LEGISLATIVE STUDY COMMISSION
ON
MENTAL HEALTH, DEVELOPMENTAL DISABILITIES,
AND
SUBSTANCE ABUSE SERVICES

REPORT TO THE

2000 SESSION OF THE

1999 GENERAL ASSEMBLY

OF NORTH CAROLINA

North Carolina General Assembly
Legislative Services Office

George R. Hall, Legislative Services Officer
(919) 733-7044

Elaine W. Robinson, Director
Administrative Division
Room 5, Legislative Building
16 W. Jones Street
Raleigh, NC 27603-5925
(919) 733-7500

Gerry F. Cohen, Director
Bill Drafting Division
Suite 401, LOB
300 N. Salisbury St.
Raleigh, NC 27603-5925
(919) 733-6660

James D. Johnson, Director
Fiscal Research Division
Suite 619, LOB
300 N. Salisbury St.
Raleigh, NC 27603-5925
(919) 733-4910

Tony C. Goldman, Director
Information Systems Division
Suite 400, LOB
300 N. Salisbury St.
Raleigh, NC 27603-5925
(919) 733-6834

Terrence D. Sullivan, Director
Research Division
Suite 545, LOB
300 N. Salisbury St.
Raleigh, NC 27603-5925
(919) 733-2578

May 5, 2000

TO: MEMBERS OF THE 1999 GENERAL ASSEMBLY

FROM: THE LEGISLATIVE STUDY COMMISSION ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES

RE: Interim Report

The Co-chairs of the Joint Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services respectfully submit on the Commission's behalf the attached Interim Report.

Senator Jim W. Phillips, Sr.

Representative Verla Insko

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PART 1. COMMITTEE PROCEEDINGS

The Legislative Study Commission on Mental Health, Developmental Disabilities and Substance Abuse Services established in G.S. 120-204, is a 23-member commission charged to study systemwide issues affecting the development, administration, and delivery of mental health, developmental disabilities, and substance abuse services, including issues relating to governance, accountability, and quality of services delivered. Membership of the Commission may be found in Appendix C of this report.

The Commission met six times prior to the convening of the 1999 General Assembly's 2000 Short Session. Below is a brief summary of each meeting. Minutes of the meetings, including copies of written materials are available in the Legislative Library.

January 11 & 12, 2000

The Department of Health and Human Services updated the Commission on the issue of organizational changes within the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), including the recent appointment of Dr. Iverson Riddle, Director of DMH/DD/SAS. The Commission also heard an overview of the issue of "use of restraints and seclusion in mental health and other facilities."

The State Auditor and contract consultants from the Public Consulting Group, Inc., provided an update of the legislatively mandated "Study of State Psychiatric Hospitals and Area Mental Health Programs." The Commission also had a presentation on the issue of conditional release of persons involuntarily committed to state psychiatric hospitals. The meeting concluded with the appointment of subcommittees to study the issue of "use of restraints and seclusion in mental health and other facilities" and the issue of "conditional release of persons involuntarily committed to state psychiatric hospitals."

February 15 & 16, 2000

The co-chairs of the Restraints and Conditional Release Subcommittees provided the Commission with brief reports on the previous day's activities. The Subcommittee on Conditional Release recommended that it no longer meet due to the DHHS decision to work with existing law to improve this practice.

Dr. David Bruton, Secretary DHHS, along with other staff within DHHS, briefed the Commission on the issue of staffing shortages at Dorothea Dix Hospital. DHHS staff also provided a progress report on the steps taken thusfar to address the problems.

Don Willis, DHHS along with other staff within DHHS, provided an overview of the State's current policies and practices when deaths occur in the DHHS' facilities. Following these presentations the Commission heard comments from the general public.

Dr. Terry Stelle presented an update on the organizational changes within the Division of Mental Health, Developmental Disabilities and Substance Abuse Services. Following

this presentation, the Commission received extensive public comment on various issues within the mental health system.

