall be authorized and executed in accordance with G.S. 143C-8-8 and G.S. 143C-8-9.

(b) Proceeds from the transfer or sale of surplus, obsolete, or unused equipment of State facilities shall be deposited and accounted for in accordance with G.S. 143-49(4).

(c) The net proceeds from the sale, lease, rental, or other disposition of real estate owned by a State facility shall be deposited and accounted for in accordance with G.S. 146-30.

(d) All proceeds from the operation of vending facilities as defined in G.S. 111-42(d) and operated by State facilities shall be deposited and accounted for in accordance with the State Budget Act, Chapter 143C of the General Statutes.

(e) All other revenues and other receipts collected by a State facility shall be deposited to the credit of the State treasury in accordance with G.S. 147-77. (1899, c. 1, s. 34; Rev., s. 4552; C.S., s. 6167; 1963, c. 1166, s. 13; 1973, c. 476, s. 133; 1985, c. 589, s. 2; 2000-140, s. 93.1(a); 2001-424, s. 12.2(b); 2006-203, s. 68.)

§ 122C-186. General Assembly visitors of State facilities.

The members of the General Assembly are ex officio visitors of all State facilities, provided that the common law right of visitation of a State facility is abrogated to the extent that it does not include the right to access to confidential information. This right of access is only as granted by statute. (1963, c. 1184, s. 1; 1973, c. 476, s. 133; 1985, c. 589, s. 2.)

§§ 122C-187 through 122C-190. Reserved for future codification purposes.

Part 6. Quality Assurance.

§ 122C-191. Quality of services.

(a) The assurance that services provided are of the highest possible quality within available resources is an obligation of the area authority and the Secretary.

(b) Each area authority and State facility shall comply with the rules of the Commission regarding quality assurance activities, including: program evaluation; utilization and peer review; and staff qualifications, privileging, supervision, education, and training. These rules may not nullify compliance otherwise required by Chapter 126 of the General Statutes.

(c) Each area authority and State facility shall develop internal processes to monitor and evaluate the level of quality obtained by all its programs and services including the activities prescribed in the rules of the Commission.

(d) The Secretary shall develop rules for a review process to monitor area facilities and State facilities for compliance with the required quality assurance activities as well as other rules of the Commission and the Secretary. The rules may provide that the Secretary has the authority to determine whether applicable standards of practice have been met.

(e) For purposes of peer review functions only:

(1) A member of a duly appointed quality assurance committee who acts without malice or fraud shall not be subject to liability for damages in any civil action on account of any act, statement, or proceeding undertaken, made, or performed within the scope of the functions of the committee.

(2) The proceedings of a quality assurance committee, the records and materials it produces, and the material it considers shall be confidential and not considered public records within the meaning of G.S. 132-1, " 'Public records' defined," and shall not be subject to discovery or introduction into evidence in any civil action against a facility or a provider of professional health services that results from matters which are the subject of evaluation and review by the committee. No person who was in attendance at a meeting of the committee shall be required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of the committee or as to any findings, recommendations, evaluations, opinions, or other actions of the committee or its members. However, information, documents or records otherwise available are not immune from discovery or use in a civil action merely because they were presented during proceedings of the committee, and nothing herein shall prevent a provider of professional health services from using such otherwise available information, documents or records in connection with an administrative hearing or civil suit relating to the medical staff membership, clinical privileges or employment of the provider. Documents otherwise available as public records within the meaning of G.S. 132-1 do not lose their status as public records merely because they were presented or considered during proceedings of the committee. A member of the committee or a person who testifies before the committee may be subpoenaed and be required to testify in a civil action as to events of which the person has knowledge independent of the peer review process, but cannot be asked about

the person's testimony before the committee for impeachment or other purposes or about any opinions formed as a result of the committee hearings.

(3) Peer review information that is confidential and is not subject to discovery or use in civil actions under this section may be released to a professional standards review organization that contracts with an agency of this State or the federal government to perform any accreditation or certification function, including the Joint Commission on Accreditation of Healthcare Organizations. Information released under this subdivision shall be limited to that which is reasonably necessary and relevant to the standards review organization's determination to grant or continue accreditation or certification. Information released under this subdivision retains its confidentiality and is not subject to discovery or use in any civil actions as provided under this subsection, and the standards review organization shall keep the information confidential subject to this section. (1977, c. 568, s. 1; 1979, c. 358, s. 1; 1983, c. 383, s. 1; 1985, c. 589, s. 2; 1989 (Reg. Sess., 1990), c. 1053, s. 1; 1998-212, s. 12.35C(d); 1999-222, s. 1; 2004-149, s. 2.7.)

§ 122C-192. Review and protection of information.

(a) Notwithstanding G.S. 8-53, G.S. 8-53.3, or any other law relating to confidentiality of communications involving a patient or client, as needed to ensure quality assurance activities, the Secretary may review any writing or other record concerning the admission, discharge, medication, treatment, medical condition, or history of a client of an area authority or State facility. The Secretary may also review the personnel records of employees of an area authority or State facility.

(b) An area authority, State facility, its employees, and any other individual interviewed in the course of an inspection are immune from liability for damages resulting from disclosure of any information to the Secretary.

Except as required by law, it is unlawful for the Secretary or his representative to disclose:

(1) Any confidential or privileged information obtained under this section unless the client or his legally responsible person authorizes disclosure in writing; or

(2) The name of anyone who has furnished information concerning an area authority or State facility without that individual's consent.

Violation of this subsection is a Class 3 misdemeanor punishable only by a fine, not to exceed five hundred dollars ($500.00).

(c) The Secretary shall adopt rules to ensure that unauthorized disclosure does not occur.

(d) All confidential or privileged information obtained under this section and the names of individuals providing such information are not public records under Chapter 132 of the General Statutes. (1985, c. 589, s. 2; 1993, c. 539, s. 926; 1994, Ex. Sess., c. 24, s. 14(c).)

§ 122C-193. Reserved for future codification purposes.

Part 7. Contested Case Hearings for Eligible Assaultive and Violent Children.

§§ 122C-194 through 122C-200: Repealed by Session Laws 2000-67, s. 11.21(e).

Article 5.

Procedure for Admission and Discharge of Clients.

Part l. General Provisions.

§ 122C-201. Declaration of policy.

It is State policy to encourage voluntary admissions to facilities. It is further State policy that no individual shall be involuntarily committed to a 24-hour facility unless that individual is mentally ill or a substance abuser and dangerous to self or others. All admissions and commitments shall be accomplished under conditions that protect the dignity and constitutional rights of the individual.

It is further State policy that, except as provided in G.S. 122C-212(b), individuals who have been voluntarily admitted shall be discharged upon application and that involuntarily committed individuals shall be discharged as soon as a less restrictive mode of treatment is appropriate. (1973, c. 723, s. 1; c. 726, s. 1; c. 1084; c. 1408, s. 1; 1977, c. 400, s. 1; 1979, c. 915, ss. 2, 11; 1983, c. 638, s. 1; c. 864, s. 4; 1985, c. 589, s. 2; 1995 (Reg. Sess., 1996), c. 739, s. 2.)

§ 122C-202. Applicability of Article.

This Article applies to all facilities unless expressly provided otherwise. Specific provisions that are delineated by the disability of the client, whether the client has a mental illness, has an intellectual or other developmental disability, or is a substance abuser, also apply to all facilities for that client's disability. Provisions that refer to a specific facility or type of facility apply only to the designated facility or facilities. (1985, c. 589, s. 2; 1989, c. 625, s. 20; 2019-76, s. 4.)

§ 122C-202.1. Hospital privileges.

Nothing in this Article related to admission, commitment, or treatment shall be deemed to mandate hospitals to grant or deny to any individuals privileges to practice in hospitals. (1985, c. 589, s. 2.)

§ 122C-202.2. LME/MCO community crisis services plan; commitment examiners; transporting agencies; training; collaboration.

(a) Every LME/MCO shall adopt a community crisis services plan in accordance with this section to facilitate first examination in conjunction with a health screening at the same location required pursuant to Parts 7 and 8 of this Article within its catchment area. The community crisis services plan for the LME/MCO's catchment area shall be comprised of separate plans, known as "local area crisis services plans" for each of the local areas or regions within the catchment area that the LME/MCO identifies as an appropriate local planning area, taking into consideration the available resources and interested stakeholders within a particular geographic area or region of the catchment area. Each LME/MCO may determine the number and geographic boundaries of the local planning areas within its catchment area. Each local area crisis services plan shall, for the local area covered by the local plan, do at least all of the following:

(1) Incorporate the involuntary commitment transportation agreement adopted pursuant to G.S. 122C-251(g) for the cities and counties within the local planning areas which identifies the law enforcement officers, designees under G.S. 122C-251(g), or individuals or entities otherwise required to provide custody and transportation of a respondent for a first examination in conjunction with a health screening at the same location required by G.S. 122C-263(a) and G.S. 122C-283. Notwithstanding the foregoing, counties and cities shall retain the responsibilities for custody and transportation set forth

in this Article, except as otherwise set forth in a plan developed, agreed upon, and adopted in compliance with this section and G.S. 122C-251(g).

(2) Identify one or more area facilities or other locations in accordance with G.S. 122C-263 and G.S. 122C-283. Each LME/MCO shall contract with one or more facilities or other locations described in G.S. 122C-263 and G.S. 122C-283 for the provision of health screenings and first examinations required by G.S. 122C-263 and G.S. 122C-283 for the provision of first examination in conjunction with a health screening required by G.S. 122C-263 and G.S. 122C-283, to meet the needs of its local planning area.

(3) Identify available training for law enforcement personnel and other persons designated or required under G.S. 122C-251(g) to provide transportation and custody of involuntary commitment respondents. Law enforcement officers may request to participate in the training program identified by the LME/MCO. Persons who are designated in compliance with G.S. 122C-251(g) to provide all or part of the transportation and custody required for involuntary commitment proceedings under this Article and who are not law enforcement officers shall participate in the training. To the extent feasible, the identified training shall address the use of de-escalation strategies and techniques, the safe use of force and restraint, respondent rights relevant to custody and transportation, the location of any area facilities identified by the LME/MCO pursuant to subdivision (1) of this subsection, and the completion and return of the custody order to the clerk of superior court. The training identified by the LME/MCO may be comprised of one or more programs and may include a Crisis Intervention Team program or other mental health training program or a combination of these programs.

(b) Law enforcement agencies, acute care hospitals, magistrates, area facilities with identified commitment examiners, and other affected agencies shall participate with the LME/MCO in the development of the local area crisis services plans described in this section. Other stakeholders and community partners identified by the LME/MCO may be invited to participate in the planning. No local area crisis services plan developed under this section shall be adopted or thereafter be effective or implemented unless such plan first has been mutually agreed upon in writing by all entities identified in the plan pursuant to subsection (a) of this section. If any member of the Crisis Planning Committee fails to agree to the plan in writing, the Secretary shall develop a procedure to attempt to resolve the conflict in order to achieve approval of the Plan.

(c) The plans adopted under this section may, by mutual agreement of all entities identified in the plan, address any other matters necessary to facilitate the custody, transportation, examination, and treatment of respondents to commitment proceedings under Parts 7 and 8 of this Article. (2018-33, s. 8.)

§ 122C-203. Admission or commitment and incompetency proceedings to have no effect on one another.

The admission or commitment to a facility of an individual who allegedly has a mental illness, an alleged substance abuser, or an individual who allegedly has an intellectual or other developmental disability under the provisions of this Article shall in no way affect incompetency proceedings as set forth in Chapter 35A or former Chapters 33 or 35 of the General Statutes and incompetency proceedings under those Chapters shall have no effect upon admission or

commitment proceedings under this Article. (1963, c. 1184, s. 1; 1985, c. 589, s. 2; 1989, c. 625, s. 21; 1989 (Reg. Sess., 1990), c. 1024, s. 26(b); 2019-76, s. 5.)

§ 122C-204. Civil liability for corruptly attempting admission or commitment.

Nothing in this Article relieves from liability in any suit instituted in the courts of this State any individual who unlawfully, maliciously, and corruptly attempts to admit or commit any individual to any facility under this Article. (1963, c. 1184, s. 1; 1985, c. 589, s. 2.)

§ 122C-205. Return of clients to 24-hour facilities.

(a) When a client of a 24-hour facility who:

(1) Has been involuntarily committed;
(2) Is being detained pending a judicial hearing;
(3) Has been voluntarily admitted but is a minor or incompetent adult;
(4) Has been placed on conditional release from the facility; or
(5) Has been involuntarily committed or voluntarily admitted and is the subject of a detainer placed with the 24-hour facility by an appropriate official

escapes or breaches a condition of his release, if applicable, the responsible professional shall notify or cause to be notified immediately the appropriate law enforcement agency in the county of residence of the client, the appropriate law enforcement agency in the county where the facility is located, and the appropriate law enforcement agency in any county where there are reasonable grounds to believe that the client may be found. The responsible professional shall determine the amount of personal identifying and background information reasonably necessary to divulge to the law enforcement agency or agencies under the particular circumstances involved in order to assure the expeditious return of the client to the 24-hour facility involved and protect the general public.

(b) When a competent adult who has been voluntarily admitted to a 24-hour facility escapes or breaches a condition of his release, the responsible professional, in the exercise of accepted professional judgment, practice, and standards, will determine if it is reasonably foreseeable that:

(1) The client may cause physical harm to others or himself;
(2) The client may cause damage to property;
(3) The client may commit a felony or a violent misdemeanor; or
(4) That the health or safety of the client may be endangered

unless he is immediately returned to the facility. If the responsible professional finds that any or all of these occurrences are reasonably foreseeable, he will follow the same procedures as those set forth in subsection (a) of this section.

(c) Upon receipt of notice of an escape or breach of a condition of release as described in subsections (a) and (b) of this section, an appropriate law enforcement officer shall take the client into custody and have the client returned to the 24-hour facility from which the client has escaped or has been conditionally released. Transportation of the client back to the 24-hour facility shall be provided in the same manner as described in G.S. 122C-251 and G.S. 122C-408(b). Law enforcement agencies who are notified of a client's escape or breach of conditional release shall be notified of the client's return by the responsible 24-hour facility. Under the circumstances described in this section, the initial notification by the 24-hour facility of the client's escape or breach of conditional release shall be given by telephone communication to the appropriate law enforcement agency or agencies and, if available and appropriate, by Department of Public Safety message to any law enforcement agency in or out of state and by entry into the National Crime

Information Center (NCIC) telecommunications system. As soon as reasonably possible following notification, written authorization to take the client into custody shall also be issued by the 24-hour facility. Under this section, law enforcement officers shall have the authority to take a client into custody upon receipt of the telephone notification or Department of Public Safety message prior to receiving written authorization. The notification of a law enforcement agency does not, in and of itself, render this information public information within the purview of Chapter 132 of the General Statutes. However, the responsible law enforcement agency shall determine the extent of disclosure of personal identifying and background information reasonably necessary, under the circumstances, in order to assure the expeditious return of a client to the 24-hour facility involved and to protect the general public and is authorized to make such disclosure. The responsible law enforcement agency may also place any appropriate message or entry into either the Department of Public Safety's Criminal Information System or National Crime Information System, or both, as appropriate.

(d) In the situations described in subsections (a) and (b) of this section, the responsible professional shall also notify or cause to be notified as soon as practicable:

(1) The next of kin of the client or legally responsible person for the client;
(2) The clerk of superior court of the county of commitment of the client;
(3) The area authority of the county of residence of the client, if appropriate;
(4) The physician or eligible psychologist who performed the first examination for a commitment of the client, if appropriate; and
(5) Any official who has placed a detainer on a client as described in subdivision (a)(5) of this section

of the escape or breach of condition of the client's release upon occurrence of either action and of his subsequent return to the facility. (1899, c. 1, s. 27; Rev., s. 4563; C.S., s. 6175; 1927, c. 114; 1945, c. 952, s. 12; 1953, c. 256, s. 1; 1955, c. 887, s. 3; 1973, c. 673, s. 11; 1983, c. 548; 1985, c. 589, s. 2; c. 695, s. 2; 1985 (Reg. Sess., 1986), c. 863, ss. 12-14; 1987, c. 749, s. 1; 2014-100, s. 17.1(eee).)

§ 122C-205.1. Discharge of clients who escape or breach the condition of release.

(a) As described in G.S. 122C-205(a), when a client of a 24-hour facility escapes or breaches the condition of his release and does not return to the facility, the facility shall:

(1) If the client was admitted under Part 2 of this Article or under Parts 3 or 4 of this Article to a nonrestrictive facility, discharge the client based on the professional judgment of the responsible professional;
(2) If the client was admitted under Part 3 or Part 4 of this Article to a restrictive facility, discharge the client when the period for continued treatment, as specified by the court, expires;
(3) If the client was admitted pending a district court hearing under Part 7 of this Article, request that the court consider dismissal or continuance of the case at the initial district court hearing; or
(4) If the client was committed under Part 7 of this Article, discharge the client when the commitment expires.

(b) As described in G.S. 122C-205(a), when a client of a 24-hour facility who was admitted under Part 8 of this Article escapes or breaches the conditions of his release and does not return to the facility, the facility may discharge the client from the facility based on the professional

judgment of the responsible professional and following consultation with the appropriate area authority or physician.

(c) Upon discharge of the client, the 24-hour facility shall notify all the persons directed to be notified of the client's escape or breach of conditional release under 122C-205(a), (b) and (d) that the client has been discharged.

(d) If the client is returned to the 24-hour facility subsequent to discharge from the facility, applicable admission or commitment procedures shall be followed, when appropriate. (1987, c. 674, s. 1.)

§ 122C-206. Transfers of clients between 24-hour facilities; transfer of clients from 24-hour facilities to acute care hospitals.

(a) Before transferring a voluntary adult client from one 24-hour facility to another, the responsible professional at the original facility shall: (i) get authorization from the receiving facility that the facility will admit the client; (ii) get consent from the client; and (iii) if consent to share information is granted by the client, or if the disclosure of information is permitted under G.S. 122C-53(b), notify the next of kin of the time and location of the transfer. The preceding requirements of this paragraph may be waived if the client has been admitted under emergency procedures to a State facility not serving the client's region of the State. Following an emergency admission, the client may be transferred to the appropriate State facility without consent according to the rules of the Commission.

(b) Before transferring a respondent held for a district court hearing or a committed respondent from one 24-hour facility to another, the responsible professional at the original facility shall:

(1) Obtain authorization from the receiving facility that the facility will admit the respondent; and

(2) Provide reasonable notice to the respondent or the legally responsible person, and to the respondent's counsel, of the reason for the transfer and document the notice in the client's record.

No later than 24 hours after the transfer, the responsible professional at the original facility shall notify the petitioner, the clerk of court, the respondent's counsel, and, if consent is granted by the respondent, or if the disclosure of the information is permitted under G.S. 122C-53 or other applicable law, the next of kin, that the transfer is complete. If the transfer is completed before the judicial commitment hearing, these proceedings shall be initiated by the receiving facility. If the respondent is a minor, an incompetent adult, or is deemed incapable, then the responsible professional at the original facility shall, not later than 24 hours after the transfer, notify the respondent's legally responsible person of the location of the transfer and that the transfer is complete.

(c) Minors and incompetent adults, admitted pursuant to Parts 3 and 4 of this Article, may be transferred from one 24-hour facility to another following the same procedures specified in subsection (b) of this section. In addition, the legally responsible person shall be consulted before the proposed transfer and notified, within 24 hours after the transfer is complete, of the location of the transfer and that the transfer is complete. If the transfer is completed before the judicial determination required in G.S. 122C-223 or G.S. 122C-232, these proceedings shall be initiated by the receiving facility.

(c1) If a client described in subsections (b) or (c) of this section is to be transferred from one 24-hour facility to another, or to an acute care hospital pursuant to subsection (e) of this section,

and transportation is needed, the responsible professional at the original facility shall notify the clerk of court or magistrate, and the clerk of court or magistrate shall issue a custody order for transportation of the client as provided by G.S. 122C-251.

(d) Minors and incompetent adults, admitted pursuant to Part 5 of this Article and incapable adults admitted pursuant to Part 2A of this Article, may be transferred from one 24-hour facility to another provided that prior to transfer the responsible professional at the original facility shall:

(1) Obtain authorization from the receiving facility that the facility will admit the client; and

(2) Provide reasonable notice to the client regarding the reason for transfer and document the notice in the client's record; and

(3) Provide reasonable notice to and consult with the legally responsible person regarding the reason for the transfer and document the notice and consultation in the client's record.

No later than 24 hours after the transfer, the responsible professional at the original facility shall notify the legally responsible person that the transfer is completed.

(e) The responsible professional may transfer a client from one 24-hour facility to another or to an acute care hospital for emergency medical treatment, emergency medical evaluation, or emergency surgery without notice to or consent from the client. Within a reasonable period of time the responsible professional shall notify the next of kin or the legally responsible person of the client of the transfer.

(f) When a client is transferred from one 24-hour facility to another solely for medical reasons, the client shall be returned to the original facility when the medical care is completed unless the responsible professionals at both facilities concur that discharge of the client who is not subject to G.S. 122C-266(b) is appropriate.

(f1) When a client is transferred from a 24-hour facility to an acute care hospital solely for medical reasons, the hospital shall return the client to the original facility as soon as the next client space becomes available at the original facility after completion of the client's medical care. With the exception of facility-based crisis centers, the original facility must allow at least 12 hours for the client's return before assigning the client's room or bed to another patient, unless both facilities agree that return of the client in this time period is not feasible. The original facility must accept the return of the client in priority over other clients seeking admission, except in the cases of patients designated incapable to proceed to trial by court order. If the responsible professionals at both facilities concur that discharge of a client who is not subject to G.S. 122C-266(b) is appropriate, the client may be discharged. If, at the time of the transfer, a client is being held under a custody order pending a second commitment examination or a district court hearing under involuntary commitment proceedings, the custody order shall remain valid throughout the period of time necessary to complete the client's medical care and transport the client between the 24-hour facility and the acute care hospital; provided, however, that the requirement for a timely hearing under G.S. 122C-268(a) applies. Any decision to terminate the proceedings because the respondent no longer meets the criteria for commitment or because a hearing cannot be held within the time required by G.S. 122C-268(a) shall be documented and reported to the clerk of superior court in accordance with G.S. 122C-266(c).

(g) The Commission may adopt rules to implement this section. (1919, c. 330; C.S., s. 6163; 1925, c. 51, s. 1; 1945, c. 925, s. 5; 1947, c. 537, s. 9; c. 623, s. 1; 1953, c. 675, s. 15; 1955, c. 1274, s. 1; 1959, c. 1002, s. 11; 1963, c. 1166, ss. 10, 12; 1973, c. 475, s. 1; c. 476, s. 133; c. 673, ss.

7, 8; c. 1436, ss. 6, 7; 1977, c. 679, s. 7; 1981, c. 51, s. 3; c. 328, ss. 1, 2; 1985, c. 589, s. 2; 1985 (Reg. Sess., 1986), c. 863, s. 15; 1991, c. 704, s. 1; 2018-33, s. 9.)

§ 122C-207. Confidentiality.

Court records made in all proceedings pursuant to this Article are confidential, and are not open to the general public except as provided for by G. S. 122C-54(d). (1977, c. 696, s. 1; 1979, c. 164, s. 2; c. 915, s. 20; 1985, c. 589, s. 2.)

§ 122C-208. Voluntary admission not admissible in involuntary proceeding.

Except when considering treatment history as it pertains to an involuntary outpatient commitment, the fact that an individual has been voluntarily admitted for treatment shall not be competent evidence in an involuntary commitment proceeding. (1985, c. 589, s. 2.)

§ 122C-209. Voluntary admissions acceptance.

Nothing contained in Parts 2 through 5 of this Article requires a private physician or private facility to accept an individual as a client for examination or treatment. Examination or treatment at a private facility or by a private physician is at the expense of the individual to the extent that charges are not disposed of by contract between the area authority and private facility. (1985, c. 589, s. 2.)

§ 122C-210. Guardian to pay expenses out of estate.

It is the duty of the guardian who has legal custody of the estate of an incompetent individual held pursuant to the provisions of this Article in a facility to supply funds for his support in the facility during the stay as long as there are sufficient funds for that purpose over and beyond maintaining and supporting those individuals who may be legally dependent on the estate. (1985, c. 589, s. 2.)

§ 122C-210.1. Immunity from liability.

No facility, person, or entity, including an area facility, a facility licensed under this Chapter, an acute care hospital, a general hospital, an area authority, a law enforcement officer, an LME, or an LME/MCO, or any of their officials, staff, or employees, or any other physician or individual who is responsible for the custody, transportation, examination, admission, management, supervision, treatment, or release of a respondent or client and who is not grossly negligent, is civilly or criminally liable, personally or otherwise, for that person's or entity's actions or omissions arising from these responsibilities or for the actions or omissions of a respondent or client. This immunity is in addition to any other legal immunity from liability to which these persons, entities, facilities, agencies, or individuals may be entitled and applies to actions performed in connection with, or arising out of, the custody, transportation, examination, commitment, admission, management, supervision, treatment, or release of any individual pursuant to or under the authority of this Article or otherwise. (1899, c. 1, s. 31; Rev., s. 4560; C.S., s. 6172; 1961, c. 511, s. 1; 1973, c. 673, s. 10; 1983, c. 638, s. 15; c. 864, s. 4; 1985, c. 589, s. 2; 1995 (Reg. Sess., 1996), c. 739, s. 3; 2018-33, s. 10.)

§ 122C-210.2. Research at State facilities for the mentally ill.

(a) For research purposes, State facilities for the mentally ill may be designated by the Secretary as facilities for the voluntary admission of adults who are not admissible as clients

otherwise. Designation of these facilities shall be made in accordance with rules of the Secretary that assure the protection of those admitted for research purposes.

(b) Individuals may be admitted to such designated facilities on either an outpatient or inpatient basis.

(c) The Human Rights Committee of the designated facility shall monitor the care of individuals admitted for research during their participation in any research program.

(d) For these individuals admitted to such designated facilities for research purposes only, the following provisions shall apply:

(1) A written application for admission pursuant to G.S. 122C-211(a) and an examination by a physician within 24 hours of admission shall be provided to each of these individuals;

(2) They shall be exempt from the provisions of G.S. 122C-57(a) governing the rights to treatment and to a treatment plan; the requirements of G.S. 122C-61(2) and G.S. 122C-212(b); and the requirements of any single portal of entry and exit plan; however, nothing in this section shall take away the individual's right to be informed of the potential risks and alleged benefits of their participation in any research program;

(3) The Secretary shall exempt these individuals from the provisions of Article 7 of Chapter 143 of the General Statutes requiring payment for treatment in a State institution. The Secretary may also authorize reasonable compensation to be paid to individuals participating in research projects for their services; provided, that the compensation is paid from research grant funds; and

(4) The Commission shall adopt rules regarding the admission, care and discharge of those individuals admitted for research purposes only. (1987, c. 358, s. 1.)

§ 122C-210.3. Electronic and facsimile transmission of custody orders.

A custody order entered by the clerk or magistrate pursuant to this Chapter may be delivered to the law enforcement officer or other person designated or required to provide transportation and custody pursuant to G.S. 122C-251 by electronic or facsimile transmission. (2015-176, s. 2.5(b); 2018-33, s. 11.)

Part 2. Voluntary Admissions and Discharges, Competent Adults, Facilities for the Mentally Ill and Substance Abusers.

§ 122C-211. Admissions.

(a) Except as provided in subsections (b) through (f) of this section, any individual, including a parent in a family unit, in need of treatment for mental illness or substance abuse may seek voluntary admission at any facility by presenting himself or herself for evaluation to the facility. No physician's statement is necessary, but a written application for evaluation or admission, signed by the individual seeking admission, or the individual's legally responsible person, is required. The application form shall be available at all times at all facilities. However, no one shall be denied admission because application forms are not available. An evaluation shall determine whether the individual is in need of care, treatment, habilitation or rehabilitation for mental illness or substance abuse or further evaluation by the facility. Information provided by family members regarding the individual's need for treatment shall be reviewed in the evaluation. If applicable, information provided in an advance instruction for mental health treatment by the client or the client's legally responsible person shall be reviewed in the evaluation. An individual

may not be accepted as a client if the facility determines that the individual does not need or cannot benefit from the care, treatment, habilitation, or rehabilitation available and that the individual is not in need of further evaluation by the facility. The facility shall give to an individual who is denied admission a referral to another facility or facilities that may be able to provide the treatment needed by the client.

(b) In 24-hour facilities the application shall acknowledge that the applicant may be held by the facility for a period of 72 hours after any written request for release that the applicant may make, and shall acknowledge that the 24-hour facility may have the legal right to petition for involuntary commitment of the applicant during that period. At the time of application, the facility shall tell the applicant about procedures for discharge.

(c) Any individual who voluntarily seeks admission to a 24-hour facility in which medical care is an integral component of the treatment shall be examined and evaluated by a physician of the facility within 24 hours of admission. The evaluation shall determine whether the individual is in need of treatment for mental illness or substance abuse or further evaluation by the facility. If the evaluating physician determines that the individual will not benefit from the treatment available, the individual shall not be accepted as a client.

