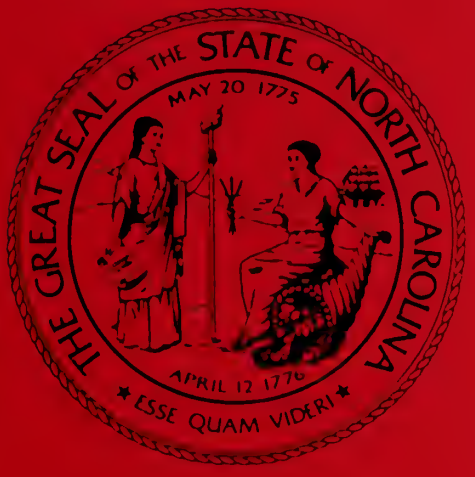
North Carolina
Mental Health Study Commission



Final Report and Recommendations

February, 1987

North Carolina

MENTAL HEALTH STUDY COMMISSION

Final Report and Recommendations
To The Governor and
The 1987 General Assembly

Senator Kenneth C. Royall, Jr., Co-Chairman
Representative Chris S. Barker, Jr., Co-Chairman
Representative Anne Barnes
Representative Daniel T. Blue
Mr. Sam Carter
Representative James W. Crawford, Jr.
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Mr. David Stewart
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Senator Lura Tally
Senator Russell Walker
Senator Marvin Ward

February 1987

State of North Carolina

Mental Health Study Commission

February, 1987

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Dear Governor, Members of the 1987 General Assembly and
Citizens Interested in the Delivery of
Mental Health, Mental Retardation and Substance
Abuse Services

This document includes the 1987 final report and recommendations of the North Carolina Mental Health Study Commission. As co-chairmen we would like to sincerely thank the members of the Commission for their many hours of thoughtful deliberation. It is through these hours spent in meetings and at public hearings that concerns and problems related to the delivery of mental health, mental retardation, and substance abuse services can be solved. We would also like to thank the staff of the Division of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Human Resources who provided valuable assistance in addressing the issues before the Study Commission.

The reports of two of the special studies undertaken by the Commission were initially developed by special Commission appointed ad hoc task groups. The professionals and citizens who served on these working groups deserve a special acknowledgement for their dedication and a special statement of appreciation for their work.

We would also like to acknowledge the more than sixty individuals who took time from their work and families to appear before the Commission at public hearings held in Morganton and Greenville.

On behalf of all who participated so actively in the development of these recommendations, we urge each reader's support.

Sincerely yours,

Kenneth C. Royall, Jr.
Senate Co-Chairman

Chris S. Barker, Jr.
House Co-Chairman

OFFICERS: Senator Kenneth C. Royall, Jr., Co-Chairman and Representative Chris S. Barker, Jr., Co-Chairman.
SENATORS: Harold Hardison, Ollie Harris, William Martin, Helen Marvin, Bill Redman, Lura Tally, Russell Walker and Marvin Ward.
REPRESENTATIVES: Anne Barnes, Jim W. Crawford, C. B. Hauser, Maggie Keesee-Farrester, Martin Lancaster, Sidney Locks, Edith Lutz and Frank Rhodes.
CITIZENS: Mr. Sam Carter, Mr. Grady Hunter, Mr. V. B. (Hawk) Jahnsan, Dr. Jeanne Margaret McNally, Dr. Ira Smith and Mr. David Stewart.

Synopsis

Chapter 792 (Part IX), 1985 Session Laws (see Appendix A, p. 25), authorized the continuation of the Mental Health Study Commission until June 30, 1987 and directed the Commission to study, in addition to other studies authorized by law, (1) the funding of area authorities; and (2) child mental health services, including the juvenile [sic] admissions law. In the fall of 1985 when the Commission began its work, it adopted a work plan that concentrated efforts in these two specific areas of study, but also allowed for follow-up on two issues of previous interest to the Commission and consideration of other matters that might be raised at public hearings scheduled for the fall of 1986.

Over the last several years members of the General Assembly had received complaints about funding policies for area authorities. Issues raised included an apparent inequitable distribution of State funds between areas, lack of flexibility, claims of excessive paper work and concerns regarding the general inadequacy of resources to meet the needs for services across the State. The Commission spent several meetings trying to learn about and understand the realities and causes of these concerns.

In the summer of 1986 the Commission appointed an ad hoc Committee on Funding Policy Development that consisted of representatives of six different types of constituencies which have an interest in funding policies for area authorities. This FPD Committee presented a preliminary report to the Commission in September, 1986, and was directed to continue its deliberations to further refine its report.

The Final Report of the FPD Committee was submitted to the Commission in December, 1986 (see Appendix C, p. 27). After serious consideration and a couple of amendments, the report and recommendations were adopted by the Commission as its recommendations to the Governor and the General Assembly regarding funding policies (see Appendix D, p. 62).

At the same time that the Commission was investigating the nature and causes of funding policy problems, an ad hoc Task Force on Child Mental Health (appointed by the Commission) was reviewing the current status of child mental health service delivery for children and adolescents with mental health problems who are not members of the Willie M. class. The CMH Task Force also reviewed some recommendations that had been made to the Commission regarding the statute that establishes the judicial review of admissions of minors to restrictive mental health or substance abuse facilities.

The CMH Task Force presented its report and recommendations to the Commission in April, 1986. The report included a proposed Child Mental Health Plan for the ten-year development of a comprehensive system of child mental health

services (see Appendix F, p. 66) and a proposed rewrite of the minors' admissions law (see Appendix H, p. 89). After receiving public review and comment and after making some adjustments to the Child Mental Health Plan, the Commission adopted the proposals as Commission recommendations to the Governor and the General Assembly.

Public review and comment on the Child Mental Health Plan also encouraged the Commission to consider the adoption of a similar, though specifically formulated, Youth Substance Abuse Plan. Because the Commission did not have time to develop the specifics for the Youth Substance Abuse Plan, it asked the Department of Human Resources, Division of Mental Health, Mental Retardation and Substance Abuse Services to develop the document and submit it to the Commission by March 1, 1987.

The Commission does recommend that both plans be adopted by resolution of the General Assembly as policy guidance for the development of services over the next ten years (see Appendix G, p. 88).

The Commission also received two special study reports on issues that had been of previous interest to the Commission. Specifically, in December 1986, the Commission reviewed the results of the 1985 authorized study of the Needs of the Developmentally Disabled and the 1984 directed study of the Implementation of S.B. 724--Chemical Dependency Legislation. The Commission report includes recommendations developed in response to these two study reports (see Appendices I, p. 99; J, p. 108; and L, p. 114).

Of the concerns expressed at the public hearings in the fall of 1986, the Commission elected to formulate specific recommendations regarding two issues: (1) Funding for the special autism living and training center (see Appendix K, p. 112); and (2) Psychiatric Hospitals and The Chronically Mentally Ill (see Appendix O, p. 136). While other issues and concerns were raised at the public hearings, the Commission did not believe that it had adequate background, information or understanding regarding those issues to allow it to develop specific recommendations.

Within the current recommendations of the Commission, several items will require continued oversight and study by the Commission as the General Assembly and administration take action on these items. The recommendations regarding the pioneer testing of funding policy changes, the implementation of the Child Mental Health and Youth Substance Abuse Plans and the issues regarding the Psychiatric Hospitals and the Chronically Mentally Ill all suggest further work by the Commission. Therefore, the final recommendation of the Commission is that the Mental Health Study Commission be continued for an additional two year period (to end June 30, 1989) for these purposes (see Appendix M, p. 115).

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Description of the Mental Health Study Commission

The Mental Health Study Commission was originally established by resolution of the General Assembly in 1973 to study the delivery of mental health, mental retardation, alcohol and other related services. The Commission has been reauthorized to continue every two years since its inception.

The makeup of the membership of the Commission has changed several times since the original Commission was established. During this particular tenure of the Commission, it has included twenty-four members, eight appointed each by the Governor, by the Lt. Governor and by the N. C. Speaker of the House. During the 1985-1987 period, the Commission has been co-chaired by Senator Kenneth C. Royall, Jr. (appointed by the Lt. Governor) and Representative Chris S. Barker, Jr. (appointed by the Speaker). Appendix B (p. 26) includes a list of all of the members who have served during this 1985-1987 tenure.

Introduction

The 1985 legislation that continued the Mental Health Study Commission (1985 Session Laws, Chapter 792, Part IX, see Appendix A, p. 25) directed the Commission to report to the Governor and the 1987 General Assembly regarding recommendations specific to its directed study in the areas of (1) funding policies for area mental health, mental retardation and substance abuse authorities and (2) child mental health services (including the minors' admissions law) and on any other areas related to its original purpose.

The Commission, in fact, is making recommendations not only in the areas of funding policies and child mental health, but also in the following additional areas: youth substance abuse services, services for persons with developmental disabilities and head trauma, special autism services, chemical dependency study results, and psychiatric hospitals and services for the chronically mentally ill. Finally, a recommendation is made to continue the Study Commission.

The recommendations regarding funding policies and child mental health were developed over months of concerted study by the Commission and two ad hoc task groups appointed by the Commission to assist in its efforts. The other recommendations were developed after reviewing comments received at one of two public hearings held in the fall of 1986, or after reviewing the results of special studies conducted on matters that had previously been initiated by the Study Commission. The background, rationale and description of each set of recommendations is presented in the narrative discussions in this report. Where necessary to implement specific recommendations, legislation is proposed and is presented in the appendices.

Funding Study

As mentioned in the introduction, the legislation that continued the Mental Health Study Commission until June 30, 1987, directed the Commission to study funding policies for area mental health, mental retardation and substance abuse authorities. In fact, during previous tenures (1977-79, 1979-81, 1983-85) the Commission had examined various portions of funding policies and had made some minor recommendations.

During the first six months of effort in this study, the Commission examined the current funding policies related to the delivery of mental health, mental retardation and substance abuse services by area authorities. Through its review of issues, problems and concerns the Commission identified the following as current funding policy problems that needed attention:

- variations in service availability both in types of services and in capacity of comparable programs; because of local authority, different priorities, different stages of development, and limited resources;
- "model" projects funded initially but without follow through to expand statewide;
- emphasis on categorical funding, with reduced proportion of area general funds thus limiting areas' ability to respond to local needs. Also categorical funds sometimes appropriated when an area may or may not have been ready to develop the particular service;
- program standards address how to provide a service rather than what to provide uniformly;
- budget priority process that leaves some areas without ability to meet local priority needs;
- an accountability/data system that does not allow meaningful statewide comparisons of either what is provided or what is needed;
- confusing messages about the roles of community programs as compared to State facilities.

In reviewing these problems it was acknowledged that the problems have occurred, not by design, but rather because of a series of piecemeal funding policies.

Due to the complexity of issues and concerns the Commission established the Committee on Funding Policy Development and requested that the Committee formulate a set of recommendations for the Commission's consideration. The FPD Committee was composed of representatives from six types of constituencies (legislators, administration officials, county officials, area officials, consumer organizations, and private contract providers). The Committee presented the Commission with a preliminary concept paper in September, 1986, and was asked to continue its work in order to further refine its proposals.

The Final Report of the Funding Policy Development Committee was presented to the Commission in December, 1986. The Commission made some adjustments to the report and adopted the revised report (see Appendix C, p. 27) as its final recommendations regarding funding policies for area authorities.

The report includes proposals for policy changes which, if adopted statewide, would have a marked impact on the delivery of services by area authorities and on the relationship between the State, the areas, and the counties. Because of this potential impact, which cannot be fully delineated at the present time, the report recommends that the concepts and policy changes be tested in five pioneer project sites selected by the Commission.

The funding concepts and policy recommendations to be tested in the pioneer project sites include:

1. Adoption of a Circle of Services that designates the Client/Service Type groups for which State funds may be used.

2. Adoption of Standardized Levels of Care which would be utilized to establish statewide equalization of service availability supported with State resources.

3. Development of a prospective unit cost reimbursement model of accounting with concomitant client information reporting.

4. Consideration of a variety of cost determination and cost sharing alternatives.

5. Adoption of new broader categories of funding with related flexibility rules and guidelines.

6. Adoption of standardized, but locally managed, quality assurance procedures and activities to be monitored by the State on an audit basis.

7. Incorporation of new guidelines for budget preparation and expansion budget development.

Even though representatives of the area authorities participated in the development of the recommendations, area directors and board members from some area programs have expressed concern regarding some of the specifics of the proposal. The North Carolina Council on Community Mental Health, Mental Retardation and Substance Abuse Programs submitted to the Commission (on January 21, 1987) a Resolution expressing concerns regarding the future development of the project (see Appendix E, p. 64). The Commission encourages the General Assembly to review the specifics of the resolution as it reviews the Pioneer Testing Plan during budget deliberations of the 1987 Session.

The Commission believes that these and other legitimate concerns will be addressed by the Division as it further plans implementation of the pioneer testing during the February-June, 1987 planning phase. As such, the Commission is hesitant to postpone consideration of pioneer testing for possibly another year, and therefore the Commission recommends that:

> The General Assembly adopt legislation authorizing the testing of the proposed funding concepts and policy recommendations in five pioneer sites beginning August 1987; and consider sites recommended by the Commission. (Appendix D, p. 62--Legislative Proposal #1)

And, the Commission recommends that:

> Funding of area authorities during "transition" (between pioneer testing and any statewide implementation) be made consistent with the recommendations incorporated in the Final Report of the Funding Policy Development Committee (see Appendix C, pp. 35-36).

It is assumed that the Joint Appropriations Committee will not only review the recommendations as they are included in this report and as they may be adjusted through Division and project site planning, but also will welcome public comment not only from the Council but from other constituency organizations which will ultimately be affected by funding policy changes. Furthermore, it is recommended that:

> Progress on the pioneer testing be reported by the Department to the Mental Health Study Commission on a regular basis and that there be no statewide implementation prior to further General Assembly review.

Child Mental Health Plan

The Commission was directed by Chapter 792, Part IX, to study Child Mental Health Services, including the juvenile [sic] admissions law. This direction had originated with the 1983-85 Commission because it had received a proposal to revise the judicial review procedures for admission of minors to restrictive treatment facilities and because Commission members had become concerned about the many children and adolescents who did not qualify as Willie M. class members but were in need of mental health treatment.

Acknowledging that a meaningful assessment of current services, service overlaps and service gaps could best be conducted by professionals, interest groups and interested citizens, the Commission appointed a Child Mental Health Task Force to conduct the study and formulate proposed recommendations for the Commission's consideration.

The Child Mental Health Task Force presented its final report to the Commission in April, 1986. The Commission sent the report to interested agencies, groups and individuals for review and comment. Numerous individuals appeared at the public hearings held in Morganton and Greenville in the fall of 1986.

In general, the 29 individuals who commented endorsed the adoption of the Child Mental Health Plan as policy guidance for the ten-year development of a comprehensive system of care for children and adolescents with mental health problems. The Commission reviewed specific suggestions that were made for changes and amended the plan in accordance with those it elected to support. The revised plan is presented in Appendix F (p.66). In revising the plan, the Commission also made adjustments to conform the funding recommendations of the plan with the recommendations of the Commission regarding funding policies.

In order for the Child Mental Health Plan to become an official North Carolina document, the Commission recommends that:

> The 1987 General Assembly adopt, by Resolution, the Child Mental Health Plan as policy guidance for the development of a comprehensive system of child mental health services over the next ten years. (Appendix G, p. 88--Legislative Proposal #2)

Youth Substance Abuse Plan

During the public hearings, the Commission received several recommendations not only supportive of the Child Mental Health Plan, but also suggesting the adoption of a similar, though specific, plan for the development of a comprehensive system of services for youth with substance abuse problems. Because of the timing of these suggestions, it was not feasible for the Commission to call on the Task Force or to develop, itself, such a document. The Commission, however, did agree that such a plan was desirable.

In order to accomplish the goal of development of a specific Youth Substance Abuse Plan, the Commission requested that the Department of Human Resources, Division of Mental Health, Mental Retardation and Substance Abuse Services develop the plan with input from relevant agencies and special interest groups. The Commission requested that the plan be submitted to the Commission by March 1, 1987.

Although the Commission itself will not have time to review the document in detail, it is assumed that the regular review conducted by relevant committees of the General Assembly will also provide adequate consideration and opportunity for public comment. Therefore, the Commission recommends that:

> The 1987 General Assembly adopt, by Resolution, the Youth Substance Abuse Plan as policy guidance for the development of a comprehensive system of youth substance abuse services over the next ten years. (Appendix G, p. 88--Legislative Proposal #2)

Minors' Admissions Law

As noted earlier in the discussion on Child Mental Health, one of the duties of the Commission which was delegated to the Child Mental Health Task Force for initial consideration was review of a specific proposal to change the judicial review procedures for review of admissions of minors to restrictive mental health or substance abuse treatment facilities. The initial proposal substituted a complex administrative review for the current judicial review.

The Child Mental Health Task Force, after receiving public input, elected not to support that proposal but rather to develop what it considered to be a "compromise" proposal. Legislative Proposal #3 (see Appendix H, p. 89) is the proposed "compromise" legislation developed by the Child Mental Health Task Force. The term "compromise" is presented in quotation marks because the proposal is a theoretical compromise, rather than a proposal to which differing constituencies have agreed.

The proposal is designed to continue the procedures of judicial review but to change the responsibilities of the counsel appointed to represent the minor in those hearings so that counsel is responsible to represent the "best interest" of the minor. The proposal also is designed to reduce the adversarial nature of the hearings by more clearly stating that the purpose of the hearing is a review of the admission rather than a commitment. Further changes are proposed in order to limit the authority of the presiding judge in setting the specific length of stay in the treatment facility so that the determining factor in length of stay is the professional judgement regarding the needs of the minor. In addition, the proposed rewrite clarifies procedures for handling situations when a minor in treatment reaches the age of majority.

Provisions are included to allow treatment facilities to provide their own transportation for minors to hearings and to eliminate the serving of court documents by law enforcement officers inside the treatment facility by requiring the counsel of the minor to be responsible for such documents. Finally, the proposal provides new discharge procedures including an allowance for parents or guardians to remove the minor from the facility if they so choose.

The Commission notes that it received comments at its public hearings questioning the advisability of changes related to counsel responsibility and limitations on judicial authority. However, the Commission considered that the arguments that were presented were too complex for the Commission to thoroughly evaluate in its limited timeframe. Furthermore, while the Commission believes that these specific changes should be recommended so that they can be debated through the legislative process, there are other

portions of the proposed legislation that received no controversial comment. Therefore, the Commission elected to forward to the General Assembly for its study and review the proposal as it was developed by the Child Mental Health Task Force. As such, the Commission recommends that:

> The 1987 General Assembly consider for adoption the proposed rewrite of the Minors' Admissions Law. (Appendix H, p. 89--Legislative Proposal #3)

Services for Persons with Developmental Disabilities and Head Trauma

Background

In 1985, the Mental Health Study Commission recommended legislation to the General Assembly that would have designated the Division of Mental Health, Mental Retardation and Substance Abuse Services as the lead State agency to be responsible for the needs assessment, design and development of services for persons with developmental disabilities and head trauma. This proposal had been developed in response to a significant amount of concern raised at public hearings held across the State between 1983 - 1985. The legislation proposed some statutory changes and requested an appropriation to establish case management responsibility with the area mental health, mental retardation and substance abuse authorities and to begin development of services. The proposal, however, was based on theoretical professional considerations of needs and not on specific data about needs for service as such data were unavailable.

The 1985 General Assembly was reticent to begin an initiative that would expand service responsibility at both the State and local level without adequate data regarding current or potential needs for service. As such, the General Assembly held final action on the legislation and appropriated funds to the Division of Mental Health, Mental Retardation and Substance Abuse Services to undertake a needs assessment study.

Study Summary

The Division contracted with the Model Services Project to conduct the needs assessment. The full report of that study is available in the Study Commission files.

The study included results from two types of data gathering. First, a specific questionnaire regarding services currently provided and services needed was completed by agency representatives from all types of local human service agencies and consumer organizations. Secondly, group meetings were held in thirteen subregions of the State where representatives from provider agencies, local government and consumer organizations together identified and prioritized the types of services most needed in their geographic areas.

This report was presented to the Mental Health Study Commission in December, 1986. In summary, the report highlighted several findings:

(a) A significant number (c. 100,000) of developmentally disabled and head trauma persons currently receive some limited services from a wide spectrum of local and State service agencies. Many of these individuals can

be considered underserved in that they do not receive all of the kinds of services that they currently need.

(b) A conservative estimate of the number of unserved persons is approximately 15,000. Of these, approximately 9752 persons were identified who have multiple disabilities and they require specialized interdisciplinary services.

(c) The survey projects the volume of specific types of services that are needed by this population [both from the questionnaire data and from the small group sessions].

(d) Services that are currently provided at the local level are fragmented and families do not have a specific agency to which they can turn for assistance in accessing an extremely complex set of agencies.

(e) At the State level there are a variety of agencies which either plan and manage (i) services of one particular type [e.g., evaluation by the Developmental Evaluation Centers]; or (ii) services for one subpopulation [e.g., the Mental Retardation Section of the Division of Mental Health, Mental Retardation and Substance Abuse Services]. While these agencies cooperate on project bases, there is no systematic, coordinated planning based on needs among all agencies.

Proposed Response

The Study Commission acknowledges the wisdom of the General Assembly in requesting that the needs assessment be conducted. The results have further reinforced the need for some special legislation that will focus responsibility for responding to persons with developmental disabilities and head trauma at both the local and the State levels. The results also provide the State with information about the specific priority needs of this population, such that specifically responsive services can be planned and developed.

The recommendation of the Study Commission is somewhat varied from the original proposal submitted in 1985. The study results that indicate the volume of services currently provided by a wide range of agencies suggest that State level responsibility must continue to be shared between a wide range of agencies. Rather than focus concentrated responsibility with one agency and, thus, create organizational confusion and possible dysfunction, it is suggested that there be a focused effort at better coordination in both planning and service delivery.

The Council on Developmental Disabilities, which includes consumer as well as agency representation, was originally established in 1973 to conform with federal requirements for the development of a "State Plan" and to monitor the expenditure of federal allocations to the State for the developmentally disabled. (The 1973 Council was adapted from the preceding Council on Mental Retardation and Developmental Disabilities and the preceding Council on Mental Retardation that was established in North Carolina by State statute originally in 1963.)

In 1973 the relative proportion of federal monies to State funds for services to the developmentally disabled was significantly higher than it is today. However, over the years the Council has concentrated its time and energy in responding to federal requirements. While those requirements continue to exist, the results of the needs assessment study indicate an extant need for greater coordination between State level service agencies regarding planning and development of services supported by State funds. Since all relevant State agencies participate on this Council, it seems appropriate that the Council's responsibility for this coordination be emphasized rather than delegating the responsibility to another existing agency or creating a new agency.

Therefore, the Study Commission recommends that:

a. The Council on Developmental Disabilities' duties and responsibilities be explicitly expanded to conduct needs analyses and coordination of planning and service development among all State agencies that provide State funded services to persons with developmental disabilities and head trauma. And, that the Council's responsibility be expanded to include persons with head trauma as well as the developmentally disabled. (Appendix I, p. 99--Legislative Proposal #4)

b. The Division of Mental Health, Mental Retardation and Substance Abuse Services be authorized to manage the delivery of and be responsible for planning and development of services to developmentally disabled and head trauma persons only for those types of services provided for the mentally retarded [which are the most prevalent subcategory of developmentally disabled]. (See recommendation below regarding service expansion.) (Appendix J, p. 108--Legislative Proposal #5)

c. Each State agency currently responsible for specific service types or specific subpopulations retain their current responsibility for service planning and delivery.