Don Willis, DHHS, presented an overview of the "placement of persons with mental health disabilities in adult care homes." The meeting concluded with a brief presentation by Dr. Pat Porter, DHHS, regarding the consolidation of the former Thomas S Section with the Developmental Disabilities Section.

March 7 & 8, 2000

Rep. Verla Insko provided a brief update on the activities of the Restraints and Seclusion Subcommittee. Following, the Commission heard from various staff within DHHS regarding staff shortages at Dorothea Dix Hospital. Dr. Lenore Behar, DHHS, updated the Commission on the consolidation of the former Willie M Program into the Child Mental Health Section. Tara Larson and Daphne Lyon, DHHS, provided a brief overview on the need and progress of DHHS' Utilization Review Initiative. The Commission had many questions and expressed concerns regarding the DHHS' Utilization Management initiative.

The following day, the Commission heard from Don Willis, DHHS; Beth Melcher, NC Alliance for the Mentally Ill; Lou Wilson, NC Association of Long-term Care Facilities; and Bob Fitzgerald, DHHS on the issue of "placement of persons with mental health disabilities in adult care homes." The Commission asked the presenters to begin working on a framework to begin addressing the issues raised during the presentations.

Bob Hargett, NC Attorney General's Office presented on the recent Supreme Court decision, *Olmstead v. LC and EW:* State Responsibilities for Mental Health Services.

March 21 & 22, 2000

Rep. Verla Insko provided a brief update on the activities of the Restraints and Seclusion Subcommittee. Following the update, the Commission heard a presentation from Dr. Scott Stroup, UNC-CH Department of Psychiatry on the "placement of persons with mental disabilities in adult care homes." Don Willis, DHHS, followed with an update on the results of a meeting aimed at addressing issues raised by the Commission. The briefing addressed several principles to consider regarding residential services for mental health clients.

Charles Davis, DHHS, presented a Division of Mental Health and Community System Budget Overview and Deficit of Services Update. Following, Beth Melcher, NC Alliance for the Mentally Ill presented the Coalition 2001 budget concerns and funding request. The Commission also heard from the following providers: Larry Thompson, Blue Ridge Center; Ron Morton, CenterPoint Behavioral Health Center; Steve Ashby, Durham Area Mental Health Program; and Fred Waddle, Providers' Council regarding the impact of local mental health services program/services closures.

Finally, the Commission heard from DHHS consultant, Barbara Matula and Coalition 2001 representative Dave Richards, regarding the State's efforts to plan for the State's response to the US Supreme Court decision in Olmstead v. LC and EW.

April 11 & 12, 2000

Mr. Ralph Campbell, State Auditor, and representatives from the Public Consulting Group, Inc. presented the findings and recommendations from the "Study of State Psychiatric Hospitals and Area Mental Health Programs." Following the presentation the Commission received public comments on the study.

The Commission heard responses to the "Study of State Psychiatric Hospitals and Area Mental Health Programs" from the following: Patrice Roesler, NC Association of County Commissioners; David Swan, Vice-President, NC Council of Community Programs; Myrna Miller, Vice-Chair, NC Coalition for Persons Disabled by Mental Illness; Carl Britton-Watkins, Chair-Elect, NC Substance Abuse Federation; and Dave Richards, NC Developmental Disabilities Consortium.

Following the responses to the Study, Rep. Verla Insko presented a "Proposal for Implementation of Mental Health Reform." The proposal was reviewed and approved by the Commission, along with direction to staff to draft a bill to implement the reform proposal.

The meeting concluded with staff explanation of a draft seclusion and restraints bill. After several amendments, the Commission directed staff to contact the federal Health Care Financing Administration to clarify several concerns and bring back the draft bill for final vote.

April 24, 2000

The meeting began with a formal response from Dr. David Bruton, Secretary, DHHS, to the "Study of State Psychiatric Hospitals and Area Mental Health Programs."

Following this presentation, Commission staff reviewed the Commission's draft bills. The Commission reviewed, amended and approved final draft bills on "Restraints in Facilities" and "Mental Health System Reform" and directed the bills be included in the Commission's report to the 1999 General Assembly.