(d) Any individual who voluntarily seeks admission to any 24-hour facility, other than one in which medical care is an integral component of the treatment, shall have a medical examination within 30 days before or after admission if it is reasonably expected that the individual will receive treatment for more than 30 days or shall produce a current, valid physical examination report, signed by a physician, completed within 12 months prior to the current admission. When applicable, this examination may be included in an examination conducted to meet the requirements of G.S. 122C-223 or G.S. 122C-232.

(e) Repealed by Session Laws 2018-33, s. 12, effective October 1, 2019, and applicable to proceedings initiated on or after that date.

(f) A family unit may voluntarily seek admission to a 24-hour substance abuse facility that is able to provide, directly or by contract, treatment, habilitation, or rehabilitation services that will specifically address the family unit's needs. These services shall include gender-specific substance abuse treatment, habilitation, or rehabilitation for the parent as well as assessment, well-child care, and, as needed, early intervention services for the child. A family unit that voluntarily seeks admission to a 24-hour substance abuse facility shall be evaluated by the facility to determine whether the family unit would benefit from the services of the facility. A facility shall not accept a family unit as a client if the facility determines that the family unit does not need or cannot benefit from the care, habilitation, or rehabilitation available at the facility. The facility shall give to a family unit that is denied admission a referral to another facility or facilities that may be able to provide treatment needed by the family unit. Except as otherwise provided, this section applies to a parent in a family unit seeking admission under this section.

(f1) Repealed by Session Laws 2018-33, s. 12, effective October 1, 2019, and applicable to proceedings initiated on or after that date.

(g) As used in this Part, the term "family unit" means a parent and the parent's dependent children under the age of three years. (1945, c. 952, s. 471/2; 1963, c. 1184, s. 22; 1973, c. 723, s. 1; c. 1084; 1983, c. 383, s. 4; 1985, c. 589, s. 2; 1985 (Reg. Sess., 1986), c. 863, s. 16; 1989, c. 287; 1998-47, s. 1(a); 1998-198, s. 6; 1998-217, s. 53(a)(1), (2); 1999-456, s. 5; 2018-33, s. 12.)

§ 122C-212. Discharges.

(a) Except as provided in subsection (b) of this section, an individual who has been voluntarily admitted to a facility shall be discharged upon the individual's own request. A request for discharge from a 24-hour facility shall be in writing.

(b) An individual who has been voluntarily admitted to a 24-hour facility may be held for 72 hours after the individual's written application for discharge is submitted. (1973, c. 723, s. 1; c. 1084; 1983, c. 383, s. 4; 1985, c. 589, s. 2; 2018-33, s. 13.)

§ 122C-213: Reserved for future codification purposes.

§ 122C-214: Reserved for future codification purposes.

§ 122C-215: Reserved for future codification purposes.

Part 2A. Voluntary Admissions and Discharges; Incapable Adults; Facilities for Individuals With Mental Illness and Substance Use Disorder.

§ 122C-216. Voluntary admission of individuals determined to be incapable.

(a) An individual in need of treatment for mental illness and who is incapable, as defined in G.S. 122C-3 and G.S. 122C-72, may be admitted to and treated in a facility pursuant to an advance instruction for mental health treatment executed in accordance with Part 2 of Article 3 of this Chapter or pursuant to the authority of a health care agent named in a valid health care power of attorney executed in accordance with Article 3 of Chapter 32A of the General Statutes.

(b) Except as otherwise provided in this Part, G.S. 122C-211 applies to admissions of incapable adults under this Part.

(c) An advance instruction for mental health treatment shall be governed by Part 2 of Article 3 of this Chapter.

(d) When a health care power of attorney authorizes a health care agent pursuant to G.S. 32A-19 to make mental health treatment decisions for an incapable individual, the health care agent shall act for the individual in applying for admission and consenting to treatment at a facility, consistent with the extent and limitations of authority granted in the health care power of attorney for as long as the individual remains incapable.

(e) A 24-hour facility may not hold an individual under a voluntary admission who is determined to be incapable at the time of admission and who is admitted pursuant to an advance instruction for mental health treatment for more than 15 days, except as provided in G.S. 122C-211(b); provided, however, that an individual who regains sufficient understanding and capacity to make and communicate mental health treatment decisions may elect to continue his or her admission and treatment pursuant to the individual's informed consent in accordance with G.S. 122C-211. A 24-hour facility may file a petition for involuntary commitment pursuant to Article 5 of this Chapter if an individual meets applicable criteria at the conclusion of this 15-day period.

(f) For purposes of this section, if an incapable adult in need of treatment has no health care power of attorney or advance instruction for mental health treatment that addresses the needed treatment, and the incapable adult has not been adjudicated incompetent under Chapter 35A of the General Statutes, the legally responsible person for the incapable adult shall be one of the persons listed in subdivisions (3) through (7) of subsection (c) of G.S. 90-21.13, to be selected based on the priority order indicated in said subdivisions (3) through (7); provided that the persons listed in subdivisions (4) through (7) of subsection (c) of G.S. 90-21.13 shall not have the authority to admit

an incapable adult to a 24-hour facility where the adult will be subject to the same or similar restrictions on freedom of movement present in the State facilities for the mentally ill. (2018-33, s. 14; 2019-240, s. 26(e).)

§ 122C-217. Discharge of individuals determined to be incapable.

(a) The responsible professional shall unconditionally discharge an individual admitted to a facility pursuant to this Part at any time it is determined the individual is no longer mentally ill or in need of treatment at the facility.

(b) An individual who has been voluntarily admitted to a facility pursuant to this Part and who is no longer deemed incapable shall be discharged upon his or her own request. An individual's request for discharge from a 24-hour facility shall be in writing. A facility may hold an individual who has been voluntarily admitted to a 24-hour facility pursuant to this Part for up to 72 hours after the individual submits a written request for discharge, but the facility shall release the individual upon the expiration of 72 hours following submission of the written request for discharge unless the responsible professional obtains an order under Part 7 or 8 of this Article to hold the client.

(c) A health care agent named in a valid health care power of attorney or the legally responsible person may submit on behalf of an individual admitted to a facility under this Part a written request to have the individual discharged from the facility, provided (i) the individual remains incapable at the time of the request and (ii) the request is not inconsistent with the authority expressed in the health care power of attorney or other controlling document. A facility may hold an individual for up to 72 hours after a health care agent submits a written request for the individual's discharge but shall release the individual upon the expiration of 72 hours following submission of the written request for discharge unless the responsible professional obtains an order under Part 7 or 8 of this Article to hold the client.

(d) If, in the opinion of a physician or eligible psychologist, an individual admitted to a facility under this Part regains sufficient understanding and capacity to make and communicate mental health treatment decisions while in treatment, and the individual refuses to sign an authorization for continued treatment within 72 hours after regaining decisional capacity, the facility shall discharge the individual unless the responsible professional obtains an order under Part 7 or 8 of this Article to hold the client.

(e) In any case in which an order is issued authorizing the involuntary commitment of an individual admitted to a facility under this Part, the facility's further treatment and holding of the individual shall be in accordance with Part 7 or 8 of this Article, whichever is applicable. (2018-33, s. 14.)

§ 122C-218: Reserved for future codification purposes.

§ 122C-219: Reserved for future codification purposes.

§ 122C-220: Reserved for future codification purposes.

Part 3. Voluntary Admissions and Discharges, Minors, Facilities for the Mentally Ill and Substance Abusers.

§ 122C-221. Admissions.

(a) Except as otherwise provided in this Part, a minor may be admitted to a facility if the minor is mentally ill or a substance abuser and in need of treatment. Except as otherwise provided in this Part, the provisions of G.S. 122C-211 shall apply to admissions of minors under this Part. Except as provided in G.S. 90-21.5, in applying for admission to a facility, in consenting to medical treatment when consent is required, and in any other legal procedure under this Article, the legally responsible person shall act for the minor. The application of the minor shall be in writing and signed by the legally responsible person. If a minor reaches the age of 18 while in treatment under this Part, further treatment is authorized only on the written authorization of the client or under the provisions of Part 7 or Part 8 of Article 5 of this Chapter.

(b) The Commission shall adopt rules governing procedures for admission to 24-hour facilities not falling within the category of facilities where freedom of movement is restricted. These rules shall be designed to ensure that no minor is improperly admitted to or improperly remains in a 24-hour facility. (1973, c. 1084; 1983, c. 302, s. 1; 1985, c. 589, s. 2; 1987, c. 370, s. 1; 2018-33, s. 15.)

§ 122C-222. Admissions to State facilities.

Admission of a minor who is a resident of a county that is not in a single portal area shall be made to a State facility following screening and upon referral by an area authority, a physician, or an eligible psychologist. Further planning of treatment and discharge for the minor is the joint responsibility of the State facility and the person making the referral. (1987, c. 370, s. 1.)

§ 122C-223. Emergency admission to a 24-hour facility.

(a) In an emergency situation, when the legally responsible person does not appear with the minor to apply for admission, a minor who is mentally ill or a substance abuser and in need of treatment may be admitted to a 24-hour facility upon his own written application. The application shall serve as the initiating document for the hearing required by G.S. 122C-224.

(b) Within 24 hours of admission, the facility shall notify the legally responsible person of the admission unless notification is impossible due to an inability to identify, to locate, or to contact him after all reasonable means to establish contact have been attempted.

(c) If the legally responsible person cannot be located within 72 hours of admission, the responsible professional shall initiate proceedings for juvenile protective services as described in Article 3 of Chapter 7B of the General Statutes in either the minor's county of residence or in the county in which the facility is located.

(d) Within 24 hours of an emergency admission to a State facility, the State facility shall notify the area authority and, as appropriate, the minor's physician or eligible psychologist. Further planning of treatment and discharge for the minor is the joint responsibility of the State facility and the appropriate person in the community. (1973, c. 1084; 1983, c. 302, s. 1; 1985, c. 589, s. 2; 1987, c. 370, s. 1; 1998-202, s. 13(ff).)

§ 122C-224. Judicial review of voluntary admission.

(a) When a minor is admitted to a 24-hour facility where the minor will be subjected to the same restrictions on his freedom of movement present in the State facilities for the mentally ill, or to similar restrictions, a hearing shall be held by the district court in the county in which the 24-hour facility is located within 15 days of the day that the minor is admitted to the facility. A continuance of not more than five days may be granted.

(b) Before the admission, the facility shall provide the minor and his legally responsible person with written information describing the procedures for court review of the admission and informing them about the discharge procedures. They shall also be informed that, after a written request for discharge, the facility may hold the minor for 72 hours during which time the facility may apply for a petition for involuntary commitment.

(c) Within 24 hours after admission, the facility shall notify the clerk of court in the county where the facility is located that the minor has been admitted and that a hearing for concurrence in the admission must be scheduled. At the time notice is given to schedule a hearing, the facility shall (i) notify the clerk of the names and addresses of the legally responsible person and the responsible professional and (ii) provide the clerk with a copy of the legally responsible person's written application for admission of the minor and the facility's written evaluation of the minor, both of which are required under G.S. 122C-211(a). (1975, c. 839; 1977, c. 756; 1979, c. 171, s. 1; 1983, c. 889, ss. 1, 2; 1985, c. 589, s. 2; 1987, c. 370, s. 1; 2018-33, s. 16.)

§ 122C-224.1. Duties of clerk of court.

(a) Within 48 hours of receipt of notice that a minor has been admitted to a 24-hour facility wherein his freedom of movement will be restricted, an attorney shall be appointed for the minor in accordance with rules adopted by the Office of Indigent Defense Services. When a minor has been admitted to a State facility for the mentally ill, the attorney appointed shall be the attorney employed in accordance with G.S. 122C-270(a) through (c). All minors shall be conclusively presumed to be indigent, and it shall not be necessary for the court to receive from any minor an affidavit of indigency. The attorney shall be paid a reasonable fee in accordance with rules adopted by the Office of Indigent Defense Services. The judge may require payment of the attorney's fee from a person other than the minor as provided in G.S. 7A-450.1 through G.S. 7A-450.4.

(b) Upon receipt of notice that a minor has been admitted to a 24-hour facility wherein his freedom of movement will be restricted, the clerk shall calendar a hearing to be held within 15 days of admission for the purpose of review of the minor's admission. Notice of the time and place of the hearing shall be given as provided in G.S. 1A-1, Rule 4(j) to the attorney in lieu of the minor, as soon as possible but not later than 72 hours before the scheduled hearing. Notice of the hearing shall be sent to the legally responsible person and the responsible professional as soon as possible but not later than 72 hours before the hearing by first-class mail postage prepaid to the individual's last known address.

(c) The clerk shall schedule all hearings and rehearings and send all notices as required by this Part. (1987, c. 370, s. 1; 2000-144, s. 37.)

§ 122C-224.2. Duties of the attorney for the minor.

(a) The attorney shall meet with the minor within 10 days of his appointment but not later than 48 hours before the hearing. In addition, the attorney shall inform the minor of the scheduled hearing and shall give the minor a copy of the notice of the time and place of the hearing no later than 48 hours before the hearing.

(b) The attorney shall counsel the minor concerning the hearing procedure and the potential effects of the hearing proceeding on the minor. If the minor does not wish to appear, the attorney shall file a motion with the court before the scheduled hearing to waive the minor's right to be present at the hearing procedure except during the minor's own testimony. If the attorney determines that the minor does not wish to appear before the judge to provide his own testimony,

the attorney shall file a separate motion with the court before the hearing to waive the minor's right to testify.

(c) In all actions on behalf of the minor, the attorney shall represent the minor until formally relieved of the responsibility by the judge. (1987, c. 370, s. 1.)

§ 122C-224.3. Hearing for review of admission.

(a) Hearings shall be held at the 24-hour facility in which the minor is being treated, if it is located within the judge's district court district as defined in G.S. 7A-133, unless the judge determines that the court calendar will be disrupted by such scheduling. In cases where the hearing cannot be held in the 24-hour facility, the judge may schedule the hearing in another location, including the judge's chambers. The hearing may not be held in a regular courtroom, over objection of the minor's attorney, if in the discretion of the judge a more suitable place is available.

(b) The minor shall have the right to be present at the hearing unless the judge rules favorably on the motion of the attorney to waive the minor's appearance. However, the minor shall retain the right to appear before the judge to provide his own testimony and to respond to the judge's questions unless the judge makes a separate finding that the minor does not wish to appear upon motion of the attorney.

(c) Certified copies of reports and findings of physicians, psychologists and other responsible professionals as well as previous and current medical records are admissible in evidence, but the minor's right, through his attorney, to confront and cross-examine witnesses may not be denied.

(d) Hearings shall be closed to the public unless the attorney requests otherwise.

(e) A copy of all documents admitted into evidence and a transcript of the proceedings shall be furnished to the attorney, on request, by the clerk upon the direction of a district court judge. The copies shall be provided at State expense.

(f) For an admission to be authorized beyond the hearing, the minor must be (1) mentally ill or a substance abuser and (2) in need of further treatment at the 24-hour facility to which he has been admitted. Further treatment at the admitting facility should be undertaken only when lesser measures will be insufficient. It is not necessary that the judge make a finding of dangerousness in order to support a concurrence in the admission.

(g) The court shall make one of the following dispositions:

(1) If the court finds by clear, cogent, and convincing evidence that the requirements of subsection (f) have been met, the court shall concur with the voluntary admission and set the length of the authorized admission of the minor for a period not to exceed 90 days; or

(2) If the court determines that there exist reasonable grounds to believe that the requirements of subsection (f) have been met but that additional diagnosis and evaluation is needed before the court can concur in the admission, the court may make a one time authorization of up to an additional 15 days of stay, during which time further diagnosis and evaluation shall be conducted; or

(3) If the court determines that the conditions for concurrence or continued diagnosis and evaluation have not been met, the judge shall order that the minor be released.

(h) The decision of the District Court in all hearings and rehearings is final. Appeal may be had to the Court of Appeals by the State or by any party on the record as in civil cases. The minor may be retained and treated in accordance with this Part, pending the outcome of the appeal, unless

otherwise ordered by the District Court or the Court of Appeals. (1987, c. 370; 1987 (Reg. Sess., 1988), c. 1037, s. 113.)

§ 122C-224.4. Rehearings.

(a) A minor admitted to a 24-hour facility upon order of the court for further diagnosis and evaluation shall have the right to a rehearing if the responsible professional determines that the minor is in need of further treatment beyond the time authorized by the court for diagnosis and evaluation.

(b) A minor admitted to a 24-hour facility upon the concurrence of the court shall have the right to a rehearing for further concurrence in continued treatment before the end of the period authorized by the court. The court shall review the continued admission in accordance with the hearing procedures in this Part. The court may order discharge of the minor if the minor no longer meets the criteria for admission. If the minor continues to meet the criteria for admission the court shall concur with the continued admission of the minor and set the length of the authorized admission for a period not to exceed 180 days. Subsequent rehearings shall be scheduled at the end of each subsequent authorized treatment period, but no longer than every 180 days.

(c) The responsible professional shall notify the clerk, no later than 15 days before the end of the authorized admission, that continued stay beyond the authorized admission is recommended for the minor. The clerk shall calendar the rehearing to be held before the end of the current authorized admission. (1987, c. 370, s. 1.)

§ 122C-224.5. Transportation.

When it is necessary for a minor to be transported to a location other than the treating facility for the purpose of a hearing, transportation shall be provided under the provisions of G.S. 122C-251. However, the 24-hour facility may obtain permission from the court to routinely provide transportation of minors to and from hearings. (1987, c. 370, s. 1.)

§ 122C-224.6. Treatment pending hearing and after authorization for or concurrence in admission.

(a) Pending the initial hearing and after authorization for further diagnosis and evaluation, or concurrence in admission, the responsible professional may administer to the minor reasonable and appropriate medication and treatment that is consistent with accepted medical standards and consistent with Article 3 of this Chapter.

(b) The responsible professional may release the minor conditionally for periods not in excess of 30 days on specified appropriate conditions. Violation of the conditions is grounds for return of the minor to the 24-hour facility. A law enforcement officer, on request of the responsible professional, shall take the minor into custody and return him to the facility in accordance with G.S. 122C-205. (1987, c. 370, s. 1.)

§ 122C-224.7. Discharge.

(a) The responsible professional shall unconditionally discharge a minor from treatment at any time that it is determined that the minor is no longer mentally ill or a substance abuser, or no longer in need of treatment at the facility.

(b) The legally responsible person may file a written request for discharge from the facility at any time. The facility may hold the minor in the facility for 72 hours after receipt of the request for discharge. If the responsible professional believes that the minor is mentally ill and dangerous

to himself or others, he may file a petition for involuntary commitment under the provisions of Part 7 of this Article. If the responsible professional believes that the minor is a substance abuser and dangerous to himself or others, he may file a petition for involuntary commitment under the provisions of Part 8 of this Article. If an order authorizing the holding of the minor under involuntary commitment procedures is issued, further treatment and holding shall follow the provisions of Part 7 or Part 8 whichever is applicable. If an order authorizing the holding of the minor under involuntary commitment procedures is not issued, the minor shall be discharged.

(c) If a client reaches age 18 while in treatment, and the client refuses to sign an authorization for continued treatment within 72 hours of reaching 18, he shall be discharged unless the responsible professional obtains an order to hold the client under the provisions of Part 7 or Part 8 of this Article pursuant to an involuntary commitment. (1975, c. 839; 1977, c. 756; 1979, c. 171, s. 1; 1983, c. 889, ss. 1, 2; 1985, c. 589, s. 2; 1987, c. 370, s. 1.)

§ 122C-225: Reserved for future codification purposes.

§ 122C-226: Reserved for future codification purposes.

§ 122C-227: Reserved for future codification purposes.

§ 122C-228: Reserved for future codification purposes.

§ 122C-229: Reserved for future codification purposes.

Part 4. Voluntary Admissions and Discharges, Incompetent Adults, Facilities for the Mentally Ill and Substance Abusers.

§ 122C-230. Applicability of Part 4.

This Part applies to adults who are adjudicated incompetent by a court of competent jurisdiction. This Part does not apply to the admission of adults who are deemed incapable but who have not been adjudicated incompetent. (2018-33, s. 17.)

Part 4. Voluntary Admissions and Discharges, Incompetent Adults, Facilities for the Mentally Ill and Substance Abusers.

§ 122C-231. Admissions.

Except as otherwise provided in this Part an incompetent adult may be admitted to a facility when the individual is mentally ill or a substance abuser and in need of treatment. The provisions of G.S. 122C-211 shall apply to admissions of an incompetent adult under this Part except that the legally responsible person shall act for the individual, in applying for admission to a facility, in consenting to medical treatment when consent is required, in giving or receiving any legal notice, and in any other legal procedure under this Article. (1973, c. 1084; 1983, c. 302, s. 1; 1985, c. 589, s. 2.)

§ 122C-232. Judicial determination.

(a) When an incompetent adult is admitted to a 24-hour facility where the incompetent adult will be subjected to the same restrictions on freedom of movement present in the State facilities for the mentally ill, or to similar restrictions, a hearing shall be held in the district court in the county in which the 24-hour facility is located within 10 days after the day the incompetent

adult is admitted to the facility. A continuance of not more than five days may be granted upon motion [of] any of the following:

(1) The court.

(2) Respondent's counsel.

(3) The responsible professional.

The Commission shall adopt rules governing procedures for admission to other 24-hour facilities not falling within the category of facilities where freedom of movement is restricted; these rules shall be designed to ensure that no incompetent adult is improperly admitted to or remains in a facility.

(a1) Prior to admission, the facility shall provide the incompetent adult and the legally responsible person with written information describing the procedures for court review of the admission and the procedures for discharge.

(a2) Within 24 hours after admission, the facility shall notify the clerk of court of the county in which the facility is located that the incompetent adult has been admitted and that a hearing for concurrence in the admission must be scheduled. At the time the facility provides notice to the court to schedule a hearing for concurrence, the facility shall notify the clerk of the names and addresses of the legally responsible person and the responsible professional and provide a copy of the legally responsible person's written application for evaluation or admission of the incompetent adult and the facility's evaluation of the incompetent adult.

(b) In any case requiring the hearing described in subsection (a) of this section, no petition is necessary; the written application for voluntary admission shall serve as the initiating document for the hearing. The court shall determine whether the incompetent adult is mentally ill or a substance abuser and is in need of further treatment at the facility. Further treatment at the facility should be undertaken only when lesser measures will be insufficient. If the court finds by clear, cogent, and convincing evidence that these requirements have been met, the court shall concur with the voluntary admission of the incompetent adult and set the length of the authorized admission for a period not to exceed 90 days. If the court finds that these requirements have not been met, it shall order that the incompetent adult be released. A finding of dangerousness to self or others is not necessary to support the determination that further treatment should be undertaken.

(c) Unless otherwise provided in this Part, the hearing specified in subsection (a) of this section, including the provisions for representation of indigent incompetent adults, all subsequent proceedings, and conditional release are governed by the involuntary commitment procedures of Part 7 of this Article.

(d) In addition to the notice of hearings and rehearings to the incompetent adult and his or her counsel required under Part 7 of this Article, notice shall be given by the clerk to the legally responsible person or a successor to the legally responsible person. The legally responsible person or a successor to the legally responsible person may also file with the clerk of court a written waiver of the right to receive notice. (1975, c. 839; 1977, c. 756; 1979, c. 171, s. 1; 1983, c. 889, ss. 1, 2; 1985, c. 589, s. 2; 2018-33, s. 18.)

§ 122C-233. Discharges.

(a) Except as provided in subsection (b) of this section, an incompetent adult shall be discharged upon the request of the legally responsible person as provided in G.S. 122C-212.

(b) After the court has concurred in the admission of an incompetent adult to a 24-hour facility as provided in G.S. 122C-232, only the facility or the court may release the incompetent adult at any time when either determines that the incompetent adult does not need further treatment

at the facility. If the legally responsible person believes that release is in the best interest of the incompetent adult, and the facility refuses release, the legally responsible person may apply to the court for a hearing for discharge. (1975, c. 839; 1977, c. 756; 1979, c. 171, s. 1; 1983, c. 889, ss. 1, 2; 1985, c. 589, s. 2.)

§§ 122C-234 through 122C-240: Reserved for future codification purposes.

Part 5. Voluntary Admissions and Discharges, Minors and Adults, Facilities for Individuals with Developmental Disabilities.

§ 122C-241. Admissions.

(a) Except as provided in subsection (c) of this section, an individual with intellectual or other developmental disabilities may be admitted to a facility for individuals with intellectual or other developmental disabilities to receive care, habilitation, rehabilitation, training, or treatment. Application for admission is made as follows:

(1) A minor with intellectual or other developmental disabilities may be admitted upon application by both the father and the mother if they are living together and, if not, by the parent or parents having custody or by the legally responsible person.

(2) An adult with intellectual or other developmental disabilities who has been adjudicated incompetent under Chapter 35A or former Chapters 33 or 35 of the General Statutes may be admitted upon application by the adult's guardian.

(3) An adult with intellectual or other developmental disabilities who has not been adjudicated incompetent under Chapter 35A or former Chapters 33 or 35 of the General Statutes may be admitted upon the adult's own application.

(b) Prior to admission to a 24-hour facility, the individual shall be examined and evaluated by a physician or psychologist to determine whether the individual has a developmental disability. In addition, the individual shall be examined and evaluated by a qualified developmental disabilities professional no sooner than 31 days prior to admission or within 72 hours after admission to determine whether the individual is in need of care, habilitation, rehabilitation, training, or treatment by the facility. If the evaluating professional determines that the individual will not benefit from an admission, the individual shall not be admitted as a client.

(c) An admission to an area or State 24-hour facility of an individual from a single portal area shall follow the procedures as prescribed in the area plan. When an individual from a single portal area presents himself or herself or is presented for admission directly to a State developmental center and is in need of an emergency admission, he or she may be accepted for admission. The State developmental center shall notify the area authority within 24 hours of the admission and further planning of treatment for the individual is the joint responsibility of the area authority and the State developmental center as prescribed in the area plan. (1963, c. 1184, s. 6; 1965, c. 800, s. 12; 1973, c. 476, s. 133; 1977, c. 679, s. 7; 1981, c. 51, s. 3; 1983, c. 383, s. 7; 1985, c. 589, s. 2; c. 695, s. 14; 1989, c. 625, s. 22; 1989 (Reg. Sess., 1990), c. 1024, s. 26(d); 2019-76, s. 6.)

§ 122C-242. Discharges.

(a) Except as provided in subsections (b) through (d) of this section, discharges from facilities for individuals with developmental disabilities are made upon request of the individual authorized in G.S. 122C-241(a) to make application for admission or by the director of the facility.

(b) Any adult who has not been declared incompetent and who is admitted to a 24-hour facility shall be discharged upon his own request, unless the director of the facility has reason to believe that the adult is endangering himself by the discharge. In this case the individual may be held for a period not to exceed five days while the director petitions for the adjudication of incompetency of the individual and the appointment of an interim guardian under Chapter 35A of the General Statutes.

(c) Any individual admitted to a 24-hour facility may be discharged when in the judgment of the director of the facility the individual is no longer in need of care, treatment, habilitation or rehabilitation by the facility or the individual will no longer benefit from the service available. In the case of an area or State facility rules adopted by the Commission or by the Secretary in accordance with G.S. 122C-63 shall be followed.

(d) When the individual to be discharged from an area or State 24-hour facility is a resident of a single portal area, the discharge shall follow the procedures described in the area plan. (1963, c. 1184, s. 6; 1973, c. 476, s. 133; 1983, c. 383, s. 8; 1985, c. 589, s. 2; 1989, c. 625, s.22; 1989 (Reg. Sess., 1990), c. 1024, s. 26(c).)

§§ 122C-243 through 122C-250. Reserved for future codification purposes.

Part 6. Involuntary Commitment – General Provisions.

§ 122C-251. Custody and transportation.

(a) Except as provided in subsections (c), (f), and (g) [of this section], 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 physically 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 physically 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 (c), (f), and (g) [of this section] or in G.S. 122C-408(b), transportation between counties under the involuntary commitment proceedings of this Article for a first examination as described in G.S. 122C-263(a) and G.S. 122C-283(a) and 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 who 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 (i) by city- or county-owned vehicles, (ii) by private vehicle by contract with the city or county, or (iii) as provided in an agreement developed and adopted under subsection (g) of this section and G.S. 122C-202.2. 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 taken into custody and transported to receive treatment and for their own safety and that of others.

(d) To the extent feasible, 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 taking custody and providing transportation as required by this section, the law enforcement officer may use reasonable force to restrain the respondent if it appears necessary to protect the law enforcement officer, the respondent, or others. Any use of restraints shall be as reasonably determined by the officer to be necessary under the circumstances for the safety of the respondent, the law enforcement officer, and other persons. Every effort to avoid restraint of a child under the age of 10 shall be made by the transporting officer unless the child's behavior or other circumstances dictate that restraint is necessary. The law enforcement officer shall respond to all inquiries from the facility concerning the respondent's behavior and the use of any restraints related to the custody and transportation of the respondent, except in circumstances where providing that information is confidential or would otherwise compromise a law enforcement investigation. No law enforcement officer or other person designated or required to provide custody or transport of a client under G.S. 122C-251 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 either a health care provider of the respondent or 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 health care provider of the respondent, the family or friends of the respondent, or the respondent himself or herself is not substantial. The health care provider of the respondent or 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 shall adopt a plan known as an "involuntary commitment transportation agreement" or "transportation agreement" for the custody and transportation of respondents in involuntary commitment proceedings under this Article as follows:

(1) Law enforcement and other affected agencies, including local acute care hospitals and other mental health providers, shall participate in developing the transportation agreement. The area authority may participate in developing the transportation agreement.