At the local level the issue is not only coordinated service planning and delivery but also simplification for families on how to access needed services. Currently, area mental health, mental retardation and substance abuse programs utilize local Interagency Councils to cooperatively plan and respond to the individual needs of persons with mental retardation. These Councils include representatives from numerous county level and regional agencies (and can be expanded to include other agency representatives), and they effectively function on a cooperative basis as a single source response to families of the mentally retarded. Because of this existing and effective structure, the Commission recommends that:

d. The area mental health, mental retardation and substance abuse authorities be considered as the local agency responsible for coordination of the delivery of services to persons with developmental disabilities and head trauma. (See also the recommendation below regarding service expansion.) (Appendix J, p. 108--Legislative Proposal #5)

In order to carry out this function and to work effectively through the Interagency Councils, the areas will need additional staff resources. Legislative Proposal #5 (see Appendix J, p. 108) includes resources for "developmental disability specialists" for each area to staff the Interagency Councils as they identify client problems and needs, develop individualized service plans, coordinate delivery of services from all agencies, monitor and evaluate service delivery, analyze aggregate local needs data, and coordinate local service planning and development.

Aggregated local needs data can be transmitted from the local level to the Division and from the Division to the Council on Developmental Disabilities for the State level coordinated planning that is necessary. Additional information about service needs will also be available from each of the relevant State agencies and coordination of interagency planning efforts can be undertaken by the Council prior to the development of specific agency budget requests.

As noted earlier, the study identified specific types of services that are currently needed by the unserved (and underserved) population. In order to provide the local level coordination through developmental disability specialists, to open existing services to those in need and to begin development of expanded services in accordance with those needs, it is recommended that:

e. There be appropriated $2,821,992 in FY 1987-88 and $6,107,324 in FY 1988-89 for:

	1987-88	1988-89
41 area DD specialists	594,500	1,189,000
4 regional DD specialists	62,000	124,000
1 State DD specialists	16,500	33,000
DD Study Maintenance	65,000	75,000
Staff Training	120,000	120,000
Reserve-special projs.	--	400,000
Respite Care	70,000	210,000
In-Home Support	120,000	360,000
Supported Employment	180,000	540,000
Early Childhood--new	550,000	1,100,000
Early Childhood--add on	280,232	560,464
Early Child specialists	--	574,000
Alternative Living	180,000	540,000
3 Group Homes	600,000	359,120
Totals	2,838,232	6,185,584

to expand services for persons with developmental disabilities and head trauma. (Appendix J, p. 108--Legislative Proposal #5)

f. Existing categories of funds appropriated by the State through the Division of Mental Health, Mental Retardation and Substance Abuse Services for specific services for the mentally retarded be amended to allow delivery of services to persons with other developmental disabilities and head trauma when the service is appropriate to the individual's needs. (Appendix J, p. 108--Legislative Proposal #5)

Consistency with Funding Policy Recommendations

Earlier in this report the Study Commission recommended the adoption of legislation that authorizes Pioneer Testing of Proposed Funding Policies for area mental health, mental retardation and substance abuse authorities (see Appendix D, p. 62--Legislative Proposal #1). It is the intent of the Study Commission that the recommendations regarding service delivery for the developmentally disabled and head trauma be consistent with those policy recommendations if both are authorized by the General Assembly. It is not the intent of the Study Commission that new monies appropriated for service expansion be established in special, restrictive categorical programs, but rather that the appropriation and accounting be incorporated into existing and proposed categories where appropriate.

Summary

The above recommendations regarding services for persons with developmental disabilities and head trauma have been developed with the assistance of staff from some, but not all, of the relevant agencies of the Department of Human Resources. Because of the limited amount of time available for formulation of these legislative proposals, they have not been available for review by area mental health, mental retardation and substance abuse authorities, by all agencies, or by any of the special organizations that represent the consumers who would be affected by these recommendations.

Rather than delay consideration of these suggestions for an additional year or two, the Study Commission elected to formally make these recommendations to the General Assembly in the form of proposed legislation (see Appendices I, p. 99 & J, p. 108--Legislative Proposals #'s 4 & 5). The Commission encourages the General Assembly to carefully scrutinize them through its regular committee process. The Commission further urges all special interest groups to review the proposals and to provide comment to the committees which will be reviewing the proposals.

Funding for Special Autism Project

In 1985 the Mental Health Study Commission recommended and the General Assembly adopted a proposal to develop a special living and training center for adult persons with autism who had aged beyond public school services. During the two years since this authorization, the North Carolina Society for Autistic Adults and Children and Division TEACCH of the School of Medicine at the University of North Carolina at Chapel Hill have worked to locate State property that might be used for this purpose.

At the Greenville public hearing the Society presented the results of the unfortunately unsuccessful efforts to locate State-owned property near the University in Chapel Hill. However, the Society was able to identify some private property that could be used for the living and training center. The owner has agreed to dedicate the property and transfer the deed of the property to the project if the Society is able to provide resources for basic road, water, sewer and electrical improvements to the property.

In order to follow through on the original intent of the Commission and the General Assembly to begin development of the special living and training center, the Commission recommends that:

> The 1987 General Assembly adopt legislation to appropriate $438,000 for the purpose of improving property for the living and training center, contingent upon approval of the State Budget Office that appropriate provisions for the transfer of title of the property are made. (Appendix K, p. 112--Legislative Proposal #6)

Chemical Dependency Study Report

In 1984, the Mental Health Study Commission recommended and the General Assembly adopted S.B. 724--Chemical Dependency Treatment legislation which modified insurance laws, treatment facility licensing laws, and the certificate of need law. The legislation also required the Department of Human Resources to evaluate the implementation of the legislation and to present an interim report to the 1987 General Assembly.

As requested, the Department presented its interim report to the Study Commission in December, 1986. The study results indicated that there remain, amongst treatment facilities and insurance agencies, considerable confusion and misunderstanding regarding the legislation. The Department in its letter of transmittal with the report makes a commitment to the General Assembly to undertake special efforts to reduce this confusion and misunderstanding. In addition, the Department proposes, as required by the legislation, to continue its evaluation efforts in order to be prepared for a final report in 1989.

In addition to this report, the Commission received comment at its public hearings regarding the financial limits for insurance reimbursement established in the legislation. While the Commission had originally intended that the 30-day financial limit set in the legislation would serve as a "floor" for the development of group insurance contracts, it appears that the amount has been used as a "ceiling" in most policies issued to date. Presenters argued that the provisions of the Teachers and State Employees Health Plan have been used by private carriers as a model.

These presenters urged the Commission to propose legislation that would raise the limits in the State Health Plan and raise the minimums in the group insurance laws. However, the Commission was cognizant of current financial strains within the State Health Plan. Also, the Commission felt that the best assessment regarding the feasibility of adjusting the State Health Plan could be done by the Joint Legislative Committee on the Health Plan as it considers other changes to the Plan. Therefore, rather than make specific legislative recommendations, the Commission elected to refer the matter to the Legislative Committee for further study (see Appendix L, p. 114).

Psychiatric Hospitals and the Chronically Mentally Ill

Among other issues and concerns raised at the two public hearings held by the Study Commission many presenters raised concern about the care and treatment of chronically mentally ill people in both the psychiatric hospitals and the communities. In general, the concern expressed was for more adequate, appropriate and effective care and treatment for those mentally ill individuals who are at times in need of psychiatric hospitalization.

The majority of specific comments can be summarized in three broad areas. In addition, a couple of presenters remarked on additional items. These are summarized in Appendix O (p. 136).

Because of time constraints and the complexity of some of the issues raised, the Commission was unable to examine the issues in any detail. However, the members of the Commission wanted to be on record expressing their concern regarding the needs of the chronically mentally ill.

In addition, the Commission elected to recommend to the General Assembly that:

(1) The Joint Appropriations Committee carefully examine the needs of the psychiatric hospitals for additional health care technicians and support additional positions as needed.
(2) The Joint Appropriations Committee, or other appropriate committees, examine the list of issues raised at the public hearings of the Commission (see Appendix O, p. 136) and take appropriate action to respond to those concerns.
(3) The Mental Health Study Commission be continued to June 30, 1989, and that it be authorized to undertake studies on the issues raised and similar concerns after a review of the actions in this area by the 1987 General Assembly (see Appendix M, p. 115--Legislative Proposal #7).

Continuation of the Mental Health Study Commission

Four of the recommendations discussed previously in this report (i.e., Funding Study, Child Mental Health Plan, Youth Substance Abuse Plan, and Psychiatric Hospitals and the Chronically Mentally Ill) specifically include oversight and study roles for a continued Mental Health Study Commission. In addition, there will always be other issues and concerns regarding the delivery of mental health, mental retardation and substance abuse services that will require learned examination and study.

Therefore, the Commission recommends that:

> The 1987 General Assembly adopt legislation to continue the Mental Health Study Commission until June 30, 1989 to carry out identified oversight and study responsibilities. (Appendix M, p. 115--Legislative Proposal #7)

Summary

This final report to the Governor and the 1987 General Assembly includes several recommendations consistent with the Commission's original purpose and specifically designated responsibilities. In addition to narrative discussion on the background, methods and content of a variety of study activities, the report includes more thorough descriptions of the Funding Policy Study and the Child Mental Health Plan in the appendices.

The appendices also include seven specific legislative proposals:

(1) Authorizing legislation to test concepts and policy change recommendations for State funding of area authorities through five pioneer projects.

(2) A Resolution to adopt the Child Mental Health Plan and the Youth Substance Abuse Plan as policy guidance for the development of comprehensive systems of care over the next ten years.

(3) A rewrite of the law requiring judicial review of the admissions of minors to restrictive mental health and substance abuse facilities.

(4) Legislation expanding the responsibilities of the Council on Developmental Disabilities to include coordination of planning and service delivery among State funded agencies providing services to the developmentally disabled and head trauma persons.

(5) Legislation expanding the responsibilities of the Division of Mental Health, Mental Retardation and Substance Abuse Services and the area authorities to provide services to individuals with developmental disabilities in addition to those with mental retardation, and to those with head trauma.

(6) Legislation to fund specific costs related to the development of a previously authorized living and training center for adult autistic persons.

(7) Legislation to continue the Mental Health Study Commission until June 30, 1987, delineating oversight responsibility and study in specific areas in addition to other studies related to its original purpose.

The Commission urges the General Assembly to carefully consider these recommendations and to openly receive input from special interest groups regarding them. The Governor, the Secretary of Human Resources and the Director of the Division of Mental Health, Mental Retardation and Substance Abuse Services are urged to carefully review and ultimately support those recommendations that will require administrative action for their implementation.

In conclusion, the Commission acknowledges the active involvement of many individuals, organizations and agencies in the formulation of these recommendations and extends to all who participated its sincere appreciation.

by G.S. 138-5. The Speaker of the House of Representatives and the President of the Senate shall each appoint from their appointees one member from the House of Representatives and from the Senate who will serve as cochairmen of the Commission.

Sec. 8.2. The Commission is authorized to review, analyze, and report on:

(a) The availability of professional and commercial liability and property insurance in this State and the factors causing and compounding diminutions in underwriting capacity.

(b) The underwriting and marketing practices of admitted and nonadmitted liability and property insurers and producers doing business in this State.

(c) Optional methods of risk management or risk sharing that may be utilized by the citizens of this State.

(d) The effect of diminished underwriting capacity in professional and commercial liability and property insurance on the economy of this State.

(e) Any other subjects deemed by the Commission to be relevant to this study.

Sec. 8.3. With the prior approval of the Legislative Services Commission, the Commission may meet in the State Legislative Building or Legislative Office Building and utilize the services of the clerical and professional staff of the Legislative Services Office. The Commission may utilize the staff of the Department of Insurance.

Sec. 8.4. The Commission shall submit a final report to the 1987 General Assembly on its convening date.

Sec. 8.5. There is appropriated from the General Fund to the Legislative Services Commission for fiscal year 1985-86 the sum of seventeen thousand dollars ($17,000) to carry out the provisions of this Part.

PART VIII.——JUVENILE LAW STUDY COMMISSION.

Sec. 9. There is appropriated from the General Fund to the Department of Administration the sum of ten thousand dollars ($10,000) for the fiscal year 1985-86, and the sum of ten thousand dollars ($10,000) for the fiscal year 1986-87, for the Juvenile Law Study Commission, to enable the Commission to carry out its legislative mandate as defined in G.S. 7A-740.

PART IX.——MENTAL HEALTH STUDY COMMISSION.

Sec. 10.1. Section 2 of Resolution 80, Session Laws of 1973, as amended by Chapter 806, Session Laws of 1973, and Section 2 of Chapter 184, Session Laws of 1977, is rewritten to read:

"Sec. 2. Appointment of Members. The Commission shall consist of 24 members. The Speaker of the House shall appoint eight members at least six of whom at the time of their appointment are members of the House, and one of those six shall be Chairman of the Mental Health Committee of the House of Representatives. The President of the Senate shall appoint eight members at least six of whom at the time of their appointment are members of the Senate, and one of those six shall be Chairman of the Senate Human Resources Committee. The Governor shall appoint eight

members, two of whom at the time of their appointment shall be county commissioners taken from a list of four candidates nominated by the North Carolina Association of County Commissioners. If that Association fails to make nominations by September 1, 1985, the Governor may appoint any two county commissioners."

Sec. 10.2. The first two sentences of Section 3 of Resolution 80, Session Laws of 1973, are deleted and the following sentence is inserted in lieu thereof:

"The President of the Senate and the Speaker of the House of Representatives shall appoint a cochairman each from the Commission's membership."

Sec. 10.3. Section 4 of Resolution 80, Session Laws of 1983, is amended by deleting "and ex officio members" all three times those words appear.

Sec. 10.4. The Mental Health Study Commission, established and structured by 1973 General Assembly Resolution 80; Chapter 806, 1973 Session Laws; Chapter 185, 1975 Session Laws; Chapter 184, 1977 Session Laws; Chapter 215, 1979 Session Laws; 1979 General Assembly Resolution 20; Chapter 49, 1981 Session Laws, and Chapter 268, Session Laws of 1983, as amended by this Part, is revived and authorized to continue in existence until July 1, 1987.

Sec. 10.5. The continued Mental Health Study Commission shall have all the powers and duties of the original Study Commission as they are necessary to continue the original study, to assist in the implementation of the original and succeeding Study Commission recommendations and to plan further activity on the subject of the study.

Sec. 10.6. Members and staff of the continued Mental Health Study Commission shall receive compensation and expenses as under the original authorization in the 1973 General Assembly Resolution 80. Expenses of the Commission shall be expended by the Department of Human Resources from Budget Code 14460 subhead 1110.

Sec. 10.7. In addition to other studies authorized by law, the Mental Health Study Commission shall study:

(1) the funding of area authorities; and

(2) child mental health services, including the juvenile admissions law.

The Mental Health Study Commission shall report to the 1987 General Assembly and may also report to the 1985 General Assembly, Second Session 1986.

PART X.——STATE PARKS AND RECREATION AREAS STUDY COMMISSION.

Sec. 11.1. There is created a Study Commission on State Parks and Recreation Areas to be composed of nine members, three Senators to be appointed by the President of the Senate, three Representatives to be appointed by the Speaker of the House, and three public members to be appointed by the Governor. Appointments to the Study Commission shall be made within 30 days subsequent to the adjournment of the General Assembly in 1985. The President of the Senate and the Speaker of the House shall each designate a cochairman from their appointees. Either cochairman may call the first meeting of the Study Commission. With the

NORTH CAROLINA
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FINAL REPORT

MHSC
COMMITTEE ON FUNDING
POLICY DEVELOPMENT

Dec. 8, 1986

SUMMARY OF CONCEPTS AND IMPLEMENTATION PROPOSAL

State Funding for Area MHMRSA Programs

Introduction

As discussed in the background section (p. 29) of this report, the Mental Health Study Commission was directed by the 1985 General Assembly to study community program funding policies. The Funding Policy Development Committee (see Appendix C-1, p. 37) was appointed by the Commission to develop recommendations for the Commission's consideration on how to address several types of funding problems.

The FPD Committee began its effort by establishing common philosophical positions on a variety of questions related to the State's responsibility for the mentally ill, mentally retarded and substance abusing citizens of the State. By approaching the funding problems in this way, what emerged as solutions were not specific technologies for specific problems, but rather a series of policy concepts which when taken together imply a "Purchase of Service Funding System".

If, the ultimate goal of the public mental health, mental retardation and substance abuse system is:

> To provide cost effective, appropriate services to those mentally ill, mentally retarded and substance abusing citizens who need services regardless of their geographic location.

And, if the availability of State resources is limited, then; The goal of the State's funding policy system should be:

> To assure that the State's resources are allocated and utilized to provide appropriate services to those who are most in need of services and to assure that the resources are allocated fairly and reasonably and that the funds are expended for the purpose for which they were intended.

The proposed funding policy system includes several component concepts which are designed not only to meet these goals, but also to balance the various interests that are legitimately concerned with meeting the goals. Each of the constituencies [legislators, administration officials, county officials, area officials, consumers and private providers] have unique as well as shared objectives in how a funding policy is devised. To revise any single concept (or its specific policy implementation recommendation) separately from other concepts poses the risk of imbalance in the system as a whole.

On September 8, 1986 the Funding Policy Development Committee of the Mental Health Study Commission completed a Concept Paper that proposed the adoption of a series of policy recommendations regarding State Funding of Area Mental Health, Mental Retardation and Substance Abuse Programs. When the Concept Paper was presented to the Study Commission it was acknowledged that many of the concepts needed further refinement in order to explicitly describe how new policies might work and what the potential impact of the new policies might be.

The Study Commission authorized the continuing work of the Funding Policy Development Committee and requested that it examine a variety of issues and develop as much detailed refinement as possible over the next couple of months. This document reports on the results of that effort. Throughout the document the term "State Funds" is used to refer to both State appropriations and State allocated Federal Funds.

Incorporated in this report are:

(1) a brief description of the concepts as amended through the refinement work,

(2) a proposal on how to test, through pioneer projects, the concepts (and the specific policy recommendations which have been developed to implement the concepts), and

(3) a discussion of the policy questions to be addressed through the pioneer testing effort.

The reader who wishes a more thorough and detailed understanding of the concepts and proposals should also review the original Concept Paper and the Reports of Subcommittees which completed the further refinement work. However, there are specific differences between this and previous documents. These differences are intended and reflect the final consensus conclusions reached by the Funding Policy Development Committee.

Background

Through its review of issues, problems and concerns regarding State Funding for Area Programs the MHSC identified the following:

- service availability variations both in types of services and in capacity of comparable programs; because of local authority, different priorities, different stages of development, and limited resources;
- "model" project funding starts/without follow through;
- emphasis on categorical funding, with reduced proportion of area general funds, limiting areas' ability to respond to local needs. Also categorical funds sometimes appropriated when an area may or may not have been ready to develop the particular service;

program standards address how to provide a service rather than what to provide uniformly;
budget priority process that leaves some areas without ability to meet local priority needs;
an accountability/data system that does not allow meaningful statewide comparisons of either what is provided or what is needed;
confusing messages about the roles of community programs as compared to State facilities.

In reviewing these problems it is acknowledged that they have occurred, not by design, but rather because of a series of piecemeal funding policies.

Circle of Services

Because of the broad definition of services that an area can provide under the current system the demand for State dollars is almost unfathomable. Not even the highest funded area is meeting all of the demand/need for service for any client group. In order to address this component problem the concept of a "circle of services" is employed to differentiate target populations and services for which the State will pay. Areas are not to be limited in their authority or ability to provide services outside of the State circle, but would have to do so with revenues generated elsewhere.

The decision about which clients and which services are inside the circle and which are outside the circle is the most important policy implication of the system. The breadth or narrowness of the circle will impact on virtually all other concepts individually and in combination. If the concept is adopted for statewide implementation at some time in the future, the ultimate decision will rest with the legislature after balancing the full range of interests represented by all constituencies.

In order to test the concept it was necessary to define the target clients and services that would be considered in the State's "circle of services". The detailed definition of the circle (and noncircle) clients and services that is proposed for use during the pioneer testing is presented in Appendix C-2, (p. 38). In general the proposed circle includes the clients who are considered to be the most severely impaired based on their diagnosis and their level of independent functioning. Specific services that are considered appropriate for those clients will be supported by State resources. In addition, very limited services are proposed for those clients with mild levels of impairment and early intervention services for children and adolescents are defined within the circle.

Standardized Levels

The concept of standardized levels is the most difficult to describe, and thus to understand. It would have to be the last concept to be operationalized. For each client/service group within the circle a standardized (based on need per 100,000 population) level "goal/limit" would be established jointly by the administration and the general assembly. This standardized level would be converted to a local goal/limit based on the area's base population. The standardized level would serve two functions: as a mechanism for achieving equal availability of services across all area programs and as a tool for planning and allocation of new appropriations. [See Appendix C-3, p. 47 for a more detailed explanation of the Standardized Levels Concept.]

Cost Reimbursement and Uniform Statistical Data Reporting

In order to meet the State's need to know how State resources are being utilized, it is recommended that the areas be reimbursed for actual units of service delivered at a negotiated prospective rate. The provisions of the Local Fiscal Control Act (and cost finding) would still require areas to establish line item budgets and to have yearly audits against those budgets, but routine reporting to the Division/Department would be based on units of service delivery (like Willie M). Along with a reimbursement request, simple basic client information--age, race, sex, level of dysfunction, disability--would be reported. The State would determine additional client characteristic data (i.e., client income, insurance coverage, living arrangement, employment status, etc.) that the areas would need to maintain on each client, but this data would only by accessed by the State for special analyses or on an audit basis. Areas would be required to maintain similar data on all clients served, but would only routinely report on those for whom State reimbursement was sought.

Cost Determination/Cost Sharing

Closely aligned to the concept of unit cost reimbursement are issues related to cost determination and cost sharing. Theoretically, all costs of providing a service should be included in the cost determination including administrative and capital costs. Previous experience indicates that there are a variety of mechanisms that can be used to operationalize this concept, each with different effects. Rather than adopt a specific method prematurely, it is recommended that a variety of mechanisms (and their policy impact) be assessed through the pioneer effort.

A similar position is recommended on cost sharing. At the present time State (including federal) funding accounts for 66% of area budgets statewide. The balance is supported by 1st and 3rd party receipts, county general funds and other locally generated revenues. On an area by area basis the relative proportion varies.

As suggested earlier the size of the circle of services will play a driving force in this proposed system. Whether circle services are to be supported by 100% State funding and other revenues totally used outside the circle, or whether some kind of cost sharing should be utilized (i.e., by subtracting patient generated revenues, etc.) can not realistically be determined by consensus. Therefore, one of the objectives of the pioneer effort is to examine the policy ramifications and actual impact of a variety of cost sharing alternatives.

"Quality Assurance"

In the proposed system, quality assurance would be a responsibility of the local authority under guidelines established by the State. The types of quality assurance activities would be required, but rather than either reported regularly or managed at the State level, audits would be used by the State to assure compliance. The types of activities would include: appropriateness, quality (professionalism), and outcome measurements. Since the client/service targets within the State-funded circle include measures of levels of dysfunctioning, both appropriateness and outcome issues can use similar concepts.

Flexibility

Because all areas will have uniform definitions of client/service groups to be supported by State funding, and because reporting will be specific by type of client, type of service and cost, strict categorical guidelines would no longer be necessary as control mechanisms for State appropriations under the proposed system. Information gathered from local budget planning and service reporting would be specific, but could be aggregated into broader categories for appropriation and bottom line accountability.