The Commission also reviewed and approved its draft findings and recommendations and directed staff to incorporate the findings and recommendations into its interim report. During this discussion the Commission expressed concern regarding residential services for children and directed staff to ensure the inclusion of this area for future study.

Finally, the Commission voted to endorse the FY2000/01 budget requests presented by the Coalition 2001 during the Commission's March 21-22, 2000 meeting.

PART 2. FINDINGS AND RECOMMENDATIONS

A. MENTAL HEALTH SYSTEM REFORM

FINDING ONE: The Commission finds that the current system of public mental health, developmental disabilities and substance abuse services is in a state of crisis and in need of system reform. The Commission also finds that a comprehensive study by the Public Consulting Group, Inc. entitled "Study of State Psychiatric Hospitals and Area Mental Health Programs," April 1, 2000, and coordinated by and under contract with the Office of the State Auditor, provides the blueprint for a planning process to reform the public mental health system.

RECOMMENDATION ONE: The General Assembly should enact the proposed legislation attached as Appendix A, entitled "AN ACT TO ESTABLISH THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES, AND TO DIRECT THE OVERSIGHT COMMITTEE TO DEVELOP A PLAN TO REFORM THE STATE SYSTEM FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES. The oversight committee proposed in the attached legislation would oversee the development of a plan to reform the system and address other issues including structure, governance and financing of services, downsizing of state hospitals, developmental disabilities services, quality of services, and ongoing involvement of consumers and families.

B. CONDITIONAL RELEASE [OUTPATIENT COMMITMENT]

FINDING TWO: The Commission finds that current State law governing outpatient commitment, when applied at the State and local levels to provide appropriate levels of care and support for individuals on outpatient commitment, can be an effective means of treatment for certain individuals in the community.

RECOMMENDATION TWO: The Commission recommends that current State law on outpatient commitment not be amended to set up a new conditional release system. .

C. RESTRAINTS/SECLUSION AND REPORTING OF DEATHS IN FACILITIES

FINDING THREE: The Commission finds that State law and rules regarding the appropriate use of restraints and seclusion have not adequately protected citizens receiving services in public and private hospitals, group homes, adult care homes, and other residential care and treatment facilities and settings across the State.

RECOMMENDATION THREE: The General Assembly should enact legislation attached as Appendix B, entitled "AN ACT TO REGULATE THE USE OF RESTRAINTS, SECLUSION, AND OTHER PROCEDURES IN CERTAIN FACILITIES, TO REQUIRE THE REPORTING OF DEATHS IN CERTAIN FACILITIES AND IMPOSING PENALTIES FOR FAILURE TO REPORT, AND TO

AUTHORIZE THE GOVERNOR'S ADVOCACY COUNCIL FOR PERSONS WITH DISABILITIES TO HAVE ACCESS TO INFORMATION ABOUT THESE DEATHS. The proposed legislation regulates the use of restraint, seclusion and other procedures in mental health facilities, residential childcare centers, and adult care homes. The proposed legislation also requires these facilities to report deaths and the surrounding circumstances to the Department of Health and Human Services, and to enable the Governor's Advocacy Council for Persons with Disabilities to have access to information about these deaths.

FINDING FOUR: The Commission finds that State law lacks a clear, mandatory system of reporting deaths in public and private hospitals, group homes, and other residential care and treatment facilities across the state. The Commission also finds that this deficiency in the law impairs the collection of data, prompt investigation, and the development of policies and oversight which might allow the state to reduce preventable deaths in public and private hospitals, group homes, and other residential care and treatment facilities across the state.

RECOMMENDATION FOUR: The Commission recommends that the General Assembly enact legislation attached as Appendix B (See Recommendation Three.)

D. PLACEMENT OF PERSONS WITH MENTAL HEALTH DISABILITIES IN ADULT CARE HOMES/SENATE BILL 10

FINDING FIVE: The Commission finds that adult care homes play a major role in providing residential services to clients with mental health disabilities. The Commission also finds that some portion of these clients are in need of mental health treatment services while residing in adult care homes. Finally, the Commission finds that a lack of appropriate residential services is problematic for some clients resulting in placement in adult care homes.