(2) The transportation agreement may designate law enforcement officers, volunteers, or other public or private personnel who have agreed pursuant to subsection (g) of this section to provide all or parts of the custody and transportation required by involuntary commitment proceedings. Persons so designated or otherwise required to provide all or parts of the custody and transportation required by involuntary commitment proceedings shall be trained as set forth in G.S. 122C-202.2(a)(3), and the plan shall assure adequate safety and protections for both the public and the respondent. Any person or agency designated or required to provide all or parts of the custody and transportation required by involuntary commitment proceedings shall follow the procedures in this Article. References in this Article to a law enforcement officer apply to any person or entity designated to provide custody or transportation. The transportation agreement may provide that private

personnel or agencies may contract for transportation services to transport respondents under involuntary commitment from one entity to another.

(3) A person shall not be designated under subsection (g) of this section without that person's written consent and the written consent of his or her employer, if applicable. An agency, corporation, or entity shall not be designated without the written consent of that agency, corporation, or entity. Any person, agency, corporation, or other entity shall be designated to provide only the services which the person, agency, corporation, or other entity has previously consented in writing to provide and shall be permitted to withdraw from or discontinue providing services, in whole or in part, upon written notice to the designating governing body. The transportation agreement shall be submitted to the magistrates in the city or county's judicial district, to the county clerks of court, to the LME/MCO that serves the city or county, and to the Division of Mental Health, Developmental Disabilities, and Substance Use Services on or before January 1, 2019. If the city or county modifies the transportation agreement, it will submit the modified agreement to their magistrates in their judicial district, county clerks of court, the LME/MCO that serves the city or county, and the Division of Mental Health, Developmental Disabilities, and Substance Use Services at least 10 days prior to the effective date of the new plan.

(4) Counties and cities shall retain and be required to perform the responsibilities set forth in this Article, except as set forth in a plan developed, agreed upon, and adopted in compliance with this subsection.

(h) The cost and expenses of custody and transportation of a respondent as required by the involuntary commitment procedures of this Article, to the extent they are not reimbursed by a third-party insurer, are 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 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 the reasonable cost of transportation it has paid to the State, a city, or a county. Provided that the county of residence provides the respondent or other individual liable for the respondent's support a reasonable notice and opportunity to object to the reimbursement, the county of residence of the respondent may recover that cost from:

(1) The respondent, if the respondent is not indigent;

(2) Any person or entity that is legally liable for the resident's support and maintenance provided there is sufficient property to pay the cost;

(3) Any person or entity that is contractually responsible for the cost; or

(4) Any person or entity that otherwise is liable under federal, State, or local law for the cost. (1899, c. 1, s. 32; Rev., s. 4555; 1919, c. 326, s. 4; C.S., ss. 6201, 6202; 1945, c. 952, ss. 29, 30; 1953, c. 256, s. 6; 1961, c. 186; 1963, c. 1184, s. 1; 1969, c. 982; 1973, c. 1408, s. 1; 1979, c. 915, ss. 21, 22; 1983, c. 138, ss. 1, 2; 1985, c. 589, s. 2; 1987, c. 268; 1995 (Reg. Sess., 1996), c. 739, s. 4; 1999-201, s. 1; 1999-456, s. 36; 2015-176, s. 2.5(a); 2018-33, s. 19; 2019-240, s. 26(f); 2021-138, s. 6(a); 2023-65, s. 5.2(b).)

§ 122C-252. Twenty-four hour facilities for custody and treatment of involuntary clients.

State facilities, 24-hour facilities licensed under this Chapter or hospitals licensed under Chapter 131E may be designated by the Secretary as facilities for the custody and treatment of involuntary clients. Designation of these facilities shall be made in accordance with rules of the Secretary that assure the protection of the client and the general public. Facilities so designated may detain a client under the procedures of Parts 7 and 8 of this Article both before a district court hearing and after commitment of the respondent. (1973, c. 726, s. 1; c. 1408, s. 1; 1977, c. 400, s. 4; c. 679, s. 8; c. 739, s. 1; 1979, c. 358, s. 27; c. 915, s. 4; 1983, c. 380, ss. 4, 10; c. 638, ss. 6, 7, 25.1; c. 864, s. 4; 1985, c. 589, s. 2.)

§ 122C-253. Fees under commitment order.

Nothing contained in Parts 6, 7, or 8 of this Article requires a private physician, private psychologist, commitment examiner, or private facility to accept a respondent as a client either before or after commitment. Treatment at a private facility or by a private physician, psychologist, or commitment examiner is at the expense of the respondent to the extent that the charges are not disposed of by contract between the area authority and the private facility. An area authority and its contract agencies shall set and recover fees for inpatient or outpatient treatment services provided under a commitment order in accordance with G.S. 122C-146. (1973, c. 726, s. 1; c. 1408, s. 1; 1977, c. 400, s. 8; c. 739, s. 2; 1979, c. 358, s. 26; c. 915, ss. 8, 15, 16; 1981, c. 537, s. 1; 1983, c. 380, s. 8; c. 638, s. 14; c. 864, s. 4; 1985, c. 589, s. 2; c. 695, s. 3; 2018-33, s. 20.)

§ 122C-254. Housing responsibility for certain clients in or escapees from involuntary commitment.

(a) Any individual who has been involuntarily committed under the provisions of this Article to a 24-hour facility:

(1) Who escapes from or is absent without authorization from the facility before being discharged; and

(2) Who is charged with a criminal offense committed after the escape or during the unauthorized absence; and

(3) Whose involuntary commitment is determined to be still valid by the judge or judicial officer who would make the pretrial release determination regarding the criminal offense under the provisions of G.S. 15A-533 and G.S. 15A-534; or

(4) Who is charged with committing a crime while still residing in the facility and whose commitment is still valid as prescribed by subdivision (3) of this section;

shall be denied pretrial release pursuant to G.S. 15A-533 and G.S. 15A-534. In lieu of pretrial release, and pending the additional proceedings on the criminal offense, the individual shall be returned to the 24-hour facility in which he was residing at the time of the alleged crime or from which he escaped or absented himself for continuation of his commitment.

(b) Absent findings of lack of mental responsibility for his criminal offense or lack of competency to stand trial for the criminal offense, the involuntary commitment of an individual as described in subsection (a) of this section shall not be utilized in lieu of nor shall it constitute a bar to proceeding to trial for the criminal offense. At any time that the district court or the responsible professional of the 24-hour facility finds that the individual should be unconditionally discharged, committed for outpatient treatment, or conditionally released, the facility shall notify the clerk of superior court in the county in which the criminal charge is pending before making the change in status. At this time, a pretrial release determination pursuant to the provisions of G.S. 15A-533 and

G.S. 15A-534 shall be made. In this event, arrangements for returning the individual for the pretrial release determination shall be the responsibility of the clerk of superior court.

(c) An individual who has been processed in accordance with subsections (a) and (b) of this section may not later be returned to a 24-hour facility before trial except pursuant to involuntary commitment proceedings by the district court in accordance with Parts 7 and 8 of this Article or after proceedings in accordance with the provisions of G.S. 15A-1002 or G.S. 15A-1321.

(d) Other involuntarily committed respondents who escape, but do not meet the additional criteria specified in subsection (a) of this section, are handled in accordance with the provisions of G.S. 122C-205. (1981, c. 936, s. 1; 1985, c. 589, s. 2.)

§ 122C-255. Report required.

Each 24-hour facility that (i) falls under the category of nonhospital medical detoxification, facility-based crisis service, or inpatient hospital treatment, (ii) is not a State facility under the jurisdiction of the Secretary of Health and Human Services, and (iii) is designated by the Secretary of Health and Human Services as a facility for the custody and treatment of individuals under a petition of involuntary commitment pursuant to G.S. 122C-252 and 10A NCAC 26C.0101 shall submit a written report on involuntary commitments each January 1 and each July 1 to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Use Services. The report shall include all of the following:

(1) The number and primary presenting conditions of individuals receiving treatment from the facility under a petition of involuntary commitment.

(1a) The transportation method utilized by individuals admitted under a petition of involuntary commitment to the 24-hour facility.

(1b) The number of individuals moved to voluntary status at any time between arrival at the 24-hour facility and completion of the required 24-hour examination.

(2) The number of individuals for whom an involuntary commitment proceeding was initiated at the facility, who were referred to a different facility or program.

(3) The reason for referring the individuals described in subdivision (2) of this section to a different facility or program, including the need for more intensive medical supervision. (2011-346, s. 2; 2018-33, s. 21; 2021-77, s. 5; 2023-65, s. 5.2(b).)

§ 122C-256. Capacity restoration pilot programs.

(a) The following definitions apply in this section:

(1) CBCRP. – Community-based capacity restoration program.

(2) DCCRP. – Detention center capacity restoration program.

(b) Community-Based Capacity Restoration Program. – The Department or an LME/MCO may contract for three or more CBCRPs. CBCRPs may be county-based or regionally based. If regionally based, a CBCRP shall align with the State-operated psychiatric hospital within closest proximity. The Department may consult with one or more LME/MCOs for the purposes of contracting for CBCRPs under this subsection.

(c) Detention Center Capacity Restoration Program. – The Department or an LME/MCO, in consultation and with the consent of relevant sheriffs, may contract for up to three DCCRPs. DCCRPs may be county-based or regionally based. All county sheriffs choosing to participate in a regional program must enter into an operational agreement with the sheriff hosting the regional

program prior to referring defendants to the program. A regionally based DCCRP shall align with the State-operated psychiatric hospital within closest proximity. The Department may consult with one or more LME/MCOs for the purposes of contracting for DCCRPs under this subsection. (2025-27, s. 6.1(a).)

§ 122C-257. Reserved for future codification purposes.

§ 122C-258. Reserved for future codification purposes.

§ 122C-259. Reserved for future codification purposes.

§ 122C-260. Reserved for future codification purposes.

Part 7. Involuntary Commitment of the Mentally Ill; Facilities for the Mentally Ill.

§ 122C-261. Affidavit and petition before clerk or magistrate when immediate hospitalization is not necessary; custody order.

(a) Anyone who has knowledge of an individual who has a mental illness and is either (i) dangerous to self, as defined in G.S. 122C-3(11)a., or dangerous to others, as defined in G.S. 122C-3(11)b., or (ii) in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness, may appear before a clerk or assistant or deputy clerk of superior court or a magistrate and execute an affidavit to this effect, and petition the clerk or magistrate for issuance of an order to take the respondent into custody for examination by a commitment examiner. The affidavit shall include the facts on which the affiant's opinion is based. If the affiant has knowledge or reasonably believes that the respondent, in addition to having a mental illness, also has an intellectual disability, this fact shall be stated in the affidavit. Jurisdiction under this subsection is in the clerk or magistrate in the county where the respondent resides or is found.

(b) If the clerk or magistrate finds reasonable grounds to believe that the facts alleged in the affidavit are true and that the respondent probably has a mental illness and is either (i) dangerous to self, as defined in G.S. 122C-3(11)a., or dangerous to others, as defined in G.S. 122C-3(11)b., or (ii) in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness, the clerk or magistrate shall issue an order to a law enforcement officer or any other designated person under G.S. 122C-251 to take the respondent into custody for examination by a commitment examiner. If the clerk or magistrate finds that, in addition to probably having a mental illness, the respondent also probably has an intellectual disability, the clerk or magistrate shall contact the area authority before issuing a custody order and the area authority shall designate the facility to which the respondent is to be taken for examination by a commitment examiner. The clerk or magistrate shall provide the petitioner and the respondent, if present, with specific information regarding the next steps that will occur for the respondent.

(c) If the clerk or magistrate issues a custody order, the clerk or magistrate shall also make inquiry in any reliable way as to whether the respondent is indigent within the meaning of G.S. 7A-450. A magistrate shall report the result of this inquiry to the clerk.

(d) If the affiant is a commitment examiner, who is filing a petition and affidavit for an involuntary commitment in a county that has not implemented an electronic filing system approved by the Director of the Administrative Office of the Courts, all of the following apply:

(1) If the affiant has examined the respondent, the affiant may execute the affidavit before any official authorized to administer oaths. This affiant is not required to appear before the clerk or magistrate for this purpose. This affiant shall file the affidavit with the clerk or magistrate by delivering to the clerk or magistrate the original affidavit, by transmitting a copy in paper form that is printed through the facsimile transmission of the affidavit, or by delivering the affidavit through electronic transmission. If the affidavit is filed through electronic or facsimile transmission, the affiant shall mail the original affidavit no later than five days after the facsimile transmission of the affidavit to the clerk or magistrate to be filed by the clerk or magistrate with the facsimile copy of the affidavit.

(2) This affiant's examination shall comply with the requirements of the initial examination as provided in G.S. 122C-263(c). The affiant shall document in writing and file the examination findings with the affidavit delivered to the clerk or magistrate in accordance with subdivision (1) of subsection (d) of this section.

(3) If the commitment examiner recommends outpatient commitment according to the criteria for outpatient commitment set forth in G.S. 122C-263(d)(1) and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for outpatient commitment, the clerk or magistrate shall issue an order that a hearing before a district court judge be held to determine whether the respondent will be involuntarily committed. The commitment examiner shall contact the LME/MCO that serves the county where the respondent resides or the LME/MCO that coordinated services for the respondent to inform the LME/MCO that the respondent has been scheduled for an appointment with an outpatient treatment physician or center. The commitment examiner shall provide the respondent with written notice of any scheduled appointment and the name, address, and telephone number of the proposed outpatient treatment physician or center.

(4) If the commitment examiner recommends inpatient commitment based on the criteria for inpatient commitment set forth in G.S. 122C-263(d)(2) and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for inpatient commitment, the clerk or magistrate shall issue an order to a law enforcement officer to take the respondent into custody for transportation to a 24-hour facility described in G.S. 122C-252, provided that if a 24-hour facility is not immediately available or appropriate to the respondent's medical condition, the respondent may be temporarily detained under appropriate supervision and, upon further examination, released in accordance with G.S. 122C-263(d)(2).

(5) If the affiant is a physician or eligible psychologist at a 24-hour facility described in G.S. 122C-252 who recommends inpatient commitment; the respondent is physically present on the premises of the same 24-hour facility; and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for inpatient commitment, then the clerk or magistrate shall issue an order by facsimile transmission or by electronic transmission to the physician or eligible psychologist at the 24-hour facility, or a designee, to take the respondent into custody at the 24-hour facility and proceed according to

G.S. 122C-266. Upon receipt of the custody order, the physician or eligible psychologist at the 24-hour facility, or a designee, shall immediately (i) notify the respondent that the respondent is not under arrest and has not committed a crime but is being taken into custody to receive treatment and for the respondent's own safety and the safety of others, (ii) take the respondent into custody, and (iii) complete and sign the appropriate portion of the custody order and return the order to the clerk or magistrate either by facsimile transmission or by scanning it and sending it by electronic transmission. The physician or eligible psychologist, or a designee, shall mail the original custody order no later than five days after returning it by means of facsimile or electronic transmission to the clerk or magistrate. The clerk or magistrate shall file the original custody order with the copy of the custody order that was electronically returned.

Notwithstanding the provisions of this subdivision, a clerk or magistrate shall not issue a custody order to a physician or eligible psychologist at a 24-hour facility, or a designee, if the physician or eligible psychologist, or a designee, has not completed training in proper service and return of service. As used in this subdivision, the term "designee" includes the 24-hour facility's on-site police security personnel.

The Department of Health and Human Services shall cooperate and collaborate with the Administrative Office of the Courts and the UNC School of Government to develop protocols to implement this section, including a procedure for notifying clerks and magistrates of the names of the physicians, psychologists, and designees who have completed the training. The Secretary of the Department shall oversee implementation of these protocols.

(6) If the clerk or magistrate finds probable cause to believe that the respondent, in addition to having a mental illness, also has an intellectual disability, the clerk or magistrate shall contact the area authority before issuing the order and the area authority shall designate the facility to which the respondent is to be transported.

(7) If a commitment examiner executes an affidavit for inpatient commitment of a respondent, a physician who is not the commitment examiner who performed the examination under this section shall be required to perform the examination required by G.S. 122C-266.

(8) No commitment examiner, area facility, acute care hospital, general hospital, or other site of first examination, or its officials, staff, employees, or other individuals responsible for the custody, examination, detention, management, supervision, treatment, or release of an individual examined for commitment, who is not grossly negligent, shall be held liable in any civil or criminal action for taking measures to temporarily detain an individual for the period of time necessary to complete a commitment examination, submit an affidavit to the magistrate or clerk of court, and await the issuance of a custody order as authorized by this section.

(d1) If the affiant is a commitment examiner filing a petition and affidavit for an involuntary commitment in a county that has implemented an electronic filing system approved by the Director of the Administrative Office of the Courts, the same provisions of subsection (d) of this section

apply except that (i) the commitment examiner or their designee shall file the affidavit and petition, as well as any other supporting documentation required by law, through the electronic filing system, and (ii) the original affidavit and original custody order are not required to be mailed to the clerk or magistrate. In such counties, commitment examiners shall also file any subsequent documentation and notifications prescribed by statute to the clerk of superior court through the electronic filing system.

(e) Except as provided in subdivision (5) of subsection (d) of this section, upon receipt of the custody order of the clerk or magistrate or a custody order issued by the court pursuant to G.S. 15A-1003, a law enforcement officer, person designated under G.S. 122C-251(g), or other person identified in the order shall take the respondent into custody within 24 hours after the order is signed, and proceed according to G.S. 122C-263. The custody order is valid throughout the State.

Notwithstanding the provisions of this section, in no event shall an individual known or reasonably believed to have an intellectual disability be admitted to a State psychiatric hospital, except the following:

(1) Persons described in G.S. 122C-266(b).
(2) Persons admitted pursuant to G.S. 15A-1321.
(3) Respondents who are so extremely dangerous as to pose a serious threat to the community and to other patients committed to non-State hospital psychiatric inpatient units, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Use Services or the Director's designee.
(4) Respondents who are so gravely disabled by both multiple disorders and medical fragility or multiple disorders and deafness that alternative care is inappropriate, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Use Services or the Director's designee.

Individuals transported to a State facility for individuals with mental illnesses who are not admitted by the facility may be transported by appropriate law enforcement officers or designated staff of the State facility in State-owned vehicles to an appropriate 24-hour facility that provides psychiatric inpatient care.

No later than 24 hours after the transfer, the responsible professional at the original facility shall notify the petitioner, the clerk of court, and, if consent is granted by the respondent, the next of kin, that the transfer has been completed.

(f) Repealed by Session Laws 2018-33, s. 46, effective October 1, 2019. (1973, c. 726, s. 1; c. 1408, s. 1; 1977, c. 400, s. 3; 1979, c. 164, s. 2; c. 915, ss. 3, 18; 1983, c. 383, s. 5; c. 638, ss. 3-5; c. 864, s. 4; 1985, c. 589, s. 2; c. 695, ss. 2, 4; 1985 (Reg. Sess., 1986), c. 863, s. 17; 1989 (Reg. Sess., 1990), c. 823, ss. 1, 2; c. 1024, s. 27.1; 1991, c. 37, s. 7; 1995 (Reg. Sess., 1996), c. 739, s. 6; 1997-456, s. 47; 2004-23, s. 1(a); 2005-135, s. 1; 2009-315, s. 1; 2009-340, s. 1; 2013-308, ss. 1, 2; 2018-33, s. 22; 2019-76, s. 7; 2019-240, s. 26(g); 2023-65, s. 5.2(b); 2023-103, s. 13(a); 2024-33, s. 16.)

§ 122C-262. Special emergency procedure for individuals needing immediate hospitalization.

(a) Anyone, including a law enforcement officer, who has knowledge of an individual who is subject to inpatient commitment according to the criteria of G.S. 122C-263(d)(2) and who

requires immediate hospitalization to prevent harm to self or others, may transport the individual directly to an area facility or other place, including a State facility for individuals with mental illnesses, for examination by a commitment examiner in accordance with G.S. 122C-263(c).

(b) Upon examination by the commitment examiner, if the individual meets the inpatient commitment criteria specified in G.S. 122C-263(d)(2) and requires immediate hospitalization to prevent harm to self or others, the commitment examiner shall so certify in writing before any official authorized to administer oaths. The certificate shall also state the reason that the individual requires immediate hospitalization. If the commitment examiner knows or has reason to believe that the individual has an intellectual disability, the certificate shall so state.

(c) If the commitment examiner executes the oath, appearance before a magistrate shall be waived. The commitment examiner shall send a copy of the certificate to the clerk of superior court (i) through the electronic filing system, if the county has implemented a system approved by the Director of the Administrative Office of the Courts, or (ii) by the most reliable and expeditious means otherwise available. If it cannot be reasonably anticipated that the clerk will receive the copy within 24 hours, excluding Saturday, Sunday, and holidays, of the time that it was signed, the physician or eligible psychologist shall also communicate the findings to the clerk by telephone.

(d) Anyone, including a law enforcement officer if necessary, may transport the individual to a 24-hour facility described in G.S. 122C-252 for examination and treatment pending a district court hearing. If there is no area 24-hour facility and if the respondent is indigent and unable to pay for care at a private 24-hour facility, the law enforcement officer or other designated person providing transportation shall take the respondent to a State facility for individuals with mental illnesses designated by the Commission in accordance with G.S. 143B-147(a)(1)a. and immediately notify the clerk of superior court of this action. The commitment examiner's certificate shall serve as the custody order and the law enforcement officer or other designated person shall provide transportation in accordance with G.S. 122C-251. If a 24-hour facility is not immediately available or appropriate to the respondent's medical condition, the respondent may be temporarily detained under appropriate supervision in accordance with G.S. 122C-263(d)(2) and released in accordance with G.S. 122C-263(d)(2).

In the event an individual known or reasonably believed to have an intellectual disability is transported to a State facility for individuals with mental illnesses, in no event shall that individual be admitted to that facility unless the individual is in one or more of the following categories:

(1) Persons described in G.S. 122C-266(b).
(2) Persons admitted pursuant to G.S. 15A-1321.
(3) Respondents who are so extremely dangerous as to pose a serious threat to the community and to other patients committed to non-State hospital psychiatric inpatient units, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Use Services or the Director's designee.
(4) Respondents who are so gravely disabled by both multiple disorders and medical fragility or multiple disorders and deafness that alternative care is inappropriate, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Use Services or the Director's designee.

Individuals transported to a State facility for individuals with mental illnesses who are not admitted by the facility may be transported by law enforcement officers or designated staff of the

State facility in State-owned vehicles to an appropriate 24-hour facility that provides psychiatric inpatient care.

No later than 24 hours after the transfer, the responsible professional at the original facility shall notify the petitioner, the clerk of court, and, if consent is granted by the respondent, the next of kin, that the transfer has been completed.

(e) Respondents received at a 24-hour facility under this section shall be examined by a second physician in accordance with G.S. 122C-266. After receipt of notification that the district court has determined reasonable grounds for the commitment, further proceedings shall be carried out in the same way as for all other respondents under this Part.

(f) If, upon examination of a respondent presented in accordance with subsection (a) of this section, the commitment examiner finds that the individual meets the criteria for inpatient commitment specified in G.S. 122C-263(d)(2) but does not require immediate hospitalization to prevent harm to self or others, the commitment examiner may petition the clerk or magistrate in accordance with G.S. 122C-261(d) for an order to take the individual into custody for transport to a 24-hour facility described in G.S. 122C-252. If the commitment examiner recommends inpatient commitment and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for inpatient commitment, the clerk or magistrate shall issue an order for transport to or custody at a 24-hour facility described in G.S. 122C-252. If, however, a 24-hour facility is not immediately available or appropriate to the respondent's medical condition, the respondent may be temporarily detained under appropriate supervision in accordance with G.S. 122C-263(d)(2) and released in accordance with G.S. 122C-263(d)(2).

(g) This section applies exclusively to an individual who is transported to an area facility or other place for an examination by a commitment examiner in accordance with subsection (a) of this section. (1973, c. 726, s. 1; c. 1408, s. 1; 1985, c. 589, s. 2; c. 695, s. 2; 1987, c. 596, s. 1; 1995 (Reg. Sess., 1996), c. 739, s. 7; 2018-33, s. 23; 2019-76, s. 8; 2023-65, s. 5.2(b); 2023-103, s. 13(b).)

§ 122C-263. Duties of law enforcement officer; first examination.

(a) Without unnecessary delay after assuming custody, the law enforcement officer or the individual designated or required to provide transportation pursuant to G.S. 122C-251(g) shall take the respondent to a facility or other location identified by the LME/MCO in the community crisis services plan adopted pursuant to G.S. 122C-202.2 that has an available commitment examiner and is capable of performing a first examination in conjunction with a health screening at the same location, unless circumstances indicate the respondent appears to be suffering a medical emergency in which case the law enforcement officer will seek immediate medical assistance for the respondent. If a commitment examiner is not available, whether on-site, on-call, or via telehealth, at any facility or location, or if a plan has not been adopted, the person designated to provide transportation shall take the respondent to an alternative non-hospital provider or facility-based crisis center for a first examination in conjunction with a health screening at the same location. If no non-hospital provider or facility-based crisis center for a first examination in conjunction with a health screening at the same location for health screening and first examination exists, the person designated to provide transportation shall take the respondent to a private hospital or clinic, a general hospital, an acute care hospital, or a State facility for individuals with mental illnesses. If a commitment examiner is not immediately available, the respondent may be temporarily detained in an area facility, if one is available; if an area facility is not available, the respondent may be detained under appropriate supervision in the respondent's home, in a private

hospital or a clinic, in a general hospital, or in a State facility for individuals with mental illnesses, but not in a jail or other penal facility. For the purposes of this section, "non-hospital provider" means an outpatient provider that provides either behavioral health or medical services.

(a1) A facility or other location to which a respondent is transported under subsection (a) of this section shall provide a health screening of the respondent. The health screening shall be conducted by a commitment examiner or other individual who is determined by the area facility, contracted facility, or other location to be qualified to perform the health screening. The Department will work with commitment examiner professionals to develop a screening tool for this purpose. The respondent may either be in the physical face-to-face presence of the person conducting the screen or may be examined utilizing telehealth equipment and procedures. Documentation of the health screening required under this subsection that is completed prior to transporting the patient to any general hospital, acute care hospital, or designated facility shall accompany the patient or otherwise be made available at the time of transportation to the receiving facility.

(b) The examination set forth in subsection (a) of this section is not required under any of the following circumstances:

(1) The affiant who obtained the custody order is a commitment examiner who recommends inpatient commitment.

(2) The custody order states that the respondent was charged with a violent crime, including a crime involving assault with a deadly weapon, and the respondent was found incapable of proceeding.

(3) Repealed by Session Laws 1987, c. 596, s. 3.

In any of these cases, the law enforcement officer or person designated under G.S. 122C-251(g) shall take the respondent directly to a 24-hour facility described in G.S. 122C-252.

(c) The commitment examiner described in subsection (a) of this section shall examine the respondent as soon as possible, and in any event within 24 hours after the respondent is presented for examination. When the examination set forth in subsection (a) of this section is performed by a commitment examiner, the respondent may either be in the physical face-to-face presence of the commitment examiner or may be examined utilizing telehealth equipment and procedures. A commitment examiner who examines a respondent by means of telehealth must be satisfied to a reasonable medical certainty that the determinations made in accordance with subsection (d) of this section would not be different if the examination had been done in the physical presence of the commitment examiner. A commitment examiner who is not so satisfied must note that the examination was not satisfactorily accomplished, and the respondent must be taken for a face-to-face examination in the physical presence of a person authorized to perform examinations under this section. As used in this section, "telehealth" means the use of two-way, real-time interactive audio and video where the respondent and commitment examiner can hear and see each other. A recipient is referred by one provider to receive the services of another provider via telehealth.

The examination shall include an assessment of at least all of the following with respect to the respondent:

(1) Current and previous mental illness and intellectual disability including, if available, previous treatment history.

(2) Dangerousness to self, as defined in G.S. 122C-3(11)a. or others, as defined in G.S. 122C-3(11)b.

(3) Ability to survive safely without inpatient commitment, including the availability of supervision from family, friends, or others.

(4) Capacity to make an informed decision concerning treatment.

(d) After the conclusion of the examination the commitment examiner shall make the following determinations:

(1) If the commitment examiner finds all of the following, the commitment examiner shall so show on the examination report and shall recommend outpatient commitment:

a. The respondent has a mental illness.

b. The respondent is capable of surviving safely in the community with available supervision from family, friends, or others.

c. Based on the respondent's psychiatric history, the respondent is in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness as defined by G.S. 122C-3(11).

d. The respondent's current mental status or the nature of the respondent's illness limits or negates the respondent's ability to make an informed decision to seek voluntarily or comply with recommended treatment.

In addition, the commitment examiner shall show the name, address, and telephone number of the proposed outpatient treatment physician or center in accordance with subsection (f) of this section. The person designated in the order to provide transportation shall return the respondent to the respondent's regular residence or, with the respondent's consent, to the home of a consenting individual located in the originating county, and the respondent shall be released from custody.