Ultimately administrative costs and complications could be reduced if the system could function with only three general appropriations categories. However, as an interim step in order to reassure that the flexibility concept in conjunction with accountability changes will provide the necessary management controls, the recommendation is that funds be appropriated in six general categories (plus Willie M)--Adult and Child Mental

Health, Adult and Child Mental Retardation, and Adult and Youth* Substance Abuse. Subcategories under each would be used for aggregated comparisons--Periodic Services, Day/Night Services, and Residential/Inpatient Services. [See Appendix C-4, p. 50 and see Appendix C-2, p. 38 which includes a listing of the service types under each subcategory on the "circle" matrices.]

While an area would project at the beginning of a budget cycle to provide x units of service a under the Periodic Type for Youth with Substance Abuse problems, the area would have local authority to "reallocate" anticipated State revenues to another type of Periodic Service for Youth with Substance Abuse Problems. Division approval would be required for reallocation between Periodic and Day/Night Services. Reallocation between the six categories would follow regular Executive Budget Act restrictions. The year end settlement would be made against the bottom line of the subcategory allocation rather than the specific service allocation.

In making this specific recommendation two particular issues arise that warrant special attention during the pioneer testing phase. Because appropriations categories transferability is limited to the rules of the Executive Budget Act service program complications arise for "aging" out clients (those who reach adulthood while continuing to need specific service) and for dually diagnosed clients. These are not new problems created by the proposed system. But changing systems may be an appropriate mechanism for determining a sound and consistent way to alleviate the problems.

Budget Development

Continuation budget planning would follow rules that are in effect at the present time. Only significant "program" changes would need explanation. Jordan/Adams principles could continue because areas would continue to plan their budgets in accordance with line item budgeting. New prospective unit cost rates could be adjusted on a yearly basis.

Area programs would establish expansion budget priorities based on local needs and demands for service as long as the expansion request would not exceed the Standardized Level for a given service (expansion would include the provision of additional units of service in existing programs or the development of new specific services).

Because specific categorical funding would no longer be necessary, the administration would request funds in the broader categories. In so doing, it would be possible to have as many as 15-20 different local priorities represented in a $2.5m request

*[The term "Youth" is substituted for "Child" in order to be consistent with the proposal to develop a Youth Substance Abuse Plan.]

for Child Mental Health, for example. The administration would be able to provide back up information that would describe which area was to receive funding for what particular type of service. It could also provide back up information according to service types across all areas.

Since area need/priorities are always likely to be in excess of expansion funding availability, it is assumed that reductions in requests will be made at the Division, Department or State Budget Office levels. These decisions can be made more rationally with the type of information that will be made available. Regardless of the criteria used in formulating State level priorities, it is recommended that the original expansion budget request from the areas be provided to each level of the administration and the legislature in order to more accurately reflect the perceived need and readiness at the area authority level. Administrative justifications of priority expansion requests would be routine and information about exclusions could be made on a special inquiry basis.

Implementation

Although all constituencies have been represented on the FPD Committee and on working subcommittees and although some further refinement of concepts has occurred over the last several months, numerous details (and their policy implication) are yet to be determined. Therefore, it is recommended that the State not adopt as policy the concepts in whole or in part until further refinement can be developed, tested and assessed in five pioneer projects. Rather it is recommended that the General Assembly adopt authorizing legislation (after an open hearing on the question can be held by the Joint Appropriations Committee) that would allow for special pioneer testing and further development. The authorization would also need to include authority to waive certain current rules, so that the pioneer projects would not have to operate under two entirely different systems at the same time.

In order to maintain consistency in thinking and process, it is suggested that the MHSC designate a member to work with representatives from the administration and the Council of Community Programs to consider applications from area programs to become pioneer sites. At its final meeting, scheduled for February 9, 1987, the Commission can review the recommendations of the designated member and officially elect to recommend to the General Assembly the specific area programs that will participate as pioneer project sites. Further discussion on criteria for site recommendation is discussed in the appendix of this report in the section on implementation.

In addition, it is recommended that the Division Director, who will be responsible for the pioneer phase, establish an Implementation Advisory Committee to be comprised of at least one representative from each constituency group, to advise on policy questions and their interpretation during this pioneer testing phase.

No actual implementation of concepts would occur until the General Assembly endorsed the Pioneer Project Effort and appropriated whatever funds would be necessary for such an effort.

Appendix C-5 (p. 51) includes a more detailed discussion of the implementation proposed through the pioneer projects.

Funding During Transition

If the Study Commission and the General Assembly adopt in principle the testing of these concepts through pioneer projects it is only logical that expansion funding for area programs conform as much as possible to the concepts incorporated in the System Funding Policy Proposal. At a minimum it is anticipated that a full cycle under the proposal for the pioneers will not be completed before July 1989. Statewide implementation, if it were to be adopted could be expected to take an additional 2-3 years.

In the meantime it is recommended that expansion funding be of three types:

a. "Catch Up": Dollars to be appropriated to those areas below the Mean Adjusted Total Per Capita current allocation. (Adjusted=using updated area match formula; Total=State and state-allocated Federal dollars). [See Appendix C-6 (p. 60) for a chart that shows adjusted per capita figures.]

b. "Implementation": Initially implementation dollars would only apply to the Pioneer Projects, however, should the concepts be adopted statewide additional implementation dollars may be necessary to cover some administrative expenses in either personnel or data management systems.

c. "New Service Dollars": Should revenues allow for regular expansion funding for services, all area programs (pioneer sites and "catch up" funded areas) should be eligible to receive allocations, because the needs far exceed current capacities statewide. No specific recommendation on allocation of new service dollars is made.

"Catch up" funds should be earmarked for the circle of services or designated for the infrastructure (administration,

equipment, data systems, etc.) of area programs that are so weakly funded that they do not have in place the organizational strength necessary to support expanded service delivery. It is recommended that "catch up" funds not require a match since the majority of funds used in the computation of the formula did not require a match. In addition, the goal of equity of funding on a percapita model should be a onetime goal (computed on 1986-87 allocations) regardless of the length of time necessary to reach the weighted mean per capita.

Implementation funding for pioneer projects will be limited to the minimum amount of administrative expenses required to implement and test the new system. As noted in the implementation section of this report [see Appendix E, p. 57], specific figures for the costs related to pioneer testing (at the local and Division) level can be calculated during the February-June planning phase.

During transition it is further recommended that the pioneer sites be "held harmless" regarding State and county allocations. During the first year it is assumed that actual payments on the unit of service system will not occur. During the second year it is hoped that actual testing will be undertaken, but the pioneer sites should be assured that their risk taking will not place the program in financial jeopardy.

Summary

This final report of the Funding Policy Development Committee of the Mental Health Study Commission proposes a significant series of changes to the manner by which the State funds area mental health, mental retardation and substance abuse authorities. What is proposed is a system of funding that includes several interlocking concepts. The real policy implication of the changes are delineated through the specific policy implementation proposals defined for each concept.

The system is not complete in that numerous details are yet to be formulated. Many of the alternatives that could be adopted can only be examined in their real application to real area program experiences. Therefore, it is recommended that the General Assembly authorize the further exploration of these concepts and their detailed policy proposals through testing in five pioneer sites.

Further work through pioneer projects will allow different ideas to be explored. Throughout this report several issues have already been identified for examination (see Appendix C-7, p. 61); others are likely to arise during the trial. This approach will also allow nonsites and other interest groups opportunities to assess the potential impact of any "to be proposed" statewide policy changes prior to their statewide adoption.

Appendix C-1

Funding Policy Development Committee Members

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Senator Ollie Harris

Senator Russell Walker

Representative Dan Blue

Representative Jim Crawford

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Harry Myers, Commissioner
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David Stewart, Commissioner
Catawba County

Wyman Yelton, Manager
Wayne County

CONSUMERS

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Sam Carter, N. C. Alliance
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Leigh Derby, Director
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Robert Klepfer, Board
Guilford Area Program

Malvise Scott, Board
Wake Area Program

Ruth Straka, Director
Roanoke-Chowan Area Program

APPENDIX C-2

Circle of Services

The concept of a "circle of services" assumes that there will be some clients and/or some services for which the State will pay and other clients and/or other services for which the State will not pay. The circle of services concept does not limit the types of clients an area authority may choose to serve or the types of services it may choose to provide. The area authority will retain autonomous authority to determine "outside circle" clients and services, however, those clients and services will need to be supported with nonstate revenues.

The definition or listing of which clients and which services will be inside the circle becomes the actual policy implementation of the concept. As such, there are an infinite number of alternative policy recommendations that could be considered.

The policy recommendation to be examined through the pioneer projects is to differentiate State responsibility primarily on the level of dysfunctioning of the client. The policy is further differentiated by identifying specific types of service which would be appropriate for given clients at a defined level of dysfunctioning.

The definitions of functional levels is presented below. The specific definitions of service type are to be consistent with the current "Service Definition" manual of the Division [APSM 100-1]. The proposed circle of services (which services for which clients will be supported by State funding) is portrayed in the attached matrices.

One of the primary purposes of the pioneer testing effort is to determine whether or not the proposed "circle" is the best policy for the State of North Carolina. The impact of this proposal on clients for whom State funding of services is limited is of particular import. Another question that needs to be addressed through the pioneer effort is how to best address the issue of client changes in functioning levels. As a beginning point it is to be assumed that the functional assessment should measure where the client would be if s/he does not receive the service. How often that assessment should be made and policy guidance related to changes in functioning must be determined.

Eligibility Definitions - Levels of Dysfunctioning

Basic Human Functional Areas: (1) vocational/educational (2) self care (3) familial, (4) social, (5) housing/living skills.

Level I - Severe: Individuals who require sustained long-term support from qualified professionals simply to maintain a minimal quality of life. Without a planned, long term, treatment program, these individuals are recurrent admissions to public treatment programs including state institutions. Such people feel profound distress, have serious behavior problems, and/or have severely diminished capacities, leaving them essentially unable to survive without appropriate ongoing support. They have a history of impairment in three or more basic human functional areas.

Level II - Moderate: Individuals who require periodic/intermittent support from qualified professionals in order to maintain a reasonable level of quality of life in the community. These impairments may be either severe but temporary, or less severe but chronic and ongoing. Without appropriate and readily available support, these individuals are likely to become more severely impaired and, consequently, will utilize more expensive public treatment programs. On at least a periodic basis, these individuals have difficulty maintaining at least two basic human functions listed previously.

Level III - Mild: Individuals whose diagnosed impairment is neither total nor chronic but which causes significant problems at home, at work, or at school. Such condition could lead to job loss, family breakdown, school failure, abusive or violent situations and possible suicide. With readily available treatment, these individuals can usually return to normal levels of all basic human functions.

Level IV - At Risk: Individuals, especially children, who are judged to be at high risk of becoming moderately or severely disabled because of genetic, environmental, social or other factors. Without early diagnosis and readily available professional treatment, such "at risk" individuals are very likely to develop much more severe impairments later requiring expensive public treatment.

Client Specific Eligibility Definitions

Adult Mental Health Clients

Level I: Requires documented long-term impairment in three or more functional areas and diagnosis on Axis I of a major disorder such as schizophrenic; paranoid; bipolar; recurrent major depression; other psychotic; primary degenerative dementias; or other organic mental disorder or a diagnosis on Axis II of a personality disorder.

Level II: Documented impairment (either current or long-term) in two functional areas and diagnosis on Axis I or II (as listed in Level I) or the diagnosis of an acute paranoid, schizophreniform, reactive psychosis or major depression with psychotic features or other diagnosis resulting in functional deficits.

Level III: Requires documentation that the individual is experiencing mental health or emotional problems which are of concern, but which do not significantly impair their long-term ability to function although they may be temporarily unable to perform well in one area.

Level IV: At risk is not applicable to adults.

Child Mental Health Clients

Level I: Seriously emotionally disturbed children and adolescents with DSM-III diagnosis and two of the following:

a. Disorder lasting more than 12 months, historically or projected.
b. Developmental, social, or academic delay of more than 2 years.
c. Requires services of more than 2 agencies concurrently.
d. Requires more than 2 types of mental health services concurrently.
e. Has been served or needs to be served in a psychiatric hospital or intensive residential treatment program.

Level II: Moderately emotionally disturbed children and adolescents with DSM-III diagnosis and one of the above characteristics.

Level III: Mildly emotionally disturbed children and adolescents with DSM-III diagnosis whose impairment is less severe and less chronic than Levels I and II. May have significant problems at home, at school or in the community which may lead to school failure, family breakdown, or suicide attempts; with readily available treatment these youngsters can function normally.

Level IV: Individuals who are considered at high risk of becoming moderately or severely emotionally disturbed because of genetic, environmental, social, or other factors.

Mental Retardation Clients (regardless of age)

Level I: Profoundly (IQ below 20 or 25) and Severely (IQ between 20 and 40) retarded individuals who require continuing and close supervision, but may be able to perform simple self-help tasks. [Note: If authorized by the General Assembly, may include other Developmentally Disabled, dependent individuals.]

Level II: Moderately (IQ between 35 and 55) retarded individuals who can learn self-help, communication, social and simple occupational skills but only limited academic or vocational skills. Mildly retarded individuals with other severe handicapping conditions such as behavior disorders, physical and sensory impairments*.

Level III: Mildly (IQ between 55 and 70) retarded individuals who can usually master basic academic skills and may maintain themselves independently or semi-independently in the community.

Level IV: At risk children are infants who exhibit developmental delays but are too young for appropriate diagnostic labelling.

*Mildly retarded individuals with other severe handicapping conditions can be either Level I or Level II clients.

Adult Substance Abuse Clients

Level I: Chronically dysfunctional individuals who are characterized by physical deterioration, a complete breakdown in social relationships and considerable mental deterioration or confusion. The individuals in this group exhibit all of the following symptoms: uncontrolled use of alcohol and/or other drugs, complete ethical breakdown, paranoia, use of substitutes when preferred substance is not available, physical withdrawal symptoms, and psychomotor dysfunctions.

Level II: Individuals who have become addicted to the use of substances resulting in moderate physical, mental and social deterioration. These individuals may exhibit any of the following symptoms: Compulsive substance use, rationalization for use, aggression, guilt and remorse, decay of social relationships, problems on the job or in school, and family problems. Physical dependence is apparent in these individuals. Withdrawal symptoms may occur.

Level III: Individuals who are first experiencing mild physical, mental and social deterioration. They may exhibit any of the following symptoms: problem use of substances, increased tolerance, occasional blackouts, preoccupation with substance use, hiding evidence of substance use, and guilt. This type of individual is usually able to function in society but is beginning to indicate deterioration in social relations, employment and/or school performance.

Level IV: Individuals who are identified as being particularly susceptible to becoming alcohol and other drug misusers. These individuals are usually targeted by organized drug prevention efforts and often includes groups such as the elderly and middle-aged housewives. Examples include children of alcoholics, abuse victims, school dropouts, teenage pregnancy, economically disadvantaged, delinquent, disturbed, suicidal or disabled. This category includes experimenters and recreational users of chemical substances.

Youth Substance Abuse Clients

Level I: Severely impaired chemically dependent youth who exhibit two or more of the following in their alcohol and/or drug using behavior:

a. Use of alcohol and/or other drugs four or more times weekly with frequent intoxication
b. Polydrug or intravenous use
c. Compulsive alcohol or other drug use
d. Increased tolerance to alcohol and other drugs
e. Withdrawal symptoms
f. Parental/familial history of alcohol or drug dependency
g. Alcohol/drug centered peer relationships;

and at least one of the following additional symptoms:

a. Physical/mental health problems
b. School discontinued or performance severely impaired
c. Delinquent behavior or legal difficulties
d. Significant family problems
e. Suicidal behavior

Level II: Youth who are moderately impaired due to alcohol and/or other drug abuse. They will exhibit one of the drug using behaviors listed under Level I and one of the additional symptoms; or exhibit initial evidence of developing these symptoms (i.e., frequent drug use, drop in grades, change in friends, truancy).

Level III: Youth who are experimental users but who have no consequences or minimal consequences as a result. They are characterized by: infrequent alcohol and/or other drug use, no polydrug or intravenous use, isolated incidences of intoxication, normal social functioning.

Level IV: Youth are defined at risk when the following characteristics are present without current use of alcohol or other drugs: parental or familial alcoholism or other chemical dependency, victim of sexual, physical or psychological abuse, chronic physical pain, committed a violent or delinquent act, has mental health problems, has attempted suicide, has discontinued school, has become pregnant.

Target Clients and Services To Be Supported with State Funds[1]

	Adult Mental Health				Child Mental Health			
Level of Dysfunct.	I	II	III	IV	I	II	III	IV
Type of Service								
PERIODIC SERVICES								
Agency Consultation	X	X	O	O	X	X	O	O
Education	O	O	X	X	O	O	X	X
Prevention	O	O	O	O	O	O	O	O
Evaluation	X	X	O	O	X	X	O	O
Forensic Screening	X	X	X	O	X	X	X	O
Emergency	X	X	X	X	X	X	X	X
Screening	X	X	O	O	X	X	O	O
Institutional Liason	X	X	O	O	X	X	O	O
Follow-up	X	X	O	O	X	X	O	O
Case Management	X	X	O	O	X	X	O	O
Companion Sitter	X	X	O	O	X	X	O	O
Outpatient Counselling	X	X	*X	O	X	X	*X	O
Early Intervention	O	O	O	O	O	O	O	X
(*limited to 3 visits)								
DAY/NIGHT SERVICES								
Day Treatment	X	X	O	O	X	X	O	O
Night Care	X	X	O	O	X	X	O	O
Partial Hospitalization	X	X	O	O	X	X	O	O
Sheltered Workshop	X	X	O	O	X	X	O	O
Supported Employment	X	X	O	O	X	X	O	O
Community Support	X	X	O	O	O	O	O	O
RESID/INPAT SERVICES								
Respite	X	X	O	O	X	X	*X	O
Specialized Foster Care	O	O	O	O	X	X	O	O
Alternate Residence	X	X	O	O	X	X	O	O
Inpatient Psych. Hosp.	X	X	O	O	X	X	**X	O
Supervised Ind. Living	X	X	O	O	X	X	O	O
Group Living	X	X	O	O	X	X	O	O

(*limited to 10 days per year;
**limited to 14 days per episode)

[1]The client/services for which State funds can be used are indicated by "X" and the noncircle (nonState supported) client/services are indicated by "O".

These charts are a staff extension of the specific charts approved by the FPD Committee. There has not been time for staff to varify the interpretation of the decisions into this format. As such they may need minor revision after being reviewed by Committee members.

	Mentally Retarded Regardless of Age			
Level of Dysfunct.	I	II	III	IV
Type of Service				
PERIODIC SERVICES				
Agency Consultation	X	X	O	O
Education	O	O	X	X
Prevention	O	O	O	O
Evaluation	X	X	X	X
Forensic Screening	*	*	*	*
Emergency	*	*	*	*
Screening	*	*	*	*
Institutional Liason	X	X	O	O
Follow-up	X	X	O	O
Case Management	X	X	O	O
Companion Sitter	X	X	O	O
Outpatient Counselling*	*	*	*	*
Early Intervention	X	X	X	X
In Home Community Outreach	X	X	O	O
Comm. Alt. (CAP/MR)	X	X	O	O
DAY/NIGHT SERVICES				
Developmental Day	X	X	O	O
ADAP	X	X	O	O
Night Care	X	X	O	O
Partial Hospitalization	*	*	*	*
Sheltered Workshop	X	X	O	O
Supported Employment	X	X	O	O
RESID/INPAT SERVICES				
Respite	X	X	O	O
Specialized Foster Care	X	X	O	O
Alternate Residence	X	X	O	O
Inpat. Psych. Hosp.	*	*	*	*
Supervised Ind. Living	X	X	O	O
Group Living	X	X	O	O

*Services indicated with the asteric are to be provided through Generic Mental Health Programs and State payment would still be controlled by the level of dysfunctioning criteria designated.

	Adult Substance Abuse				Youth Sub. Abuse			
Level of Dysfunct.	I	II	III	IV	I	II	III	IV
Type of Service								
PERIODIC SERVICES								
Agency Consultation	X	X	O	O	X	X	O	O
Education	O	O	O	O	O	O	X	X
Prevention	O	O	O	O	O	O	O	X
Evaluation	O	X	O	O	X	X	O	O
Forensic Screening	X	X	X	O	X	X	X	O
Emergency	X	X	X	X	X	X	X	X
Screening	O	X	O	O	X	X	O	O
Institutional Liason	O	X	O	O	X	X	O	O
Follow-up	O	X	O	O	X	X	O	O
Case Management	X	X	O	O	X	X	O	O
Outpatient Detox	X	X	O	O	X	X	O	O
Outpatient Counselling	O	X	*X	**X	X	X	*X	**X
Student Assistance	O	O	O	O	X	X	X	X
DES	O	O	O	O	O	O	O	O
ADETS	O	O	O	O	O	O	O	O
Methadone Treatment	X	X	O	O	X	X	O	O
TASC	X	X	O	O	X	X	O	O
(*limited to 12 visits; **limited to 5 visits)								
DAY/NIGHT SERVICES								
Intens. Outpt.	O	X	O	O	X	X	O	O
RESID/INPAT SERVICES***								
Inpatient Hosp.-Detox	X	X	O	O	X	X	O	O
Detox	X	X	O	O	X	X	O	O
Halfway House	X	O	O	O	O	O	O	O
Intens. Treatment	O	X	O	O	X	X	O	O

***Additional models for youth are yet to be developed.

Appendix C-3

STANDARDIZED LEVELS OF CARE

This table represents a sample of how the concept of Standardized Levels could be utilized in establishing a Ceiling of State Funding. The Ceiling would be used not to limit the amount of service an area should or could provide, but rather to serve as a equalizing factor across areas. Because areas will have somewhat different costs per unit, and will have different demands for particular service, equalization is seen as the State's commitment to equal availability of service resources rather than equal availability of dollars per se.

If State funding is directed to services within the Circle, and if the Cost is to be borne by the State, locally generated revenues, including county funds, would support both units of service provided above the Standardized Funding Level (ceiling) and for client/services outside the circle.

Adult MI--National Estimate
1% (severe, moderate)
Standardized Levels By Units of Service

Type of Service (Population Base)	Standardized (100,000)		Area A (57,000)		Area B (157,000)	
	100%	Goal	Goal	Current	Goal	Current
Day/Night						
CSP	52000	20%	5928	2600	16328	14600
Day Care	26000	5%	741	0	2041	0
Night Care	10400	10%	593	0	1633	0
Part. Hosp.	52000	20%	5928	4800	16328	10000
S/W	26000	10%	1482	780	4082	1825
Res/Inp						
Alt.Res.	73000	10%	4161	0	1146	10000
Respite	2500	50%	713	0	1963	1800
Grp. Living	36500	5%	1040	0	2865	**3230**
Acute Inp.	4000	50%	1140	0	3140	**4000**
Periodic						
Case Mgmt.	66560	30%	11382	2080	31350	30000
Emergency	**4800**	**100%**	**2736**	**4000**	**7536**	**8500**
Eval/Screen	4800	50%	1368	1200	3768	3000
Forensic	**480**	**100%**	**274**	**300**	**754**	**800**
In Home	2000	10%	114	0	314	289
Outpt Couns	5000	20%	570	**1500**	1570	1498
Follow-up	10400	50%	2964	1040	8164	7998

The Standardized Level would be a "best professional judgement" estimate of the number of units of a particular service that would be needed per 100,000 population base. While this estimate will be initially very rough, experience will lead to better judgements.

The Goal % (limit) would be the proportion of need to be met statewide before additional State resources could be used to provide more of that specific service in any area. This % would be applied to an area's population base to set a fixed goal ceiling. Whether this percentage figure would be set at 10% or 50% or 75% would be a policy determination set jointly by the Department and the Legislature. It is necessary to make clear that the Standardized Level Concept is a goal and ceiling limit concept. The Standardized Level is neither a mandated level requirement on an area to provide service at the specific target, nor is it an obligation of the State to provide the funds for the areas to be able to meet each of the levels.