RECOMMENDATION FIVE: The Commission recommends the creation of an ad hoc task force, with representation from the Department of Health and Human Services, State and local government, advocacy organizations, families, business/industry and affected providers to look further into the issue of residential services for clients with mental health disabilities. The Commission further recommends that the task force address residential services for children.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S/H D

99-LNZ-219B(4.24.00)
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Mental Health System Reform. Public

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES, AND TO DIRECT THE OVERSIGHT COMMITTEE TO DEVELOP A PLAN TO REFORM THE STATE SYSTEM FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

Whereas, in 1998 and 1999 the General Assembly directed the State Auditor to coordinate and contract for a study of the State Psychiatric Hospitals and Area Mental Health Programs; and

Whereas, the "Study of State Psychiatric Hospitals and Area Mental Health Programs" ("Study"), April 1, 2000, was conducted by the Public Consulting Group, Inc., under the coordination of the State Auditor, and with the cooperation and assistance of the Department of Health and Human Services and other organizations and individuals; and

Whereas, the findings and recommendations of the Study present a comprehensive blueprint for reform of the State's mental health system; and

Whereas, the General Assembly endorses the findings of the Study; and

Whereas, effective implementation of mental health reform requires continuous legislative oversight to review and consider the recommendations of the Study and other matters and to recommend the necessary changes to State law and policy;

Now, therefore,
The General Assembly of North Carolina enacts:

Section 1. Findings. -- The General Assembly finds that:

(1) The State and local government entities are not using effectively and efficiently available resources to administer and provide mental health, developmental disabilities, and substance abuse services uniformly across the State.

(2) Effective implementation of State policy to assist individuals with mental illness, developmental disabilities, and substance abuse problems, requires that a standard system of services, designed to identify, assess, and meet client needs within available resources, be available in all regions of the State.

(3) The findings of recent comprehensive independent studies, and recent federal court decisions, compel the State to consider significant changes in the operation and utilization of State psychiatric hospital services.

(4) State and local government funds for mental health, developmental disabilities, and substance abuse services must be committed on a continuing, stabilized basis, and will need to be increased over time to ensure that the purposes of mental health system reform are achieved.

(5) Reform of the State mental health, developmental disabilities, and substance abuse services system is necessary and should begin immediately. Reform efforts should focus on correcting system inefficiencies, inequities in service availability, and deficiencies in funding and accountability, and on improving and enhancing services to North Carolina's citizens.

Section 2. Oversight Committee Established. -- Chapter 120 of the General Statutes is amended by adding the following new Article to read:

"Article 27.

'The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

'§ 120-240. Creation and membership of Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(a) Establishment; definition. -- There is established the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(b) Membership and Terms. -- The Committee shall consist of 16 members, as follows:

(1) Eight members of the Senate appointed by the President Pro Tempore of the Senate, as follows:

a. At least two members of the Senate Committee on Appropriations.

b. The chair of the Senate Appropriations Committee on Human Resources.

c. At least two members of the minority party.

(2) Eight members of the House of Representatives appointed by the Speaker of the House of Representatives, as follows:

a. At least two members of the House of Representatives Committee on Appropriations.

b. The co-chairs of the House of Representatives Appropriations Subcommittee on Health and Human Services.

c. At least two members of the minority party.

(c) Terms on the Committee are for two years and begin on the convening of the General Assembly in each odd-numbered year, except the terms of the initial members, which begin on appointment and end on the day of the convening of the 2001 General Assembly. Members may complete a term of service on the Committee even if they do not seek re-election or are not re-elected to the General Assembly, but resignation or removal from service in the General Assembly constitutes resignation or removal from service on the Committee.

A member continues to serve until the member's successor is appointed. A vacancy shall be filled within 30 days by the officer who made the original appointment.

'§ 120-241. Purpose of Committee.