(2) If the commitment examiner finds that the respondent has a mental illness and is dangerous to self, as defined in G.S. 122C-3(11)a., or others, as defined in G.S. 122C-3(11)b., the commitment examiner shall recommend inpatient commitment, and shall so show on the examination report. If, in addition to mental illness and dangerousness, the commitment examiner also finds that the respondent is known or reasonably believed to have an intellectual disability, this finding shall be shown on the report. Upon notification, the law enforcement officer or other designated person shall take the respondent to a 24-hour facility described in G.S. 122C-252 pending a district court hearing. To the extent feasible, in providing the transportation of the respondent, the law enforcement officer shall act within six hours of notification. The other designated person shall take the respondent to a 24-hour facility described in G.S. 122C-252 pending a district court hearing within six hours of notification. If there is no area 24-hour facility and if the respondent is indigent and unable to pay for care at a private 24-hour facility, the law enforcement officer or other designated person shall take the respondent to a State facility for individuals with mental illnesses designated by the Commission in accordance with G.S. 143B-147(a)(1)a. for custody, observation, and treatment and immediately notify the clerk of superior court of this action. If a 24-hour facility is not immediately available or appropriate to the respondent's medical condition, the respondent may be temporarily detained under appropriate supervision at the

site of the first examination. Upon the commitment examiner's determination that a 24-hour facility is available and medically appropriate, the law enforcement officer or other designated person shall transport the respondent after receiving a request for transportation by the facility of the commitment examiner. To the extent feasible, in providing the transportation of the respondent, the law enforcement officer shall act within six hours of notification. The other designated person shall transport the respondent without unnecessary delay and within six hours after receiving a request for transportation by the facility of the commitment examiner. At any time during the respondent's temporary detention under appropriate supervision, if a commitment examiner determines that the respondent is no longer in need of inpatient commitment, the proceedings shall be terminated and the respondent transported and released in accordance with subdivision (3) of this subsection. However, if the commitment examiner determines that the respondent meets the criteria for outpatient commitment, as defined in subdivision (1) of this subsection, the commitment examiner may recommend outpatient commitment, and the respondent shall be transported and released in accordance with subdivision (1) of this subsection. Any decision to terminate the proceedings or to recommend outpatient commitment after an initial recommendation of inpatient commitment shall be documented and reported to the clerk of superior court in accordance with subsection (e) of this section. If the respondent is temporarily detained and a 24-hour facility is not available or medically appropriate seven days after the issuance of the custody order, a commitment examiner shall report this fact to the clerk of superior court and the proceedings shall be terminated. Termination of proceedings pursuant to this subdivision shall not prohibit or prevent the initiation of new involuntary commitment proceedings when appropriate. A commitment examiner may initiate a new involuntary commitment proceeding prior to the expiration of this seven-day period, as long as the respondent continues to meet applicable criteria. Affidavits filed in support of proceedings terminated pursuant to this subdivision shall not be submitted in support of any subsequent petitions for involuntary commitment. If the affiant initiating new commitment proceedings is a commitment examiner, the affiant shall conduct a new examination and shall not rely upon examinations conducted as part of proceedings terminated pursuant to this subdivision.

In the event an individual known or reasonably believed to have an intellectual disability is transported to a State facility for individuals with mental illnesses, in no event shall that individual be admitted to that facility unless the individual is in one or more of the following categories:

a. Persons described in G.S. 122C-266(b).
b. Persons admitted pursuant to G.S. 15A-1321.
c. Respondents who are so extremely dangerous as to pose a serious threat to the community and to other patients committed to non-State hospital psychiatric inpatient units, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Use Services or the Director's designee.

d. Respondents who are so gravely disabled by both multiple disorders and medical fragility or multiple disorders and deafness that alternative care is inappropriate, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Use Services or the Director's designee.

Individuals transported to a State facility for individuals with mental illnesses who are not admitted by the facility may be transported by law enforcement officers or designated staff of the State facility in State-owned vehicles to an appropriate 24-hour facility that provides psychiatric inpatient care.

No later than 24 hours after the transfer, the responsible professional at the original facility shall notify the petitioner, the clerk of court, and, if consent is granted by the respondent, the next of kin, that the transfer has been completed.

(3) If the commitment examiner finds that neither condition described in subdivisions (1) or (2) of this subsection exists, the proceedings shall be terminated. The person designated in the order to provide transportation shall return the respondent to the respondent's regular residence or, with the respondent's consent, to the home of a consenting individual located in the originating county and the respondent shall be released from custody.

(e) The findings of the commitment examiner and the facts on which they are based shall be in writing in all cases. The commitment examiner shall send a copy of the findings to the clerk of superior court by the most reliable and expeditious means. If it cannot be reasonably anticipated that the clerk will receive the copy within 48 hours of the time that it was signed, the physician or eligible psychologist shall also communicate his findings to the clerk by telephone.

(f) When outpatient commitment is recommended, the commitment examiner, if different from the proposed outpatient treatment physician or center, shall contact the LME/MCO that serves the county where the respondent resides or the LME/MCO that coordinated services for the respondent to inform the LME/MCO that the respondent is being recommended for outpatient commitment. The commitment examiner shall give the respondent a written notice listing the name, address, and telephone number of the proposed outpatient treatment physician or center.

(g) The commitment examiner, at the completion of the examination, shall provide the respondent with specific information regarding the next steps that will occur. (1973, c. 726, s. 1; c. 1408, s. 1; 1977, c. 400, s. 4; c. 679, s. 8; c. 739, s. 1; 1979, c. 358, s. 27; c. 915, s. 4; 1983, c. 380, ss. 4, 10; c. 638, ss. 6, 7, 25.1; c. 864, s. 4; 1985, c. 589, s. 2; c. 695, ss. 2, 5, 6; 1985 (Reg. Sess., 1986), c. 863, s. 18; 1987, c. 596, s. 3; 1989, c. 225, s. 2; c. 770, s. 74; 1989 (Reg. Sess., 1990), c. 823, ss. 3, 4; 1991, c. 37, s. 8; c. 636, s. 2(1); c. 761, s. 49; 1995 (Reg. Sess., 1996), c. 739, s. 8(a)-(d); 2009-315, s. 2; 2009-340, s. 2; 2018-33, s. 24; 2018-76, s. 3.2(a); 2019-76, s. 9; 2019-177, s. 7(a); 2021-77, s. 6(a); 2023-65, s. 5.2(b).)

§ 122C-263.1. Secretary's authority to certify commitment examiners; training of certified commitment examiners performing first examinations.

(a) Physicians and eligible psychologists are qualified to perform the commitment examinations required under G.S. 122C-263(c) and G.S. 122C-283(c). The Secretary of Health and Human Services may individually certify to perform the first commitment examinations required by G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 other health, mental health, and substance abuse professionals whose scope of practice includes

diagnosing and documenting psychiatric or substance use disorders and conducting mental status examinations to determine capacity to give informed consent to treatment as follows:

(1) The Secretary has received a request:
   a. To certify a licensed clinical social worker, a master's or higher level degree nurse practitioner, a licensed clinical mental health counselor, a licensed marriage and family therapist, or a physician assistant to conduct the first examinations described in G.S. 122C-263(c) and G.S. 122C-283(c).
   b. To certify a master's level licensed clinical addictions specialist to conduct the first examination described in G.S. 122C-283(c).

(2) The Secretary shall review the request and may approve it upon finding all of the following:
   a. The request meets the requirements of this section.
   b., c. Repealed by Session Laws 2018-33, s. 25, effective October 1, 2019.
   d. The Department determines that the applicant possesses the professional licensure, registration, or certification to qualify the applicant as a professional whose scope of practice includes diagnosing and documenting psychiatric or substance use disorders and conducting mental status examinations to determine capacity to give informed consent to treatment.
   e. The applicant for certification has successfully completed the Department's standardized training program for involuntary commitment and has successfully passed the examination for that program.

(3) Repealed by Session Laws 2018-33, s. 25, effective October 1, 2019.

(4) A certification granted by the Secretary under this section shall be in effect for a period of up to three years and may be rescinded at any time within this period if the Secretary finds the certified individual has failed to meet the requirements of this section. Certification may be renewed every three years upon completion of a refresher training program approved by the Department.

(5) In no event shall the certification of a licensed clinical social worker, master's or higher level degree nurse practitioner, licensed clinical mental health counsellor, a licensed marriage and family therapist, physician assistant, or master's level certified clinical addictions specialist under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the master's level nurse practitioner, licensed clinical mental health counselor, a licensed marriage and family therapist, physician assistant, or the master's level certified clinical addictions specialist.

(6) The Department shall require that individuals certified to perform initial examinations under this section have successfully completed the Department's standardized involuntary commitment training program and examination. The Department shall maintain a list of these individuals on its website.

(7) Repealed by Session Laws 2018-33, s. 25, effective October 1, 2019.

(7a) No less than annually, the Department shall submit a list of certified first commitment examiners to the Chief District Court Judge of each judicial

district in North Carolina and maintain a current list of certified first commitment examiners on its website.

(8) A master's level licensed clinical addiction specialist shall only be authorized to conduct the initial examination of individuals meeting the criteria of G.S. 122C-281(a).

(9) A licensed marriage and family therapist shall not be authorized to conduct the initial examination of an individual married to a patient of the licensed marriage and family therapist.

(b) The Department shall expand its standardized certification training program to include refresher training for all certified providers performing initial examinations pursuant to subsection (a) of this section. (2011-346, s. 1; 2018-33, s. 25; 2019-240, ss. 3(i), 26(h); 2020-82, s. 2(a); 2025-25, s. 29(5).)

§ 122C-263.2. Mental health crisis management: reasonable safety and containment measures.

An acute care hospital licensed under Chapter 131E, a department thereof, or other site of first examination that that uses reasonable safety or containment measures and precautions to manage the population of patients being held under appropriate supervision pending involuntary commitment placement and that does not otherwise operate as a licensable mental health facility shall not be deemed to be acting as a 24-hour facility; operating a psychiatric, substance abuse, or special care unit; offering psychiatric or substance abuse services; or acting as a licensed or unlicensed mental health facility. Actions considered to be reasonable safety or containment measures and precautions shall include the following: (i) altering rooms or removing items to prevent injury; (ii) placing patients in a consolidated location of the hospital; (iii) improvements to security and protection of staff; and (iv) any other reasonable measures that do not violate applicable law.

Reasonable safety or containment measures and precautions shall not be considered a violation of rules regulating acute care hospitals or mental health facilities. Placing patients in a consolidated location of the hospital pursuant to this subsection shall not constitute a special care unit. Nothing in this subsection relieves an acute care hospital or other site of first examination from complying with all other applicable laws or rules. (2012-128, s. 1.)

§ 122C-264. Duties of clerk of superior court and the district attorney.

(a) Upon receipt of a commitment examiner's finding that the respondent meets the criteria of G.S. 122C-263(d)(1) and that outpatient commitment is recommended, the clerk of superior court of the county where the petition was initiated, upon direction of a district court judge, shall calendar the matter for hearing and shall notify the respondent, the proposed outpatient treatment physician or center, and the petitioner of the time and place of the hearing. The petitioner may file a written waiver of his right to notice under this subsection with the clerk of court.

(b) Upon receipt by the clerk of superior court pursuant to G.S. 122C-266(c) of a commitment examiner's finding that a respondent meets the criteria of G.S. 122C-263(d)(2) and that inpatient commitment is recommended, the clerk of superior court of the county where the 24-hour facility is located shall, after determination required by G.S. 122C-261(c) and upon direction of a district court judge, assign counsel if necessary, calendar the matter for hearing, and notify the respondent, his counsel, and the petitioner of the time and place of the hearing. The

petitioner or respondent, directly or through counsel, may file a written waiver of the right to notice under this subsection with the clerk of court.

(b1) Upon receipt of a commitment examiner's certificate that a respondent meets the criteria of G.S. 122C-261(a) and that immediate hospitalization is needed pursuant to G.S. 122C-262, the clerk of superior court of the county where the treatment facility is located shall submit the certificate to the Chief District Court Judge. The court shall review the certificate within 24 hours, excluding Saturday, Sunday, and holidays, for a finding of reasonable grounds in accordance with [G.S.] 122C-261(b). The clerk shall notify the treatment facility of the court's findings by telephone and shall proceed as set forth in subsections (b), (c), and (f) of this section.

(c) Notice to the respondent, required by subsections (a) and (b) of this section, shall be given as provided in G.S. 1A-1, Rule 4(j) at least 72 hours before the hearing. Notice to other individuals shall be sent at least 72 hours before the hearing by first-class mail postage prepaid to the individual's last known address. G.S. 1A-1, Rule 6 shall not apply.

(d) In cases described in G.S. 122C-266(b) in addition to notice required in subsections (a) and (b) of this section, the clerk of superior court shall notify the chief district judge and the district attorney in the county in which the defendant was found incapable of proceeding. The notice shall be given in the same way as the notice required by subsection (c) of this section. The judge or the district attorney may file a written waiver of his right to notice under this subsection with the clerk of court.

(d1) For hearings and rehearings pursuant to G.S. 122C-268.1 and G.S. 122C-276.1, the clerk of superior court shall calendar the hearing or rehearing and shall notify the respondent, his counsel, counsel for the State, and the district attorney involved in the original trial. The notice shall be given in the same manner as the notice required by subsection (c) of this section. Upon receipt of the notice, the district attorney shall notify any persons he deems appropriate, including anyone who has filed with his office a written request for notification of any hearing or rehearing concerning discharge or conditional release of a respondent. Notice sent by the district attorney shall be by first-class mail to the person's last known address.

(e) Repealed by Session Laws 2017-158, s. 21, effective July 21, 2017.

(f) 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 the respondent has been committed to a 24-hour facility in a county other than his 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. (1973, c. 1408, s. 1; 1977, c. 400, s. 5; c. 414, s. 1; 1979, c. 915, s. 5; 1983, c. 380, s. 9; c. 638, ss. 8, 16; c. 864, s. 4; 1985, c. 589, s. 2; c. 695, s. 7; 1985 (Reg. Sess., 1986), c. 863, s. 19; 1987, c. 596, s. 2; 1991, c. 37, s. 4; 1995 (Reg. Sess., 1996), c. 739, s. 9; 2017-158, s. 21; 2018-33, s. 26.)

§ 122C-265. Outpatient commitment; examination and treatment pending hearing.

(a) If a respondent, who has been recommended for outpatient commitment by [a] commitment examiner different from the proposed outpatient treatment physician or center, fails to appear for examination by the proposed outpatient treatment physician or center at the designated time, the physician or center shall notify the clerk of superior court who shall issue an order to a law enforcement officer to take the respondent into custody and take him immediately to the outpatient treatment physician or center for evaluation. The custody order is valid throughout the State. The

law-enforcement officer may wait during the examination and return the respondent to his home after the examination.

(b) The examining commitment examiner or the proposed outpatient treatment physician or center may prescribe to the respondent reasonable and appropriate medication and treatment that are consistent with accepted medical standards pending the district court hearing.

(c) In no event may a respondent released on a recommendation that he or she meets the outpatient commitment criteria be physically forced to take medication or forcibly detained for treatment pending a district court hearing.

(d) If at any time pending the district court hearing the outpatient treatment physician or center determines that the respondent does not meet the criteria of G.S. 122C-263(d)(1), the physician shall release the respondent and notify the clerk of court and the proceedings shall be terminated.

(e) If a respondent becomes dangerous to self as defined in G.S. 122C-3(11)a., or others, as defined in G.S. 122C-3(11)b., pending a district court hearing on outpatient commitment, new proceedings for involuntary inpatient commitment may be initiated.

(f) If an inpatient commitment proceeding is initiated pending the hearing for outpatient commitment and the respondent is admitted to a 24-hour facility to be held for an inpatient commitment hearing, notice shall be sent by the clerk of court in the county where the respondent is being held to the clerk of court of the county where the outpatient commitment was initiated and the outpatient commitment proceeding shall be terminated. (1983, c. 638, s. 11; c. 864, s. 4; 1985, c. 589, s. 2; c. 695, s. 6; 1989 (Reg. Sess., 1990), c. 823, s. 5; 1991, c. 636, s. 2(2); c. 761, s. 49; 2004-23, s. 2(a); 2018-33, s. 27.)

§ 122C-266. (Effective until December 1, 2027) Inpatient commitment; second examination and treatment pending hearing.

(a) Except as provided in subsections (b) and (e), within 24 hours of arrival at a 24-hour facility described in G.S. 122C-252, the respondent shall be examined by a physician. This physician shall not be the same physician who completed the certificate or examination under the provisions of G.S. 122C-262 or G.S. 122C-263. The examination shall include but is not limited to the assessment specified in G.S. 122C-263(c).

(1) If the physician finds that the respondent is mentally ill and is dangerous to self, as defined by G.S. 122C-3(11)a., or others, as defined by G.S. 122C-3(11)b., the physician shall hold the respondent at the facility pending the district court hearing.

(2) If the physician finds that the respondent meets the criteria for outpatient commitment under G.S. 122C-263(d)(1), the physician shall show these findings on the physician's examination report, release the respondent pending the district court hearing, and notify the clerk of superior court of the county where the petition was initiated of these findings. In addition, the examining physician shall show on the examination report the name, address, and telephone number of the proposed outpatient treatment physician or center. The physician shall give the respondent a written notice listing the name, address, and telephone number of the proposed outpatient treatment physician or center and directing the respondent to appear at that address at a specified date and time. The examining physician before the appointment shall notify by

telephone and shall send a copy of the notice and the examination report to the proposed outpatient treatment physician or center.

(3) If the physician finds that the respondent does not meet the criteria for commitment under either G.S. 122C-263(d)(1) or G.S. 122C-263(d)(2), the physician shall release the respondent and the proceedings shall be terminated.

(4) If the respondent is released under subdivisions (2) or (3) of this subsection, the law enforcement officer or other person designated to provide transportation shall return the respondent to the respondent's residence in the originating county or, if requested by the respondent, to another location in the originating county.

(a1) The second examination of a respondent required by subsection (a) of this section to determine whether the respondent will be involuntarily committed due to mental illness may be conducted either in the physical face-to-face presence of a physician or utilizing telehealth equipment and procedures, provided that the physician who examines the respondent by means of telehealth is satisfied to a reasonable medical certainty that the determinations made in accordance with subdivisions (a)(1) through (a)(3) of this section would not be different if the examination had been done in the physical presence of the examining physician. An examining physician who is not so satisfied shall note that the examination was not satisfactorily accomplished, and the respondent shall be taken for a face-to-face examination in the physical presence of a physician. As used in this section, "telehealth" means the use of two-way, real-time interactive audio and video where the respondent and commitment examiner can hear and see each other.

(b) If the custody order states that the respondent was charged with a violent crime, including a crime involving assault with a deadly weapon, and that he was found incapable of proceeding, the physician shall examine him as set forth in subsection (a) of this section. However, the physician may not release him from the facility until ordered to do so following the district court hearing.

(c) The findings of the physician and the facts on which they are based shall be in writing, in all cases. A copy of the findings shall be sent to the clerk of superior court (i) through the electronic filing system, if the county has implemented a system approved by the Director of the Administrative Office of the Courts, or (ii) by the most reliable and expeditious means otherwise available.

(d) Pending the district court hearing, the physician attending the respondent may administer to the respondent reasonable and appropriate medication and treatment that is consistent with accepted medical standards. Except as provided in subsection (b) of this section, if at any time pending the district court hearing, the attending physician determines that the respondent no longer meets the criteria of either G.S. 122C-263(d)(1) or (d)(2), he shall release the respondent and notify the clerk of court and the proceedings shall be terminated.

(e) If the 24-hour facility described in G.S. 122C-252 or G.S. 122C-262 is the facility in which the first examination by a physician or eligible psychologist occurred and is the same facility in which the respondent is held, the second examination shall occur not later than the following regular working day. (1973, c. 726, s. 1; c. 1408, s. 1; 1977, c. 400, s. 6; 1979, c. 915, s. 6; 1983, c. 380, s. 5; c. 638, ss. 9, 10; c. 864, s. 4; 1985, c. 589, s. 2; c. 695, s. 2; 1987, c. 596, s. 4; 1989 (Reg. Sess., 1990), c. 823, s. 6; 1991, c. 37, s. 9; 1995 (Reg. Sess., 1996), c. 739, s. 10(a), (b); 2021-77, s. 6(b); 2023-103, s. 13(c).)

§ 122C-266. (Effective December 1, 2027) Inpatient commitment; second examination and treatment pending hearing.

(a) Except as provided in subsections (b), (b1), and (e), within 24 hours of arrival at a 24-hour facility described in G.S. 122C-252, the respondent shall be examined by a physician. This physician shall not be the same physician who completed the certificate or examination under the provisions of G.S. 122C-262 or G.S. 122C-263. The examination shall include but is not limited to the assessment specified in G.S. 122C-263(c).

(1) If the physician finds that the respondent is mentally ill and is dangerous to self, as defined by G.S. 122C-3(11)a., or others, as defined by G.S. 122C-3(11)b., the physician shall hold the respondent at the facility pending the district court hearing.

(2) If the physician finds that the respondent meets the criteria for outpatient commitment under G.S. 122C-263(d)(1), the physician shall show these findings on the physician's examination report, release the respondent pending the district court hearing, and notify the clerk of superior court of the county where the petition was initiated of these findings. In addition, the examining physician shall show on the examination report the name, address, and telephone number of the proposed outpatient treatment physician or center. The physician shall give the respondent a written notice listing the name, address, and telephone number of the proposed outpatient treatment physician or center and directing the respondent to appear at that address at a specified date and time. The examining physician before the appointment shall notify by telephone and shall send a copy of the notice and the examination report to the proposed outpatient treatment physician or center.

(3) If the physician finds that the respondent does not meet the criteria for commitment under either G.S. 122C-263(d)(1) or G.S. 122C-263(d)(2), the physician shall release the respondent and the proceedings shall be terminated.

(4) If the respondent is released under subdivisions (2) or (3) of this subsection, the law enforcement officer or other person designated to provide transportation shall return the respondent to the respondent's residence in the originating county or, if requested by the respondent, to another location in the originating county.

(a1) The second examination of a respondent required by subsection (a) of this section to determine whether the respondent will be involuntarily committed due to mental illness may be conducted either in the physical face-to-face presence of a physician or utilizing telehealth equipment and procedures, provided that the physician who examines the respondent by means of telehealth is satisfied to a reasonable medical certainty that the determinations made in accordance with subdivisions (a)(1) through (a)(3) of this section would not be different if the examination had been done in the physical presence of the examining physician. An examining physician who is not so satisfied shall note that the examination was not satisfactorily accomplished, and the respondent shall be taken for a face-to-face examination in the physical presence of a physician. As used in this section, "telehealth" means the use of two-way, real-time interactive audio and video where the respondent and commitment examiner can hear and see each other.

(b) If the custody order states that the respondent was charged with a violent crime, including a crime involving assault with a deadly weapon, and that he was found incapable of proceeding, the physician shall examine him as set forth in subsection (a) of this section. However,

the physician may not release him from the facility until ordered to do so following the district court hearing.

(b1) If the custody order states that the respondent has had a conviction for a violent offense, as defined in G.S. 15A-531, within the previous 10 years, and has been subject to a prior order of involuntary commitment within the previous five years, the physician shall examine the respondent as set forth in subsection (a) of this section. However, the physician may not release the respondent from the facility until one of the following criteria are met:

(1) The court has ordered the respondent's release following the district court hearing.

(2) Both of the following has occurred:

a. The physician has provided written certification to the court of all of the following:

1. The imminent risk has been remitted.
2. Any necessary follow-up appointments or medications have been arranged or provided.
3. Any necessary safety plan or housing plan is in place.
4. Reasonable efforts have been made to contact the next of kin or a designated support person for the respondent.

b. A district court judge has issued an order authorizing release prior to the district court hearing.

(c) The findings of the physician and the facts on which they are based shall be in writing, in all cases. A copy of the findings shall be sent to the clerk of superior court (i) through the electronic filing system, if the county has implemented a system approved by the Director of the Administrative Office of the Courts, or (ii) by the most reliable and expeditious means otherwise available.

(d) Pending the district court hearing, the physician attending the respondent may administer to the respondent reasonable and appropriate medication and treatment that is consistent with accepted medical standards. Except as provided in subsection (b) of this section, if at any time pending the district court hearing, the attending physician determines that the respondent no longer meets the criteria of either G.S. 122C-263(d)(1) or (d)(2), he shall release the respondent and notify the clerk of court and the proceedings shall be terminated.

(e) If the 24-hour facility described in G.S. 122C-252 or G.S. 122C-262 is the facility in which the first examination by a physician or eligible psychologist occurred and is the same facility in which the respondent is held, the second examination shall occur not later than the following regular working day. (1973, c. 726, s. 1; c. 1408, s. 1; 1977, c. 400, s. 6; 1979, c. 915, s. 6; 1983, c. 380, s. 5; c. 638, ss. 9, 10; c. 864, s. 4; 1985, c. 589, s. 2; c. 695, s. 2; 1987, c. 596, s. 4; 1989 (Reg. Sess., 1990), c. 823, s. 6; 1991, c. 37, s. 9; 1995 (Reg. Sess., 1996), c. 739, s. 10(a), (b); 2021-77, s. 6(b); 2023-103, s. 13(c); 2025-93, s. 9.5(a).)

§ 122C-267. Outpatient commitment; district court hearing.

(a) A hearing shall be held in district court within 10 days of the day the respondent is taken into custody pursuant to G.S. 122C-261(e). Upon its own motion or upon motion of the proposed outpatient treatment physician or the respondent, the court may grant a continuance of not more than five days.

(b) The respondent shall be present at the hearing. A subpoena may be issued to compel the respondent's presence at a hearing. The petitioner and the proposed outpatient treatment physician or his designee may be present and may provide testimony.

(c) Certified copies of reports and findings of commitment examiners and medical records of previous and current treatment are admissible in evidence.

(d) At the hearing to determine the necessity and appropriateness of outpatient commitment, the respondent need not, but may, be represented by counsel. However, if the court determines that the legal or factual issues raised are of such complexity that the assistance of counsel is necessary for an adequate presentation of the merits or that the respondent is unable to speak for himself, the court may continue the case for not more than five days and order the appointment of counsel for an indigent respondent. Appointment of counsel shall be in accordance with rules adopted by the Office of Indigent Defense Services.

(e) Hearings may be held at the area facility in which the respondent is being treated, if it is located within the judge's district court district as defined in G.S. 7A-133, or in the judge's chambers. A hearing may not be held in a regular courtroom, over objection of the respondent, if in the discretion of a judge a more suitable place is available.

(f) The hearing shall be closed to the public unless the respondent requests otherwise.

(g) A copy of all documents admitted into evidence and a transcript of the proceedings shall be furnished to the respondent on request by the clerk upon the direction of a district court judge. If the client is indigent, the copies shall be provided at State expense.

(h) To support an outpatient commitment order, the court is required to find by clear, cogent, and convincing evidence that the respondent meets the criteria specified in G.S. 122C-263(d)(1). The court shall record the facts which support its findings and shall show on the order the center or physician who is responsible for the management and supervision of the respondent's outpatient commitment. (1973, c. 726, s. 1; c. 1408, s. 1; 1975, cc. 322, 459; 1977, c. 400, s. 7; c. 1126, s. 1; 1979, c. 915, ss. 7, 13; 1983, c. 380, s. 6; c. 638, ss. 12, 13; c. 864, s. 4; 1985, c. 589, s. 2; c. 695, s. 8; 1987, c. 282, s. 18; 1987 (Reg. Sess., 1988), c. 1037, s. 113.1; 2000-144, s. 38; 2018-33, s. 28.)

§ 122C-268. Inpatient commitment; district court hearing.

(a) A hearing shall be held in district court within 10 days of the day the respondent is taken into law enforcement custody pursuant to G.S. 122C-261(e) or G.S. 122C-262. If a respondent temporarily detained under G.S. 122C-263(d)(2) is subject to a series of successive custody orders issued pursuant to G.S. 122C-263(d)(2), the hearing shall be held within 10 days after the day that the respondent is taken into custody under the most recent custody order. A continuance of not more than five days may be granted upon motion of any of the following:

(1) The court.

(2) Respondent's counsel.

(3) The State, sufficiently in advance to avoid movement of the respondent.

(b) The attorney, who is a member of the staff of the Attorney General assigned to one of the State's facilities for the mentally ill or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill, shall represent the State's interest at commitment hearings, rehearings, and supplemental hearings held for respondents admitted pursuant to this Part or G.S. 15A-1321 at the facility to which he is assigned.

In addition, the Attorney General may, in his discretion, designate an attorney who is a member of his staff to represent the State's interest at any commitment hearing, rehearing, or supplemental

hearing held in a place other than at one of the State's facilities for the mentally ill or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill.

(c) If the respondent's custody order indicates that the respondent was charged with a violent crime, including a crime involving an assault with a deadly weapon, and that the respondent was found incapable of proceeding, the clerk shall give notice of the time and place of the hearing to the chief district judge and the district attorney in the county in which the defendant was found incapable of proceeding as provided in G.S. 122C-264(d). The district attorney in the county in which the respondent was found incapable of proceeding may represent the State's interest at the hearing. Notwithstanding the provisions of G.S. 122C-269, if the district attorney elects to represent the State's interest, upon motion of the district attorney, the venue for the hearing, rehearings, and supplemental rehearings shall be the county in which the respondent was found incapable of proceeding.

(d) The respondent shall be represented by counsel of his choice; or if he is indigent within the meaning of G.S. 7A-450 or refuses to retain counsel if financially able to do so, he shall be represented by counsel appointed in accordance with rules adopted by the Office of Indigent Defense Services.