Ideally, the level would be set above currently existing service levels across the areas (because it is assumed that no area is currently providing all of the needed services). However, as the above example indicates, some services (e.g. Area B's level of Grp. Living and Acute Inpatient Care) may be above the statewide level. State funds currently allocated to support these services could be reallocated by Area B to the other types of Res/Inp service; or, to Day/Night or Periodic Services with Division approval.

As the sample indicates there may be some client/services for which the State may not want to set a fixed ceiling (e.g., emergency and eval/screening). In these cases, as shown above with bold print, the State may pay for units provided above the ceiling as long as the total dollars allocated to the category (adult mentally ill) are not exceeded.

If the standardized level were to be established above the mean (across all areas) for a particular client/service but below the higher levels, then it would serve as a mechanism for the State to direct the reallocation of current State resources within the higher funded programs. Again, it must be remembered that these limits, at whatever level they may be set, are not limits on what an area can do, but rather a limit on State payment for area services.

In addition to serving as a method of equalizing the expenditure of State funds--and thus equalizing the availability of services--across area programs, the Standardized Level concept would be used as a budget planning and expansion funding allocation guide.

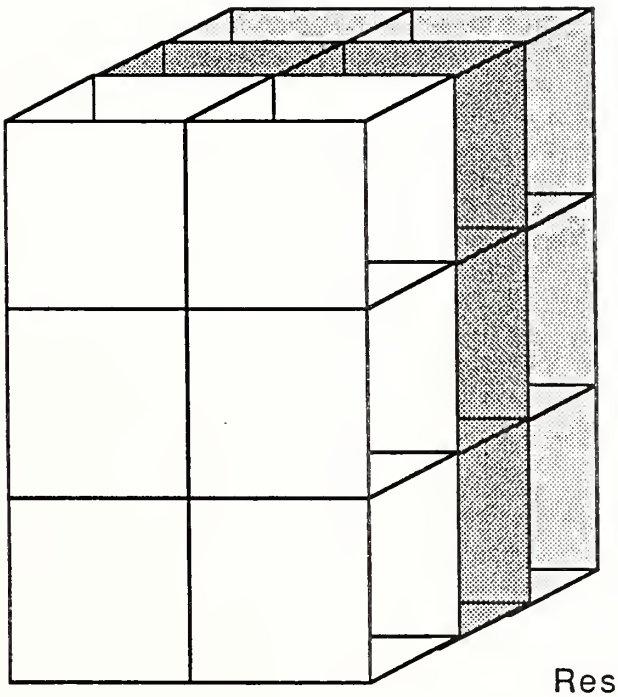
As a specific area assesses unmet need and demand for services in any given budget planning cycle, the Standardized Level would be a guide in setting local priorities. Again, using Area B in the sample chart, Area B would be eligible for expansion funding for Day/Night services, but not for Res/Inp services except in the particular client/services where it was still below the standardized levels.

It is also safe to assume that Area B might be farther from meeting its standardized levels in child mental health than in adult mental health. Through the budget development process (within DHR and the State Budget Office) Area B's local priority for Child Mental Health funding could surface to the top as an expansion budget request, where its priority for additional Adult Mental Health Day/Night services might not.

The administration could set as a particular biennium goal the priority of bringing all areas (who project a priority need for a specific client/service) closer to the standardized levels. Allocations of the Division would then be made to those areas which projected the need and which are also (based on current allocations) farther from their ability to meet the standardized goal than other areas. This is not to suggest that the administration would have to set such a priority, it would rather be simply one example of how the priority decision making might occur.

Appendix C-4

SERVICE CATEGORIES



Mental Health

Mental Retardation

Substance Abuse

Periodic
Day/Night
Residential/Inpatient

Children/ Youth

Adults

Appendix C-5

Proposed Implementation Plan for Pioneer Testing of Funding Policy Proposals

Because many of the constituency groups have not had time to be fully informed and to fully understand the proposals encompassed in this report and because further detail and alternatives need to be examined, authorization for pioneer testing, rather than statewide adoption and implementation is recommended.

Pioneer sites would have as their purpose:

- to adapt and demonstrate specific methods that will be required to implement the purchase of service system;
- to develop client/service information, determine service costs, clarify policies to be considered prior to statewide implementation;
- to provide realistic data and information which can be used to analyze the impact of circle of service definitions, cost determinations, standardized levels, etc.

PIONEER PROJECT SITE SELECTION

While it is understood that implementation of the proposals through pioneer projects must await legislative authorization, there is a great deal of time saving-planning that could be done between the time that the Study Commission endorses the concepts and when the Appropriations Committee and General Assembly would finalize the authorization. If the Study Commission, at its December 17 meeting, generally endorses the proposals to proceed, it is recommended that the process of site selection for the pioneer projects begin immediately thereafter.

Specifically it is suggested that the Study Commission write directly to all 41 area programs and solicit their interest in participating. The areas would be asked to complete (by January 30) the attached form and to indicate (by signature of the Director and the Area Board Chairman) whether or not, if selected, they would be willing to be a pioneer project.

It is further recommended that the Study Commission appoint a member to work with representatives of the Division and the Council on Community Programs to review the applications in accordance with the below listed characteristics. The designated member will formulate a proposal for consideration by the Study Commission on those sites it wishes to recommend to the General Assembly to be designated as the sites for pioneer testing. While the final decision on implementation, and thus on pioneer testing *per se*, will require General Assembly authorization, the recommended pioneer sites can work with the Division on issues of more explicit planning between February and June.

It is suggested that a variety of characteristics be taken into account in identifying recommendations for pioneer project sites. Because the 41 areas are different, it is important that a variety of areas be selected in order to be able to assess the realistic effects of adopting the policies statewide.

The first characteristic to be taken into account is that of size/governance. To facilitate consideration of this variable it is recommended that one site be selected from each of the following five types of programs:

Large Single Urban County: Cumberland, Durham, Guilford, Mecklenburg, Wake

Large Multi-County Urban/Rural: Blue Ridge, Forsyth-Stokes, Gaston-Lincoln, Piedmont, Alamance-Caswell, Southeastern (Wilmington), Tri-County

Large/Medium Multi-County Rural: Foothills, New River, Neuse, Orange-Person-Chatham, Sandhills, Smoky Mountain, Southeastern Regional

Small/Medium Multi-County: Albemarle, Duplin-Sampson, Edgecombe-Nash, Lee-Harnett, Roanoke-Chowan, Rutherford-Polk, Surry-Yadkin, Tideland, TREND, VGFW, Wilson-Greene

Small/Medium Single County: Catawba, Cleveland, Davidson, Halifax, Johnston, Lenoir, Onslow, Pitt, Randolph, Rockingham, Wayne

In reviewing this listing it should be remembered that areas will be selected only if they volunteer. If volunteers do not step forward from one of the "area types", further solicitation may be necessary.

In addition to the "area type" characteristic it is suggested that the following information be taken into account with the goal of having a representative balance within the pioneer project sites:

- regional balance
- existing administrative capabilities
- existing data management capabilities
- variety of existing service types
- utilization of contract agencies
- overall state funding, level of county funding, amount of 1st and 3rd party receipts
- degree of centralization/decentralization of administration in multi-county programs; degree of county control in single county programs

NOTE: See p. 63 for listing of Study Commission recommended sites.

OTHER RECOMMENDATIONS REGARDING IMPLEMENTATION

Because of the complexity and interrelatedness of the concepts incorporated in the Funding Policy Proposals, it will be necessary for all components of the Division to be actively involved at various stages in the implementation. In order to focus accountability and to provide leadership, it is recommended that a single individual be selected as Project Director. The Project Director should be appointed by and responsible to the Division Director. This Project Director would have the following duties and responsibilities:

provide leadership consistent with the policy proposals for both the pioneer projects and the Division,
supervise the activities of the project--including having the authority to make routine day to day decisions and to draw upon necessary Division resources as needed,
identify policy issues which need decision by either the Division Director or the Legislature,
prepare and disseminate regular progress and policy issue reports.

The kinds of Division professionals who will most frequently need to be involved in the project effort will be those in the support staff--both administration and quality assurance. In addition, a person familiar with mental health, etc. service delivery and computer systems should be involved on a regular ongoing basis. It is recommended, therefore, that a project team, to include three individuals, be assigned on a full time basis to carry out most of the day to day work with the pioneer projects. At those points in the development of the pioneers where specific disability knowledge is required the Deputies should be involved as needed (both to assist in the formulation of decisions and as a checkpoint regarding potential statewide implications of the decisions).

As discussed previously, the elapsed time of the entire project can be shortened by as much as a year (and possibly a biennium) if the Project Director, the three person Project Team is identified and the pioneer sites are identified for recommendation at the final meeting of the MHSC. [This is not meant to assume Legislative agreement on all points or Legislative adoption. It is hopefully a positive risk to invest a significant amount of planning time.] The amount of detail refinements that can be worked out between February 1987 and July 1987 should benefit Legislative consideration. However, actual implementation would not begin until the Legislature so authorizes.

In order to accomplish this front end work, it is recommended that current Division positions be utilized for the Project Director and Project Team members. It is also the general consensus that the entire effort will move more smoothly and effectively if specific individuals who are currently involved in the system (by knowledge and experience) are selected for these positions rather than hiring new individuals who may be unfamiliar with both the current system and the policy proposals.

Since drawing from existing resources will mean that these individuals can not carry out current responsibilities, it is recommended that costs related to replacement staff be considered as a part of the project development costs.

Most of the actual specific refinement of details and procedures should be accomplished with and through the pioneer projects. Whether all pioneer projects should be working on the same procedures, or different pioneers should be working on different components, or whether different pioneer sites could test different alternative details should be a decision of the the Project Director, the team and the sites themselves.

Even with the amount of thinking and work that has gone into the development of the concepts (as presented in this report) key decision points are likely to occur as the pioneers develop. On many of these decisions, the basic underlying philosophy and the logical consequence vis a vis a particular decision will be clear. On other decisions, options or choices may emerge with less clear guidance afforded by the policy construct. Finally, it is probable that some kinds of decisions may need to be made where there is little or no guidance or where there are conflicts regarding the appropriate course to take.

It is recommended that the Division Director appoint an Implementation Advisory Committee [IAC] to be made up of six individuals--a legislator, an administration official, an area official, a county official, a contract agency director and an individual who represents a consumer organization. The Co-chairmen of the Mental Health Study Commission shall make a recommendation regarding the legislator and the President of the N.C. Association of County Commissioners shall make a recommendation regarding the county official. The Project Director would report implementation progress on a monthly or bi-monthly basis to the IAC (with copies to the MHSC and to all area programs). The IAC would:

advise the Division Director on any general problems with the implementation progress and any specific problems that raise question with the policy proposals directly;

advise the Project Director on any policy related issues (e.g., those for which policy guidance is in question or when there are conflicts in interpretation) [The involvement of the IAC in these decisions would assure that the implementation process is responsive to the full array of concerns and interests that will be ultimately affected by the decisions.];

advise the Division Director on those existing rules and regulations which should be waived for the pioneer projects during the implementation phase [see notes on Waiver of Current Rules.];

review, assess and advise the Division Director on those policies and procedures which should be recommended to the legislature for statewide implementation during the project implementation.

TIMELINE NARRATIVE

Attached is a timeline chart which shows the current projections on the time necessary to undertake the development tasks. This chart has been prepared under the assumption that both the Study Commission and the Administration are supportive of the proposal to undergo significant pioneer testing and to begin this effort immediately.

The chart was also prepared under a "best possible case scenario". It is crucial to note that more clear timelines are one of the first tasks for the project team and sites. As with other experimental proposals unforeseen barriers may occur. While the timeline indicates a goal of decision on statewide implementation to be made prior to the end of the 1989 Session of the General Assembly, this particular timeframe may need adjustment.

As described above, the Implementation Advisory Committee will play an important role in process review and interpretation of the activities, methodologies and policies themselves. The Division Director, upon recommendation of the IAC, will have authority during the process to recommend to the legislature (Study Commission) a green light on implementation statewide of any of the component parts of the policy proposal package. In the end it is recommended that adequate time be provided all constituencies for review and reaction prior to statewide implementation of any or all concepts.

WAIVERS OF CURRENT RULES

There has not been time to identify a specific listing of current administrative or Commission rules that should be waived for the pioneers in order for them to efficiently convert to new ways of doing business. One of the "legal" options available to the Study Commission is to designate an individual to have legal authority to waive rules under specified conditions. Although it is conceivable that such a listing can be developed between January and June the most realistic option available would be for the legislative authorization of the pioneer projects to include a provision to allow the Secretary to waive both Department and Commission rules after consideration of the recommendations of the Implementation Advisory Committee.

DATA PROCESSING POLICY AND REQUIREMENTS

The Division of MH/MR/SA Services will have to modify its Information Systems to meet the expected requirements of the Purchase of Service Model of funding area programs. Changes will be needed in the Client Information, Fiscal Information and Volume of Service Information Reports submitted by area programs.

Since the majority of area programs have automated systems to manage one or more of these types of data, changes in Division reporting requirements will necessitate modifications to area programs' data processing systems as well as the Division's systems. While many of the details of the requirements and design of the new systems will be worked out with the pioneer sites during the Transition Phase, a framework of the Division's data processing policy and broad reporting requirements are needed to guide the development process as well as to help area programs and the Division plan for the future.

The structure of North Carolina's Mental Health, Mental Retardation and Substance Abuse service delivery system dictates the need for a special approach to data processing system development. The data processing system should have the following features:

Local Computers - The primary site of data entry, processing and reporting should be the area program.

Local Entry of Data - Information should be entered and stored at the area program.

Transmittal of Required State Data - The Division should specify its data requirements, which should be a rather small subset of local data requirements. Area programs should transmit required data to the Division via telecommunications, computer tape, or diskette.

Local Processing to meet Area Program Management Needs - Area programs data processing needs are much more specific and detailed than the Division's. The key element of any system is the applications software that is used. The software should be required to meet Division reporting requirements. Beyond that, area programs should be permitted to choose the software that best suits their needs.

Primary Purpose of Division Level Data Processing to Meet Division Needs - The Division's System is currently designed provide information to area programs as well as well as the Division. The primary focus of the design of the Division Level system should be to meet Division needs. Local needs should be met for the most part by the local systems.

DATA REQUIREMENTS

The Division must specify its data requirements. Since these requirements must be an element of each Area Programs' data processing system, it is important to select requirements with cost efficiency in mind. It is also important to provide plenty of lead time when requirements are added or changed so that the necessary modifications to the Area Programs' systems can be made.

Provisions for funding data processing system development should be made. There will be development and adaptation costs needed at both the Division level and for pioneer programs during the pioneer effort. Under the Purchase of Service funding model, the cost of area program computer hardware and software will be an element of administrative costs. Only if absolutely necessary should computer hardware or software costs be covered under any type of special funding by the State.

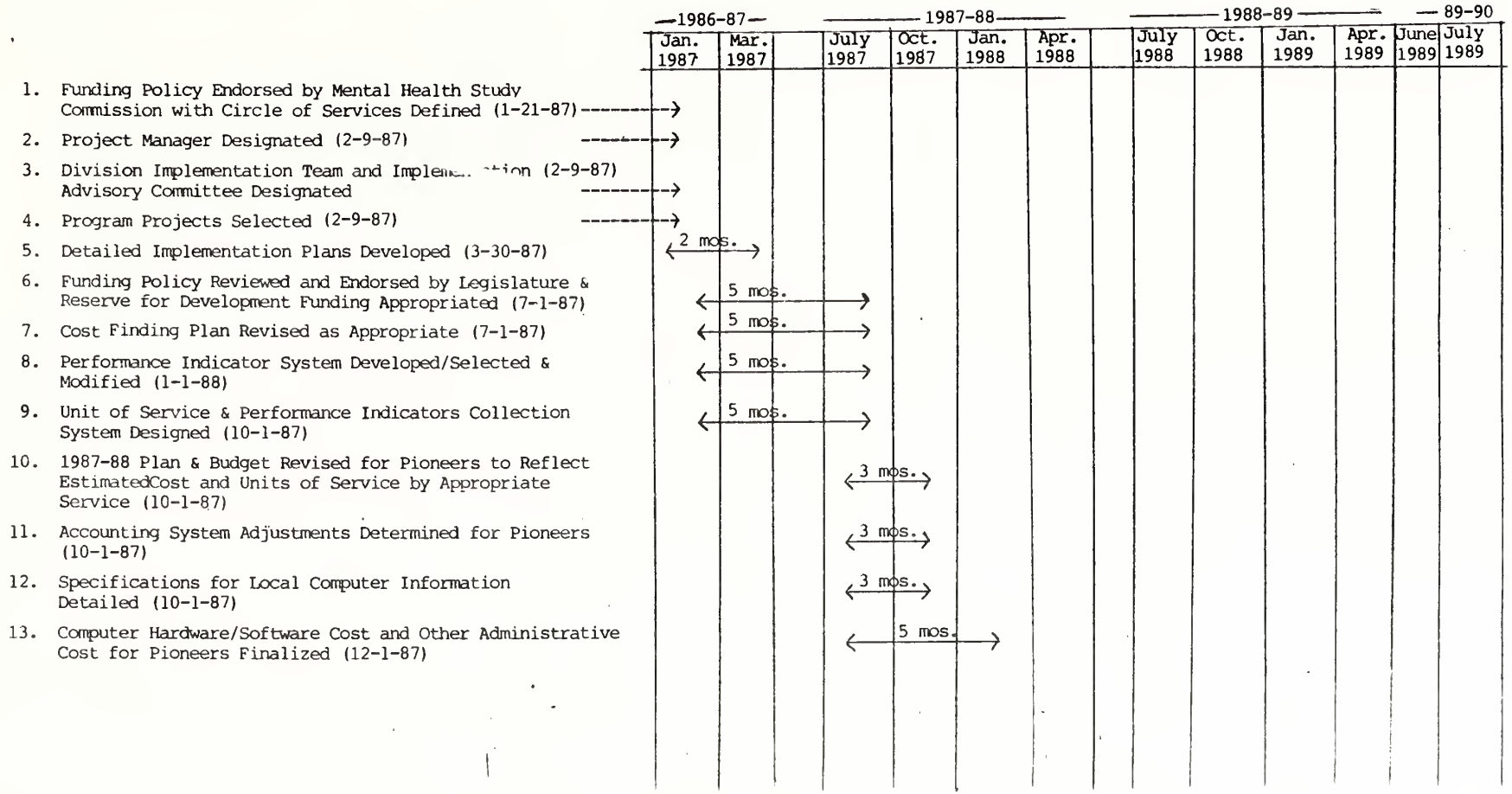
COSTS OF IMPLEMENTATION

Throughout discussion of the policy proposals it has been acknowledged that various administrative costs--personnel and computer systems--would be required to develop and implement a purchase of service system. In the Implementation discussion above, certain administrative staff support will be necessary within the Division but Division needs for computer system support will not be known until the specifics of the data needs are defined. Before the pioneer sites are identified it is impossible to estimate pioneer project implementation costs. However, when the Site Selection Committee makes its recommendations, it will be possible to estimate within a limited range the amount of special funding that will be needed in order to begin implementation should the Legislature authorize the Policy Project. (This estimate can be specifically refined during the February - July work and a more appropriate figure would be available for the Appropriations'Committee consideration.) If the Study Commission elects to recommend pioneer testing of these proposals, it is recommended that the authorizing legislation include an appropriation for a reserve to be utilized for the administrative and computer support necessary to implement the concepts in the pioneer sites and in the Division.

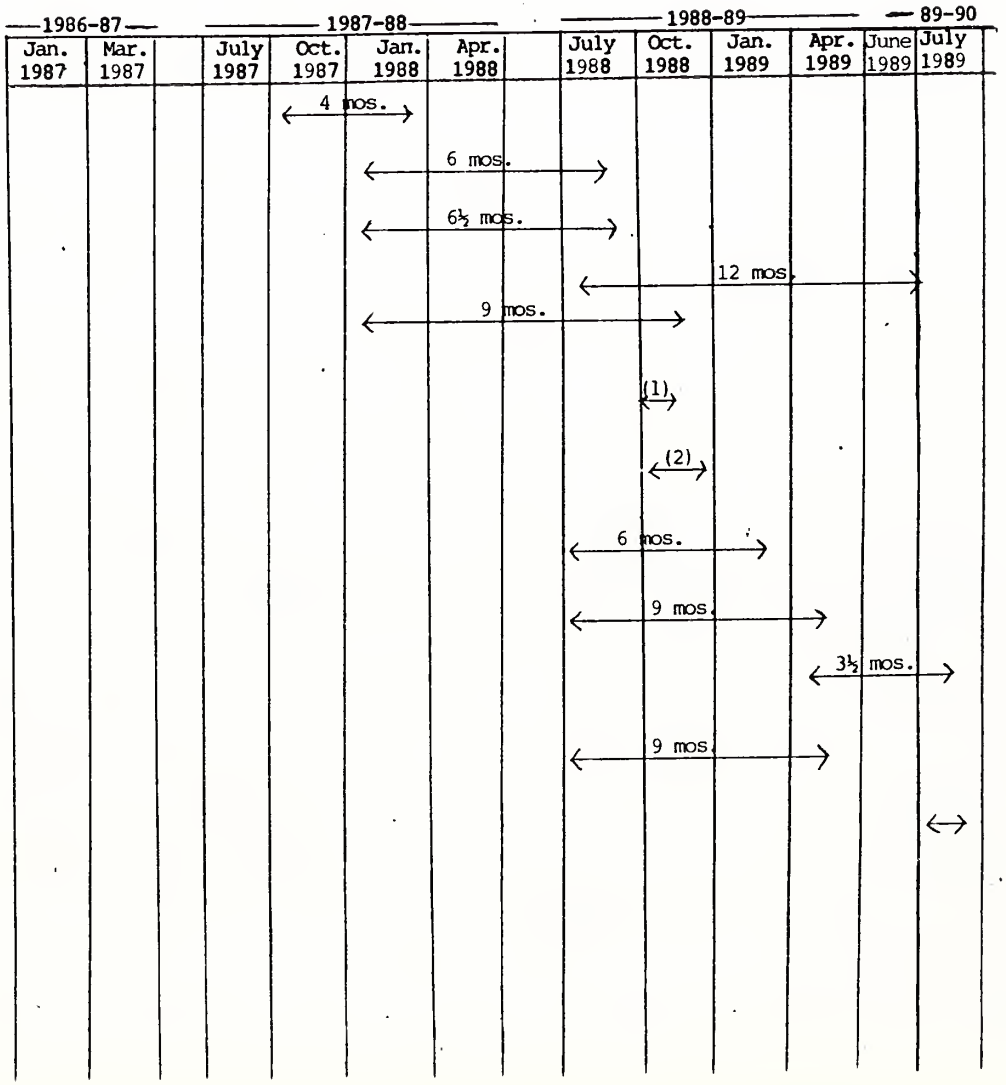
DEPARTMENT OF HUMAN RESOURCES

DIVISION OF MENTAL HEALTH, MENTAL RETARDATION & SUBSTANCE ABUSE SERVICES

FUNDING POLICY - IMPLEMENTATION SCHEDULE



14. Computer Hardware/Software Purchased and Operational (2-1-88)
15. Unit of Service Provided & Performance Indicators Reported for 4th Quarter 1987-88 (7-1-88)
16. Annual Plans & Budgets for 1988-89 Submitted by Pioneers in Appropriate Format (7-15-88)
17. Pioneers Funded in Accordance with New Policy (7-1-88)
18. Interim Report to Mental Health Study Commission (10-1-88)
19. Non-Pilot Area Programs Conduct a Simulation of Budget Realignment In Accordance With Funding Policy To Determine Funding Mix Impact (10-1-88)
20. Review By The Implementation Committee of Concepts and Consideration About Proceeding On A Statewide Basis (12-1-88)
21. Five (5) Months Report And Recommendation on Statewide Implementation to Mental Health Study Commission (1-1-89)
22. Administrative Cost at Local/State for Statewide Implementation Determined (4-1-89)
23. 1989-90 Annual Plan & Budgets Prepared by All Area Programs In New Format (7-15-89)
24. Seven (7) Months Results From Pioneers Reported to Legislature and Funds Requested By DHR For Administrative Cost of Full Implementation (4-1-89)
25. Statewide Implementation Depending Upon Assessment Modification, Policy Adjustment & APA Requirements (7-1-89)



AREA PROGRAM FUNDING MODEL
FY87 STATE AND FEDERAL ALLOCATIONS
ADJUSTED PER CAPITA FUNDING

AREA PROGRAM	MATCH %	MATCH ADJMENT	POP	ADJ. POP.	STATE $	FEDERAL $	DMH$	DMH$/ADJ.CAP.	EQUITY RATE	EQUITY AMT.	DIFF	RANK
Tri-County Area	60	1.2000	218,379	262,055	2,010,546	247,442	2,257,988	8.616473	12.951712	3,394,058	1,136,070	41
Onslow Area Prog.	63	1.2600	122,502	154,353	1,238,302	77,266	1,315,568	8.523139	12.951712	1,999,129	683,561	40
Blue Ridge Area	64	1.2800	215,606	275,976	2,399,552	138,509	2,538,061	9.196684	12.951712	3,574,358	1,036,297	39
Cumberland Area	59	1.1800	256,087	302,183	2,599,636	332,640	2,932,276	9.703654	12.951712	3,913,783	981,507	38
Southeastern Area	63	1.2600	182,004	229,325	2,010,068	303,145	2,313,213	10.087049	12.951712	2,970,152	656,939	37
Foothills Area	64	1.2800	208,693	267,127	2,634,001	254,509	2,888,510	10.813245	12.951712	3,459,752	571,242	36
Neuse Area Progra	66	1.3200	148,959	196,626	1,802,430	194,900	1,997,330	10.158022	12.951712	2,546,642	549,312	35
Catawba Area	51	1.0200	112,602	114,854	1,070,618	175,015	1,245,633	10.845356	12.951712	1,487,556	241,923	34
Albemarle Area	62	1.2400	88,763	110,066	1,118,473	53,864	1,172,337	10.651207	12.951712	1,425,545	253,208	33
Wayne Area Prog.	61	1.2200	98,638	120,338	1,216,753	120,423	1,337,176	11.111802	12.951712	1,558,588	221,412	32
Rockingham Area	65	1.3000	85,320	110,916	1,050,392	214,941	1,265,333	11.408029	12.951712	1,436,552	171,219	31
Forsyth-Stokes	56	1.1200	293,063	329,127	3,282,250	574,352	3,856,602	11.717687	12.951712	4,262,752	406,150	30
Roanoke-Chowan	72	1.4400	77,006	110,889	1,182,139	126,673	1,308,812	11.802940	12.951712	1,436,198	127,386	29
Piedmont Area	56	1.1200	220,362	246,805	2,648,698	214,921	2,863,619	11.602739	12.951712	3,196,553	332,934	28
Surry-Yadkin	66	1.3200	90,192	119,053	1,091,389	375,831	1,467,220	12.324045	12.951712	1,541,946	74,726	27
Tideland Area	65	1.3000	94,538	122,899	1,420,491	100,711	1,521,202	12.377619	12.951712	1,591,758	70,556	26
Halifax Area	72	1.4400	55,961	80,584	940,610	72,157	1,012,767	12.567867	12.951712	1,043,699	30,932	25
Cleveland Area	54	1.0800	86,102	93,055	970,148	73,729	1,043,877	11.217854	12.951712	1,205,221	161,344	24
Southeastern Reg	70	1.4000	222,441	311,...	3,362,401	585,848	3,948,249	12.678319	12.951712	4,033,388	85,139	23
Lenoir Area	61	1.2200	60,482	73,788	877,955	74,655	952,610	12.910087	12.951712	955,681	3,071	22
Edgecombe-Nash	64	1.2800	129,203	165,380	1,946,488	195,464	2,141,952	12.951712	12.951712	2,141,952	0	21
V-W-G-F Area	71	1.4200	124,159	176,306	1,841,790	496,497	2,338,287	13.262679	13.262679	2,338,287	(0)	20
Wilson-Greene	64	1.2800	80,854	103,493	1,253,071	124,875	1,377,946	13.314373	13.314373	1,377,946	0	19
Sandhills Area	65	1.3000	173,449	225,484	2,581,097	474,564	3,055,661	13.551583	13.551583	3,055,661	(0)	18
Duplin-Sampson	66	1.3200	91,928	121,345	1,466,486	179,586	1,646,072	13.565228	13.565228	1,646,072	0	17
TREND Area Pgm.	58	1.1600	91,767	106,450	1,212,432	78,081	1,290,513	12.123216	12.123216	1,290,513	0	16
Gaston-Lincoln	60	1.2000	217,410	260,892	3,372,694	304,004	3,676,698	14.092797	14.092797	3,676,698	0	15
Davidson Area	55	1.1000	118,480	130,328	1,658,649	185,902	1,844,551	14.153144	14.153144	1,844,551	0	14
Pitt County Area	55	1.1000	95,862	105,448	1,412,142	128,360	1,540,502	14.609088	14.609088	1,540,502	0	13
Guilford Area	51	1.0200	326,502	333,032	4,417,986	708,343	5,126,329	15.392900	15.392900	5,126,329	0	12
Mecklenburg Area	50	1.0000	442,498	442,498	6,968,579	592,388	7,560,967	17.087008	17.087008	7,560,967	0	11
New River Area	62	1.2400	143,086	177,427	2,907,458	206,811	3,114,269	17.552432	17.552432	3,114,269	0	10
O-P-C Area	56	1.1200	148,075	165,844	2,416,662	417,552	2,834,214	17.089638	17.089638	2,834,214	0	9
Lee-Harnett Area	62	1.2400	103,549	128,401	1,989,845	222,837	2,212,682	17.232624	17.232624	2,212,682	0	8
Wake Area Program	50	1.0000	353,801	353,801	5,672,287	557,976	6,230,263	17.609512	17.609512	6,230,263	0	7
Durham Area	53	1.0600	161,625	171,323	2,646,024	399,969	3,045,993	17.779293	17.779293	3,045,993	0	6
Rutherford-Polk	56	1.1200	71,329	79,888	1,251,968	102,315	1,354,283	16.952169	16.952169	1,354,283	0	5
Randolph Area	59	1.1800	97,233	114,735	1,812,071	257,194	2,069,265	18.035177	18.035177	2,069,265	0	4
Alamance Area	64	1.2800	124,699	159,615	2,415,237	483,658	2,898,895	18.161827	18.161827	2,898,895	0	3
Smoky Mtn. Area	64	1.2800	143,065	183,123	2,760,148	104,095	2,864,243	15.641071	15.641071	2,864,243	0	2
Johnston Area	59	1.1800	76,817	90,644	1,654,607	367,994	2,022,601	22.313663	22.313663	2,022,601	0	1
GRAND TOTAL			6,253,951	7,426,892	88,584,573	10,899,996	99,484,569	13.395183		107,279,497	7,794,928	
		MAT %/50		POP*MAT. RATE			STATE$+FED$	DMH$/ADJ.POP	MEDIAN*			

Appendix C-7

Issues to Be Addressed and Assessed During Pioneer Testing Of the Purchase of Service System

The decision about which clients and which services are inside the circle and which are outside the circle is the most important policy implication of the system. The breadth or narrowness of the circle will impact on virtually all other concepts individually and in combination. [One specific question that needs to be assessed is what is the impact on noncircle clients (particularly indigents) of the outpatient counselling visit limits.

Also questions need to be addressed about how to deal with the issue of client's changes in functioning levels.

Pioneer testing of the concept and implementation of standardized levels including consideration of how those will be "officially" established must be undertaken.

The client characteristic data items to be required to be collected at the area level and those that must be reported routinely to the State.

Rather than adopt a specific method for determining the best approach to account for administrative and capital costs prematurely, it is recommended that a variety of mechanisms (and their policy impact) be assessed through the pioneer effort.

One of the objectives of the pioneer effort is to examine the policy ramifications and actual impact of a variety of cost sharing alternatives.

The quality assurance requirements of area authorities must be developed and assessed through the pioneer effort.

Because appropriations categories transferability is limited to the rules of the Executive Budget Act service program complications arise for "aging" out clients (those who reach adulthood while continuing to need specific service) and for dually diagnosed clients.

The formats and procedures for area budget proposals must be developed and assessed through the pioneer effort.

Additional issues may arise during testing and the project team, the sites, and the Implementation Advisory Committee should have authority to raise issues as they may become necessary.

Appendix D

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR PIONEER TESTING OF FUNDING POLICY PROPOSALS FOR MENTAL HEALTH, MENTAL RETARDATION, AND SUBSTANCE ABUSE.

The General Assembly of North Carolina enacts:

Section 1. Part 4 of Article 4 of Chapter 122C of the General Statutes is amended by adding a new section to read:

"**§122C-151.1 Pioneer Testing.** (a) Notwithstanding G.S. 122C-147 through G.S. 122C-150, the Secretary may implement a pioneer testing program for state funding of area authorities. Such implementation shall generally be as recommended by the Mental Health Study Commission in its February, 1987 report to the General Assembly. After consideration of the sites recommended by the Mental Health Study Commission in that report, pioneer sites shall be chosen by the General Assembly, except that if the General Assembly has not chosen the sites by August 1, 1987, they shall be chosen by the Secretary. In implementing the pioneer testing program, the Secretary may waive Department and Commission rules relating to budget formats and program standards.

(b) The Secretary shall report to the Mental Health Study Commission on a regular basis the implementation of the pioneer testing program."

Sec. 2. There is appropriated from the General Fund to the Department of Human Resources for fiscal year 1987-88 the sum

of _____ to cover Department and pioneer site administrative costs in implementing this act, including personnel and information systems.

Sec. 3. This act is effective upon ratification, except Section 2 shall become effective July 1, 1987.

ADDENDUM*

The Mental Health Study Commission, at its final meeting on February 9, 1987, in accordance with and after approval and adoption of the Final Report, elected to recommend the five following area programs for pioneer testing of the funding policy proposals:

Lg Single Urban County:	**Guilford**
Lg Multi-County Urb/Rur:	**Blue Ridge**
Lg/Med Rur. Multi-County:	**Sandhills**
Sm/Med Rur. Multi-County:	**Roanoke-Chowan**
Sm/Med Single County:	**Halifax**

*This language is not a part of this proposed legislation, but is inserted here for ready referrence for the reader.

North Carolina Council of
Community
Mental Health,
Mental Retardation &
Substance Abuse Programs

PO Box 26206, Raleigh, North Carolina 27611 (919) 755-0680

RESOLUTION:

RESPONSE TO THE PROPOSED FUNDING POLICY PLAN
UNDER CONSIDERATION BY THE MENTAL HEALTH STUDY COMMISSION
(resolution adopted by the NC Council on January 9, 1987 in Greensboro)

WHEREAS:

- The NC Council strongly supports the basic goals and concepts of the proposed plan for State funding of the public mental health, mental retardation and substance abuse services in North Carolina, which are understood to be: (a) a clearer delineation of clients for whom State dollars may used; (b) equity of available services to those clients throughout the state; (c) local authority to provide needed services to clients for whom the State does not pay; (d) enhanced quality assurance; and (e) improved accountability based on fewer and broader appropriation categories, performance contracting using a prospective unit cost reimbursement system and simplified uniform client data.

- The NC Council believes the changes proposed in the plan will provide needed direction to guide the MH/MR/SA system and will help assure that State and local funds are being effectively used to meet the needs of the mentally and chemically disabled citizens of North Carolina.

- The NC Council feels that the plan (as tentatively adopted by the Mental Health Study Commission on 12/17/86), leaves unanswered some important questions about the process of refinement and implementation which, if addressed prior to final action by the General Assembly, will help assure that the opportunities embodied in the plan are not squandered by hasty implementation and costly administrative requirements.

THEREFORE BE IT RESOLVED:

THAT NC Council strongly urges that the following points be attached as additional guidance to the policy plan that is transmitted to the General Assembly.

1. **Realistic timetables for pioneer testing to assure successful statewide implementation.** Recent experience with the Willie M unit cost system clearly indicates that two years is insufficient time to move from development and demonstration of new systems of client information, budgeting and reimbursements to statewide implementation. Adequate time must be provided to evaluate the impact of these changes on clients, on state and county budgets and on the statewide policy decisions to be faced by the General Assembly. While some limited elements of the plan might be ready for statewide action by July 1989, a more realistic target to begin full statewide implementation would be July 1991, leaving open the possibility of an earlier startup if all issues are resolved sooner. The extended time frame would allow first for the development of a data simulation model prior to the pioneer project stage, and then for an adequate evaluation process of the pioneer experience prior to statewide implementation.

2. **Develop simplified administrative procedures during the trial phase of the plan.** Complex definitions for client eligibility in the proposed circle of services will lead to an extremely complicated eligibility determination process. Consistent with the valid goals of setting limits and assuring

accountability in the use of state funds, the Project Director should be explicitly directed to seek ways of simplifying the proposed administrative procedures and minimizing administrative costs. Toward that end, consideration should be given to the funding model used in Colorado which allows state funds to be used for a percentage of clients (say 10%) outside the state circle of services. Such a system would allow local programs the latitude of accounting for state funds on a regular summary basis rather than on a client-by-client basis.

3. **A clearly defined evaluation plan to verify the achievement of plan results** should be explicitly called for in the authorizing legislation. Such a plan would be developed jointly by the Division project staff and the implementation advisory committee before the end of 1987 and would specify the criteria to be used in monitoring and evaluating the pioneer projects. In addition to considering the administrative and funding allocation elements of the new system, the evaluation plan should particularly address the identification of such key policy consequences as the impact of the new system on actual client services and its effect on the role of the area programs as primary providers of comprehensive community mental health, mental retardation and substance abuse services.

4. **Responsiveness to local needs in the resolution of implementation conflicts.** Based on past experience, there is a real risk that local needs and circumstances will not be adequately considered in the resolution of conflicts and questions during the pioneer and implementation process. Colorado's experience clearly indicates that such conflicts will arise and that they should be anticipated and systematically managed. An appeal process should be built in to the plan dealing with state/local differences over such things as the negotiation of unit costs. In that light, it is requested that the composition of the implementation advisory committee be modified to include one area program director and one area board member to more adequately reflect both the technical and policy issues involved in local implementation.

5. **Equity of service availability is a long-term goal.** Statements in the proposed plan regarding "catch-up" funds suggest that one investment of state funds will resolve the existing problem of inequality among area programs across the state. After that, the plan indicates that the concept of "standardized levels of care" will assure that state funding levels will move towards greater equity in service availability in all parts of the state. The significance of this issue deserves even more recognition as a stated goal of the plan. Particularly, the following objectives should be made explicit: (a) that equity in service availability is a central goal of the proposed plan and the achievement of this goal (within the framework of standardized level of care) is likely to require additional appropriations of state funds to those areas which have less funding; b) that, in the future, the utilization of state institutional resources be clearly incorporated as an element in the determination of state funding equity. At the same time, the derivation and ultimate utilization of the adjusted per capita formula should be clarified in the final report. Understanding would be improved by a comparison of the adjusted formula for allocating catch up funds with a straight per capita formula.

6. **Recognition of the special needs of children.** Particular attention must be paid to the special mental health needs of children where early intervention can have a significant impact on reducing the severity of disability later in life. In that light, it is recommended that the service funding levels called for in the Mental Health Study Commission's report on Child Mental Health Services be incorporated in the circle of service element of the Funding Task Force Report.

North Carolina Child Mental Health Plan:
A COMPREHENSIVE SYSTEM OF CHILD MENTAL HEALTH SERVICES

NORTH CAROLINA
MENTAL HEALTH STUDY COMMISSION
(Adapted from the report of its
TASK FORCE ON CHILD MENTAL
HEALTH SERVICES)

February 1987

INTRODUCTION

This document outlines a comprehensive system of mental health services for North Carolina children and youth to be provided by the publicly supported area programs and state institutions.

To effectively respond to the broad range of child mental health problems and their various causes, two factors must be recognized. First, the comprehensive system of child mental health services must have the flexibility and capacity to respond to any children and youth with mental health problems who present themselves, are presented by their families or are referred by other child-serving agencies. It is acknowledged that each area program cannot realistically provide all needed services. In many instances area programs will have to provide access to appropriate services within their areas to children and youth from nearby catchment areas. Second, publicly supported programs are only one source of mental health services. Public programs must coordinate with services of the private sector, other state and local agencies, churches, civic groups, advocacy groups and private professionals so that together they can meet the extensive mental health needs of our children and their families.

Four elements are necessary for the implementation and effective functioning of the comprehensive system of mental health services for North Carolina children and youth:

1. a common philosophy throughout the system;
2. common mental health principles across the state;
3. system supports for services; and
4. an integrated array of services.

Adequate and flexible funding must be provided to realize this comprehensive system of mental health services. It is further recognized that to increase child mental health services to the essential levels specified in Section IV of this document will require commensurate funding.

However, to increase the number of services without improving the delivery system is simply not enough. A cooperative, synchronized system of services that utilizes all its resources on behalf of a child is far more powerful than the individual efforts of each service.

I. Philosophy of Child Mental Health Services in North Carolina

A basic set of beliefs shall guide child mental health services in North Carolina.

- Each child or youth is unique and individually worthy, and shall receive services that recognize this individuality.

*Wherever the word parent(s) is used in this document, consider this inclusive of parent surrogates or other legally responsible persons.

- Children and youth have varying degrees and types of emotional problems requiring access to clinically appropriate mental health services regardless of their legal status, other disabilities, place of residence in North Carolina, their family's ability to pay or the willingness of their parent(s)* to participate in treatment.

- Each child or youth deserves to be treated as a whole person who has social, emotional, educational, medical and vocational needs that are interconnected.

- Children and youth with the most serious emotional problems are often unable to function effectively and have diminished chances for normal growth and development.

- Children and youth are best served when mental health problems are prevented or identified and treated early.

- Each child or youth needs the involvement and support of a caring family. Disruptions in living situations often result in increased severity of emotional problems.

- Children and youth with emotional problems are best served in programs which provide treatment in settings which are most consistent with normal living, as is clinically appropriate.

- Children and youth with emotional problems are likely to attain effective functioning when they receive quality services provided by professionals who are knowledgeable of current advances in theory and practice.

II. Mental Health Principles

The principles are consistent with the common philosophy of the system. These principles are guidelines which the Department of Human Resources and the Division of Mental Health, Mental Retardation and Substance Abuse Services shall use in allocating funds and specifying actions for moving beyond the current level of services toward the comprehensive system of services. In many instances, these principles are goals for the future efforts of the Division of Mental Health, Mental Retardation and Substance Abuse Services.

- Because each child or youth is a unique, whole person the assessment team shall ensure that each child's social, educational, medical, vocational and emotional strengths and deficits are thoroughly assessed. Such assessments often will require an interdisciplinary evaluation and diagnosis.

- Each child or youth shall have an individual treatment plan based on their own unique needs. The treatment plan shall be written by the primary treatment agency with the participation of the child or youth, parents, agencies and others involved with the child or youth.

- Each child or youth with more than one service need shall receive case management to plan, arrange, coordinate and monitor the delivery of diverse services across all public and private agencies. Case management shall coordinate all treatment and eduction plans so that involved agencies will be working toward similar goals. Case managers shall have authority to access information and services across agencies.

- Children and youth shall not be refused treatment or rejected from treatment because the Essential Mental Health Services are not immediately available. All avenues will be pursued to meet the child or youth's identified needs with appropriate mental health services.

- Specific services provided shall be consistent with the child's age, developmental functioning and degree of disability. The rights of individuals and their ethnic and cultural values will be protected in the delivery of services.

- To optimize a child or youth's growth and development, area programs shall provide activities aimed at preventing mental health problems from occurring and which promote early identification and intervention.

- Services shall be designed to maintain the child in the family (or family setting) when it is clinically advisable. Efforts shall be made to improve the family's skills so that it can contribute positively to the mental health of their child.

- To minimize disruptions in a child or youth's life, services shall be delivered within the most normal setting consistent with their identified needs. Residential services shall be used only when less restrictive, non-residential options are determined to be ineffective. Institutional settings shall be used only when community-based services are ineffective in meeting the child or youth's treatment needs.

- A full array of Essential Mental Health Services shall be available to respond to children and youth with varying degrees and types of mental health problems. A child or youth whose individual needs change during the course of treatment shall have timely access to services which most effectively meet those needs.

B. Funding Supports

. Appropriations for child mental health services shall allow area programs flexibility to move funds between services to better meet the identified treatment needs of children and youth.

. The use of funds shall be flexible across the Mental Health, Mental Retardation and Substance Abuse Sections of the Division in order to serve children and youth who have more than one disability.

. The Division shall set long-term planning and funding goals that will lead to the development of the full array of Essential Mental Health Services for children and youth.

. Funding incentives shall support area programs in providing the Essential Mental Health Services in the least restrictive, clinically appropriate setting, with emphasis on prevention and early intervention and with the cooperation of other agencies.

. Funding shall be made available for transporting clients to services, for consultation and education with other caregivers and for case management activities.

C. Inter-Agency Supports

. Policy review mechanisms within the Department of Human Resources shall make certain that the mandates and policies of each Division complement each other and ensure cooperation in the delivery of services.

. Formal agreements between State Departments and between Divisions of the Department of Human Resources shall identify service barriers and provide mechanisms to reduce those barriers. The agreements shall also specify how to access services, who has service responsibility, accountability for serving children and what resources are committed for cooperative service delivery. Active mechanisms shall exist to oversee and enforce the terms of the agreements.

. Formal agreements between State Departments and between Divisions of the Department of Human Resources shall specify a process for local agencies to designate a lead agency responsible for the case management of children and youth who require the involvement of more than one agency. State and local agreements shall specify funding for case management.

. State Departments and Divisions of the Department of Human Resources shall give leadership to local agencies in providing cooperative and comprehensive services for children and youth. This shall include assisting local agencies in

forming cooperative agreements, jointly planning services and meeting the needs of very difficult children and youth.

D. Public Relations Supports

. Public information media shall be used to increase public awareness and support for mental health and to identify children and youth who need mental health services.

IV. The Essential Mental Health Services of the North Carolina Comprehensive System of Child Mental Health Services

The comprehensive system of services in North Carolina shall provide a variety or array of services that are integrated and synchronized with those of other child-serving agencies, public and private. These services shall be provided consistent with the mental health principles in Section II of this document.

The comprehensive system shall have the following Essential Mental Health Services which shall be developed and funded according to priorities set forth in this plan. Area programs and institutions may adapt and modify services as necessary to meet a child or youth's unique needs.

PERIODIC SERVICES

A. Community Education

Basic Requirements:

Each area program shall provide services which promote the normal growth and development of children and youth in order to prevent the occurrence of mental health problems. Services include, but are not limited to:

a. community education;
b. training of parents and other caregivers on issues such as adolescent suicide, teenage pregnancy and parenting skills;
c. support of volunteer and civic groups and individuals promoting mental health activities; and
d. the promotion of self-help groups.

B. Early Intervention

Basic Requirements:

Each area program shall provide services which identify and provide treatment for children and youth before their mental health problems become serious. Services include, but are not limited to:

a. consultation and training to parents and other caregivers;
b. campaigns to identify children-at-risk; and
c. early treatment through services such as day treatment/education, in-home treatment and outpatient treatment.