(e) With the consent of the court, counsel may in writing waive the presence of the respondent.

(f) Certified copies of reports and findings of commitment examiners and previous and current medical records are admissible in evidence, but the respondent's right to confront and cross-examine witnesses may not be denied.

(g) To the extent feasible, hearings shall be held in an appropriate room at the facility in which the respondent is being treated in a manner approved by the chief district court judge if the facility is located within the presiding judge's district court district as defined in G.S. 7A-133. Hearings may be held in the judge's chambers. A hearing may not be held in a regular courtroom, over objection of the respondent, if in the discretion of a judge a more suitable place is available. Regardless of the manner and location for hearings, hearings shall be held in a manner that complies with any applicable federal and State laws governing the confidentiality and security of confidential information. If the respondent has counsel, the respondent shall be allowed to communicate fully and confidentially with his attorney during the proceeding.

(h) The hearing shall be closed to the public unless the respondent requests otherwise.

(i) A copy of all documents admitted into evidence and a transcript of the proceedings shall be furnished to the respondent on request by the clerk upon the direction of a district court judge. If the respondent is indigent, the copies shall be provided at State expense.

(j) To support an inpatient commitment order, the court shall find by clear, cogent, and convincing evidence that the respondent is mentally ill and dangerous to self, as defined in G.S. 122C-3(11)a., or dangerous to others, as defined in G.S. 122C-3(11)b. The court shall record the facts that support its findings. (1985, c. 589, s. 2; c. 695, s. 8; 1985 (Reg. Sess., 1986), c. 1014, s. 195(b); 1987 (Reg. Sess., 1988), c. 1037, s. 114; 1989, c. 141, s. 11; 1989 (Reg. Sess., 1990), c. 823, s. 7; 1991, c. 37, s. 10; c. 257, s. 2; 1995 (Reg. Sess., 1996), c. 739, s. 11(a), (b); 2000-144, s. 39; 2014-107, s. 6.1; 2017-158, s. 16; 2018-33, s. 29; 2021-47, s. 10(l); 2025-93, s. 7(c).)

§ 122C-268.1. Inpatient commitment; hearing following automatic commitment.

(a) A respondent who is committed pursuant to G.S. 15A-1321 shall be provided a hearing, unless waived, before the expiration of 50 days from the date of his commitment.

(b) The district attorney in the county in which the respondent was found not guilty by reason of insanity may represent the State's interest at the hearing, rehearings, and supplemental rehearings. Notwithstanding the provisions of G.S. 122C-269, if the district attorney elects to represent the State's interest, upon motion of the district attorney, the venue for the hearing, rehearings, and supplemental rehearings shall be the county in which the respondent was found not guilty by reason of insanity. If the district attorney declines to represent the State's interest, then the representation shall be determined as follows. An attorney, who is a member of the staff of the Attorney General assigned to one of the State's facilities for the mentally ill or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill, may represent the State's interest at commitment hearings, rehearings, and supplemental hearings. Alternatively, the Attorney General may, in his discretion, designate an attorney who is a member of his staff to represent the State's interest at any commitment hearing, rehearing, or supplemental hearing.

(c) The clerk shall give notice of the time and place of the hearing as provided in G.S. 122C-264(d1).

(d) The respondent shall be represented by counsel of his choice, or if he is indigent within the meaning of G.S. 7A-450 or refuses to retain counsel if financially able to do so, he shall be represented by counsel appointed in accordance with rules adopted by the Office of Indigent Defense Services.

(e) With the consent of the court, counsel may in writing waive the presence of the respondent.

(f) Certified copies of reports and findings of physicians and psychologists and previous and current medical records are admissible in evidence, but the respondent's right to confront and cross-examine witnesses may not be denied.

(g) The hearing shall take place in the trial division in which the original trial was held. The hearing shall be open to the public. For purposes of this subsection, "trial division" means either the superior court division or the district court division of the General Court of Justice.

(h) A copy of all documents admitted into evidence and a transcript of the proceedings shall be furnished to the respondent on request by the clerk upon the direction of the presiding judge. If the respondent is indigent, the copies shall be provided at State expense.

(i) The respondent shall bear the burden to prove by a preponderance of the evidence that he (i) no longer has a mental illness as defined in G.S. 122C-3(21), or (ii) is no longer dangerous to others as defined in G.S. 122C-3(11)b. If the court is so satisfied, then the court shall order the respondent discharged and released. If the court finds that the respondent has not met his burden of proof, then the court shall order that inpatient commitment continue at a 24-hour facility designated pursuant to G.S. 122C-252 for a period not to exceed 90 days. The court shall make a written record of the facts that support its findings.

(j) Nothing in this section shall limit the respondent's right to habeas corpus relief. (1991, c. 37, s. 2; 1991 (Reg. Sess., 1992), c. 1034, ss. 2, 3; 1995, c. 140, s. 1; 2000-144, s. 40.)

§ 122C-269. Venue of hearing when respondent held at a 24-hour facility pending hearing.

(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-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.

(b) An official of the facility shall immediately notify the clerk of superior court of the county in which the facility is located of a determination to hold the respondent pending hearing. That clerk shall request transmittal of all documents pertinent to the proceedings from the clerk of superior court where the proceedings were initiated. The requesting clerk shall assume all duties set forth in G.S. 122C-264. The counsel provided for in G.S. 122C-268(d) shall be appointed in accordance with rules adopted by the Office of Indigent Defense Services.

(c) Upon motion of any interested person, the venue of an initial hearing described in G.S. 122C-268(c) or G.S. 122C-268.1 or a rehearing required by G.S. 122C-276(b), G.S. 122C-276.1, or subsections (b) or (b1) of G.S. 122C-277 shall be moved to the county in which the respondent was found not guilty by reason of insanity or incapable of proceeding when the convenience of witnesses and the ends of justice would be promoted by the change. (1975, 2nd Sess., c. 983, s. 133; 1981, c. 537, s. 6; 1983, c. 380, s. 7; 1985, c. 589, s. 2; 1991, c. 37, ss. 11, 12; 1995, c. 140, s. 2; 2000-144, s. 41; 2001-487, s. 29.)

§ 122C-270. Attorneys to represent the respondent and the State.

(a) In a superior court district or set of districts as defined in G.S. 7A-41.1 in which a State facility for the mentally ill is located, the Commission on Indigent Defense Services shall appoint an attorney licensed to practice in North Carolina as special counsel for indigent respondents who are mentally ill. These special counsel shall serve at the pleasure of the Commission, may not privately practice law, and shall receive annual compensation within the salary range for assistant public defenders as fixed by the Office of Indigent Defense Services. The special counsel shall represent all indigent respondents at all hearings, rehearings, and supplemental hearings held at the State facility. Special counsel shall determine indigency in accordance with G.S. 7A-450(a). Indigency is subject to redetermination by the presiding judge. If the respondent appeals, counsel for the appeal shall be appointed in accordance with rules adopted by the Office of Indigent Defense Services.

(b) The State facility shall provide suitable office space for the counsel to meet privately with respondents. The Office of Indigent Defense Services shall provide secretarial and clerical service and necessary equipment and supplies for the office.

(c) In the event of a vacancy in the office of special counsel, counsel's incapacity, or a conflict of interest, counsel for indigents at hearings or rehearings may be assigned in accordance with rules adopted by the Office of Indigent Defense Services. No mileage or compensation for travel time is paid to a counsel appointed pursuant to this subsection. Counsel may also be so assigned when, in the opinion of the Director of the Office of Indigent Defense Services, the volume of cases warrants.

(d) At hearings held in counties other than those designated in subsection (a) of this section, counsel for indigent respondents shall be appointed in accordance with rules adopted by the Office of Indigent Defense Services.

(e) If the respondent is committed to a non-State 24-hour facility, assigned counsel remains responsible for the respondent's representation at the trial level until discharged by order of district court, until the respondent is unconditionally discharged from the facility, or until the respondent voluntarily admits himself or herself to the facility. If the respondent is transferred to a State facility for the mentally ill, assigned counsel is discharged. If the respondent appeals, counsel for the appeal shall be appointed in accordance with rules adopted by the Office of Indigent Defense Services.

(f) The Attorney General may employ four attorneys, one to be assigned by him full-time to each of the State facilities for the mentally ill, to represent the State's interest at commitment hearings, rehearings and supplemental hearings held under this Article at the State facilities for respondents admitted to those facilities pursuant to Part 3, 4, 7, or 8 of this Article or G.S. 15A-1321 and to provide liaison and consultation services concerning these matters. These attorneys are subject to Chapter 126 of the General Statutes and shall also perform additional duties as may be assigned by the Attorney General. The attorney employed by the Attorney General in accordance with G.S. 114-4.2B shall represent the State's interest at commitment hearings, rehearings and supplemental hearings held for respondents admitted to the University of North Carolina Hospitals at Chapel Hill pursuant to Part 3, 4, 7, or 8 of this Article or G.S. 15A-1321. (1973, c. 47, s. 2; c. 1408, s. 1; 1977, c. 400, s. 11; 1979, c. 915, s. 12; 1983, c. 275, ss. 1, 2; 1985, c. 589, s. 2; 1987 (Reg. Sess., 1988), c. 1037, s. 115; 1989, c. 141, s. 12; 1991, c. 257, s. 1; 1995 (Reg. Sess., 1996), c. 739, s. 12(a); 2000-144, s. 42; 2006-264, s. 61(a).)

§ 122C-271. Disposition.

(a) If a commitment examiner has recommended outpatient commitment and the respondent has been released pending the district court 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 a mental illness; that the respondent is capable of surviving safely in the community with available supervision from family, friends, or others; that based on respondent's treatment history, the respondent is in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness as defined in G.S. 122C-3(11); and that the respondent's current mental status or the nature of the respondent's illness limits or negates the respondent's ability to make an informed decision to seek voluntarily or comply with recommended treatment, it may order outpatient commitment for a period not in excess of 90 days.

(2) If the court does not find that the respondent meets the criteria of commitment set out in subdivision (1) of this subsection, the respondent shall be discharged and the proposed outpatient physician center shall be so notified.

(3) Before ordering any outpatient commitment under this subsection, the court shall make findings of fact as to the availability of outpatient treatment from an outpatient treatment physician or center that has agreed to accept the respondent as a client of outpatient treatment services. The court shall show on the order the outpatient treatment physician or center that is to be responsible for the management and supervision of the respondent's outpatient commitment. If the designated outpatient treatment physician or center will be monitoring and supervising the respondent's outpatient commitment pursuant to a contract for services with an LME/MCO, the court shall show on the order the identity of the LME/MCO. The clerk of court shall send a copy of the outpatient commitment order to the designated outpatient treatment physician or center and to the respondent client or the legally responsible person. The clerk of court shall also send a copy of the order to that LME/MCO. Copies of outpatient commitment orders sent by the clerk of court to an outpatient treatment center or physician

under this section, including orders sent to an LME/MCO, shall be sent by the most reliable and expeditious means, within 48 hours of the hearing.

(b) If the respondent has been held in a 24-hour facility pending the district court hearing pursuant to G.S. 122C-268, the court may make one of the following dispositions:

(1) If the court finds by clear, cogent, and convincing evidence that the respondent has a mental illness; that the respondent is capable of surviving safely in the community with available supervision from family, friends, or others; that based on respondent's psychiatric history, the respondent is in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness as defined by G.S. 122C-3(11); and that the respondent's current mental status or the nature of the respondent's illness limits or negates the respondent's ability to make an informed decision voluntarily to seek or comply with recommended treatment, it may order outpatient commitment for a period not in excess of 90 days. If the commitment proceedings were initiated as the result of the respondent's 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 commitment order shall so show.

(2) If the court finds by clear, cogent, and convincing evidence that the respondent has a mental illness and is dangerous to self, as defined in G.S. 122C-3(11)a., or others, as defined in G.S. 122C-3(11)b., it may order inpatient commitment at a 24-hour facility described in G.S. 122C-252 for a period not in excess of 90 days. However, no respondent found to have both an intellectual disability and a mental illness may be committed to a State, area, or private facility for individuals with intellectual disabilities. An individual who has a mental illness and is dangerous to self, as defined in G.S. 122C-3(11)a., or others, as defined in G.S. 122C-3(11)b., may also be committed to a combination of inpatient and outpatient commitment at both a 24-hour facility and an outpatient treatment physician or center for a period not in excess of 90 days. If the commitment proceedings were initiated as the result of the respondent's 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 commitment order shall so show. If the court orders inpatient commitment for a respondent who is under an outpatient commitment order, the outpatient commitment is terminated; and the clerk of the superior court of the county where the district court hearing is held shall send a notice of the inpatient commitment to the clerk of superior court where the outpatient commitment was being supervised. The clerk of court shall send a copy of the inpatient commitment order to the designated inpatient treatment physician or center and to the respondent client or the legally responsible person. The clerk of court shall also send a copy of the order to that LME/MCO. Copies of inpatient commitment orders sent by the clerk of court to an inpatient treatment center or physician under this section, including orders sent to an LME/MCO, shall be sent by the most reliable and expeditious means, within 48 hours of the hearing.

(3) If the court does not find that the respondent meets either of the commitment criteria set out in subdivisions (1) and (2) of this subsection, the respondent shall

be discharged, and the facility in which the respondent was last a client shall be so notified.

(4) Before ordering any outpatient commitment, the court shall make findings of fact as to the availability of outpatient treatment from an outpatient treatment physician or center that has agreed to accept the respondent as a client of outpatient treatment services. The court shall also show on the order the outpatient treatment physician or center who is to be responsible for the management and supervision of the respondent's outpatient commitment. When an outpatient commitment order is issued for a respondent held in a 24-hour facility, the court may order the respondent held at the facility for no more than 72 hours in order for the facility to notify the designated outpatient treatment physician or center of the treatment needs of the respondent. The clerk of court in the county where the facility is located shall send a copy of the outpatient commitment order to the designated outpatient treatment physician or center and to the respondent or the legally responsible person. If the designated outpatient treatment physician or center shall be monitoring and supervising the respondent's outpatient commitment pursuant to a contract for services with an LME/MCO, the clerk of court shall show on the order the identity of the LME/MCO. The clerk of court shall send a copy of the order to the LME/MCO. Copies of outpatient commitment orders sent by the clerk of court to an outpatient treatment center or physician pursuant to this subdivision, including orders sent to an LME/MCO, shall be sent by the most reliable and expeditious means, within 48 hours of the hearing. If the outpatient commitment will be supervised in a county other than the county where the commitment originated, the court shall order venue for further court proceedings to be transferred to the county where the outpatient commitment will be supervised. Upon an order changing venue, the clerk of superior court in the county where the commitment originated shall transfer the file to the clerk of superior court in the county where the outpatient commitment is to be supervised.

(c) If the respondent was found not guilty by reason of insanity and has been held in a 24-hour facility pending the court hearing held pursuant to G.S. 122C-268.1, the court may make one of the following dispositions:

(1) If the court finds that the respondent has not proved by a preponderance of the evidence that the respondent no longer has a mental illness or that the respondent is no longer dangerous to others, it shall order inpatient treatment at a 24-hour facility for a period not to exceed 90 days.

(2) If the court finds that the respondent has proven by a preponderance of the evidence that the respondent no longer has a mental illness or that the respondent is no longer dangerous to others, the court shall order the respondent discharged and released. (1973, c. 726, s. 1; c. 1408, s. 1; 1977, c. 400, s. 8; c. 739, s. 2; 1979, c. 358, s. 26; c. 915, ss. 8, 15, 16; 1981, c. 537, s. 1; 1983, c. 380, s. 8; c. 638, s. 14; c. 864, s. 4; 1985, c. 589, s. 2; c. 695, s. 2; 1985 (Reg. Sess., 1986), c. 863, ss. 20-22; 1989, c. 225, s. 1; c. 770, s. 73; 1989 (Reg. Sess., 1990), c. 823, s. 8; 1991, c. 37, s. 13; 1991 (Reg. Sess., 1992), c. 1034, s. 5; 1995 (Reg. Sess., 1996), c. 739, s. 13; 2018-33, s. 30; 2019-76, s. 10; 2025-54, s. 11(a).)

§ 122C-272. Appeal.

Judgment of the district court is final. Appeal may be had to the Court of Appeals by the State or by any party on the record as in civil cases. Appeal does not stay the commitment unless so ordered by the Court of Appeals. The Attorney General represents the State's interest on appeal. The district court retains limited jurisdiction for the purpose of hearing all reviews, rehearings, or supplemental hearings allowed or required under this Part. (1973, c. 726, s. 1; c. 1408, s. 1; 1979, c. 915, s. 19; 1985, c. 589, s. 2; 2009-570, s. 27.)

§ 122C-273. Duties for follow-up on commitment order.

(a) Unless prohibited by Chapter 90 of the General Statutes, if the commitment order directs outpatient treatment, the outpatient treatment physician may prescribe or administer, or the center may administer, to the respondent reasonable and appropriate medication and treatment that are consistent with accepted medical standards.

(1) If the respondent fails to comply or clearly refuses to comply with all or part of the prescribed treatment, the physician, the physician's designee, or the center shall make all reasonable effort to solicit the respondent's compliance. These efforts shall be documented and reported to the court with a request for a supplemental hearing.

(2) If the respondent fails to comply, but does not clearly refuse to comply, with all or part of the prescribed treatment after reasonable effort to solicit the respondent's compliance, the physician, the physician's designee, or the center may request the court to order the respondent taken into custody for the purpose of examination. Upon receipt of this request, the clerk shall issue an order to a law-enforcement officer to take the respondent into custody and to take him immediately to the designated outpatient treatment physician or center for examination. The custody order is valid throughout the State. The law-enforcement officer shall turn the respondent over to the custody of the physician or center who shall conduct the examination and then release the respondent. The law-enforcement officer may wait during the examination and return the respondent to his home after the examination. An examination conducted under this subsection in which a physician or eligible psychologist determines that the respondent meets the criteria for inpatient commitment may be substituted for the first examination required by G.S. 122C-263 if the clerk or magistrate issues a custody order within six hours after the examination was performed.

(3) In no case may the respondent be physically forced to take medication or forcibly detained for treatment unless he poses an immediate danger to himself or others. In such cases inpatient commitment proceedings shall be initiated.

(4) At any time that the outpatient treatment physician or center finds that the respondent no longer meets the criteria set out in G.S. 122C-263(d)(1), the physician or center shall so notify the court and the case shall be terminated; provided, however, if the respondent was initially committed as a result of conduct resulting in his 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 outpatient treatment physician or center shall notify the clerk that discharge is recommended. The clerk shall calendar a

supplemental hearing as provided in G.S. 122C-274 to determine whether the respondent meets the criteria for outpatient commitment.

(5) Any individual who has knowledge that a respondent on outpatient commitment has become dangerous to himself, as defined by G.S. 122C-3(11)a., and others, as defined in G.S. 122C-3(11)b., may initiate a new petition for inpatient commitment as provided in this Part. If the respondent is committed as an inpatient, the outpatient commitment shall be terminated and notice sent by the clerk of court in the county where the respondent is committed as an inpatient to the clerk of court of the county where the outpatient commitment is being supervised.

(b) If the respondent on outpatient commitment intends to move or moves to another county within the State, the designated outpatient treatment physician or center shall request that the clerk of court in the county where the outpatient commitment is being supervised calendar a supplemental hearing.

(c) If the respondent moves to another state or to an unknown location, the designated outpatient treatment physician or center shall notify the clerk of superior court of the county where the outpatient commitment is supervised and the outpatient commitment shall be terminated.

(d) If the commitment order directs inpatient treatment, the physician attending the respondent may administer to the respondent reasonable and appropriate medication and treatment that are consistent with accepted medical standards. The attending physician shall release or discharge the respondent in accordance with G.S. 122C-277. (1983, c. 638, s. 16; c. 864, s. 4; 1985, c. 589, s. 2; 1985 (Reg. Sess., 1986), c. 863, ss. 23-26; 1989 (Reg. Sess., 1990), c. 823, s. 9; 1991, c. 37, s. 14; 2004-23, s. 2(b).)

§ 122C-274. Supplemental hearings.

(a) Upon receipt of a request for a supplemental hearing, the clerk shall calendar a hearing to be held within 14 days and notify, at least 72 hours before the hearing, the petitioner, the respondent, his attorney, if any, and the designated outpatient treatment physician or center. The respondent shall be notified at least 72 hours before the hearing by personally serving on him an order to appear. Other persons shall be notified as provided in G.S. 122C-264(c).

(b) The procedures for the hearing shall follow G.S. 122C-267.

(c) In supplemental hearings for alleged noncompliance, the court shall determine whether the respondent has failed to comply and, if so, the causes for noncompliance. If the court determines that the respondent has failed or refused to comply it may:

(1) Upon finding probable cause to believe that the respondent is mentally ill and dangerous to himself, as defined in G.S. 122C-3(11)a., or others, as defined in G.S. 122C-3(11)b., order an examination by the same or different physician or eligible psychologist as provided in G.S. 122C-263(c) in order to determine the necessity for continued outpatient or inpatient commitment;

(2) Reissue or change the outpatient commitment order in accordance with G.S. 122C-271; or

(3) Discharge the respondent from the order and dismiss the case.

(d) At the supplemental hearing for a respondent who has moved or intends to move to another county, the court shall determine if the respondent meets the criteria for outpatient commitment set out in G.S. 122C-263(d)(1). If the court determines that the respondent no longer meets the criteria for outpatient commitment, it shall discharge the respondent from the order and

dismiss the case. If the court determines that the respondent continues to meet the criteria for outpatient commitment, it shall continue the outpatient commitment but shall designate a physician or center at the respondent's new residence to be responsible for the management or supervision of the respondent's outpatient commitment. The court shall order the respondent to appear for treatment at the address of the newly designated outpatient treatment physician or center and shall order venue for further court proceedings under the outpatient commitment to be transferred to the new county of supervision. Upon an order changing venue, the clerk of court in the county where the outpatient commitment has been supervised shall transfer the records regarding the outpatient commitment to the clerk of court in the county where the commitment will be supervised. Also, the clerk of court in the county where the outpatient commitment has been supervised shall send a copy of the court's order directing the continuation of outpatient treatment under new supervision to the newly designated outpatient treatment physician or center.

(e) At any time during the term of an outpatient commitment order, a respondent may apply to the court for a supplemental hearing for the purpose of discharge from the order. The application shall be made in writing by the respondent to the clerk of superior court of the county where the outpatient commitment is being supervised. At the supplemental hearing the court shall determine whether the respondent continues to meet the criteria specified in G.S. 122C-263(d)(1). The court may either reissue or change the commitment order or discharge the respondent and dismiss the case.

(f) At supplemental hearings requested pursuant to G.S. 122C-277(a) for transfer from inpatient to outpatient commitment, the court shall determine whether the respondent meets the criteria for either inpatient or outpatient commitment. If the court determines that the respondent continues to meet the criteria for inpatient commitment, it shall order the continuation of the original commitment order. If the court determines that the respondent meets the criteria for outpatient commitment, it shall order outpatient commitment for a period of time not in excess of 90 days. If the court finds that the respondent does not meet either criteria, the respondent shall be discharged and the case dismissed. (1983, c. 638, s. 17; c. 864, s. 4; 1985, c. 589, s. 2; c. 695, s. 2; 1989 (Reg. Sess., 1990), c. 823, s. 10.)

§ 122C-275. Outpatient commitment; rehearings.

(a) Fifteen days before the end of the initial or subsequent periods of outpatient commitment if the outpatient treatment physician or center determines that the respondent continues to meet the criteria specified in G.S. 122C-263(d)(1), he shall so notify the clerk of superior court of the county where the outpatient commitment is supervised. If the respondent no longer meets the criteria, the physician shall so notify the clerk who shall dismiss the case; provided, however, if the respondent was initially committed as a result of conduct resulting in his 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 physician or center shall notify the clerk that discharge is recommended. The clerk, at least 10 days before the end of the commitment period, on order of the district court, shall calendar the rehearing.

(b) Notice and procedures of rehearings are governed by the same procedures as initial hearings, and the respondent has the same rights he had at the initial hearing including the right to appeal.

(c) If the court finds that the respondent no longer meets the criteria of G.S. 122C-263(d)(1), it shall unconditionally discharge him. A copy of the discharge order shall be furnished by the clerk to the designated outpatient treatment physician or center. If the respondent

continues to meet the criteria of G.S. 122C-263(d)(1), the court may order outpatient commitment for an additional period not in excess of 180 days. (1983, c. 638, s. 20; c. 864, s. 4; 1985, c. 589, s. 2; 1991, c. 37, s. 15.)

§ 122C-276. Inpatient commitment; rehearings for respondents other than insanity acquittees.

(a) Fifteen days before the end of the initial inpatient commitment period if the attending physician determines that commitment of a respondent beyond the initial period will be necessary, he shall so notify the clerk of superior court of the county in which the facility is located. The clerk, at least 10 days before the end of the initial period, on order of a district court judge of the district court district as defined in G.S. 7A-133 in which the facility is located, shall calendar the rehearing. 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, the clerk shall also notify the chief district court judge, the clerk of superior court, and the district attorney in the county in which the respondent was found incapable of proceeding of the time and place of the hearing.

(b) Fifteen days before the end of the initial treatment period of a respondent who was initially committed as a result of conduct resulting in his being charged with a violent crime, including a crime involving an assault with a deadly weapon, having been found incapable of proceeding, if the attending physician determines that commitment of the respondent beyond the initial period will not be necessary, he shall so notify the clerk of superior court who shall schedule a rehearing as provided in subsection (a) of this section.

(c) Subject to the provisions of G.S. 122C-269(c), rehearings shall be held as authorized in G.S. 122C-268(g). 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.

(d) Notice and proceedings of rehearings are governed by the same procedures as initial hearings and the respondent has the same rights he had at the initial hearing including the right to appeal.

(e) At rehearings the court may make the same dispositions authorized in G.S. 122C-271(b) except a second commitment order may be for an additional period not in excess of 180 days.

(f) Fifteen days before the end of the second commitment period and annually thereafter, the attending physician shall review and evaluate the condition of each respondent; and if he determines that a respondent is in continued need of inpatient commitment or, in the alternative, in need of outpatient commitment, or a combination of both, he shall so notify the respondent, his counsel, and the clerk of superior court of the county, in which the facility is located. Unless the respondent through his counsel files with the clerk a written waiver of his right to a rehearing, the clerk, on order of a district court judge of the district in which the facility is located, shall calendar a rehearing for not later than the end of the current commitment period. The procedures and standards for the rehearing are the same as for the first rehearing. No third or subsequent inpatient recommitment order shall be for a period longer than one year.

(g) At any rehearings the court has the option to order outpatient commitment for a period not in excess of 180 days in accordance with the criteria specified in G.S. 122C-263(d)(1) and following the procedures as specified in this Article. (1973, c. 726, s. 1; c. 1408, s. 1; 1977, c. 400,

s. 9; 1979, c. 915, ss. 9, 17; 1981, c. 537, ss. 2-4; 1983, c. 638, ss. 18, 19; c. 864, s. 4; 1985, c. 589, s. 2; 1987 (Reg. Sess., 1988), c. 1037, s. 116; 1991, c. 37, s. 5; 2018-33, s. 31.)

§ 122C-276.1. Inpatient commitment; rehearings for respondents who are insanity acquittees.

(a) At least 15 days before the end of any inpatient commitment period ordered pursuant to G.S. 122C-268.1, the clerk shall calendar the hearing and notify the parties as specified in G.S. 122C-264(d1), unless the hearing is waived by the respondent.

(b) The proceedings of the rehearing shall be governed by the same procedures provided by G.S. 122C-268.1.

(c) The respondent shall bear the burden to prove by a preponderance of the evidence that he (i) no longer has a mental illness as defined in G.S. 122C-3(21), or (ii) is no longer dangerous to others as defined in G.S. 122C-3(11)b. If the court is so satisfied, then the court shall order the respondent discharged and released. If the court finds that the respondent has not met his burden of proof, then the court shall order inpatient commitment be continued for a period not to exceed 180 days. The court shall make a written record of the facts that support its findings.

(d) At least 15 days before the end of any commitment period ordered pursuant to subsection (c) of this section and annually thereafter, the clerk shall calendar the hearing and notify the parties as specified in G.S. 122C-264(d1). The procedures and standards for the rehearing are the same as under this section. No third or subsequent inpatient recommitment order shall be for a period longer than one year. (1991, c. 37, s. 3; 1991 (Reg. Sess., 1992), c. 1034, s. 4.)

§ 122C-277. Release and conditional release; judicial review.

(a) Except as provided in subsections (b) and (b1) of this section, the attending physician shall discharge a committed respondent unconditionally at any time he determines that the respondent is no longer in need of inpatient commitment. 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 may request the clerk to calendar a supplemental hearing to determine whether an outpatient commitment order shall be issued. Except as provided in subsections (b) and (b1) of this section, the attending physician may also release a respondent conditionally 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 into custody and return him to the facility in accordance with G.S. 122C-205. Notice of discharge and of conditional 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.

(b) If the respondent was initially committed as the result of conduct resulting in the respondent 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 or conditional release the facility shall notify the district attorney of the district where the respondent was found incapable of proceeding and the clerk of superior court of the county in which the facility is located of the attending physician's determination regarding the proposed discharge 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. Notwithstanding the provisions of G.S. 122C-269, if the district attorney elects to represent the State's interest, upon motion of the district attorney, the venue for the hearing, rehearings, and supplemental rehearings shall be the county in which the respondent was found incapable of proceeding.

(b1) If the respondent was initially committed pursuant to G.S. 15A-1321, 15 days before the respondent's discharge 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 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) If a committed respondent under subsections (a), (b), or (b1) 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. (1973, c. 726, s. 1; c. 1408, s. 1; 1981, c. 537, s. 5; 1983, c. 383, s. 6; c. 638, s. 21; c. 864, s. 4; 1985, c. 589, s. 2; 1991, c. 37, s. 6; 2025-93, s. 7(d).)

§ 122C-278. Reexamination for capacity to proceed prior to discharge.

Whenever a respondent has been committed to either inpatient or outpatient treatment pursuant to this Chapter after having been found incapable of proceeding and referred by the court for civil commitment proceedings, the respondent shall not be discharged from the custody of the hospital or institution or the outpatient commitment case terminated until the respondent has been examined for capacity to proceed and a report filed with the clerk of court pursuant to G.S. 15A-1002. (2013-18, s. 8.)

§ 122C-279: Reserved for future codification purposes.

§ 122C-280: Reserved for future codification purposes.

Part 8. Involuntary Commitment of Substance Abusers, Facilities for Substance Abusers.

§ 122C-281. Affidavit and petition before clerk or magistrate; custody order.

(a) Any individual who has knowledge of a substance abuser who is dangerous to self or others may appear before a clerk or assistant or deputy clerk of superior court or a magistrate, execute an affidavit to this effect, and petition the clerk or magistrate for issuance of an order to take the respondent into custody for examination by a commitment examiner. The affidavit shall include the facts on which the affiant's opinion is based. Jurisdiction under this subsection is in the clerk or magistrate in the county where the respondent resides or is found.

(b) If the clerk or magistrate finds reasonable grounds to believe that the facts alleged in the affidavit are true and that the respondent is probably a substance abuser and dangerous to self or others, the clerk or magistrate shall issue an order to a law enforcement officer or any other person designated under G.S.122C-251(g) to take the respondent into custody for examination by a commitment examiner.

(c) If the clerk or magistrate issues a custody order, the clerk or magistrate shall also make inquiry in any reliable way as to whether the respondent is indigent within the meaning of G.S. 7A-450. A magistrate shall report the result of this inquiry to the clerk.

(d) If the affiant is a commitment examiner who has examined the respondent, he or she may execute the affidavit before any official authorized to administer oaths. The commitment examiner is not required to appear before the clerk or magistrate for this purpose. The commitment examiner's examination shall comply with the requirements of the initial examination as provided in G.S. 122C-283(c). The affiant shall file the affidavit and examination findings with the clerk of court in the manner described in G.S. 122C-261(d)(1) for affiants filing in counties that have not implemented an electronic filing system approved by the Director of the Administrative Office of the Courts and G.S. 122C-261(d1) for affiants filing in counties that have implemented an electronic filing system approved by the Director of the Administrative Office of the Courts. If the commitment examiner recommends commitment and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for commitment, the clerk or magistrate shall issue an order to a law enforcement officer to take the respondent into custody for transportation to a 24-hour facility, or, if the respondent is released pending hearing, as described in G.S. 122C-283(d)(1), order that a hearing be held as provided in G.S. 122C-284(a). If a physician or eligible psychologist executes an affidavit for commitment of a respondent, a second qualified professional shall perform the examination required by G.S. 122C-285. Any person or entity who or which has been designated in compliance with G.S. 122C-251 shall be permitted to complete all or part of the duties of a law enforcement officer, in accord with the designation.

(e) Upon receipt of the custody order of the clerk or magistrate, a law enforcement officer or other designated person identified in the order shall take the respondent into custody within 24 hours after the order is signed. The custody order is valid throughout the State.

(e1) No commitment examiner, area facility, acute care hospital, general hospital, or other site of first examination, or their officials, staff, employees, or other individuals responsible for the custody, examination, detention, management, supervision, treatment, or release of an individual examined for commitment, who is not grossly negligent, shall be held liable in any civil or criminal action for taking measures to temporarily detain an individual for the period of time necessary to complete a commitment examination, submit an affidavit to the magistrate or clerk of court, and await the issuance of a custody order as authorized by subsection (d) of this section.

(f) Repealed by Session Laws 2018-33, s. 32, effective October 1, 2019. (1973, c. 726, s. 1; c. 1408, s. 1; 1977, c. 400, s. 3; 1979, c. 164, s. 2; c. 915, ss. 3, 18; 1983, c. 383, s. 5; c. 638, ss. 3-5; c. 864, s. 4; 1985, c. 589, s. 2; c. 695, ss. 2, 4; 2004-23, s. 1(b); 2018-33, s. 32; 2024-33, s. 17.)

§ 122C-282. Special emergency procedure for violent individuals.

When an individual subject to commitment under the provisions of this Part is also violent and requires restraint and when delay in taking the individual to a commitment examiner for examination would likely endanger life or property, a law enforcement officer may take the person into custody and take him or her immediately before a magistrate or clerk. The law enforcement officer shall execute the affidavit required by G.S. 122C-281 and in addition shall swear that the respondent is violent and requires restraint and that delay in taking the respondent to a commitment examiner for an examination would endanger life or property.

If the clerk or magistrate finds by clear, cogent, and convincing evidence that the facts stated in the affidavit are true, that the respondent is in fact violent and requires restraint, and that delay in taking the respondent to a commitment examiner for an examination would endanger life or property, the clerk or magistrate shall order the law enforcement officer to take the respondent directly to a 24-hour facility described in G.S. 122C-252.

Respondents received at a 24-hour facility under the provisions of this section shall be examined and processed thereafter in the same way as all other respondents under this Part. (1973, c. 726, s. 1; c. 1408, s. 1; 1985, c. 589, s. 2; c. 695, s. 2; 2018-33, s. 33.)

§ 122C-283. Duties of law enforcement officer; first examination by commitment examiner.

(a) Without unnecessary delay after assuming custody, the law enforcement officer or the individual designated or required to provide transportation under G.S. 122C-251(g) shall take the respondent to a facility or other location identified by the LME/MCO in the community crisis services plan adopted pursuant to G.S. 122C-202.2 that has an available commitment examiner and is capable of performing a first examination in conjunction with a health screening in the same location, unless circumstances indicate the respondent appears to be suffering a medical emergency in which case the law enforcement officer will seek immediate medical assistance for the respondent. If a commitment examiner is not available, whether on-site, on-call, or via telehealth, at any facility or location, or if a plan has not been adopted, the person designated to provide transportation shall take the respondent to an alternative non-hospital provider or facility-based crisis center for a first examination in conjunction with a health screening at the same location. If no non-hospital provider or facility-based crisis center for a first examination in conjunction with a health screening at the same location, the person designated to provide transportations shall take the respondent to a private hospital or clinic, a general hospital, an acute care hospital, or a State facility for individuals with mental illnesses. If a commitment examiner is not immediately available, the respondent may be temporarily detained in an area facility if one is available; if an area facility is not available, the respondent may be detained under appropriate supervision, in the respondent's home, in a private hospital or a clinic, or in a general hospital, but not in a jail or other penal facility. For the purposes of this section, "non-hospital provider" means an outpatient provider that provides either behavioral health or medical services.

(b) The examination set forth in subsection (a) of this section is not required if:

(1) The affiant who obtained the custody order is a physician or eligible psychologist; or

(2) The respondent is in custody under the special emergency procedure described in G.S. 122C-282.

In these cases when it is recommended that the respondent be detained in a 24-hour facility, the law-enforcement officer shall take the respondent directly to a 24-hour facility described in G.S. 122C-252.

(c) The commitment examiner described in subsection (a) of this section shall examine the respondent as soon as possible, and in any event within 24 hours, after the respondent is presented for examination. The examination performed by a commitment examiner pursuant to subsection (a) of this section may be performed either in the physical face-to-face presence of the commitment examiner or utilizing telehealth equipment and procedures. A commitment examiner who examines a respondent by means of telehealth must be satisfied to a reasonable medical certainty that the determinations made in accordance with subsection (d) of this section would not be different if the examination had been conducted in the physical presence of the commitment examiner. A commitment examiner who is not so satisfied shall note that the examination was not satisfactorily accomplished, and the respondent shall be taken for a face-to-face examination in the physical presence of a person authorized to perform examinations under this section. As used in this section, "telehealth" is the use of two-way, real-time interactive audio and video where the respondent and commitment examiner can hear and see each other. A recipient is referred by one

provider to receive the services of another provider via telehealth. The examination shall include but is not limited to an assessment of all of the following:

(1) The respondent's current and previous substance abuse including, if available, previous treatment history.

(2) The respondent's dangerousness to self or others as defined in G.S. 122C-3(11).

(d) After the conclusion of the examination the physician or eligible psychologist shall make the following determinations:

(1) If the physician or eligible psychologist finds that the respondent is a substance abuser and is dangerous to himself or others, he shall recommend commitment and whether the respondent should be released or be held at a 24-hour facility pending hearing and shall so show on [the] his examination report. Based on the physician's or eligible psychologist's recommendation the law-enforcement officer or other designated individual shall take the respondent to a 24-hour facility described in G.S. 122C-252 or release the respondent.

(2) If the physician or eligible psychologist finds that the condition described in subdivision (1) of this subsection does not exist, the respondent shall be released and the proceedings terminated.

(e) The findings of the physician or eligible psychologist and the facts on which they are based shall be in writing in all cases. A copy of the findings made by the physician or eligible psychologist and the commitment examiner shall be sent to the clerk of superior court (i) through the electronic filing system, if the county has implemented a system approved by the Director of the Administrative Office of the Courts, or (ii) by the most reliable and expeditious means otherwise available. If it cannot be reasonably anticipated that the clerk will receive the copy within 48 hours of the time that it was signed, the physician or eligible psychologist shall also communicate his findings to the clerk by telephone. (1973, c. 726, s. 1; c. 1408, s. 1; 1977, c. 400, s. 4; c. 679, s. 8; c. 739, s. 1; 1979, c. 358, s. 27; c. 915, s. 4; 1983, c. 380, ss. 4, 10; c. 638, ss. 6, 7, 25.1; c. 864, s. 4; 1985, c. 589, s. 2; c. 695, ss. 2, 9; 2018-33, s. 34; 2018-76, s. 3.2(b); 2019-177, s. 7(b); 2021-77, s. 6(c); 2023-103, s. 13(d).)

§ 122C-284. Duties of clerk of superior court.

(a) Upon receipt by the clerk of superior court of a finding made by a commitment examiner or other qualified professional pursuant to G.S. 122C-285(c) that a respondent is a substance abuser and dangerous to self or others and that commitment is recommended, the clerk of superior court of the county where the facility is located, if the respondent is held in a 24-hour facility, or the clerk of superior court where the petition was initiated shall upon direction of a district court judge assign counsel, calendar the matter for hearing, and notify the respondent, the respondent's counsel, and the petitioner of the time and place of the hearing. The petitioner or respondent, directly, or through counsel, may file a written waiver of the right to notice under this subsection with the clerk of court.

(b) Notice to the respondent required by subsection (a) of this section shall be given as provided in G.S. 1A-1, Rule 4(j) at least 72 hours before the hearing. Notice to other individuals shall be given by mailing at least 72 hours before the hearing a copy by first-class mail postage prepaid to the individual at his or her last known address. G.S. 1A-1, Rule 6 shall not apply.

(c) Upon receipt of notice that transportation is necessary to take a committed respondent to a 24-hour facility pursuant to G.S. 122C-290(b), the clerk shall issue a custody order for the respondent.

(d) The clerk of superior court shall upon the direction of a district court judge calendar all hearings, supplemental hearings, and rehearings and provide all notices required by this Part. (1973, c. 1408, s. 1; 1977, c. 400, s. 5; c. 414, s. 1; 1979, c. 915, s. 5; 1983, c. 380, s. 9; c. 638, s. 8; c. 864, s. 4; 1985, c. 589, s. 2; c. 695, s. 10; 1985 (Reg. Sess., 1986), c. 863, s. 27; 2018-33, s. 35.)

§ 122C-285. Commitment; second examination and treatment pending hearing.

(a) Within 24 hours of arrival at a 24-hour facility described in G.S. 122C-252, the respondent shall be examined by a qualified professional. This professional shall be a physician if the initial commitment evaluation was conducted by a commitment examiner who is not a physician. The examination shall include the assessment specified in G.S. 122C-283(c). If the physician or qualified professional finds that the respondent is a substance abuser and is dangerous to self or others, the physician or qualified professional shall hold and treat the respondent at the facility or designate other treatment pending the district court hearing. If the physician or qualified professional finds that the respondent does not meet the criteria for commitment under G.S. 122C-283(d)(1), the physician or qualified professional shall release the respondent and the proceeding shall be terminated. In this case the reasons for the release shall be reported in writing to the clerk of superior court of the county in which the custody order originated. If the respondent is released, the law enforcement officer or other person designated or required under G.S. 122C-251(g) to provide transportation shall return the respondent to the originating county.

(a1) The second examination of a respondent required by subsection (a) of this section to determine whether the respondent will be involuntarily committed due to substance abuse may be conducted either in the physical face-to-face presence of a physician or utilizing telehealth equipment and procedures, provided that the physician who examines the respondent by means of telehealth is satisfied to a reasonable medical certainty that the determinations made in accordance with subsection (a) of this section would not be different if the examination had been done in the physical presence of the commitment examiner. An examining physician who is not so satisfied shall note that the examination was not satisfactorily accomplished, and the respondent shall be taken for a face-to-face examination in the physical presence of a qualified professional; provided, however, that if the initial commitment examination was performed by a qualified professional, then this face-to-face examination shall be in the presence of a physician. As used in this section, "telehealth" means the use of two-way, real-time interactive audio and video where the respondent and commitment examiner can hear and see each other.

(b) If the 24-hour facility described in G.S. 122C-252 is the facility in which the first examination by a commitment examiner occurred and is the same facility in which the respondent is held, the second examination must occur not later than the following regular working day.

(c) The findings of the physician or qualified professional along with a summary of the facts on which they are based shall be made in writing in all cases. A copy of the written findings shall be sent to the clerk of superior court by reliable and expeditious means. (1973, c. 726, s. 1; c. 1408, s. 1; 1977, c. 400, s. 6; 1979, c. 915, s. 6; 1983, c. 380, s. 5; c. 638, ss. 9, 10; c. 864, s. 4; 1985, c. 589, s. 2; c. 695, s. 11; 1985 (Reg. Sess., 1986), c. 863, s. 28; 2018-33, s. 36; 2021-77, s. 6(d).)

§ 122C-286. Commitment; district court hearing.

(a) A hearing shall be held in district court within 10 days of the day the respondent is taken into custody. If a respondent temporarily detained under G.S. 122C-263(d)(2) is subject to a series of successive custody orders issued pursuant to G.S. 122C-263(d)(2), the hearing shall be held within 10 days after the day the respondent is taken into custody under the most recent custody

order. Upon its own motion or upon motion of the responsible professional, the respondent, or the State, the court may grant a continuance of not more than five days.

(b) The respondent shall be present at the hearing unless the respondent, through counsel, submits a written waiver of personal appearance. A subpoena may be issued to compel the respondent's presence at a hearing. The petitioner and the responsible professional of the area facility or the proposed treating physician or a designee of the proposed treating physician may be present and may provide testimony.

(c) Certified copies of reports and findings of physicians, psychologists, and other commitment examiners and medical records of previous and current treatment are admissible in evidence, but the respondent's right to confront and cross-examine witnesses shall not be denied.

(d) The respondent may be represented by counsel of choice. If the respondent is indigent within the meaning of G.S. 7A-450, counsel shall be appointed to represent the respondent in accordance with rules adopted by the Office of Indigent Defense Services.

(e) Hearings may be held at a facility if it is located within the judge's district court district as defined in G.S. 7A-133 or in the judge's chambers. A hearing may not be held in a regular courtroom, over objection of the respondent, if in the discretion of a judge a more suitable place is available.

(f) The hearing shall be closed to the public unless the respondent requests otherwise. The hearing for a respondent being held at a 24-hour facility shall be held in a location and in the manner provided in G.S. 122C-268(g).

(g) A copy of all documents admitted into evidence and a transcript of the proceedings shall be furnished to the respondent on request by the clerk upon the direction of a district court judge. If the respondent is indigent, the copies shall be provided at State expense.

(h) To support a commitment order, the court shall find by clear, cogent, and convincing evidence that the respondent meets the criteria specified in G.S. 122C-283(d)(1). The court shall record the facts that support its findings and shall show on the order the area facility or physician who is responsible for the management and supervision of the respondent's treatment. (1985, c. 589, s. 2; c. 695, s. 8; 1985 (Reg. Sess., 1986), c. 863, ss. 29, 30; 1987 (Reg. Sess., 1988), c. 1037, s. 117; 2000-144, s. 43; 2018-33, s. 37.)

§ 122C-286.1. Venue of district court hearing when respondent held at a 24-hour facility pending hearing.

(a) In all cases where the respondent is held at a 24-hour facility pending the district court hearing as provided in G.S. 122C-286, 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.

(b) An official of the facility shall immediately notify the clerk of superior court of the county in which the facility is located of a determination to hold the respondent pending hearing. That clerk shall request transmittal of all documents pertinent to the proceedings from the clerk of superior court where the proceedings were initiated. The requesting clerk shall assume all duties set forth in G.S. 122C-284. The counsel provided for in G.S. 122C-286(d) shall be appointed in accordance with rules adopted by the Office of Indigent Defense Services. (1985 (Reg. Sess., 1986), c. 863, s. 31; 2000-144, s. 44.)

§ 122C-287. Disposition.

The court may make one of the following dispositions:

(1) If the court finds by clear, cogent, and convincing evidence that the respondent is a substance abuser and is dangerous to self or others, it shall order for a period not in excess of 180 days commitment to and treatment by an area facility or physician who is responsible for the management and supervision of the respondent's commitment and treatment. The clerk of court shall send a copy of the commitment order to the designated area facility or physician responsible for the management and supervision of the respondent's commitment and treatment by the most reliable and expeditious means. Before ordering commitment to and treatment by an area facility or a physician who is not a physician at an inpatient facility, the court shall follow the procedures specified in G.S. 122C-271(a)(3) and G.S. 122C-271(b)(4), as applicable.

(2) If the court finds that the respondent does not meet the commitment criteria set out in subdivision (1) of this subsection, the respondent shall be discharged and the facility in which he was last treated so notified. (1973, c. 726, s. 1; c. 1408, s. 1; 1977, c. 400, s. 8; c. 739, s. 2; 1979, c. 358, s. 26; c. 915, ss. 8, 15, 16; 1981, c. 537, s. 1; 1983, c. 380, s. 8; c. 638, s. 14; c. 864, s. 4; 1985, c. 589, s. 2; 2018-33, s. 38; 2025-54, s. 11(b).)

§ 122C-288. Appeal.

Judgment of the district court is final. Appeal may be had to the Court of Appeals by the State or by any party on the record as in civil cases. Appeal does not stay the commitment unless so ordered by the Court of Appeals. The Attorney General shall represent the State's interest on appeal. The district court retains limited jurisdiction for the purpose of hearing all reviews, rehearings, or supplemental hearings allowed or required under this Part. (1973, c. 726, s. 1; c. 1408, s. 1; 1979, c. 915, s. 19; 1985, c. 589, s. 2.)

§ 122C-289. Duty of assigned counsel; discharge.

If the respondent is committed, assigned counsel remains responsible for the respondent's representation at the trial level until discharged by order of district court or until the respondent is otherwise unconditionally discharged. If the respondent appeals, counsel for the appeal shall be appointed in accordance with rules adopted by the Office of Indigent Defense Services. (1973, c. 1408, s. 1; 1985, c. 589, s. 2; 2006-264, s. 61(b).)

§ 122C-290. Duties for follow-up on commitment order.

(a) The area facility or physician responsible for management and supervision of the respondent's commitment and treatment may prescribe or administer to the respondent reasonable and appropriate treatment either on an outpatient basis or in a 24-hour facility.

(b) If the respondent whose treatment is provided on an outpatient basis fails to comply with all or part of the prescribed treatment after reasonable effort to solicit the respondent's compliance or whose treatment is provided on an inpatient basis is discharged in accordance with G.S. 122C-205.1(b), the area facility or physician may request the clerk or magistrate 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 him immediately to the designated area facility or physician for examination. The custody order is valid throughout the State. The law enforcement officer shall turn the respondent over to the custody of the physician or area facility who shall conduct the examination

and release the respondent or have the respondent taken to a 24-hour facility upon a determination that treatment in the facility will benefit the respondent. Transportation to the 24-hour facility shall be provided as specified in G.S. 122C-251, upon notice to the clerk or magistrate that transportation is necessary, or as provided in G.S. 122C-408(b). If placement in a 24-hour facility is to exceed 45 consecutive days, the area facility or physician shall notify the clerk of court by the 30th day and request a supplemental hearing as specified in G.S. 122C-291.

(c) If the respondent intends to move or moves to another county within the State, the area facility or physician shall notify the clerk of court in the county where the commitment is being supervised and request that a supplemental hearing be calendared.

(d) If the respondent moves to another state or to an unknown location, the designated area facility or physician shall notify the clerk of superior court of the county where the commitment is supervised and the commitment shall be terminated. (1983, c. 638, s. 16; c. 864, s. 4; 1985, c. 589, s. 2; 1985 (Reg. Sess., 1986), c. 863, s. 32; 1987, c. 674, s. 2; c. 750; 2004-23, s. 2(c); 2018-33, s. 39.)

§ 122C-291. Supplemental hearings.

(a) Upon receipt of a request for a supplemental hearing, the clerk shall calendar a hearing to be held within 14 days and notify, at least 72 hours before the hearing, the petitioner, the respondent, his attorney, if any, and the designated area facility or physician. Notice shall be provided in accordance with G.S. 122C-284(b). The procedures for the hearing shall follow G.S. 122C-286.

(b) At the supplemental hearing for a respondent who has moved or may move to another county, the court shall determine if the respondent meets the criteria for commitment set out in G.S. 122C-283(d)(1). If the court determines that the respondent no longer meets the criteria for commitment, it shall discharge the respondent from the order and dismiss the case. If the court determines that the respondent continues to meet the criteria for commitment, it shall continue the commitment but shall designate an area facility or physician at the respondent's new residence to be responsible for the management or supervision of the respondent's commitment. The court shall order the respondent to appear for treatment at the address of the newly designated area facility or physician and shall order venue for further court proceedings under the commitment to be transferred to the new county of supervision. Upon an order changing venue, the clerk of court in the county where the commitment has been supervised shall transfer the records regarding the commitment to the clerk of court in the county where the commitment will be supervised. Also, the clerk of court in the county where the commitment has been supervised shall send a copy of the court's order directing the continuation of treatment under new supervision to the newly designated area facility or physician.

(c) At a supplemental hearing for a respondent to be held longer than 45 consecutive days in a 24-hour facility, the court shall determine if the respondent meets the criteria for commitment set out in G.S. 122C-283(d)(1). If the court determines that the respondent continues to meet the criteria and that further treatment in the 24-hour facility is necessary, the court may authorize continued care in the facility for not more than 90 days, after which a rehearing for the purpose of determining the need for continued care in the 24-hour facility shall be held, or the court may order the respondent released from the 24-hour facility and continued on the commitment on an outpatient basis. If the court determines that the respondent no longer meets the criteria for commitment the respondent shall be released and his case dismissed.

(d) At any time during the term of commitment order, a respondent may apply to the court for a supplemental hearing for the purpose of discharge from the order. The application shall be made in writing to the clerk of superior court. At the supplemental hearing the court shall determine whether the respondent continues to meet the criteria for commitment. The court may reissue or change the commitment order or discharge the respondent and dismiss the case. (1985, c. 589, s. 2; 2018-33, s. 40.)

§ 122C-292. Rehearings.

(a) Fifteen days before the end of the initial or subsequent periods of commitment if the area facility or physician determines that the respondent continues to meet the criteria specified in G.S. 122C-283(d)(1), the clerk of superior court of the county where commitment is supervised shall be notified. The clerk, at least 10 days before the end of the commitment period, on order of the district court, shall calendar the rehearing. If the respondent no longer meets the criteria, the area facility or physician shall so notify the clerk who shall dismiss the case.

(b) Rehearings are governed by the same notice and procedures as initial hearings, and the respondent has the same rights that were available to the respondent at the initial hearing including the right to appeal.

(c) If the court finds that the respondent no longer meets the criteria of G.S. 122C-283(d)(1), it shall unconditionally discharge him. A copy of the discharge order shall be furnished by the clerk to the designated area facility or physician. If the respondent continues to meet the criteria of G.S. 122C-283(d)(1), the court may order commitment for additional periods not in excess of 365 days each. (1973, c. 726, s. 1; c. 1408, s. 1; 1977, c. 400, s. 9; 1979, c. 915, ss. 9, 17; 1981, c. 537, ss. 2-4; 1983, c. 638, ss. 18-19; 864, s. 4; 1985, c. 589, s. 2; 2018-33, s. 41.)

§ 122C-293. Release by area facility or physician.

The area facility or physician as designated in the order shall discharge a committed respondent unconditionally at any time the physician determines that the respondent no longer meets the criteria of G.S. 122C-283(d)(1). Notice of discharge and the reasons for the release shall be reported in writing to the clerk of superior court of the county in which the commitment was ordered. (1973, c. 726, s. 1; c. 1408, s. 1; 1981, c. 537, s. 5; 1983, c. 383, s. 6; c. 638, s. 21; c. 864, s. 4; 1985, c. 589, s. 2; 2018-33, s. 42.)

§ 122C-294. Local plan and data submission.

(a) The "local area crisis services plans" adopted in accordance with G.S. 122C-202.2 and G.S. 122C-251(g) shall be submitted to the Division of Mental Health, Developmental Disabilities, and Substance Use Services beginning October 1, 2019, but no later than August 1, 2020. If the area authority modifies any plan, the modified plan shall be submitted to the Division of Mental Health, Developmental Disabilities, and Substance Use Services at least 10 days prior to the effective date of the new plan.

(b) The Department shall provide the data collected by the Division of Mental Health, Developmental Disabilities, and Substance Use Services concerning the number of respondents receiving treatment under involuntary commitment in designated facilities to the Fiscal Research Division and the Joint Legislative Oversight Committee for Health and Human Services on October 1 of each year beginning in 2019 and any other time upon request. (1973, c. 1408, s. 1; 1977, c. 679, s. 8; 1979, c. 358, ss. 26, 27; 1985, c. 589, s. 2; 2018-33, s. 43; 2019-240, s. 26(i); 2023-65, s. 5.2(b).)

§§ 122C-295 through 122C-300. Reserved for future codification purposes.

Part 9. Public Intoxication.

§ 122C-301. Assistance to an individual who is intoxicated in public; procedure for commitment to shelter or facility.

(a) An officer may assist an individual found intoxicated in a public place by taking any of the following actions:

(1) The officer may direct or transport the intoxicated individual home;

(2) The officer may direct or transport the intoxicated individual to the residence of another individual willing to accept him;

(3) If the intoxicated individual is apparently in need of and apparently unable to provide for himself food, clothing, or shelter but is not apparently in need of immediate medical care, the officer may direct or transport him to an appropriate public or private shelter facility;

(4) If the intoxicated individual is apparently in need of but apparently unable to provide for himself immediate medical care, the officer may direct or transport him to an area facility, hospital, or physician's office; or the officer may direct or transport the individual to any other appropriate health care facility; or

(5) If the intoxicated individual is apparently a substance abuser and is apparently dangerous to himself or others, the officer may proceed as provided in Part 8 of this Article.

(b) In providing the assistance authorized by subsection (a) of this section, the officer may use reasonable force to restrain the intoxicated individual if it appears necessary to protect himself, the intoxicated individual, or others. No officer may be held criminally or civilly liable for assault, false imprisonment, or other torts or crimes on account of reasonable measures taken under authority of this Part.

(c) If the officer takes the action described in either subdivision (a)(3) or (a)(4) of this section, the facility to which the intoxicated individual is taken may detain him only until he becomes sober or a maximum of 24 hours. The individual may stay a longer period if he wishes to do so and the facility is able to accommodate him.

(d) Any individual who has knowledge that a person assisted to a shelter or other facility under subdivisions (a)(3) or (a)(4) of this section is a substance abuser and is dangerous to himself or others may proceed as provided in Part 8 of this Article. (1977, 2nd Sess., c. 1134, s. 2; 1981, c. 519, s. 5; 1985, c. 589, s. 2.)

§ 122C-302. Cities and counties may employ officers to assist intoxicated individuals.

A city or county may employ officers to assist individuals who are intoxicated in public. Officers employed for this purpose shall be trained to give assistance to those who are intoxicated in public including the administration of first aid. An officer employed by a city or county to assist intoxicated individuals has the powers and duties set out in G.S. 122C-301 within the same territory in which criminal laws are enforced by law-enforcement officers of that city or county. (1977, 2nd Sess., c. 1134, s. 2; 1985, c. 589, s. 2.)

§ 122C-303. Use of jail for care for intoxicated individual.