C. Emergency Services

Basic Requirements:

Each area program shall provide access to 24-hour emergency assessment and evaluation (including face-to-face contact when appropriate), referral to appropriate services and short-term crisis counseling. Such specialized services shall be the responsibility of the area program, but should be provided in timely coordination with all existing local children's emergency service systems. Examples of these service systems include emergency shelters and crisis intervention teams that operate along with social services caseworkers in abuse and custody cases.

D. Case Management

Basic Requirements:

Each area program shall provide case management or ensure access to case management for children and youth with more than one service need by means of agreements with other child-serving agencies. Case management includes case planning, service brokerage, client advocacy and monitoring of services delivered to clients.

E. Outpatient

Basic Requirements:

Each area program shall ensure the availability and accessibility of adequately staffed outpatient services for children and youth which include, but are not limited to:
a. diagnosis and evaluation;
b. emergency counseling;
c. home-based counseling and support;
d. individual, family and group therapy; and
e. life-skills training.

DAY/NIGHT SERVICES

Basic Requirements:

Each area program shall ensure the availability and accessibility of adequately staffed day/night services for children and youth which include but are not limited to:

a. day treatment/education programs;
b. night care;
c. partial hospitalization;
d. sheltered workshop; and
e. supported employment.

RESIDENTIAL/INPATIENT SERVICES

A. Residential

Basic Requirements:

Each area program shall provide or have access (on at least a subregional level) to specialized, long-term and intermediate stay residential care. This includes group homes, therapeutic homes for individual children and supervised apartment living. In addition, special schools for the emotionally disturbed shall be available at the regional level. These services shall be age appropriate and be available until age 18.

B. Inpatient

Basic Requirements:

Each area program shall have reasonable access to inpatient services, including short-term and long-term inpatient care (available at least at a regional level). Emergency inpatient services shall be provided on a subregional level.

SYSTEM SUMMARY

The Mental Health Study Commission recommends this system as policy for North Carolina to use in the development and promotion of child mental health services. Service planning and development in accordance with this comprehensive system of child mental health services will best meet the needs of North Carolina children and youth with mental health problems.

STRATEGIES FOR THE IMPLEMENTATION OF THE COMPREHENSIVE SYSTEM OF CHILD MENTAL HEALTH SERVICES FOR NORTH CAROLINA CHILDREN AND YOUTH

The Mental Health Study Commission is proposing the **Comprehensive System of Child Mental Health Services for North Carolina Children and Youth** as policy guidance for North Carolina. This section of the document sets forth the strategies that should be taken to implement the **Comprehensive System of Services.**

The strategies presented are divided into two categories. They are;

1. strategies for the development and funding of child mental health services and
2. strategies for systems development of child mental health services.

These strategies are presented by the Mental Health Study Commission for consideration by the North Carolina General Assembly and the Department of Human Resources.

STRATEGIES FOR THE DEVELOPMENT AND FUNDING OF CHILD MENTAL HEALTH SERVICES

PRIORITY POPULATIONS FOR INCREASED SERVICES AND NEW SERVICES DEVELOPMENT

Three priority populations are considered by the Study Commission as the focus of increased services development over the next five bienniums. Each of these populations should receive concurrent attention. They are:

1. Seriously emotionally disturbed children and youth who are not Willie M. Classmembers;
2. Young children, ages 0 to 7 years old, who can most benefit from early intervention and prevention activities; and
3. Children and youth with more than one disability.

The goal of service development for these populations is to provide timely treatment in the community and thereby prevent the unnecessary admission of these children and youth into institutions.

Area programs and institutions are providing treatment to many children and youth in these three priority populations as well as to many others. The Study Commission recommends increased efforts to coordinate between other public and private agencies which provide treatment in order to meet the extensive demands for child mental health services and to most effectively utilize state dollars.

In addition to the recommendations in the area of child mental health, the Study Commission has made additional recommendations to the General Assembly regarding area program funding policies. If the General Assembly adopts the funding recommendations, the policy changes will be tested in several pioneer area sites.

The funding policy recommendations also suggest that any new service funding during the period of pioneer testing follow the policy recommendations incorporated in that report as much as possible. As such, the following recommendations regarding service development have been slightly revised (from the original Child Task Force Report dated April 1986) to conform to funding policy recommendations.

If the General Assembly adopts changes in funding policies for area mental health, mental retardation and substance abuse programs in general, it is expected that those decisions will prevail over these specific recommendations.

PRIORITIES FOR INCREASED SERVICES AND NEW SERVICES DEVELOPMENT

After studying the needs of North Carolina children and youth with mental health problems, the Study Commission recognizes the uneven development of mental health services across the state. It is therefore recommended that increased state funding over the next five bienniums be made available to develop services based upon each area's need for these services.

The funding policy recommendations suggest funding at the category level of Child Mental Health. Within this broad category area programs would have the flexibility to allocate resources to a wide range of service types within the subcategories of "periodic", "day/night", and "residential/inpatient". An area program would project need for new service funding specific to service types and projected units of service to be delivered. However, some degrees of flexibility would be allowed to meet special circumstances during a given contract period.

While acknowledging this general funding policy recommendation, the study of child mental health service needs led the Study Commission to identify the following categories as services that appear to be needed statewide. Allocation of new service funds to specific areas should be made where these service needs exist.

Category # 1

Community-Based Nonresidential Services. These services are less costly than residential services and are often effective in reducing the need for future residential placements. These services are:

1. Outpatient Services, including:
   a. diagnostic and evaluation capabilities;
   b. intensive in-home therapy services as an alternative to removing a child from the home;
   c. individual and family counseling; and
   d. day treatment/education programs as needed.
2. Case Management for children with more than one service need.
   a. Case management includes case planning, brokerage of services, client advocacy and monitoring of services provided.
   b. Case management can be done by the primary therapist (if therapy caseloads are 20-22 children) or by other persons hired to do the service.
3. Emergency Services, which include:
   a. crisis assessment and counseling, and
   b. emergency facilities accessible to each area program.
4. Transportation Services for children and families who need assistance in getting to treatment services.

Category # 2

Community-Based Residential Treatment Programs For Seriously Emotionally Disturbed Children and Youth. These services include:

1. emergency shelters and respite care homes;
2. supervised independent living programs;
3. therapeutic homes for individual children;
4. group homes (with day treatment/education programs, as needed); and
5. substance abuse programs for adolescents that are jointly developed by mental health and substance abuse professionals.

These services shall be developed in each area program or be readily accessible on a subregional level.

Category # 3

Prevention and Early Intervention Services, including:

1. consultation and training for parents and other caregivers;
2. support groups for teens on issues such as pregnancy prevention, family life skills and being a new parent;
3. home-based treatment and day treatment/education programs for young children, as needed;
4. campaigns to identify children at risk of developing mental health problems; and
5. community education.

These services shall be "decategorized" so that they can serve children with more than one disability. These services shall be available in each area program.

Category # 4

Regional and Subregional Facility beds to be maintained in accordance with actual needs. These services include:
1. Inpatient Regional Hospital Units, and
2. Special Care Facilities, such as Re-Education programs.

GENERAL GUIDELINES FOR THE ALLOCATION OF NEW FUNDS TO AREA PROGRAMS

The Study Commission recommends that the following guidelines be utilized by the Department and the General Assembly in making decisions regarding the allocation of new service funds--until such time that general funding policies are changed statewide.

1. Funding shall be allocated to area programs that demonstrate that they are developing services consistent with the Philosophy and Principles stated in the **Comprehensive System of Services.** [Special attention should be given to each area's cooperative working arrangements with other child serving agencies.]
2. Funds shall be allocated to develop the Essential Mental Health Services for each of the priority populations listed on page 9.
3. The Essential Mental Health Services that currently exist shall receive increased funding to maintain them at adequate levels of service.
4. Funding shall be allocated to equalize the availability of the Essential Mental Health Services across the state in relation to identified needs of children and youth for these services. The emphasis in allocating limited funds shall be on increasing services in those area programs with the greatest lack of services.

HOW SHALL THE DIVISION OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES DETERMINE HOW MUCH FUNDING TO ALLOCATE TO EACH AREA PROGRAM AND INSTITUTION?

Until such time that the General Assembly adopts different statewide funding policies (either in accordance with current recommendations or alternatives) it is recommended that planning and budgeting for child mental health services be undertaken as discussed below.

Strong consideration must be given to the service planning and budgeting process of the Division of MH/MR/SAS in order to develop

the **Comprehensive System of Services** over the next five bienniums. The process recommended below is consistent with the current organizational structure of the Department of Human Resources and will have to be modified if that structure changes in the future.

1. The Division of MH/MR/SAS shall work with area programs to conduct a uniform assessment of service needs of the priority populations. The assessment shall involve local child-serving agencies and area program disability sections. The Division shall analyze the results and provide them to area programs for use in planning and budgeting over the next five bienniums.
2. Area programs shall determine their funding requests for increased and new services based upon:
   a. the Philosophy and Principles of the **Comprehensive System of Services;**
   b. results of the interagency and cross-disability needs assessment on the priority populations;
   c. listed priorities for service development for those populations during each biennium over the next five bienniums;
   d. a determination of which services to request funds to develop and which services to request available access within the Region (developed by another area program); and
   e. interagency service planning and coordination in the delivery of services.

   The budget requests will be submitted to the Regional Offices and the Central Office of the Division of MH/MR/SAS.
3. Institution plans and budget requests shall be developed consistent with the Philosophy and Principles of the **Comprehensive System of Services** and submitted to their Regional Office and the Central Office of the Division of MH/MR/SAS for review.
4. The Regional Offices shall verify the plans and budget requests using guidelines developed by the Division of MH/MR/SAS, as specified in the COORDINATION, DATA COLLECTION and MONITORING Sections. The Regional Management Teams shall review the plans and budgets and decide which area programs will develop services, such as group homes, that are shared across catchment areas in the Region. The Regional Offices shall negotiate necessary changes and forward the revised plans and budgets to the Central Office of the Division of MH/MR/SAS.
5. The Director of the Division of MH/MR/SAS shall ensure that plans and budget requests are consistent with the Philosophy and Principles of the **Comprehensive System of Services.**
6. The budget requests from the Division of MH/MR/SAS to the Department of Human Resources shall accurately reflect the actual service priorities of area programs, as developed in each region.

HOW SHALL CHILD MENTAL HEALTH SERVICES BE FUNDED BY THE NORTH CAROLINA GENERAL ASSEMBLY?

In order to provide for the effective use of funds allocated by the Legislature, it is necessary for the Legislature to adopt a funding model that will be followed in the preparation of budget requests for child mental health services. The following model is suggested for consideration by the Legislature. Funds appropriated by the Legislature will be allocated by the Division of MH/MR/SAS according to the process outlined in the above Section.

HOW SHALL THE DIVISION OF MH/MR/SAS DETERMINE HOW MUCH FUNDS TO ALLOCATE TO EACH AREA PROGRAM AND INSTITUTION?.

1. Funds shall be requested, allocated and accounted for in the categories of Child Mental Health Services and Willie M. Services (until Willie M. Services are united with Child Mental Health Services). [Current budget categories should be adjusted to these categories if and when this policy is adopted for statewide implementation.].
2. New child mental health appropriations should be made consistent, as much as possible, with the funding policy recommendations of the Study Commission and should provide for the following:
   a. flexibility for area programs to move funds from one service to another, as needed, within each of the two funding categories;
   b. allocations of funds to area programs with the least services as compared to need, while maintaining the current levels of services in other area programs;
   c. incentives for area programs to develop services according to the Philosophy and Principles of the **Comprehensive System of Services**; and
   d. accountability for the use of allocated funds.
3. When the Legislature reviews requests for increased funding for child mental health services, it can review these requests for consistency with the phase-in of the **Comprehensive System of Services** and the funding policy recommendations.
4. The Essential Mental Health Services of the **Comprehensive System of Services** shall be funded by the state and phased-in each biennium over the next five bienniums.
5. After appropriations have been made by the General Assembly, the Division of MH/MR/SAS is responsible for allocating funds promptly to area programs and institutions according to legislative mandates and the **Comprehensive System of Services.**
6. Once funds have been allocated by the Legislature, based upon area program plans approved by the Division of MH/MR/SAS, these funds shall be allocated to area programs without delay caused by duplicative approval processes.

HOW SHALL THE IMPLEMENTATION OF THE COMPREHENSIVE SYSTEM OF SERVICES PLAN BE MONITORED BY THE NORTH CAROLINA GENERAL ASSEMBLY?

In order to ensure that the Comprehensive System of Services is followed by the Department of Human Resources and the Division of MH/MR/SAS as they develop child mental health services in North Carolina, it is important that the North Carolina General Assembly monitor the implementation of the plan.

The Department of Human Resources shall make annual reports to the Mental Health Study Commission on progress being made to implement the Comprehensive System of Services. The Commission has the authority to make recommendations to the Governor and the General Assembly based upon its findings.

NEW SOURCES OF REVENUE FOR CHILD MENTAL HEALTH SERVICES

The Secretary of the Department of Human Resources shall explore new funding sources for child mental health services. Examples of funding sources to be investigated are:

1. private insurance payments for non-hospital community residential services;
2. private insurance payments for family therapy and case management services;
3. private insurance payments to area programs as eligible service providers, not just center services provided by psychiatrists;
4. joint programming with other child-serving agencies which expands quality services available and maximizes the use of federal and state dollars with small amounts of increased funds. Joint programming with Developmental Evaluation Centers, the Division of Youth Services, departments of social services and local school systems should be considered;
5. modification of the state Medicaid plan or a medicaid waiver for child mental health services that allows a more expansive use of federal and state dollars for community-based services; and
6. a development officer designated by the Department of Human Resources to provide technical assistance to local agencies to raise funds for the support of children's services.

STRATEGIES FOR SYSTEMS DEVELOPMENT OF CHILD MENTAL HEALTH SERVICES

ADOPTION OF THE COMPREHENSIVE SYSTEM OF SERVICES FOR NORTH CAROLINA

In order to communicate clearly their support and commitment, it is recommended that the Secretary of the Department of Human Resources and the Director of the Division of Mental Health, Mental Retardation and Substance Abuse Services, by August 31, 1987 or 30 days after adoption by the Legislature, formally adopt the **Comprehensive System of Services** to use for the development of child mental health services in North Carolina. Should there be a change of Secretary or Director during the 10 year period of this plan, it is recommended that he/she adopt the plan within 90 days of appointment.

COORDINATION BETWEEN SECTIONS OF THE DIVISION OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

The Director of the Division of MH/MR/SAS shall identify, within 60 days after the adoption of this plan by the Legislature, an individual or group of individuals to take the following steps.

1. Using the **Comprehensive System of Services** as a planning document, coordinate data collection (Client Information), service development (Disability Sections and Willie M.), funding (Fiscal Office) and monitoring (Quality Assurance) into a unified effort with fixed responsibilities.
2. Recommend how to share programs, staff and funds across Disability Sections and Willie M. to meet the needs of children and youth with more than one disability.
3. Ensure that decisions on funding and services development impact on the priority populations outlined in this plan and are consistent with the statewide phase-in of the **Comprehensive System of Services** over the next five bienniums.
4. Upon meeting the obligations of the lawsuit, work with the Willie M. Review Panel and with outside experts to develop a long-range plan to unite Willie M. and non-Willie M. services within the Division of MH/MR/SAS.
5. Review local interagency agreements for completeness, for consistency with the **Comprehensive System of Services** and for effective implementation.
6. Establish a procedure to resolve appeals from the Division's local and regional levels concerning children whose needs are not being met.
7. Effectively use a state interagency council to resolve the cases of difficult-to-serve children whose needs involve other child-serving agencies.

8. Monitor and report regularly on progress being made by the Division of MH/MR/SAS toward implementing the **Comprehensive System of Services** through the strategies presented in this document that are the responsibility of the Division director.

DATA COLLECTION WITHIN THE DIVISION OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

The Director of the Division of MH/MR/SAS shall identify, within 60 days after the adoption of this plan by the Legislature, an individual or group of individuals to take the following steps.

1. Decide what client information shall be collected from area programs and institutions for service planning and monitoring purposes, keeping it as simple as possible.
2. Design the forms necessary to gather the client information needed and ensure that computer systems at the state, region and local levels are compatible to store and retrieve the needed information.
3. Design mechanisms to share all client information collected with area programs and institutions.
4. Ensure that timely information on services utilization is available to the Disability Sections and Willie M. to use for budgeting decisions.

MONITORING AND EVALUATION OF SERVICES OF THE DIVISION OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

The Director of the Division of MH/MR/SAS shall identify, within 60 days after the adoption of this plan by the Legislature, an individual or group of individuals to take the following steps.

1. Devise a mechanism to do periodic onsite monitoring of the quality of mental health services for compliance with Division of MH/MR/SAS indicators of quality performance and standards. Information from monitoring shall be used in the budget and service planning process by area programs, institutions, Regional Offices and the Division of MH/MR/SAS.
2. Develop mechanisms to include representatives of other child-serving agencies as part of the monitoring teams.
3. Assess how to reduce the volume of standards and to increase their effectiveness. Clear, effective criteria should be developed for monitoring purposes.

INTERNAL POLICY AND RULE MECHANISMS OF THE DIVISION OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

The Director of the Division of MH/MR/SAS shall identify, within 60 days after the adoption of this plan by the Legislature, an individual or group of individuals to take the following steps.

1. Lead a review of standards to ensure consistency between Division Sections so that they allow services to be accessible across Disability Sections and to be flexible in meeting the identified needs of children and youth.
2. Coordinate surveys and questionnaires for information to area programs and institutions through the Client Information and Research and Evaluation Branches to avoid duplication, to ensure that the data collected is stored for other similar requests and to collect data in the most efficient manner.
3. Develop standards, with area program input before the review process, for any Essential Mental Health Services that are not currently mandated for area programs.
4. Develop rules that specify an assessment or reporting tool in the Client Record Manual to be used for an assessment of a child or youth's strengths and deficits.
5. Assess rules in the Client Record Manual to determine if they are adequate in specifying a uniform format for treatment plans across Disability Sections.

TRAINING AND TECHNICAL ASSISTANCE IN THE DIVISION OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

The Director of the Division of MH/MR/SAS shall identify, within 60 days after the adoption of this plan by the Legislature, an individual or group of individuals to take the following steps.

1. Coordinate each Section's child and adolescent training activities. Training plans and proposed events shall be reviewed to determine whether they best meet the training goals of the Division of MH/MR/SAS. Local program input shall be considered in developing training goals.
2. Provide cross disability training whenever appropriate and eliminate duplicative training events for only one Disability Section.
3. Explore ways to coordinate needed training with non-Division resources such as AHEC, DDTI, other child-serving agencies and private businesses to meet ongoing training needs.
4. Develop a plan for adequate funding to provide ongoing skills training for new staff of mental health programs and to disseminate new treatment technologies. Special attention should be given to providing training on cultural and ethnic differences as they affect the treatment of children and youth.

5. Explore the granting of scholarships to graduate students in exchange for a guaranteed number of years of service in an area program or institution.
6. Explore ways of integrating the skills needed by program staff into courses offered by universities in the state.

PUBLIC RELATIONS SUPPORTS

The Director of the Division of MH/MR/SAS shall identify, within 60 days after the adoption of this plan by the Legislature, an individual or group of individuals to take the following steps.

1. Encourage and assist area programs in developing and using public information media to promote positive mental health practices, to encourage the identification of children at risk for mental health problems and to increase local support for mental health program services.
2. Interact responsibly with advocacy and consumer groups to support, at the state and local levels, the implementation of the **Comprehensive System of Services.**

INTERAGENCY SUPPORTS

POLICIES AND MANDATES OF DIVISIONS OF THE DEPARTMENT OF HUMAN RESOURCES*

The Secretary of the Department of Human Resources shall identify, within 60 days after the adoption of this plan by the Legislature, an individual or group of individuals to take the following steps over the next five bienniums to phase-in the **Comprehensive System of Services.**

1. Examine statutes, mandates, standards and rules of each Division in order to accomplish the following:
   a. describe the present barriers to cooperative service planning and service delivery and how they can be reduced;
   b. specify services that can be jointly developed, coordinated or provided across Divisions in order to meet the needs of children and youth with mental health problems;
   c. recommend incentives that could be developed at the state, region and local levels to encourage joint program planning and coordinated service development; and
   d. recommend how future Department of Human Resources budget requests can reflect priorities agreed upon by the Division Directors for all children's services.
2. Develop a plan to coordinate and synchronize automated data collection systems across Divisions so that aggregated client data is available for the joint planning of services.

3. Explore ways to coordinate training across Divisions to meet mutual training needs.
4. Develop information packets and television and radio adds for local use in promoting positive mental health practices and increasing support for improved mental health services.

FORMAL AGREEMENTS BETWEEN STATE DEPARTMENTS** AND DIVISIONS OF THE DEPARTMENT OF HUMAN RESOURCES

The Secretary of the Department of Human Resources shall identify, within 60 days after the adoption of this plan by the Legislature, an individual or group of individuals to take the following steps over the next five bienniums to phase-in the **Comprehensive System of Services.**

1. Initiate discussions with State Departments and Divisions within the Department of Human Resources on how to provide coordinated state level leadership and technical assistance to local agencies to do the following:
   a. develop local agency agreements and effectively implement those agreements;
   b. set up difficult-to-serve children committees;
   c. coordinate planning and service delivery;
   d. carry-out joint staff training activities; and
   e. provide effective case management.
2. Initiate a review of existing state-level agreements to ensure the following in relation to children and youth with mental health needs:
   a. expectations that agencies will work together on behalf of each child needing services that cross agencies;
   b. how to access the services of each agency;
   c. mechanisms to specify the responsibilities of each agency at the local, regional and state levels in relation to the planning and delivery of services;
   d. mechanisms to carry-out the agreements, including local, regional and state level interagency bodies which can resolve issues related to services for difficult-to-serve children and hear appeals of problem situations. Consideration should be given to the role of the State Interagency Council;
   e. a process for local agencies to decide which agency has case management responsibility for children and youth who have more than one service need;
   f. funding for case management services; and
   g. the inclusion of child mental health personnel in state planning efforts on issues affecting children and youth.
3. Have ongoing monitoring responsibility to ensure that the terms of the state-level agreements are carried out and to initiate revisions of agreements as necessary.

MONITORING THE IMPLEMENTATION OF THE **COMPREHENSIVE SYSTEM OF SERVICES** BY THE SECRETARY OF THE DEPARTMENT OF HUMAN RESOURCES

The Secretary of the Department of Human Resources shall identify, within 60 days after the adoption of this plan by the Legislature, an individual who shall have the responsibility to monitor progress being made by each Division of the Department of Human Resources in implementing the strategies in this document that are the responsibility of the Secretary.

*The relevant Divisions of the Department of Human Resources are:
- Health Services
- Mental Health, Mental Retardation and Substance Abuse Services
- Social Services
- Vocational Rehabilitation Services
- Youth Services

**The relevant State Departments are:
- Administration
- Administrative Office of the Courts
- Crime Control and Public Safety
- Public Education

A JOINT RESOLUTION ADOPTING THE CHILD MENTAL HEALTH PLAN AND THE YOUTH SUBSTANCE ABUSE PLAN AS POLICY GUIDANCE FOR THE DEVELOPMENT OF SERVICES OVER THE NEXT TEN YEARS.

Be it resolved by the Senate, the House of Representatives concurring:

Section 1. The General Assembly adopts the Child Mental Health Plan as presented in the February 1987 report of the Mental Health Study Commission to the General Assembly. Such adoption by the General Assembly is solely for the purpose of providing policy guidance for the development of services for the next ten years.