In addition to the actions authorized by G.S. 122C-301(a), an officer may assist an individual found intoxicated in a public place by directing or transporting that individual to a city or county jail. That action may be taken only if the intoxicated individual is apparently in need of and apparently unable to provide for himself food, clothing, or shelter but is not apparently in need of immediate medical care and if no other facility is readily available to receive him. The officer and employees of the jail are exempt from liability as provided in G.S. 122C-301(b). The intoxicated individual may be detained at the jail only until he becomes sober or a maximum of 24 hours and may be released at any time to a relative or other individual willing to be responsible for his care. (1977, 2nd Sess., c. 1134, s. 3; 1985, c. 589, s. 2.)

§§ 122C-304 through 122C-310. Reserved for future codification purposes.

Part 10. Voluntary Admissions, Involuntary Commitments and Discharges, Inmates and Parolees, Department of Adult Correction.

§ 122C-311. Individuals on parole.

Any individual who has been released from any correctional facility on parole is admitted, committed and discharged from facilities in accordance with the procedures specified in this Article for other individuals. (1959, c. 1002, s. 24; 1963, c. 1184, s. 28; 1973, c. 253, s. 4; 1985, c. 589, s. 2.)

§ 122C-312. Voluntary admissions and discharges of inmates of the Division of Prisons of the Department of Adult Correction.

Inmates in the custody of the Division of Prisons of the Department of Adult Correction may seek voluntary admission to State facilities for the mentally ill or substance abusers. The provisions of Part 2 of this Article shall apply except that an admission may be accomplished only when the Secretary and the Secretary of the Department of Adult Correction jointly agree to the inmate's request. When an inmate is admitted he shall be discharged in accordance with the provisions of Part 2 of this Article except that an inmate who is ready for discharge, but still under a term of incarceration, shall be discharged only to an official of the Division of Prisons of the Department of Adult Correction. The Division of Prisons of the Department of Adult Correction is responsible for the security and cost of transporting inmates to and from facilities under the provisions of this section. (1979, c. 547; 1985, c. 589, s. 2; 2011-145, s. 19.1(h), (i); 2017-186, s. 2(ppppp); 2021-180, s. 19C.9(o), (p).)

§ 122C-313. Inmate becoming mentally ill and dangerous to himself or others.

(a) An inmate who becomes mentally ill and dangerous to himself or others after incarceration in any facility operated by the Division of Prisons of the Department of Adult Correction in the State is processed in accordance with Part 7 of this Article, as modified by this section, except when the provisions of Part 7 are manifestly inappropriate. A staff psychiatrist or eligible psychologist of the correctional facility shall execute the affidavit required by G.S. 122C-261 and send it to the clerk of superior court of the county in which the correctional facility is located. Upon receipt of the affidavit, the clerk shall calendar a district court hearing and notify the respondent and his counsel as required by G.S. 122C-284(a). The hearing is conducted in a district courtroom. If the judge finds by clear, cogent, and convincing evidence that the respondent is mentally ill and dangerous to himself or others, he shall order him transferred for

treatment to a State facility designated by the Secretary. The judge shall not order outpatient commitment for an inmate-respondent.

(b) If the sentence of an inmate-respondent expires while he is committed to a State facility, he is considered in all respects as if he had been initially committed under Part 7 of this Article.

(c) If the sentence of an inmate-respondent has not expired, and if in the opinion of the attending physician of the State facility an inmate-respondent ceases to be mentally ill and dangerous to himself or others, he shall notify the Division of Prisons of the Department of Adult Correction which shall arrange for the inmate-respondent's return to a correctional facility.

(d) Special counsel at a State facility shall represent any inmate who becomes mentally ill and dangerous to himself or others while confined in a correctional facility in the same county, otherwise counsel is assigned in accordance with G.S. 122C-270(d).

(e) The Division of Prisons of the Department of Adult Correction is responsible for the security and cost of transporting inmates to and from State facilities under the provisions of this section. (1899, c. 1, s. 66; Rev., s. 4619; C.S., s. 6238; 1923, c. 165, s. 55; 1945, c. 952, s. 55; 1955, c. 887, s. 14; 1957, c. 1232, s. 26; 1963, c. 1184, s. 27; 1965, c. 800, s. 13; 1973, c. 253, s. 3; c. 1433; 1977, c. 679, s. 8; 1979, c. 358, s. 27; c. 915, s. 11; 1985, c. 589, s. 2; c. 695, s. 2; 2011-145, s. 19.1(h); 2017-186, s. 2(ppppp); 2021-180, s. 19C.9(p).)

§§ 122C-314 through 122C-320: Reserved for future codification purposes.

Part 11. Voluntary Admissions, Involuntary Commitments and Discharges, the Psychiatric Service of the University of North Carolina Hospitals at Chapel Hill.

§ 122C-321. Voluntary admissions and discharges.

Any individual in need of treatment for mental illness or substance abuse may seek voluntary admission to the psychiatric service of the University of North Carolina Hospitals at Chapel Hill. Procedures for admission and discharge shall be made in accordance with Parts 2 through 4 of this Article. The applicant may be admitted only upon the approval of the director of the psychiatric service or his designee. (1955, c. 1274, s. 2; 1963, c. 1184, s. 2; 1973, c. 723, s. 3; c. 1084; 1985, c. 589, s. 2; 1989, c. 141, s. 14.)

§ 122C-322. Involuntary commitments.

(a) Except as otherwise specifically provided in this section references in Parts 6 through 8 of this Article to 24-hour facilities, outpatient treatment centers, or area authorities, or private facilities shall include the psychiatric service of the University of North Carolina Hospitals at Chapel Hill. The psychiatric service may be used for temporary detention pending a district court hearing, for commitment of the respondent after the hearing, or as the manager and supervisor of outpatient commitment. However, no individual may be held at or committed to the psychiatric service without the prior approval of the director of the psychiatric service or his designee.

(b) Initial hearings, supplemental hearings, and rehearings may be held at the psychiatric service facility or at any place in Orange County where district court can be held under G.S. 7A-133. Legal counsel for the respondent at all hearings and rehearings shall be assigned from among the members of the bar of the same county in accordance with G.S. 122C-270(d). (1977, c. 738, s. 1; 1981, c. 442; 1985, c. 589, s. 2; 1989, c. 141, s. 15.)

§§ 122C-323 through 122C-330. Reserved for future codification purposes.

Part 12. Voluntary Admissions, Involuntary Commitments and Discharges, Veterans Administration Facilities.

§ 122C-331. Voluntary admissions and discharges.

Veterans in need of treatment for mental illness or substance abuse may seek voluntary admission to a facility operated by the Veterans Administration. Procedures for admission and discharge shall be made in accordance with Parts 2 and 4 of this Article. The Veterans Administration may require additional procedures not inconsistent with these Parts. (1973, c. 1408, s. 1; 1985, c. 589, s. 2.)

§ 122C-332. Involuntary commitments.

(a) Except as otherwise specifically provided in this section, references in Parts 6 through 8 of this Article to 24-hour facilities, outpatient treatment centers, or area authorities, or private facilities shall include the facilities operated by the Veterans Administration. Veterans Administration facilities may be used for temporary detention pending a district court hearing, for commitment of the respondent after the hearing, or as the manager and supervisor of outpatient commitment. Eligibility of the veteran-respondent for treatment at a Veterans Administration facility and the availability of space shall be determined by the Veterans Administration in all cases before sending or committing a veteran-respondent.

(b) Initial hearings, supplemental hearings, and rehearings for veteran-respondents may be held at the facility or at the county courthouse in the county in which the facility is located, and counsel shall be assigned from among the members of the bar of the same county in accordance with G.S. 122C-270(d). (1985, c. 589, s. 2.)

§ 122C-333. Order of another state.

The judgment or order of commitment by a court of competent jurisdiction of another state, committing a person to the Veterans Administration or another federal agency that is located in this State shall have the same force and effect on the committed person while in this State as in the jurisdiction of the court entering the judgment or making the order. The courts of the committing state shall retain jurisdiction of the person so committed for the purpose of inquiring into the mental condition of the person, and for determining the necessity for continuance of his restraint. Consent is given to the application of the law of the committing state on the authority of the chief officer of any facility of the Veterans Administration or of any institution operated in this State by any other federal agency to retain custody, transfer, parole, or discharge the committed person. (1985, c. 589, s. 2.)

§§ 122C-334 through 122C-340. Reserved for future codification purposes.

Part 13. Voluntary Admissions, Involuntary Commitment and Discharge of Non-State Residents and the Return of North Carolina Resident Clients.

§ 122C-341. Determination of residence.

It is the responsibility of the facility to determine if a client is not a resident of the State. (1899, c. 1, s. 18; Rev., ss. 3591, 4587, 4588; C.S., ss. 6187, 6188; 1945, c. 952, ss. 16, 17; 1947, c. 537, s. 11; 1953, c. 256, s. 3; 1957, c. 1386; 1963, c. 1184, s. 1; 1973, c. 673, s. 13; 1985, c. 589, s. 2.)

§ 122C-342. Voluntary admissions and discharges.

A non-State resident may be admitted to and discharged from a facility on a voluntary basis in accordance with Parts 2 through 5 of this Article at his own expense. If the facility determines that the client should be returned to his own state the provisions of G.S. 122C-345 or G.S. 122C-361, as appropriate, shall apply. (1899, c. 1, s. 16; Rev., s. 4584; C.S., s. 6210; 1945, c. 952, s. 33; 1947, c. 537, s. 18; 1963, c. 1184, s. 1; 1971, c. 1140; 1973, c. 476, s. 133; c. 673, s. 13; 1985, c. 589, s. 2.)

§ 122C-343. Involuntary commitments.

Involuntary commitments of non-State residents are made under the provisions of Parts 6 through 8 of this Article. If after commitment to a 24-hour facility the facility determines that the respondent needs long-term care and should be returned to his state of residence, the provisions of G.S. 122C-345 or G.S. 122C-361, as appropriate, shall apply. (1899, c. 1, s. 16; Rev., s. 4584; C.S., s. 6210; 1945, c. 952, s. 33; 1947, c. 537, s. 18; 1963, c. 1184, s. 1; 1971, c. 1140; 1973, c. 476, s. 133; c. 673, s. 13; 1985, c. 589, s. 2.)

§ 122C-344. Citizens of other countries.

In addition to the provisions of G.S. 122C-341 through G.S. 122C-343, if a 24-hour facility determines that a client is not a citizen of the United States, the facility shall notify the Governor of this State of the name of the client, the country and place of his residence in the country and other facts in the case as can be obtained, together with a copy of pertinent medical records. The Governor shall send the information to the nearest consular office of the committed foreign national, with the request that the consular office tell the minister resident or plenipotentiary of the country of which the client is alleged to be a citizen. (1899, c. 1, s. 16; Rev., s. 4585; C.S., s. 6211; 1963, c. 1184, s. 1; 1985, c. 589, s. 2; 1993, c. 561, s. 86(a).)

§ 122C-345. Return of a non-State resident client to his resident state.

(a) Except as provided in subsection (c) of this section, it is the responsibility of the director of a facility to arrange for the transfer of a client to his resident state. The cost of returning the client to his resident state is the responsibility of the client or his family.

(b) A non-State resident client of an area 24-hour facility may be transferred to a State facility in accordance with G.S. 122C-206 in order for the client to be returned to his resident state.

(c) A non-State resident client of a State facility may be returned to his resident state under procedures established under G.S. 122C-346 or G.S. 122C-361. The cost of returning a client to his resident state under this subsection shall be the responsibility of the State. (1899, c. 1, s. 16; Rev., s. 4584; C.S., s. 6210; 1945, c. 952, s. 33; 1947, c. 537, ss. 18, 20; 1955, c. 887, s. 13; 1959, c. 1002, s. 22; 1963, c. 1184, s. 1; 1971, c. 1140; 1973, c. 476, s. 133; c. 673, s. 13; 1977, c. 679, s. 7; 1981, c. 51, s. 3; 1985, c. 589, s. 2.)

§ 122C-346. Authority of the Secretary to enter reciprocal agreements.

The Secretary may enter agreements with other states for the return of non-State resident clients to their resident state and for the return of North Carolina residents to North Carolina when under treatment in another state. (1947, c. 537, s. 20; 1955, c. 887, s. 13; 1959, c. 1002, s. 22; 1963, c. 1184, s. 1; 1973, c. 476, s. 133; 1977, c. 679, s. 7; 1981, c. 51, s. 3; 1985, c. 589, s. 2.)

§ 122C-347. Return of North Carolina resident clients from other states.

North Carolina residents who are in treatment in another state may be returned to North Carolina either under an agreement authorized in G.S. 122C-346 or under the provisions of G.S.

122C-361. The cost of returning a North Carolina resident to this State is the responsibility of the sending state. Within 72 hours after admission in a State facility, a returned resident shall be evaluated. The returned resident may agree to a voluntary admission or may be released, or proceedings for an involuntary commitment under this Article may be initiated as necessary by the responsible professional in the facility. (1945, c. 952, s. 34; 1947, c. 537, s. 19; 1959, c. 1002, ss. 20, 21; 1963, c. 1184, s. 1; 1965, c. 800, s. 9; 1969, c. 982; 1973, c. 476, ss. 133, 138; c. 673, s. 13; 1985, c. 589, s. 2.)

§ 122C-348. Residency not affected.

(a) A nonresident of this State who is under care in a 24-hour facility in this State is not considered a resident. No length of time spent in this State while a client in a 24-hour facility is sufficient to make a nonresident a resident or entitled to care or treatment.

(b) A North Carolina resident who is under care and treatment in a 24-hour facility in another state shall retain his residency in North Carolina. (1899, c. 1, s. 18; Rev., ss. 3591, 4587, 4588; C.S., ss. 6187, 6188; 1945, c. 952, ss. 16, 17; 1947, c. 537, ss. 11, 20; 1953, c. 256, s. 3; 1955, c. 887, s. 13; 1957, c. 1386; 1959, c. 1002, s. 22; 1963, c. 1184, s. 1; 1973, c. 476, s. 133; c. 673, s. 13; 1977, c. 679, s. 7; 1981, c. 51, s. 3; 1985, c. 589, s. 2.)

§§ 122C-349 through 122C-360. Reserved for future codification purposes.

Part 14. Interstate Compact on Mental Health.

§ 122C-361. Compact entered into; form of Compact.

The Interstate Compact on Mental Health is hereby enacted into law and entered into by this State with all other states legally joining therein in the form substantially as follows: The contracting states solemnly agree that:

Article I.

The party states find that the proper and expeditious treatment of the mentally ill and mentally deficient can be facilitated by cooperative action, to the benefit of the patients, their families, and society as a whole. Further, the party states find that the necessity of and desirability for furnishing such care and treatment bears no primary relation to the residence or citizenship of the patient but, that, on the contrary, the controlling factors of community safety and humanitarianism require that facilities and services be made available for all who are in need of them. Consequently, it is the purpose of this Compact and of the party states to provide the necessary legal basis for the institutionalization or other appropriate care and treatment of the mentally ill and mentally deficient under a system that recognizes the paramount importance of patient welfare and to establish the responsibilities of the party states in term of such welfare.

Article II.

As used in this Compact:

(a) "Sending state" shall mean a party state from which a patient is transported pursuant to the provisions of the Compact or from which it is contemplated that a patient may be so sent.

(b) "Receiving state" shall mean a party state to which a patient is transported pursuant to the provisions of the Compact or to which it is contemplated that a patient may be so sent.

(c) "Institution" shall mean any hospital or other facility maintained by a party state or political subdivision thereof for the care and treatment of mental illness or mental deficiency.

(d) "Patient" shall mean any person subject to or eligible as determined by the laws of the sending state, for institutionalization or other care, treatment, or supervision pursuant to the provisions of this Compact.

(e) "Aftercare" shall mean care, treatment and services provided a patient, as defined herein, on convalescent status or conditional release.

(f) "Mental illness" shall mean mental disease to such extent that a person so afflicted requires care and treatment for his own welfare, or the welfare of others, or of the community.

(g) "Mental deficiency" shall mean mental deficiency as defined by appropriate clinical authorities to such extent that a person so afflicted is incapable of managing himself and his affairs, but shall not include mental illness as defined herein.

(h) "State" shall mean any state, territory or possession of the United States, the District of Columbia, and the Commonwealth of Puerto Rico.

Article III.

(a) Whenever a person physically present in any party state shall be in need of institutionalization by reason of mental illness or mental deficiency, he shall be eligible for care and treatment in an institution in that state irrespective of his residence, settlement or citizenship qualifications.

(b) The provisions of paragraph (a) of this Article to the contrary notwithstanding, any patient may be transferred to an institution in another state whenever there are factors based upon clinical determinations indicating that the care and treatment of said patient would be facilitated or improved thereby. Any such institutionalization may be for the entire period of care and treatment or for any portion or portions thereof. The factors referred to in this paragraph shall include the patient's full record with due regard for the location of the patient's family, character of the illness and probable duration thereof, and such other factors as shall be considered appropriate.

(c) No state shall be obliged to receive any patient pursuant to the provisions of paragraph (b) of this Article unless the sending state has given advance notice of its intention to send the patient; furnished all available medical and other pertinent records concerning the patient; given the qualified medical or other appropriate clinical authorities of the receiving state an opportunity to examine the patient if said authorities so wish; and unless the receiving state shall agree to accept the patient.

(d) In the event that the laws of the receiving state establish a system of priorities for the admission of patients, an interstate patient under this Compact shall receive the same priority as a local patient and shall be taken in the same order and at the same time that it would be taken if he were a local patient.

(e) Pursuant to this Compact, the determination as to the suitable place of institutionalization for a patient may be reviewed at any time and such further transfer of the patient may be made as seems likely to be in the best interest of the patient.

Article IV.

(a) Whenever, pursuant to the laws of the state in which a patient is physically present, it shall be determined that the patient should receive aftercare or supervision, such care or supervision may be provided in a receiving state. If the medical or other appropriate clinical authorities have responsibility for the care and treatment of the patient in the sending state shall have reason to believe that aftercare in another state would be in the best interest of the patient and would not jeopardize the public safety, they shall request the appropriate authorities in the

receiving state to investigate the desirability of affording the patient such aftercare in said receiving state, and such investigation shall be made with all reasonable speed. The request for investigation shall be accompanied by complete information concerning the patient's intended place of residence and the identity of the person in whose charge it is proposed to place the patient, the complete medical history of the patient, and such other documents as may be pertinent.

(b) If the medical or other appropriate clinical authorities having responsibility for the care and treatment of the patient in the sending state and the appropriate authorities in the receiving state find that the best interest of the patient would be served thereby, and if the public safety would not be jeopardized thereby, the patient may receive aftercare or supervision in the receiving state.

(c) In supervising, treating, or caring for a patient on aftercare pursuant to the terms of this Article, a receiving state shall employ the same standards of visitation, examination, care, and treatment that it employs for similar local patients.

Article V.

Whenever a dangerous or potentially dangerous patient escapes from an institution in any party state, that state shall promptly notify all appropriate authorities within and without the jurisdiction of the escape in a way reasonably calculated to facilitate the speedy apprehension of the escapee. Immediately upon the apprehension and identification of any such dangerous or potentially dangerous patient, he shall be detained in the state where found pending disposition in accordance with law.

Article VI.

The duly accredited officers of any state party to this Compact, upon the establishment of their authority and the identity of the patient, shall be permitted to transport any patient being moved pursuant to this Compact through any and all states party to this Compact, without inferference.

Article VII.

(a) No person shall be deemed a patient of more than one institution at any given time. Completion of transfer of any patient to an institution in a receiving state shall have the effect of making the person a patient of the institution in the receiving state.

(b) The sending state shall pay all costs of and incidental to the transportation of any patient pursuant to this Compact, but any two or more party states may, by making a specific agreement for that purpose, arrange for a different allocation of costs as among themselves.

(c) No provision of this Compact shall be construed to alter or affect any internal relationships among the departments, agencies and officers of and in the government of a party state, or between a party state and its subdivisions, as to the payment of costs, or responsibilities therefor.

(d) Nothing in this Compact shall be construed to prevent any party state or subdivision thereof from asserting any right against any person, agency or other entity in regard to costs for which such party state or subdivision thereof may be responsible pursuant to any provision of this Compact.

(e) Nothing in this Compact shall be construed to invalidate any reciprocal agreement between a party state and a nonparty state relating to institutionalization, care or treatment of the mentally ill or mentally deficient, or any statutory authority pursuant to which such agreements may be made.

Article VIII.

(a) Nothing in this Compact shall be construed to abridge, diminish, or in any way impair the rights, duties, and responsibilities of any patient's guardian on his own behalf or in respect of any patient for whom he may serve, except that where the transfer of any patient to another jurisdiction makes advisable the appointment of a supplemental or substitute guardian, any court of competent jurisdiction in the receiving state may make such supplemental or substitute appointment and the court which appointed the previous guardian shall upon being duly advised of the new appointment, and upon the satisfactory completion of such accounting and other acts as such court may by law require, relieve the previous guardian of power and responsibility to whatever extent shall be appropriate in the circumstances; provided, however, that in the case of any patient having settlement in the sending state, the court of competent jurisdiction in the sending state shall have the sole discretion to relieve a guardian appointed by it or continue his power and responsibility, whichever it shall deem advisable. The court in the receiving state may, in its discretion, confirm or reappoint the person or persons previously serving as guardian in the sending state in lieu of making a supplemental or substitute appointment.

(b) The term "guardian" as used in paragraph (a) of this Article shall include any guardian, trustee, legal committee, conservator, or other person or agency however denominated who is charged by law with power to act for or responsibility for the person or property of a patient.

Article IX.

(a) No provision of this Compact except Article V shall apply to any person institutionalized while under sentence in a penal or correctional institution or while subject to trial on a criminal charge, or whose institutionalization is due to the commission of an offense for which, in the absence of mental illness or mental deficiency, said person would be subject to incarceration in a penal or correctional institution.

(b) To every extent possible, it shall be the policy of states party to this Compact that no patient shall be placed or detained in any prison, jail or lockup, but such patient shall, with all expedition, be taken to a suitable institutional facility for mental illness or mental deficiency.

Article X.

(a) Each party state shall appoint a "Compact Administrator" who, on behalf of his state, shall act as general coordinator of activities under the Compact in his state and who shall receive copies of all reports, correspondence, and other documents relating to any patient processed under the Compact by his state either in the capacity of sending or receiving state. The Compact Administrator or his duly designated representative shall be the official with whom other party states shall deal in any matter relating to the Compact or any patient processed thereunder.

(b) The Compact Administrators of the respective party states shall have power to promulgate reasonable rules and regulations to carry out more effectively the terms and provisions of this Compact.

Article XI.

The duly constituted administrative authorities of any two or more party states may enter into supplementary agreements for the provision of any service or facility or for the maintenance of any institution on a joint or cooperative basis whenever the states concerned shall find that such

agreements will improve services, facilities, or institutional care and treatment in the fields of mental illness or mental deficiency. No such supplementary agreement shall be construed so as to relieve any party state of any obligation which it otherwise would have under other provisions of this Compact.

Article XII.

This Compact shall enter into full force and effect as to any state when enacted by it into law and such state shall thereafter be a party thereto with any and all states legally joining therein.

Article XIII.

(a) A state party to this Compact may withdraw therefrom by enacting a statute repealing the same. Such withdrawal shall take effect one year after notice thereof has been communicated officially and in writing to the governors and Compact administrators of all other party states. However, the withdrawal of any state shall not change the status of any patient who has been sent to said state or sent out of said state pursuant to the provisions of the Compact.

(b) Withdrawal from any agreement permitted by Article VII(b) as to costs or from any supplementary agreement made pursuant to Article XI shall be in accordance with the terms of such agreement.

Article XIV.

This Compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this Compact shall be severable and if any phrase, clause, sentence or provision of this Compact is declared to be contrary to the constitution of any party state or of the United States or the applicability thereof to any government, agency, person or circumstance is held invalid, the validity of the remainder of this Compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this Compact shall be held contrary to the constitution of any state party thereto, the Compact shall remain in full force and effect as to the remaining states and in full force and effect as to the state affected as to all severable matters. (1959, c. 1003, s. 1; 1963, c. 1184, s. 12; 1985, c. 589, s. 2.)

§ 122C-362. Compact Administrator.

Pursuant to the Compact, the Secretary is the Compact Administrator and, acting jointly with like officers of other party states, may adopt rules to carry out more effectively the terms of the Compact. The Compact Administrator shall cooperate with all departments, agencies and officers of and in the government of this State and its subdivisions in facilitating the proper administration of the Compact, of any supplementary agreement, or agreements entered into by this State. (1959, c. 1003, s. 2; 1963, c. 1184, s. 12; 1973, c. 476, s. 133; 1985, c. 589, s. 2.)

§ 122C-363. Supplementary agreements.

The Compact Administrator may enter into supplementary agreements with appropriate officials of other states pursuant to Articles VII and XI of the Compact. In the event that these supplementary agreements shall require or contemplate the use of any institution or facility of this State or require or contemplate the provision of any service by this State, no such agreement shall be effective until approved by the head of the department or agency under whose jurisdiction the

institution or facility is operated or whose department or agency will be charged with the rendering of this service. (1959, c. 1003, s. 3; 1963, c. 1184, s. 12; 1985, c. 589, s. 2.)

§ 122C-364. Financial arrangements.

The Compact Administrator, with the approval of the Director of the Budget, may make or arrange for any payments necessary to discharge any financial obligations imposed upon this State by the Compact or by any supplementary agreement entered into under it. (1959, c. 1003, s. 4; 1963, c. 1184, s. 12; 1985, c. 589, s. 2.)

§ 122C-365. Transfer of clients.

The Compact Administrator is directed to consult with the immediate family or legally responsible person of any proposed transferee. (1959, c. 1003, s. 5; 1963, c. 1184, ss. 12, 38; 1985, c. 589, s. 2.)

§ 122C-366. Transmittal of copies of Part.

Copies of this Part shall, upon its approval, be transmitted by the Compact Administrator to the governor of each state, the attorney general of each state, the Administrator of General Services of the United States, and the Council of State Governments. (1959, c. 1003, s. 6; 1963, c. 1184, s. 12; 1985, c. 589, s. 2.)

§§ 122C-367 through 122C-400. Reserved for future codification purposes.

Article 6.

Special Provisions.

Part 1. Camp Butner and Community of Butner.

§ 122C-401. Use of Camp Butner Hospital authorized.

The State may use the Camp Butner Hospital, including buildings, equipment, and land necessary for the operation of modern up-to-date facilities for the care and treatment of citizens of this State. (1947, c. 789, s. 2; 1963, c. 1166, s. 10; 1973, c. 476, s. 133; 1985, c. 589, s. 2.)

§ 122C-402. Application of State highway and motor vehicle laws at State institutions on Camp Butner reservation.

The provisions of Chapter 20 of the General Statutes relating to the use of the highways of the State and the operation of motor vehicles thereon are made applicable to the streets, alleys, and driveways on the Camp Butner reservation that are on the grounds of any State facility or any State institution operated by the Department or by the Division of Prisons of the Department of Adult Correction. Any person violating any of the provisions of Chapter 20 of the General Statutes in or on these streets, alleys, or driveways shall upon conviction be punished as prescribed in that Chapter. This section does not interfere with the ownership and control of the streets, alleys, and driveways on the grounds as is now vested by law in the Department. (1949, c. 71, s. 2; 1955, c. 887, s. 1; 1959, c. 1028, s. 4; 1963, c. 1166, s. 10; 1973, c. 476, s. 133; 1985, c. 589, s. 2; 2011-145, s. 19.1(h); 2017-186, s. 2(qqqqq); 2021-180, s. 19C.9(p).)

§ 122C-403. Secretary's authority over Camp Butner reservation.

The Secretary shall administer the Camp Butner reservation except (i) those areas within the municipal boundaries of the Town of Butner and (ii) that portion of the Town of Butner's

extraterritorial jurisdiction consisting of lands not owned by the State of North Carolina. In performing this duty, the Secretary has the powers listed below. In exercising these powers the Secretary has the same authority and is subject to the same restrictions that the governing body of a city would have and would be subject to if the reservation was a city, unless this section provides to the contrary. The Secretary may do the following:

(1) Regulate airports on the reservation in accordance with the powers granted in Article 4 of Chapter 63 of the General Statutes.

(2) Take actions in accordance with the general police power granted in Article 8 of Chapter 160A of the General Statutes.

(3) Regulate the development of the reservation in accordance with the powers granted in Articles 7, 8, 11, and 12 and Parts 4 and 5 of Article 9 of Chapter 160D of the General Statutes. The Secretary shall not, however, grant a special use permit under Article 7 of that Chapter. In addition, the Secretary is not required to notify landowners of zoning classification actions under G.S. 160D-601, but the Secretary shall give the mayor of the Town of Butner at least 14 days' advance written notice of any proposed zoning change. The Secretary may establish a board to act like a Board of Adjustment to make recommendations to the Secretary concerning implementation of plans for the development of the reservation. When acting as a Board of Adjustment, the board is subject to subsections (c) and (d) of G.S. 160D-705 and subsections (f) and (g) of G.S. 160D-406.

(4) Establish one or more planning agencies in accordance with the power granted in G.S. 160D-301.

(5) Regulate streets, traffic, and parking on the reservation in accordance with the powers granted in Article 15 of Chapter 160A of the General Statutes.