Sec. 2. The General Assembly adopts the Youth Substance Abuse Plan as transmitted by the Secretary of Human Resources to the co-chairmen of the Mental Health Study Commission on March 1, 1987. Such adoption by the General Assembly is solely for the purpose of providing policy guidance for the development of services for the next ten years.

Sec. 3. This resolution is effective upon ratification.

A BILL TO BE ENTITLED

AN ACT CONCERNING VOLUNTARY ADMISSIONS AND DISCHARGES OF MINORS AT FACILITIES FOR THE MENTALLY ILL AND SUBSTANCE ABUSERS

The General Assembly of North Carolina enacts:

Section 1. Part 3 of Article 5 of Chapter 122C of the General Statutes is rewritten to read:

"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. 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.

122C-222. 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-223.

(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 44 of Chapter 7A of the General Statutes in either the minor's county of residence or in the county in which the facility is located.

122C-223. 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.

122C-223.1. 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, the clerk of superior court, under direction of the district court judge, shall appoint an attorney to serve as guardian ad litem for the minor. 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 fixed by the court in the same manner as fees for attorneys appointed in cases of indigency. 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 guardian ad litem 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.

122C-223.2. Duties of the Guardian Ad Litem.--(a) The guardian ad litem shall meet with the minor within 10 days of his appointment but not later than 48 hours before the hearing. In addition, the guardian ad litem 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 guardian ad litem shall also make an investigation to determine:

(1) the facts, including the wishes of the minor;

(2) the treatment needs of the minor; and

(3) the available resources within the family and community to meet those needs.

(c) The guardian ad litem shall carefully examine the potential effects of the hearing procedure on the minor. If the guardian ad litem believes that the procedure will be harmful to the minor or if the minor does not wish to appear, the guardian ad litem shall file a motion with the court at least 24 hours before the scheduled hearing to waive the minor's right to be present at at the hearing procedure except during the minor's own testimony. If the guardian ad litem determines that the minor does not wish to appear before the judge, the guardian ad litem shall file a separate motion with the court before the hearing to waive the minor's right to testify and waive his right to appear at the hearing.

(d) At the hearing the guardian ad litem shall apprise the judge of the quardian ad litem's findings and opinions, as well as the stated wishes of the minor, and shall explore options with the judge. In all actions on behalf of the minor the guardian ad litem shall protect and promote the best interest of the minor until formally relieved of the responsibility by the judge.

122C-223.3. 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 judicial district, 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 guardian ad litem, 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 guardian ad litem 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 guardian ad litem.

(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 guardian ad litem, to confront and cross-examine witnesses may not be denied.

(d) Hearings shall be closed to the public unless the guardian ad litem requests otherwise.

(e) A copy of all documents admitted into evidence and a transcript of the proceedings shall be furnished, to the guardian ad litem 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 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 of the minor for the recommended treatment period for a period not to exceed 90 days; however, the court shall not otherwise set the length of stay for the admission. 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.

122C-223.4. 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 90 days from the initial concurrence in treatment. 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 for the recommended treatment period, not to exceed 180 days; however the court shall not otherwise set the length of stay for the admission. 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.

122C-223.5. 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.

122C-223.6. 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.

122C-223.7. 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."

Sec. 2. This act shall become effective October 1, 1987.

87LB11

A BILL TO BE ENTITLED

AN ACT TO REVISE THE DUTIES OF THE COUNCIL ON DEVELOPMENTAL DISABILITIES.

The General Assembly of North Carolina enacts:

Section 1. Part 13 of Article 3 of Chapter 143B of the General Statutes is rewritten to read:

"Part 13. Council on Developmental Disabilities.

"**§143B-177. Council on Developmental Disabilities--creation, powers and duties.** There is hereby created the Council on Developmental Disabilities of the Department of Human Resources. The Council on Developmental Disabilities shall have the following functions and duties:

~~(1) To provide advice to the Secretary of Human Resources as will facilitate the implementation of the State plan and the fulfillment of the requirements of Public Law 91-517, the Developmental Disabilities and Facilities Construction Amendment of 1970;~~

~~(2) To study ways and means of promoting public understanding of developmental disabilities; to consider the need for new State programs and laws in the field of developmental disabilities; and to make recommendations to and advise the Secretary of Human Resources on the matters relating to developmental disabilities;~~

Material to be deleted from existing law is ~~struck-through~~, material to be added to existing law is underlined.

~~(3) To advise in the preparation of a plan describing the quality, extent and scope of services being provided, or to be provided, to persons with developmental disabilities in North Carolina;~~

~~(4) To examine the programs of all State agencies which provide services for persons with developmental disabilities and to make recommendations to the Secretary of Human Resources for coordination of programs to prevent duplication and overlapping of such services; and~~

~~(5) The Council shall advise the Secretary of Human Resources upon any matter the Secretary may refer to it.~~

(1) To advise the Secretary of Human Resources regarding the development and implementation of the State plan as required by Public Law 98-527, the Developmental Disabilities Act of 1984, by:

a. Identifying ways and means of promoting public understanding of developmental disabilities;

b. Examining the federally assisted State programs of all State agencies which provide services for persons with developmental disabilities;

c. Describing the quality, extent and scope of services being provided, or to be provided, to persons with developmental disabilities in North Carolina;

d. Recommending ways and means for coordination of programs to prevent duplication and overlapping of such services;

e. Considering the need for new State programs and laws in the field of developmental disabilities; and

f. Conducting activities which will increase and support the independence, productivity, and integration into the community of persons with developmental disabilities.

(2) To advise the Secretary of Human Resources regarding the coordination of planning and service delivery of all State funded programs which provide service to persons with developmental disabilities by:

a. Gathering, analyzing and interpreting individual and aggregate needs assessment data from all State agencies that provide services to developmentally disabled;

b. Conducting special needs assessment studies as may be necessary;

c. Specifying and supporting activities that will enhance the services delivered by individual agencies by reducing barriers between agencies;

d. Identifying service development priorities that require cooperative interagency planning and development;

e. reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

(2) The term "services for persons with developmental disabilities," as it is used in this Article, means

a. alternative community living arrangement services, employment related activities, child development services, and case management services; and

b. any other specialized services or special adaptations of generic services ~~directed toward the alleviation of a developmental disability or toward the social, personal, physical, or economic habilitation or rehabilitation of an individual with such a disability, and such term~~ includ[illegible] diagnosis, evaluation, treatment, personal care, day care, domiciliary care, special living arrangements, training, education, sheltered employment, recreation and socialization, counseling of the individual with such a disability and of his family, protective and other social and sociolegal services, information and referral services, follow-along services, nonvocational social-developmental services, and transportation

services necessary to assure delivery of services to persons with developmental disabilities, and services to promote and coordinate activities to prevent developmental disabilities.

"**§143B-179. Council on Developmental Disabilities--members; selection; quorum; compensation.--** (a)The Council on Developmental Disabilities of the Department of Human Resources shall consist of 32 members appointed by the Governor. The composition of the Council shall be as follows:

(1) Eleven members from the General Assembly and State government agencies as follows: One person who is a member of the Senate, one person who is a member of the House of Representatives, one representative of the Department of Public Instruction, one representative of the Department of Correction, and seven representatives of the Department of Human Resources to include the Secretary or his designee.

(2) Sixteen members designated as consumers of service for the developmentally disabled. A consumer of services for the developmentally disabled is a person who (1) has a developmental disability or is the parent or guardian of such a person, or (2) is an immediate relative or guardian of a person with mentally impairing developmental disability, and (3) is not an employee of a State agency that receives funds or provides services under the provisions of ~~Part A, Title I, P.L. 90-170, as~~

~~amended, "Mental Retardation Facilities and Community Health Centers Construction Act of 1963~~ Part B, Title 1, P.L. 98-527, as amended, the Developmental Disabilities Act of 1984," is not a managing employee (as defined in Section 1126(b) of the Social Security Act) of any other entity that receives funds or provides services under such Part, and is not a person with an ownership or control interest (within the meaning of Section 1124(a)(3) of the Social Security Act) with respect to such an entity. Of these 16 members, at least one third shall be persons with developmental disabilities and at least another one third shall be the immediate relatives or guardians of persons with mentally impairing developmental disabilities, of whom at least one shall be an immediate relative or guardian of an institutionalized developmentally disabled person.

(3) Five members at large~~. The five at-large members shall be chosen from local agencies, nongovernmental agencies and groups concerned with services to persons with developmental disabilities, and higher education training facilities in North Carolina, or from the interested public at large.~~ as follows: one representative of the university affiliated facility, one representative of the State protection and advocacy system, one representative of a local agency, one representative of a nongovernmental agency or nonprofit

group concerned with services to persons with developmental disabilities, and one representative from the public at large.

~~The initial members of the Council shall include the appointed members of the Council on Mental Retardation and Developmental Disabilities who shall serve for a period equal to the remainder of their current terms on the Council on Mental Retardation and Developmental Disabilities four of whose terms expire June 30, 1973, four of whose terms expire June 30, 1974, two of whose terms expire June 30, 1975, and three of whose terms expire June 30, 1986. At the end of the respective terms of office of the initial members of the Council, t~~The appointments of all members, with the exception of those from the General Assembly and State agencies shall be for terms of four years and until their successors are appointed and qualify. Any appointment to fill a vacancy on the Council created by the resignation, dismissal, death, or disability of a member shall be for the balance of the unexpired term.

The Governor shall make appropriate provisions for the rotation of membership on the Council.

(b) The Governor shall have the power to remove any member of the Council from office in accordance with the provisions of G.S. 143B-16~~ of the Executive Organization Act of 1973~~.

The Governor shall designate one member of the Council to serve as chairman at his pleasure.

Members of the Council shall receive per diem and necessary travel and subsistence expenses in accordance with the provisions of G.S. 138-5.

A majority of the Council shall constitute a quorum for the transaction of business.

All clerical and other services required by the council shall be supplied by the Secretary of Human Resources."

Sec. 2. This act shall become effective July 1, 1987.

Material to be deleted from existing law is ~~struck through~~, material to be added to existing law is underlined.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1987

87W-LB-8

THIS IS A DRAFT FOR REVIEW AND IS NOT READY FOR INTRODUCTION

Short Title: Developmental Disabilities. (Public)

Sponsors: .

A BILL TO BE ENTITLED

AN ACT CONCERNING SERVICES TO INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES.

Whereas, the State has established the precedent of providing human services for individuals who have disabling conditions caused by mental illness, mental retardation or substance abuse; and

Whereas, other individuals suffer severe disability from other conditions within the broad category of 'developmental disability' and these individuals have similar needs for services; and

Whereas, some service programs do exist under the aegis of the Division of Mental Health, Mental Retardation and Substance Abuse Services that could meet the service needs of some of these individuals; now therefore,

The General Assembly of North Carolina enacts:

Section 1. G.S. 122C-3 is amended by adding a new subdivision to read:

"(12a) 'Developmental disability' means a severe, chronic disability of a person which:

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

b. is manifested before the person attains age twenty-two, unless the disability is caused by a traumatic head injury and is manifested after 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; and

e. reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are a lifelong or extended duration and are individually planned and coordinated."

Sec. 2. G.S. 122C-3(14) is amended by adding the following at the end:

"For the purposes of Articles 2 and 3 only, 'facility' also means any person at one location, whose primary purpose is to provide services for the care, treatment, habilitation or

rehabilitation for individuals with developmental disabilities, developed under the authority of this Chapter."

Sec. 3. G.S. 122C-112(a)(10) is amended by adding immediately after the words "mental retardation," the words "developmental disabilities,".

Sec. 4. G.S. 122C-117(a)(1) is amended by adding immediately after the words "mental retardation," the words "developmental disability,"

Sec. 5. Chapter 122C of the General Statutes is amended by adding a new section to read:

"**§ 122C-123. Other agency responsibility.** Notwithstanding the provisions of G.S. 122C-112(a)(10), and G.S. 122C-117(a)(1) other agencies of the Department and other local agencies shall continue responsibility for services they provide for the developmentally disabled."

Sec. 6. There is appropriated from the General Fund to the Department of Human Resources for fiscal year 1987-88 the sum of two million eight hundred twenty-one thousand and nine hundred and ninety-two dollars ($2,821,992) and six million one hundred seven thousand three hundred twenty-four dollars ($6,107,324) for fiscal year 1988-89, for the following purposes:

	1987-88	1988-89
41 Area DD specialists	594,500	1,189,000
4 Regional DD specialists	62,000	124,000
1 State DD specialist	16,500	33,000
DD Study Maintenance	65,000	75,000
Staff Training	120,000	120,000

Reserve-spec. projects	---	400,000
Respite Care	70,000	210,000
In-Home Support	120,000	360,000
Supported Employment	180,000	540,000
Early Childhood--new	550,000	1,100,000
Early Childhood--add on	280,232	560,464
Early Child Specialists	---	574,000
Alternative Living	180,000	540,000
3 Group Homes	600,000	359,120
Totals	2,821,992	6,185,584

Rather than establishing new budget categories for these appropriations, these funds are to be added to existing budget categories as determined by the Budget office to be appropriate and area programs that receive such allocations shall have flexibility in the use of the dollars within the general program consistent with the transfer rules established for existing area program funds.

Sec. 7. Funds appropriated to the Department of Human Resources, Division of Mental Health, Mental Retardation, and Substance Abuse Services for specific services for the mentally retarded may also be used for delivery of services to persons with other developmental disabilities or head trauma when the service is appropriate to the individual's needs.

Sec. 8. This act shall become effective July 1, 1987.

87LB10

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR A SPECIAL LIVING AND TRAINING CENTER FOR AUTISTIC ADULTS.

Whereas, in 1985 the Mental Health Study Commission recommended and the General Assembly adopted a proposal to develop a special living and training center for adult persons with autism who had aged beyond public school services; and

Whereas, during the two years since then the Society for Autistic Children and Adults, and Division TEACCH of the University of North Carolina Medical School have worked to locate state property that might be used for this purpose; and

Whereas, no university property is available in Chapel Hill, but some private property has been found, and the owner is willing to dedicate the property and transfer title if resources can be found to make basic road, water, sewer, and electrical improvements to the property; and

Whereas, in order to follow through on the original intent of the General Assembly to begin development of the special living and training center; now, therefore

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the General Fund to the Department of Human Resources for fiscal year 1987-88 the sum of four hundred thirty eight thousand dollars ($438,000) for improving property for a special living and training center for

adult persons with autism who have aged beyond public school services; provided that such funds shall be expended only upon certification by the Office of State Budget and Management that appropriate provisions for transfer of title to the property have been made.

Sec. 2. This act shall become effective July 1, 1987

APPENDIX L

State of North Carolina

Mental Health Study Commission

21 January 1987

ALBEMARLE BUILDING—ROOM 1155
TELEPHONE: 919/733-6077

325 N. SALISBURY STREET
RALEIGH 27611

MEMORANDUM

TO: Senator Aaron Plyler, Senate Co-Chairman
Representative William T. Watkins, House Co-Chairman

FROM: Senator Kenneth C. Royall, Jr., Co-Chairman
Admiral Chris S. Barker, Jr., Co-Chairman

RE: Limitations on Chemical Dependency Coverage in State Health Plan

Legislation sponsored by the Mental Health Study Commission and ratified by the General Assembly in 1984 included a provision which established limits on the payment for chemical dependency treatment under the Teachers and State Employees Health Plan. The figures used to develop the original proposal were based on findings about cost in such programs that had been gathered in the fall of 1983.

During public hearings held by the Study Commission during the fall of 1986, presenters raised concern regarding the appropriateness of the specific level of reimbursement as they relate to costs in 1987. Furthermore, these presenters argued that the "ceilings" established in the State Health Plan are being used to set "ceilings" in private group plans.

The Commission did not have time to thoroughly investigate these concerns. In addition, the Commission was cognizant of the probability that the Legislative Committee on the State Health Plan would be reviewing a number of benefits during its 1987 deliberations. Therefore, rather than formulate a specific proposal to increase the benefits, the Commission elected to request that the Legislative Committee review these concerns as a part of its regular process. The purpose of this memorandum is to do so.

If we can be of further assistance on these questions please let us know.

A BILL TO BE ENTITLED

AN ACT FURTHER CONTINUING THE MENTAL HEALTH STUDY COMMISSION.

The General Assembly of North Carolina enacts:

Section 1. The Mental Health Study Commission, established and structured by 1973 General Assembly Resolution 80; Chapter 806, 1973 Session Laws; Chapter 185, 1975 Session Laws; Chapter 184, 1977 Session Laws; Chapter 215, 1979 Session Laws; 1979 General Assembly Resolution 20; Chapter 49, 1981 Session Laws, Chapter 268, Session Laws of 1983, and Chapter 792, Session Laws of 1985, is revived and authorized to continue in existence until July 1, 1989.

Sec. 2. The continued Mental Health Study Commission shall have all the powers and duties of the original Study Commission as they are necessary to continue the original study, to assist in the implementation of the original and succeeding Study Commission recommendations and to plan further activity on the subject of the study.

Sec. 3. Members and staff of the continued Mental Health Study Commission shall receive compensation and expenses as under the original authorization in the 1973 General Assembly Resolution 80. Expenses of the Commission shall be expended by the Department of Human Resources from Budget Code 14460 subhead 1110.

Sec. 4. In addition to other studies authorized by law, the Mental Health Study Commission shall:

(1) Have oversight, and review and make recommendations regarding the implementation of the Child Mental Health and Youth Substance Abuse Plans;

(2) Have oversight, and review and make recommendations regarding pioneer testing of funding policies;

(3) At its option, also examine and review actions of the 1987 General Assembly regarding concerns relating to psychiatric hospital staffing needs, treatment programs, length of stay and continuity of care between psychiatric hospitals and community servies; and, to determine whaterver further study the Commission might wish to undertake in these areas.

Sec. 5. This act is effective upon ratification.

MENTAL HEALTH STUDY COMMISSION

Summary of Remarks

Morganton Public Hearing
October 24, 1986

Mary Ellen Trivette
Board Member
Catawba Area Program
Hickory

Commends funding committee but: desire is equity of funding; must address current inequities through "catch-up"; should funding be equal like schools; concerned that circle of services is too small [need to cover on going treatment, need to have education/prevention]; unit cost reimbursement might add another level of bureaucracy [need to get rid of current accountability overload]; need to reinforce local involvement; need flexibility.

Commends Child Task Force Report; concerned about needs of non-Willie M children.

Hugh Moon
Area Director
Smoky Mountain Area Program
Dillsboro

Speaking from multi-county, very poor area, a great deal of unemployment; supports most of funding recommendations; concerns re: implementation, losses for higher funded programs that still have needs; some areas do not have available private services; middle income need services too because they may in effect be medically indigent; concern about apparent centralization of control; and ultimate effect on local decision making; concern about methodology that raises disincentive to collect reimbursements; proposes an area purchase of service from institutions. Concerns but still interested in being pioneer project.

Re: Child Mental Health Task Force--funding should not be tied to interagency agreements unless the other agencies funding is also dependent on such agreements; concern about need for administrative support to implement plan; funding should not be designed to penalize programs that have tried to serve children with limited resources-rather a balance approach that allows growth in all programs.

Ken Shull
Board Member
Piedmont Area Program
Concord

Recommends use of empty hospital beds, with mental health funding, to support local acute care. Strong support for Child

Mental Health Task Force report. Supports concepts in Funding Concept Paper--looking toward client centered accountability; maximum flexibility (recommends three categories-MH, MR, SA); equity goal through standardized levels, but need catch up funds now. Would like to see reinforcement of partnership between areas and state. Let's move forward and adopt policies and not get bogged down in details. Have areas participate in decision making as implementation moves forward.

Cynthia Waggoner
Board Member
Gaston-Lincoln Area Program
Gastonia

Commends both reports. Positive reaction to child Task Force: comprehensive services system, basic services, local planning responsibility, interagency agreements. Need to bind other agencies to requirements on interagency agreements. Need to reduce paper work. Concerned about criteria for allocation of funds. Funding study: principles endorsed, need operational flexibility, need to include all costs, need to rid system of current rules.

Harry Myers
Union County Commissioner
N.C. County Commissioner's Association
Monroe

Counties support the concept of a circle of services (defined broadly enough to allow local flexibility), recommend that state pay for services in the circle. Counties very concerned about equity between areas and generally support some kind of per capita funding concept. Recommends that areas be allowed to retain 1st & 3rd party receipts. Recommends a participatory oversight committee during implementation. Need simplification of language and reports.

Tony Womack
Area Director
Rutherford Polk Area Program
Rutherfordton

Smallest multicounty program. Difficult to provide services if funds allocated on standardized levels. Circle of services too narrow, wants category for elderly. Expresses concern about mandates on counties because it will become adversarial. Strongly supports Child Task Force report. Recommends Study Commission look at duplication in roles between DHR and Div.

Judy Nebrig
Representing: Directors of Early Intervention Programs for the Emotionally Disturbed
Brevard

Strong support for emphasis in Child Task Force on early intervention and children 0-7. However, because of history (no expansion funds since program started in 1975) need to express serious concern that there be adequate funding for such services. Also, recommends that these services be decategorized and that children at risk rather than by disability be served.

Keith Wolf
Director
Uwharrie Homes, Inc.
Albemarle

Reinforce the point in the Child Task Force report that there is a need to assure the stability of group homes for emotionally disturbed children and adolescents. Because of lack of funding increases since program set up in 1974, the State has lost 30% of the original beds. Also concerned that group homes must meet mh standards if serving any mh kids, and that expectations from multiple funding sources might come into conflict.

Dick Beyer
Board Member
Governor's Advocacy Council on Children and Youth
Morganton

Council wholeheartedly supports concepts in Child Task Force Report. Concern because the size of the population to be served is unknown. Supports target populations, concerned about the need for adequate funding without shifting resources from other children's services.

John Niblock
Executive Director
North Carolina Child Advocacy Institute
Raleigh

Strongly supports the philosophy and principles of the Child Task Force report. Particularly support the concepts of family support and development of more "family preservation" projects in other parts of the State. Additionally, see the need for strong interagency case management and individualized treatment planning for each child.

Vestal Taylor
Board Member
N.C. Mental Health Association
Jefferson

Strongly supports the long range planning effort of the Child Mental Health Task Force. Sees strength in the common philosophy and common principles that will guide the system.Strong support for the comprehensive system and the essential services. Stresses the need for effective and adequately funded implementation. Reinforces the need for flexibility so that areas can respond to local needs. Recommends incentives for areas to develop prevention and early intervention programs. Emphasis is needed on the needs for transportation.

Dr. James Alexander
Board Member
United Health Services
Charlotte

Supports the work and concepts of the Child Task Force Report. Urges the development of a similar comprehensive system of care for substance abusing adolescents: particularly, funding to provide access to intensive outpatient treatment and to inpatient treatment; funds for extended care in two types of long-term residential services (continuation of primary treatment and alternative living arrangements); funds for case management and coordination of services; and, funds for development of an evaluation and tracking system.

Lin Willis
Executive Director
Burke County Council on Alcoholism
Morganton

Acclaimed current adolescent substance abuse programs like student assistance services but stresses the need for inpatient services for those most critically dependent. Supports Outerbanks Resolution urging for a comprehensive system of adolescent substance abuse services.

Vicky Biggers
Guidance Counselor
Erwin Middle School
Asheville

Strong support for Child Task Force Report. Urges implementation.

Roger Manus
Attorney
Carolina Legal Assistance
Raleigh

Support of Child Task Force Report including most of the proposed rewrite of Minor's Admission Law. However, concerned

about the limitation of judicial authority to set length of stay of the minor. Because there are not enough programs in the community, sometimes staff hasn't tried hard enough--potential of judges releasing too early rather than putting pressure on professionals to find alternative less restrictive care.

Dr. Walter W. Stelle
Deputy Director for Mental Health
Division of MHMRSA
Raleigh

Explained some of the reasons that violence is occurring more frequently in our state hospitals; e.g. greater concentration of harder patients as communities serve others; drug abuse among younger patients leads to unpredictable behavior; larger volume of patients due to baby boom; and civil rights precludes some interventions common years ago. Described the efforts of all four hospitals to address this concern, the Committee on Patient Violence and DHR proposal to add 240 additional health care technicians to hospital staff.

Karl Moehler
Consumer
Charlotte

Described his personal battle with schizophrenia and his inability to function when medicated and his deterioration when off medicine. Criticized the lack of treatment he has received from the current mental health system and the help he is now receiving from the Alliance for the Mentally Ill. Urged that mentally ill people be kept longer and treated more effectively when they need hospitalization.

Paul Garrett
President
N.C. Alliance for the Mentally Ill
Concord

Extends appreciation for the efforts related to the funding study and thanks for opportunity for families to participate. Wishes that the funding study were looking at the funding policies and integration of community and institutional services. Opposed to any simple purchase of care model which would serve as a disincentive for areas to hospitalize when necessary. Recommends consideration of regional boards to oversee the areas and institutions in each region. Opposes any notion of a second circle of services and urges that the primary circle of services focus on the most seriously disabled. Commends the work of the Child Task Force, urges involvement of families in all aspects of treatment and receive support. Commends the progress made by the Div and Dept on the issue of violence in the hospitals, urges the Study Commission to support request for additional health care technicians. Identified need for adequate space for patients and need for air conditioning at Broughton. Finally advocate for strong quality rehabilitation programs in all hospitals.

Rachel Ledford
Parent
Alexander

Described the problems coping and getting service for a mentally ill son. Urged that he be kept long enough after a hospitalization and provided with services that would in fact treat his illness and provide rehabilitation.

Diane Phillips
Family Member
Shelby

Sister of a chronically mentally ill man who has revolved in and out of hospitals and central prison. He refuses treatment, which the laws allow him to do. After release from sentence sent to Broughton wherein he was released within 6 days on physician orders, tried to shoot someone, arrested again and now back at Broughton on an incapacity to proceed to trial. He needs treatment.

Betty Coleman
Parent
Salisbury

Mentally ill son in desperate need of support, rehabilitation and treatment services. Recommend return power to physicians to treat as needed.

Travis Carter
Consumer
Salisbury

Criticizes the effects of deinstitutionalization that may help some, but definitely hinders the effective care of many. Urges the development of adequate habilitation and vocational services within the hospitals. Need for housing in the community when the patient is ready to be released.

Don Shanks
Council Member
Governor's Advocacy Council for Persons with Disabilities
Winston-Salem

For a long time the Council has been concerned about what has appeared to be an increase in patient violence at the hospitals. Encouraged by work of the Div and Dept and urges support for the 240 health care technician positions that the Secretary is recommending. Continue to support the development of community services for the seriously disabled and appreciate the legislatures acknowledgement of the needs and urges further attention in this area. Hope that greater accountability can be developed so that areas will be given greater flexibility in the use of State funds. Commend the work of the Child Task Force and the comprehensive approach presented in the report. Supports the priority populations identified.

Larry Jones
Advocate
John Umstead Hospital
Butner

Acknowledges that serious violent episodes catch media attention but wants to point out that somewhat less serious, but still assaultive episodes occur on a daily basis. Sees the increase in direct care staff as a necessary step in addressing the problem. More attention also needs to be given to development of more active treatment. Recommends better tie in between Rehabilitation unit at Umstead and Community services with a direct return to Rehab Unit if readmission is necessary. Urges higher pay and career ladder for health care technicians. Regarding the Child Task Force recommendation on the minor's admissions law would express three concerns: (1) opposed to the limitation on judicial authority to set length of stay; (2) opposed to the recommendation to combine role of special counsel with that of a guardian ad litem--must be separate functions; (3) opposed to authority of guardian to waive minor's appearance at the hearing--might be overused. Also suggests two clarifying changes and supports other changes.

Faye Soiset
Vice-president, Charlotte Chapter
Alliance for the Mentally Ill
Charlotte

Described situation with revolving door mentally ill son and urges the development of long term treatment with active programming and rehabilitation. Until community services are adequately available it is crucial to provide these services in the State facilities. Suggest the law be changed to allow alternative "treatments" like nutrients.

Patricia Story
Parent
Morganton

Multi-handicapped son who was served as a Willie M but has now aged out. Criticizes system that disserves because of age and geographical limits. Urges policies be changed so that he can continue to receive the long term secure treatment that he needs.

Dr. Orion Hutchinson
Board Member
Tri-County Area Program
Salisbury

Commends work of both the Child Task Force and Funding Study. Reinforces the need for a comprehensive area of services for non-Willie M children. Describes the inadequacies in Tri-County due to extremely low state funding. An emphasis on "equity" of services through the circle of services is needed. Concerned about the need to invest in data management capability without adequate resources.

Ron Knouse
General Manager
Blue Ridge Electric Corporation
Lenoir

As a recovering alcoholic has become actively involved in efforts to bring more treatment for those in need due to the disease of alcoholism. Concern with provisions of S.B. 724 which imply that outpatient treatment is as effective as inpatient. Recommends amendment to allow adequate reimbursement to cover inpatient service when needed as determined by certified counselor.

Dennis Moore
Program Director
Appalachian Hall
Asheville

Expresses concern that the minimums established in S.B. 724 for chemical dependency treatment have become maximums and that this forces mislabelling as psychiatric in order to receive appropriate treatment and reimbursement.

Ed Denton
Parent
Morganton

Parent of autistic child urges support of integration of services for those with developmental disabilities. Wants system to work more effectively for families. Need for funding support tied in with needs.

Dr. Michael McCullock
Children and Youth Coordinator
Forsyth-Stokes Area Program
Winston-Salem

Strongly endorse Child Task Force report and development of continuum of care. Can be successful. Overwhelming evidence of kids treated early will help.

Ben Davis
Chairman
Human Rights Committee
Broughton Hospital

Concern about hospital violence particularly due to H.95 clients. Urge development of separate facilities or units for such patients. Need for air conditioning at Broughton. Need to improve staff patient ratio. Want more patient's advocates. Note that 25% of the buildings at Broughton don't meet standards.

Georgia Moehler
Parent
(residence not noted)

Talked of concern regarding multi-handicapped son, schizophrenic who won't keep taking medication. Funds not available to support his care and treatment. Want him located closer to home with work program. Programs needed in area of research, medical service and basic education. Recommend development of program's for children of alcoholics.

John Hardy
Area Director
Catawba Area Program
Hickory

Commends the work of both the Funding Committee and the Child Task Force and suggests that both be used as blueprint for future mental health services.

(written)
Larry King
Assistant Director
Council For Children
Charlotte

Commends the work of the Child Task Force. Expresses concern that therapists not be required to be case managers, but rather be separate functions. Also suggests a separation of the function of advocacy from the case manager, so the advocate can review the plan and implementation of the plan under the case manager's authority. Questions the development of a State level inter-agency council to resolve the needs of difficult-to-serve children, but rather sees this as a local responsibility.

(written)
TREND Area Program
Brevard

Acknowledges exceptional work of funding study and generally agrees with concepts. Questions the exclusion from the "circle of services" of `outpatient' services for (a) medically indigent nonserious mental health problems, (b) 25% mentally retarded with mental health problems, and (c) substance abusers. Further consideration should be given to 100% State funding for some services and a lower percentage of State funding for lower priority services. Concern that unit cost reimbursement will be a costly administrative burden and that incentives do not exist for centers to aggressively seek first and third party payments. Concern that "statewide levels of service" would fix program objectives and disencourage development of new alternatives. Would suggest that total proposal may be too complex and that per capita funding with a reserve for special projects would be simpler and more effective.

(written)
Joyce Parra
Social Worker
Department of Correction
Salisbury

The prison system is not designed to treat the mentally ill. However, attempts are made to provide in house counseling and to particularly do discharge planning. North Carolina needs to have affordable housing--a variety of levels of supervision. Other needs: expansion of small psychiatric units in local hospitals; community education through media; family education; law enforcement in service training; expansion of mental health center services with greater client supervision and evening hours; change in commitment laws to allow chronic patients who are not dangerous to be hospitalized for permanent care.

(written)
author not identified

Support for development of comprehensive system of services for Children. Note inconsistency between Child Task Force recommendations regarding: outpatient services and Funding concept paper which excludes outpatient except for most seriously disturbed. Mildly and moderately disturbed young people definitely need outpatient services. Recommendation that there be development of residential treatment programs for adolescents should include recommendation to augment the capacity of the public school system that will be expected to educate these children.

MENTAL HEALTH STUDY COMMISSION

Summary of Remarks

Greenville Public Hearing
November 7, 1986

Margaret Burgwyn
Board Member
Roanoke-Chowan Area Program
Woodland

Commend the work of the Child Task Force. Emphasize the need for developing specialized Children`s Mental Health Services. Urge that the report be used in the future in subsequent funding and policy decisions. Acknowledge the need to maintain flexibility and programmatic control at the local level. Regarding possible action to deal with inequities of funding, please include the federal funds allocated by the Division in considerations.

John White
Area Director
Wilson-Greene Area Program
Wilson

Sincerely hopes that these efforts at funding policy changes will come to fruition. Set priority on equity in funding but include federal funds allocated by the Division in consideration.

Dr. Liston G. Edwards
Area Director
Wayne County Area Program
Goldsboro

Urges that equity in funding be the number one priority. While other concepts are being developed should use per capita as measure.

John Niblock
Executive Director
N. C. Child Advocacy Institute
Raleigh

Supports the work of Child Task Force, philosophy and principles. Particular emphasis needs to be placed on prevention and early intervention. Recommend decategorization of early intervention monies so that children at risk can be served without being diagnosed. Also need early intervention programs for adolescents. Urge adoption and implementation of full plan.

Dr. Richard Gibson
Physician
Raleigh

Acknowledges the changing clientele in State psychiatric hospitals to more volatile and violent patients, urges the need to maintain a safe and secure environment. Recognizes that treatment beyond medication is badly needed by institutionalized patients. Recognizes that there is increased and sincere attention being paid to these issues, but increased staffing of health care technicians is also necessary. Also recommends that health care technicians be paid more.

Sandra Sink
Patient Advocate
Dorothea Dix Hospital
Raleigh

Commend the efforts to assure and improve the judicial review of minor's admission to secure facilities, but urges the separation of special counsel and guardian ad litem functions. While first priority is for the development of adequate continuum of care at the local level, while patients must be treated in the state facilities, it is crucial that these be adequately funded to provide appropriate treatment. Support the request for additional health care technicians, but also urge intensive training and provision of treatment and psycho-social services.

Sally Cameron
Board Member
Coalition for the Chronic Mental Patient
Raleigh

Very appreciative of funds that have been made available to expand community services for the chronically mentally ill. Priority interest of Coalition is development of a continuum of care--means that the needs of the hospitals and the community must be considered collaboratively. Urge support of 240 additional health care technicians for the hospitals. Urge significant new dollars for community services for the chronically mentally ill too.

Dr. James Mathis
Immed. Past President
N.C. Psychiatric Association
Greenville

There is a significant portion of mentally ill population which will need long term, structured, supervised care. There is an overrepresentation of those most prone to violence in our state facilities. Care is often relegated to those least trained to provide supervision and structure. Need to attend to the treatment needs of these patients which will require an adequate financial and planned commitment.

Louise Fisher
Board Member
N. C. Alliance for the Mentally Ill
Raleigh

Described the circumstances of the commitment of her mentally ill daughter and their mutual concern about her safety and her need for meaningful treatment services.

Steve Kaylor
Special Counsel
John Umstead Hospital
Butner

Concern about violence in State facilities. Recommends the development of separate facilities or units so that those prone to violence on others can be treated separately from those unable to care or protect themselves. Recommends having more staff available to provide more support and control. Increase in recreation and rehabilitative treatment would reduce potential for violence. Commends the work of the Child Task Force and the well thought out plan to develop comprehensive system of services. Urges adoption and adequate funding for implementation. Notes the critical need for a comprehensive treatment scheme for adults. There is a drastic need for intermediate services that provide greater supervision than is currently available.

John Baggett
Executive Director
N.C. Alliance for the Mentally Ill
Raleigh

Appreciative of the Commission's having provided opportunities for families to be involved in policy decision making. Recent accounts of violence in state facilities is attributable to overcrowding, understaffing and lack of rehabilitation programs. While hospitals are an integral part of the continuum of services it is essential that they be more adequately staffed and programmed. While our hospitals are accredited, the accrediting standards are not designed for facilities that serve the kinds of patients now being served in our state facilities. Commends the Div and Dept efforts to address these concerns and urge legislative support of Secretary`s recommendation for 240 health care technician positions. Support the recommendations of Child Task Force and urge full funding for the recommendations. Regarding the funding study it is crucial that the most seriously ill be the primary focus of the circle of services. The need for resources for community services for the seriously mentally ill is immediately critical as families, who are currently the primary care givers, age and wonder who will care for their family member in the future.

Virginia T. Oliver
Commissioner, Cumberland County
N.C. Association of County Commissioners
Fayetteville

Generally supports the efforts of the funding study but concerns re: (1) that the circle of services not be drawn so narrowly that services now in place will become the full responsibility of the counties; (2) funding commitments of local government should be locally negotiated and not mandated by the State; (3) concern that policies take into account the potential effects of changing insurance patterns; (4) immediate attention needs to be paid to per capita funding equity, and (5) there needs to be an oversight committee if policies are adopted because implementation will encounter problems.

Cindy Suitt
Nurse
John Umstead Hospital
Butner

Described working conditions at John Umstead and personal experiences with patient violence. Express concern that adequate attention and resources address the conditions so that staff could effectively provide services in a more safe environment.

Lee Pascasio
Council Member
Governor's Advocacy Council for Children and Youth
Greenville

Commends the work of Child Task Force. Strong support for philosophy and principles. Concern that the report does not address the number of children who may be in need of services. Urges implementation and adequate funding without taking funds from other important child services.

(written)
Cindy Teal
Council Member
Governor's Advocacy Council for Persons with Disabilities
Weddington

Strongly supports the development of a comprehensive system of child mental health services. Urge adoption. Particularly supports the priority populations. Importance of development of alternative community based residential treatment, more availability of outpatient services, and effective case management with effective interagency agreements behind the role. Appreciates emphasis on early intervention.

Cynthia Perry
President Elect
N.C. Mental Health Association
Greenville

Re funding policy proposals: Strongly support flexibility so that areas can be responsive to needs in their area; uniform quality assurance mechanisms that can be locally managed. Concern regarding circle of services--agree that those who most need services should have affordable, accessible and appropriate services--however, should not exclude those for whom prevention or early intervention could mean a better quality of life.

Chris Heinberg
Attorney
Carolina Legal Assistance
Raleigh

Commends the work of the Child Task Force, but expresses concern regarding the proposed change in the minor's admissions law which would limit judicial discretion in setting length of stay for minors. Under current law which grants discretion most judges agree with recommendation of treating professionals. If judge disagrees and sets shorter stay it is incentive to treating professionals to find more appropriate setting. Need to protect minor's from potential of unnecessarily lengthy admissions.

Dr. Don Adams
Member Legislative Committee
N.C. Psychological Association
Cary

Commends the work of the Child Task Force. Expresses concern that the proposed guardian ad litem's success (minor's admissions law proposal) would be dependent on quality, training and ongoing supervision of the guardians. The report emphasizes case management which is appropriate, but it is a non reimburseable service and the Commission may wish to address this fact. If the Task Force report is implemented there will be a greater need for quality staff and the Commission is urged to consider ways to promote education, training, and practicums within our institutions of higher learning and within the service system to develop the needed manpower to support his wide array of services.

Lois Batton
Area Director
Halifax Area Program
Roanoke Rapids

Endorse the recommendations of the Child Task Force--the philosophy, principles and development of a comprehensive system of services. Concerns regarding the implementation plan developed for the report: believes the plan underestimates the number of children who are seriously disturbed and underestimates

the need for transportation (cites current caseload figures). Agree that there is need for an adequate data collection system. Concern about requirements for interagency aggreements--might best be done informally, but if required, requirement must be placed on other agencies as well. Supports funding projections as long as flexibility is allowed within the "blocks". Recommends that higher cost services be developed on regional or sub-regional basis. Reenforces idea that some kind of oversight of the implementation be carried out by the legislature but that it be done with minimal paper work.

Judy Terrell
Coordinator of Children's Services
Edgecombe-Nash Area Program
Tarrboro

Supports comprehensive system of mental health services for children. Emphasis on early childhood crucial. Current problems in finding resources for children with multiple handicaps would be addressed. Urges adoption and adequate funding.

Dr. Jascha W. Danoff
Professor and Chief of Child and Adolescent Psychiatry
East Carolina University
Greenville

Applause for the extensive overview of needs and direction portrayed for child mental health services in Task Force report. Stresses need for a spectrum of prevention programs, community hospital based inpatient. Also stresses the need for a variety of facilities to address the severe problems of substance abusing adolescents.

Larry Earle
Senior Vice-President
CHAPS
Raleigh

Points out that the minimum established in S. 724 for insurance payments for treatment of chemical dependency have become maximums. Suggests that some coverage has actually decreased rather than increased. Disagree with premise that chemically dependent can be treated adequately in outpatient programs. Some need inpatient and no one can provide inpatient at a cost of $3000/mth. Particularly there is need for higher limits for the adolescent chemically dependent who need a longer length of stay. Estimates that 651 individual who sought treatment at four inpatient facilities, were denied or refused admission due to "inadequate" insurance coverage. It is this client that is ultimately hurt. Need to change coverage in State Health Plan, because it is being used as a yardstick.

Gene Parotta
President
Association for Infants and Families
Raleigh

Strong support for Child Task Force report, especially emphasis on prevention, early intervention and family involvement. Encourages integration of services. Recommends allowance for children at risk of developing problems.

Edna Dilldine
Consumer
Archdale

Describes her personal experience with manic depressive illness. After 15 months of voluntary treatment in the therapeutic community (which has been closed) she is now on her own, working 40 hour week, supporting a teenage daughter. Need more treatment like the therapeutic community, need to assure that patients are not over crowded, need to provide education in the schools about mental illness and to consumers and their families.

Gladys Fisher
Parent
Sanford

Son has been in Dix for 16 months, moved three different units, no structured program of rehabilitation and he has deteriorated. More conducive environment in addition to programming would facilitate improvement. There are effective treatment programs elsewhere and they are needed in N.C. Lack of know-how is not the problem what is needed is adequate funding and effective leadership.

Teresa Long
Consumer
Raleigh

Described personal experience of being hospitalized at Dix Adolescent program from 12-18. Even though less restrictive environment recommended locally, readmissions made by judge every year at recommendation of treatment professionals because of no alternatives. Released at end of last commitment, without finishing one additional week of school, because they had not made alternative arrangements. It would have been better had the judge ordered a regular report of efforts to find an alternative placement.

Joanne Jeffries
Executive Director
N.C. Society for Autistic Adults and Children
Raleigh

Commends the support of the Study Commission for DD study and hopes that something will come of the knowledge that there

are numerous developmentally disabled who need services. Regarding the development of the "living/learning center" for aged out autistic, it has been difficult to locate State land and the $400,000 appropriated in 1985 was reverted to the General Fund. An individual will dedicate some land for its purpose if the funds necessary for improvements can be paid. Request that the effort be continued and that there be an appropriation of $400,000 during the coming session to allow this program to become a reality.

Dr. Mel Markowski
Past President
N.C. Association for Marriage and Family Therapy
Greenville

Supports work of Child Task Force. Urges emphasis on family involvement. Recommend that marital and family therapy be the primary treatment modality. Suggests that the basic unit for case management be the family rather than the child. Recommends that certified marriage and family therapists be recognized as third party providers in N.C. Recommends that parenting classes and marriage enrichment be used in conjunction with or instead of the traditional therapist-child paradigm. Support the concept of flexibility of funding for the essential services.

Blain Cargile
Social Worker
Child & Youth Services
Tideland Area Program
Washington

Cites the current dearth of mental health services for children--no residential services readily available, no crisis intervention, no specialized foster care, limited outpatient and case management, no alternative non-residential services. Supports the comprehensive service system of Child Task Force because it would address these needs. Also sees significant need for children of all age groups to receive prevention services. Urges support of plan.

Eldon Tieje
Area Director
Cumberland Area Program
Fayetteville

Commends both Child Task Force and Funding Studies. Concern that concept of standardized levels does not take into account real local differences. Concern that administrative costs not clearly addressed. In Child Task Force implementation plan does not agree in cost projects, because doesn't take administration into account.

Macon Johnson
County Commissioner
Camden County

Urges adequate funding for area mental health programs. Commends local staff in what they do with what they have. But needs are greater, particularly for children. In rural areas there is also a desperate need to address transportation needs. Propose a penny sales tax earmarked for mental health services.

(written)
Dr. Elliot M. Silverstein
Co-Director of Psychological Services
Child Psychiatry Training Program
Dorothea Dix Hospital
Raleigh

Strongly supports the recommended change in the minor's admission law that would return to parents the right to sign their children out of restrictive treatment facilities. The change would strengthen potential alliance between treating facility and parents and would reduce liability for facilities. The proposal does still allow procedures for retaining the child if it is necessary. Ambivalently support the proposed changes in the hearing process itself--however, still question the necessity of the hearings themselves. Argues that the In re Long case required due process protections not hearings, and that the protections could be covered in other ways. Points out that U.S. Supreme Court does not require judicial hearings. If the hearings will remain, the proposed changes may improve the nature of the hearing. The limitation on judicial authority may be needed because some judges set hearings too frequently, thus forcing a focus on the hearings rather than on treatment. The proposed role of the attorney as guardian ad litem with the best interest of the minor role rather than to represent the wishes of the minor can only be judged theoretically, but it has the potential for holding the lawyer more accountable, just as the hospital has been accountable for many years.

(written)
Roslyn Savitt
Executive Director
The State Council for Social Legislation
Raleigh

Supports the efforts of the Child Task Force--especially individualized assessment, case management and the importance of coordination and linkage between service agencies. Recognizes the value of family involvement and supports development of age appropriate regional and sub-regional residential services. Urges support for adequate funding, monitoring and evaluation of the comprehensive system of services.

APPENDIX O

Summary Outline of Concerns Raised at Public Hearings Regarding Psychiatric Hospitals and The Care of The Chronically Mentally Ill

Hospital Concerns

- Direct Care Staffing
  - Need for additional health care technicians
  - Consideration of higher pay scales and career ladder for health care technicians
  - On-going training for health care technicians
- Physical Environment
  - Air conditioning at Broughton
  - Furniture and other general living conditions
  - Adequate spacing needed/patients overcrowded
  - Separate facility needed for violent patients
- Programming
  - Need for additional program staff to treat patients beyond medication
  - More active treatment and recreation
  - Psycho-social rehabilitation programming needed
  - Need for vocational programming and activities
  - Patients discharged too early without adequate treatment
  - Programs needed like the therapeutic community

Community Service Concerns

- Need for Comprehensive Service Development Plan (like Child Mental Health)
- Need for Services
  - Intermediate services with more supervision than is currently available
  - Housing--variety of lower cost arrangements
  - Vocational training and work programs
  - Expansion of current models for the seriously disabled in more communities

Continuum of Care

- Needs of hospitals and communities must be considered collaboratively
- Better linkages between hospital and community treatment programs
- Consider rehospitalization directly back to treatment if patient deteriorates when discharged

Other

- Need for more patient advocates at Broughton
- Recommendation to return more power to physicians
- Programs needed in areas of research, medical service and basic education