(6) Control erosion and sedimentation on the reservation in accordance with the powers granted in G.S. 160D-922 and Article 4 of Chapter 113A of the General Statutes.

(7) Contract with and undertake agreements with units of local government in accordance with the powers granted in G.S. 160D-402 and Part 1 of Article 20 of Chapter 160A of the General Statutes.

(8) Regulate floodways on the reservation in accordance with the powers granted in G.S. 160D-923 and Part 6 of Article 21 of Chapter 143 of the General Statutes.

(8a) Repealed by Session Laws 2007-269, s. 4. For effective date, see editor's note.

(9) Assign duties given by the statutes listed in the preceding subdivisions to a local official to the Secretary's designee.

(9a) Repealed by Session Laws 2007-269, s. 4. For effective date, see editor's note.

(10) Adopt rules to carry out the purposes of this Article. (1949, c. 71, s. 3; 1955, c. 887, s. 1; 1959, c. 1028, s. 4; 1963, c. 1166, s. 10; 1965, c. 933; 1973, c. 476, s. 133; 1985, c. 589, s. 2; 1987, c. 536, s. 2; 1995 (Reg. Sess., 1996), c. 667, s. 3; 1997-59, s. 5; 1997-443, s. 11A.118(a); 1999-140, s. 4; 2007-269, s. 4; 2015-160, s. 3; 2022-62, s. 15.)

§ 122C-404: Repealed by Session Laws 1995 (Regular Session, 1996), c. 667, s. 4.

§ 122C-405. Procedure applicable to rules.

Rules adopted by the Secretary under this Article shall be adopted in accordance with the procedures for adopting a city ordinance on the same subject, shall be subject to review in the manner provided for a city ordinance adopted on the same subject, and shall be enforceable in accordance with the procedures for enforcing a city ordinance on the same subject. Violation of a rule adopted under this Article is punishable as provided in G.S. 122C-406.

Rules adopted under this Article may apply to part or all of the Camp Butner Reservation, except those areas within the municipal boundaries of the Town of Butner and that portion of the Town of Butner's extraterritorial jurisdiction consisting of lands not owned by the State of North Carolina. If a public hearing is required before the adoption of a rule, Advisory the Secretary shall designate one or more employees of the Department to conduct the hearing. The Butner Town Council shall receive at least 14 days' advance written notice of any public hearing with all correspondence concerning such public hearings to be directed to the mayor of the Town of Butner and sent by certified mail, return receipt requested, or equivalent delivery service to Butner Town Hall. (1949, c. 71, s. 4; 1963, c. 1166, s. 10; 1973, c. 476, s. 133; 1981, c. 614, s. 6; 1985, c. 589, s. 2; 1987, c. 536, s. 4; c. 720, s. 3; 1995 (Reg. Sess., 1996), c. 667, s. 5; 1997-59, s. 6; 1999-140, s. 5; 2007-269, s. 5.)

§ 122C-406. Violations made misdemeanor.

A person who violates an ordinance or rule adopted under this Part is guilty of a Class 3 misdemeanor. (1949, c. 71, s. 5; 1985, c. 589, s. 2; 1993, c. 539, s. 927; 1994, Ex. Sess., c. 24, s. 14(c).)

§ 122C-407. Water and sewer system.

(a) The Department may acquire, construct, establish, enlarge, maintain, operate, and contract for the operation of a water supply and distribution system and a sewage collection and disposal system for the Camp Butner Reservation, and may enter into such contracts, memoranda of understanding, and other agreements with other persons or entities, including, but not limited to, local governments, authorities, and private enterprises, reasonably necessary to extend or otherwise provide water and sewer service to any portion of the Camp Butner Reservation.

(b) Those things authorized by subsection (a) of this section may be operated for the benefit of persons and property within the Camp Butner reservation and areas outside the reservation within reasonable limitations specifically including any sanitary district, water and sewer authority, county water and sewer district, or municipality in Durham or Granville Counties.

(c) The Secretary may fix and enforce water and sewer rates and charges in accordance with G.S. 160A-314 as if it were a city. (1985, c. 589, s. 2; 2007-269, s. 6.)

§ 122C-408. Former Butner Public Safety Authority; jurisdiction; fire and police protection.

(a) Police and Fire Protection. – The Town of Butner may contract with the State of North Carolina or any state agency for the provision of special police officers or fire protection or both to any State or federal institution or lands within the territory of the Camp Butner Reservation. The territorial jurisdiction of these officers shall consist of the property shown on a map produced May 20, 2003, by the Information Systems Division of the North Carolina General Assembly and kept on file in the office of the Butner Town Manager and such additional areas which are within the incorporated limits of the Town of Butner as shown on a map to be kept in the office of the Butner Town Manager.

(b) Authority of Special Police Officers. – In order to assist the Town of Butner in providing contractual services to State agencies and facilities within the territorial jurisdiction set out in subsection (a) of this section, the officers providing police services to the Town of Butner shall have the additional authority set out in this subsection. After taking the oath of office required for law-enforcement officers, the special police officers authorized by this section shall have the authority of deputy sheriffs of Durham and Granville Counties in those counties respectively. Within the territorial jurisdiction stated in subsection (a) of this section, the special police officers have the authority to enforce the laws of North Carolina, the ordinances of the Town of Butner, and any rule applicable to the Camp Butner Reservation adopted under authority of this Part or under G.S. 143-116.6 or G.S. 143-116.7 or under the authority granted any other agency of the State and also have the powers set forth for firemen in Articles 80, 82, and 83 of Chapter 58 of the General Statutes. Notwithstanding the foregoing, the Town of Butner has no obligation or responsibility to provide law enforcement or fire protection services outside of the corporate limits of the Town of Butner except pursuant to a contract with a State agency or facility, a federal entity, or a private person or entity. In the event that any State agency contracts with the Town of Butner for police services at any facility within the territorial jurisdiction described in subsection (a) of this section, any civil or criminal process to be served on any individual confined at any such State facility may be forwarded by the sheriff of the county in which the process originated to the director or chief of the Town of Butner's law enforcement department or that officer's designee. (1949, c. 71, s. 6; 1955, c. 887, s. 1; 1959, c. 35; c. 1028, s. 4; 1963, c. 1166, s. 10; 1973, c. 476, s. 133; 1981, c. 491, s. 1; c. 964, s. 19; c. 1127, s. 49; 1983, c. 761, s. 165; 1985, c. 589, s. 2; 1987, c. 827, s. 246; 1989, c. 141, s. 16; 2003-346, s. 2; 2007-269, s. 7; 2011-145, ss. 19.1(g), (jj), 19.3(b); 2011-260, ss. 1, 6(a), (b); 2011-391, s. 43(m); 2012-50, ss. 1-3; 2013-360, s. 16B.4(b).)

§ 122C-409. Community of Butner comprehensive emergency management plan.

The Department of Public Safety shall establish an emergency management agency as defined in G.S. 166A-19.3(9) for the Camp Butner Reservation, and the Town of Butner. (1985, c. 589, s. 2; 2007-269, s. 8; 2011-145, s. 19.1(g); 2012-12, s. 2(r).)

§ 122C-410. Authority of county or city over Camp Butner Reservation; zoning jurisdiction by Town of Butner over State lands.

(a) A municipality other than the Town of Butner may not annex territory extending into or extend its extraterritorial jurisdiction into the Camp Butner reservation without written approval from the Secretary and the Butner Town Council of each proposed annexation or extension. The Town of Butner may not annex territory extending into or extend its extraterritorial jurisdiction into those portions of the Camp Butner Reservation owned by the State of North Carolina without written approval from the Secretary of each proposed annexation or extension. The procedures, if any, for withdrawing approval granted by the Secretary to an annexation or extension of extraterritorial jurisdiction shall be stated in the notice of approval.

(b) A county ordinance may apply in part or all of the Camp Butner reservation (other than areas within the Town of Butner) if the Secretary gives written approval of the ordinance, except that ordinances adopted by a county under Chapter 160D of the General Statutes may not apply in the extraterritorial jurisdiction of the Town of Butner without approval of the Butner Town Council. The Secretary may withdraw approval of a county ordinance by giving written notification, by certified mail, return receipt requested, to the county. A county ordinance ceases to be effective in the Camp Butner reservation 30 days after the county receives the written notice of

the withdrawal of approval. This section does not enhance or diminish the authority of a county to enact ordinances applicable to the Town of Butner and its extraterritorial jurisdiction.

(c) Notwithstanding any other provision of this Article, no portion of the lands owned by the State as of September 1, 2007, which are located in the extraterritorial jurisdiction or the incorporated limits of the Town of Butner shall be subject to any of the powers granted to the Town of Butner pursuant to Chapter 160D of the General Statutes except as to property no longer owned by the State. If any portion of such property owned by the State of North Carolina as of September 1, 2007, is no longer owned by the State, the Town of Butner may exercise all legal authority granted to the Town pursuant to the terms of its charter or by Chapter 160D of the General Statutes and may do so by ordinances adopted prior to the actual date of transfer. Before the State shall dispose of any property inside the incorporated limits of the Town of Butner or any of that property currently under the control of the North Carolina Department of Health and Human Services or the North Carolina Department of Agriculture and Consumer Services within the extraterritorial jurisdiction of the Town of Butner, southeast of Old Highway 75, northeast of Central Avenue, southwest of 33rd Street, and northwest of "G" Street, by sale or lease for any use not directly associated with a State function, the Town of Butner shall first be given the right of first refusal to purchase said property at fair market value as determined by the average of the value of said property as determined by a qualified appraiser selected by the Secretary and a qualified appraiser selected by the Town of Butner. (1987, c. 536, s. 5; 2007-269, s. 9; 2022-62, s. 16.)

§ 122C-411: Repealed by Session Laws 2011-260, s. 2, effective June 23, 2011.

§ 122C-411.1: Repealed by Session Laws 1996, Second Extra Session, c. 18, s. 21.4.

Part 1A. Butner Planning Council.

§ 122C-412. Repealed.

§ 122C-412.1. Repealed.

§ 122C-412.2. Repealed.

Part 1B. Butner Advisory Council.

§ 122C-413: Repealed by Session Laws 2007-269, s. 10. For effective date, see Editor's note.

§ 122C-413.1: Repealed by Session Laws 2007-269, s. 10. For effective date, see Editor's note.

Part 1D. Butner Commissions.

§ 122C-414: Repealed by Session Laws 2011-260, s. 2, effective June 23, 2011.

§ 122C-415: Repealed by Session Laws 2011-266, s. 1.5, effective July 1, 2011.

§ 122C-416. Reserved for future codification purposes.

§ 122C-417. Reserved for future codification purposes.

§ 122C-418. Reserved for future codification purposes.

§ 122C-419. Reserved for future codification purposes.

§ 122C-420. Reserved for future codification purposes.

Part 2. Black Mountain Center and Julian F. Keith Alcohol and Drug Abuse Treatment Center Joint Security Force.

§ 122C-421. Joint security force.

(a) The Secretary may designate one or more special police officers who shall make up a joint security force to enforce the law of North Carolina and any ordinance or regulation adopted pursuant to G.S. 143-116.6 or G.S. 143-116.7 or pursuant to the authority granted the Department by any other law on the territory of the Black Mountain Center and the Julian F. Keith Alcohol and Drug Abuse Treatment Center in Buncombe County. After taking the oath of office for law enforcement officers as set out in G.S. 11-11, these special police officers have the same powers as peace officers now vested in sheriffs within the territory embraced by the named centers. These special police officers may arrest persons outside the territory of the named centers but within the confines of Buncombe County when the person arrested has committed a criminal offense within that territory, for which the officers could have arrested the person within that territory, and the arrest is made during the person's immediate and continuous flight from that territory.

(b) These special police officers may exercise any and all of the powers enumerated in this Part upon or in pursuit from the property formerly occupied by the Black Mountain Center and now occupied by the Department of Adult Correction. These special police officers shall exercise said powers upon the property transferred to the Department of Adult Correction only by agreement of the Department of Adult Correction and the Department of Health and Human Services.

(c) Upon assignment by the Secretary, or Secretary's designee, to any State-operated facility pursuant to G.S. 122C-183, these special police officers may exercise the same power enumerated in this Part within the territory of the named facility and within the county in which the facility is located. (1983 (Reg. Sess., 1984), c. 1116, s. 30; 1985, c. 408, ss. 3, 5; c. 589, s. 2; 1995, c. 391, s. 3; 1997-320, s. 2; 1997-443, s. 11A.118(a); 1998-202, s. 13(gg); 2011-145, s. 19.1(h); 2017-186, s. 2(rrrrr); 2019-240, s. 19(b); 2021-180, s. 19C.9(qqq).)

§§ 122C-422 through 122C-429. Reserved for future codification purposes.

Part 2A. Broughton Hospital, Western Regional Vocational Rehabilitation Facility, and J. Iverson Riddle Developmental Center Joint Security Force.

§ 122C-430. Joint security force.

(a) The Secretary may designate one or more special police officers who shall make up a joint security force to enforce the law of North Carolina and any ordinance or regulation adopted pursuant to G.S. 143-116.6 or G.S. 143-116.7 or pursuant to the authority granted the Department by any other law on the territory of the Broughton Hospital, Western Regional Vocational Rehabilitation Facility, J. Iverson Riddle Developmental Center, and the surrounding grounds and land adjacent to Broughton Hospital allocated to the Department of Agriculture and Consumer Services, all in Burke County. After taking the oath of office for law enforcement officers as set out in G.S. 11-11, these special police officers have the same powers as peace officers now vested in sheriffs within the territory embraced by the named facilities. These special police officers may arrest persons outside the territory of the named institutions but within the confines of Burke

County when the person arrested has committed a criminal offense within that territory for which the officers could have arrested the person within that territory, and the arrest is made during the person's immediate and continuous flight from that territory.

(b) Upon assignment by the Secretary, or Secretary's designee, to any State-operated facility pursuant to G.S. 122C-183, these special police officers may exercise the same power enumerated in this Part within the territory of the named facility and within the county in which the facility is located. (1997-320, s. 1; 2007-177, s. 3; 2008-187, s. 30; 2019-240, s. 19(c).)

§ 122C-430.1: Reserved for future codification purposes.

§ 122C-430.2: Reserved for future codification purposes.

§ 122C-430.3: Reserved for future codification purposes.

§ 122C-430.4: Reserved for future codification purposes.

§ 122C-430.5: Reserved for future codification purposes.

§ 122C-430.6: Reserved for future codification purposes.

§ 122C-430.7: Reserved for future codification purposes.

§ 122C-430.8: Reserved for future codification purposes.

§ 122C-430.9: Reserved for future codification purposes.

Part 2B. Cherry Hospital and O'Berry Neuro-Medical Treatment Center Joint Security Force.

§ 122C-430.10. Joint security force.

(a) The Secretary may designate one or more special police officers who shall make up a joint security force to enforce the law of North Carolina and any ordinance or regulation adopted pursuant to G.S. 143-116.6 or G.S. 143-116.7 or pursuant to the authority granted the Department by any other law on the territory of the Cherry Hospital and the O'Berry Neuro-Medical Treatment Center in Wayne County. After taking the oath of office for law enforcement officers as set out in G.S. 11-11, these special police officers have the same powers as peace officers now vested in sheriffs within the territory of the Cherry Hospital. These special police officers shall also have the power prescribed by G.S. 122C-205 outside the territory of the Cherry Hospital and the O'Berry Neuro-Medical Treatment Center but within the confines of Wayne County. These special police officers may arrest persons outside the territory of the Cherry Hospital but within the confines of Wayne County, when the person arrested has committed a criminal offense within the territory of the Cherry Hospital and the O'Berry Neuro-Medical Treatment Center, for which the officers could have arrested the person within that territory, and the arrest is made during the person's immediate and continuous flight from that territory.

(b) Upon assignment by the Secretary, or Secretary's designee, to any State-operated facility pursuant to G.S. 122C-183, these special police officers may exercise the same power enumerated in this Part within the territory of the named facility and within the county in which the facility is located. (2001-125, s. 1; 2019-240, s. 19(d).)

§ 122C-430.11: Reserved for future codification purposes.

§ 122C-430.12: Reserved for future codification purposes.

§ 122C-430.13: Reserved for future codification purposes.

§ 122C-430.14: Reserved for future codification purposes.

§ 122C-430.15: Reserved for future codification purposes.

§ 122C-430.16: Reserved for future codification purposes.

§ 122C-430.17: Reserved for future codification purposes.

§ 122C-430.18: Reserved for future codification purposes.

§ 122C-430.19: Reserved for future codification purposes.

Part 2C. Dorothea Dix Hospital Joint Security Force.

§ 122C-430.20: Repealed by Session Laws 2019-240, s. 19(e), effective November 6, 2019.

§ 122C-430.21: Reserved for future codification purposes.

§ 122C-430.22: Reserved for future codification purposes.

§ 122C-430.23: Reserved for future codification purposes.

§ 122C-430.24: Reserved for future codification purposes.

§ 122C-430.25: Reserved for future codification purposes.

§ 122C-430.26: Reserved for future codification purposes.

§ 122C-430.27: Reserved for future codification purposes.

§ 122C-430.28: Reserved for future codification purposes.

§ 122C-430.29: Reserved for future codification purposes.

Part 2D. Long Leaf Neuro-Medical Treatment Center and Eastern North Carolina School for the Deaf Joint Security Force.

§ 122C-430.30. Joint security force.

(a) The Secretary may designate one or more special police officers who shall make up a joint security force to enforce the law of North Carolina and any ordinance or regulation adopted pursuant to G.S. 143-116.6 or G.S. 143-116.7 or pursuant to the authority granted the Department

by any other law on the territory of the Long Leaf Neuro-Medical Treatment Center in Wilson County. After taking the oath of office for law enforcement officers as set out in G.S. 11-11, these special police officers have the same powers as peace officers now vested in sheriffs within the territory embraced by the Long Leaf Neuro-Medical Treatment Center. These special police officers may arrest persons outside the territory of the Long Leaf Neuro-Medical Treatment Center, but within the confines of Wilson County when the person arrested has committed a criminal offense within that territory for which the officers could have arrested the person within that territory, and the arrest is made during the person's immediate and continuous flight from that territory.

(b) These special police officers may exercise any and all of the powers enumerated in this Part upon the property of, or in pursuit from, the Eastern North Carolina School for the Deaf only by agreement of the Department of Public Instruction and the Department of Health and Human Services.

(c) Upon assignment by the Secretary, or Secretary's designee, to any State-operated facility pursuant to G.S. 122C-183, these special police officers may exercise the same power enumerated in this Part within the territory of the named facility and within the county in which the facility is located. (2009-315, s. 3; 2019-240, s. 19(f).)

Part 3. North Carolina Alcoholism Research Authority.

§ 122C-431. North Carolina Alcoholism Research Authority created.

(a) The North Carolina Alcoholism Research Authority is created and shall consist of and be governed by a nine-member board to be appointed by the Governor. Three of the members shall be appointed for a two-year term, three shall be appointed for a four-year term and three shall be appointed for a six-year term; thereafter all appointments shall be for terms of six years. Any vacancy occurring in the membership of the board shall be filled by the Governor for the unexpired term.

(b) The board shall elect one of its members as chairman and one as vice-chairman. The director of the Center for Alcohol Studies of The University of North Carolina at Chapel Hill shall serve ex officio as executive secretary to the Authority. Board members shall receive the same per diem, subsistence, and travel allowances as members of similar State boards and commissions, provided funds are available in the "Alcoholism Research Fund" for this purpose. (1973, c. 682, ss. 1, 2; 1985, c. 589, s. 2.)

§ 122C-432. Authorized to receive and spend funds.

The Authority may receive funds from State, federal, private, or other sources. These funds shall be held separately and designated as the "Alcoholism Research Fund". The Authority shall spend the Fund on research as to the causes and effects of alcohol abuse and alcoholism and for the training of alcohol research personnel. Expenditures for the purposes specified in this section shall be made as grants to nonprofit corporations, organizations, agencies, or institutions engaging in such research or training. The Authority may also pay necessary administrative expenses from the Fund. (1973, c. 682, s. 3; 1985, c. 589, s. 2.)

§ 122C-433. Applications for grants; promulgation of rules.

(a) Applications for grants are processed by the Center for Alcohol Studies. All applications shall be reviewed by scientific consultants to the Center; and the Center, after review

and study, shall make recommendations to the Authority as to the awarding of grants. The Center shall also furnish to the Authority clerical assistance as may be required.

(b) The Authority shall adopt rules relative to applications for grants, the reviewing of grants and awarding of grants. (1973, c. 682, ss. 4, 5; 1985, c. 589, s. 2.)

§ 122C-434: Reserved for future codification purposes.

§ 122C-435: Reserved for future codification purposes.

§ 122C-436: Reserved for future codification purposes.

§ 122C-437: Reserved for future codification purposes.

§ 122C-438: Reserved for future codification purposes.

§ 122C-439: Reserved for future codification purposes.

§ 122C-440: Reserved for future codification purposes.

§ 122C-441: Reserved for future codification purposes.

§ 122C-442: Reserved for future codification purposes.

§ 122C-443: Reserved for future codification purposes.

§ 122C-444: Reserved for future codification purposes.

§ 122C-445: Reserved for future codification purposes.

§ 122C-446: Reserved for future codification purposes.

§ 122C-447: Reserved for future codification purposes.

§ 122C-448: Reserved for future codification purposes.

§ 122C-449: Reserved for future codification purposes.

Part 4. Educational Services in Private Psychiatric Residential Treatment Facilities.

§ 122C-450. Definitions.

The following definitions apply in this Part:

(1) "Educational services" means appropriate education-related assessment and instruction provided to any child residing in a private psychiatric residential treatment facility, including special education and related services to a child with a disability as defined in G.S. 115C-106.3(1). An education-related assessment includes the determination of need for special education and related services.

(2) "Nonpublic Exceptional Children's Program" means a facility-based school that meets all of the following criteria:

a. Provides at least one teacher for every 14 students. The PRTF shall report exceptions to this requirement to (i) the Division of Mental Health, Developmental Disabilities, and Substance Use Services (MH/DD/SUS) to request additional funding for educational services as provided under G.S. 122C-451(d) to the extent that funds are available and, if funds are not available, (ii) the Department of Public Instruction to request a waiver from this requirement.

b. Provides at least one teacher with a North Carolina Professional Educator license in special education, if there is a child with a disability as defined in G.S. 115C-106.3(1) residing in the PRTF.

c. Registers with the Department of Administration, Division of Nonpublic Schools, under Article 39 of Chapter 115C of the General Statutes.

d. Has been approved by the Department of Public Instruction to provide educational services as promulgated by the rules adopted by the State Board of Education pursuant to the Administrative Procedures Act.

(3) "Private psychiatric residential treatment facility" (PRTF) means a facility, other than a hospital, that provides psychiatric and other behavioral health services as described in Subpart D of C.F.R. Part 441 of Chapter 42 to individuals under age 21 in an inpatient setting licensed by the Department of Health and Human Services as provided under Chapter 122C of the General Statutes. A PRTF does not include a State-operated facility. (2014-100, s. 8.39(e); 2023-65, ss. 5.2(b), (c).)

§ 122C-451. Eligibility and allocations.

(a) A child who is receiving psychiatric and other behavioral health services in a PRTF shall also receive educational services in accordance with federal and State law, if the child is eligible to enroll in public schools as provided in G.S. 115C-366, including a student who has been suspended or expelled but otherwise meets the requirements of that statute. For a child with a disability, as defined in G.S. 115C-106.3(1), who has been placed in a PRTF, all educational services shall meet applicable standards as required under Article 9 of Chapter 115C of the General Statutes.

(b) A PRTF shall be qualified to receive a funding allocation, to the extent that funds are available from the Department of Health and Human Services, to provide educational services if the following conditions are met:

(1) The PRTF is licensed by the Department of Health and Human Services pursuant to Chapter 122C of the General Statutes and has a facility-based school approved by the Department of Public Instruction as a Nonpublic Exceptional Children's Program.

(2) The PRTF documents deviations from educational and other programmatic requirements when it is medically necessary for a resident in accordance with G.S. 122C-62(e).

(c) A PRTF that meets the qualification standards required in subsection (b) of this section may enter into an educational services contract, to the extent that funds are available, with a local

school administrative unit to assist in the delivery of educational services to the children in the PRTF. The contract shall clearly define the education-related assessment, instruction, and legal responsibilities of both parties engaging in the educational services contract. A PRTF entering into an educational services contract with a local school administrative unit shall submit the educational services contract to both the Department of Public Instruction and the Department of Health and Human Services for inclusion in any required reports to the General Assembly regarding the provision of educational services to children in PRTFs.

(d) To the extent that funds are available in the Department of Public Instruction for the delivery of educational services in PRTFs as provided in this Part, those funds shall be transferred to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMH/DD/SUS). The funds transferred for the purchase of educational services within the PRTF shall not be allocated to LME/MCOs but shall be held in reserve at the DMH/DD/SUS. The DMH/DD/SUS shall use the reserve funds to pay for educational services authorized by the Department of Public Instruction and billed by the PRTFs in a process established by the DMH/DD/SUS. The funds transferred to the DMH/DD/SUS pursuant to this section shall be allocated to the PRTFs for educational services in a manner determined by the Department of Health and Human Services and the Department of Public Instruction in a Memorandum of Understanding or a Memorandum of Agreement. The Department of Health and Human Services shall disburse for these purposes only those funds transferred from the Department of Public Instruction.

(e) The Department of Health and Human Services shall cease disbursement of educational funding to a PRTF upon receipt of a written notice from the Department of Public Instruction that educational services have not been provided. Educational funding disbursement shall be reinstated by the Department of Health and Human Services upon written notice from the Department of Public Instruction that the PRTF is providing educational services.

(f) A PRTF that receives educational funding shall comply with all audit and accounting policies applicable to other public and private entities receiving public funding. (2014-100, s. 8.39(e); 2023-65, s. 5.2(b), (c).)

§ 122C-452. Information sharing.

(a) Within three business days of admitting a child into a PRTF, the admitting PRTF shall notify (i) the Department of Public Instruction and (ii) the local school administrative unit in which the child was last enrolled, if known. The PRTF shall request a copy of the child's most current Individualized Education Program and any other available documents related to the provision of appropriate educational services from the local school administrative unit. To the extent practicable, the local school administrative unit shall provide this information within three business days of receiving a request made pursuant to this subsection. Upon withdrawal or discharge of a child, the PRTF shall notify the Department of Public Instruction within three business days of such withdrawal or discharge.

(b) The PRTF and the receiving local school administrative unit shall work together to develop a transition plan, including a revised Individualized Education Program, if necessary, to be implemented upon discharge of the child residing in a PRTF. (2014-100, s. 8.39(e).)

§ 122C-453. Technical assistance and monitoring.

The State Board of Education and the Department of Public Instruction shall (i) offer training to PRTFs on compliance with special education laws and regulations, (ii) maintain a current list of

names of children residing in PRTFs along with the name and contact information of the PRTF in which each child resides, and (iii) develop and implement rules to monitor the delivery of educational services in PRTFs, including a process to inform the Department of Health and Human Services when services are not being provided. The Department of Health and Human Services shall appropriately enforce applicable licensing requirements as provided under G.S. 122C-23.1. (2014-100, s. 8.39(e).)

§ 122C-454. Reporting requirement.

The Department of Health and Human Services and the Department of Public Instruction, in collaboration with other interested agencies, shall submit, by January 15 of each year, a joint report to the Joint Legislative Education Oversight Committee and to the Joint Legislative Oversight Committee on Health and Human Services on the delivery of educational services in PRTFs, including (i) the annual number of children by age residing in a PRTF both with and without an Individualized Education Program, (ii) the average length of stay of these children, (iii) the types of educational services, including number of hours each type of service has been provided, (iv) the costs and outcomes of providing educational services, and (v) recommendations for improving the efficiency and effectiveness of delivering educational services to children residing in PRTFs. (2014-100, s. 8.39(e).)

Part 5. Traumatic Brain Injury And Posttraumatic Stress Disorder Services for Veterans.

§ 122C-465. Definitions.

As used in this Part, the following definitions apply:

(1) Authorized medical professional. – A doctor of medicine, nurse practitioner, physician assistant, or doctor of osteopathy licensed to practice in this State.

(2) Hyperbaric oxygen therapy treatment. – Treatment with a valid prescription from an authorized medical professional in either a hyperbaric chamber approved by the United States Food and Drug Administration (FDA), or a device with an appropriate FDA-approved investigational device exemption.

(3) Veteran. – A person who served on active duty, other than for training, in any component of the Armed Forces of the United States for a period of 180 days or more, unless released earlier because of service-connected disability, and who was discharged or released from the Armed Forces of the United States under other than dishonorable conditions. (2019-175, s. 2(b).)

§ 122C-466. Hyperbaric oxygen therapy treatment authorized.

(a) No person other than an authorized medical professional shall prescribe hyperbaric oxygen therapy treatment to a veteran for the treatment of traumatic brain injury or posttraumatic stress disorder. Any authorized medical professional who prescribes hyperbaric oxygen therapy treatment to a veteran for traumatic brain injury or posttraumatic stress disorder shall do so in a manner that complies with the standard approved treatment protocols for this therapy.

(b) Any veteran residing in North Carolina who has been diagnosed with a traumatic brain injury or posttraumatic stress disorder by an authorized medical professional may receive hyperbaric oxygen therapy treatment in this State. (2019-175, s. 2(b).)