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services shall examine, on a continuing basis, systemwide issues affecting the development, financing, administration, and delivery of mental health, developmental disabilities, and substance abuse services, including issues relating to the governance, accountability, and quality of services delivered. The Committee shall make ongoing recommendations to the General Assembly on ways to improve the quality and delivery of services and to maintain a high level of effectiveness and efficiency in system administration at the

State and local levels. In conducting its examination, the Committee shall study the budget, programs, administrative organization, and policies of the Department of Health and Human Services to determine ways in which the General Assembly may encourage improvement in mental health, developmental disabilities, and substance abuse services provided to North Carolinians.

'**§ 120-242. Organization of Committee.**

(a) The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall each designate a co-chair of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. The Committee shall meet at least once a quarter and may meet at other times upon the joint call of the co-chairs.

(b) A quorum of the Committee is eight members. No action may be taken except by a majority vote at a meeting at which a quorum is present. While in the discharge of its official duties, the Committee has the powers of a joint committee under G.S. 120-19 and G.S. 120-19.1 through G.S. 120-19.4.

(c) Members of the Committee receive subsistence and travel expenses as provided in G.S. 120-3.1. The Committee may contract for consultants or hire employees in accordance with G.S. 120-32.02. The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist the Committee in its work. Upon the direction of the Legislative Services Commission, the Supervisors of Clerks of the Senate and of the House of Representatives shall assign clerical staff to the Committee. The expenses for clerical employees shall be borne by the Committee."

Section 3. Plan for Mental Health System Reform. -- (a) Terms defined. -- As used in this Section, unless the context clearly provides otherwise:

(1) "Committee" means the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(2) "Mental Health System" includes the system of services for mental health, developmental disabilities, and substance abuse.

(3) "Plan" means the Plan for Mental Health System Reform developed and recommended by the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(4) "State Auditor/PCG, Inc. Study" means the 'Study of State Psychiatric Hospitals and Area Mental Health Programs', April 1, 2000, conducted by the Public Consulting Group, Inc. under coordination by and contract with the State Auditor.

(b) Development of Plan for Mental Health System Reform. -- The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services established under Article 27 of Chapter 120 of the General Statutes shall develop a Plan for Mental Health System Reform. It is the intent of the General Assembly that the Plan shall be fully implemented not later than July 1, 2005.

(c) Purpose and content of the Plan. -- The Plan shall provide for systematic, phased-in implementation of changes to the State's mental health system. In developing the Plan, the Committee shall do the following:

(1) Review and consider the findings and recommendations of the State Auditor/PCG, Inc. Study.

(2) Report to the 2001 General Assembly upon its convening the changes that should be made to the governance, structure, and financing of the State's mental health system at the State and local levels. The report shall include:

a. An explanation of how and the extent to which the proposed changes are in accord with or differ from the recommendations of the State Auditor/ PCG, Inc. Study.

b. Proposed time frames for implementing mental health system reform on a phased-in basis, and the recommended effective date for full implementation of all recommended changes.

c. An estimate of the amount of State and federal funds necessary to implement the changes. The estimate should indicate costs of each phase of implementation and the total cost of full implementation.

d. An estimate of the amount of savings in State funds expected to be realized from the changes. The estimate should show savings expected in each phase of implementation, and the total amount of savings expected to be realized from full implementation.

e. The potential financial, economic, and social impact of changes to the current governance, structure, and financing of the mental health system on providers, clients, communities, and institutions at the State and local levels.

f. Proposed legislation making the necessary amendments to the General Statutes to enact the recommended changes to the system of governance, structure, and financing.

(3) Study the administration, financing, and delivery of developmental disabilities services. The study shall be in greater depth and detail than addressed in the State Auditor/PCG, Inc. Study. The Committee shall make a progress report on its study of developmental disabilities services to the 2001 General Assembly upon its convening.

(4) Study the feasibility and impact of and best methods for downsizing of the State's four psychiatric hospitals. In conducting this study the Committee shall:

a. Take into account the need to enhance and improve community services to meet increased demand resulting from downsizing, and

b. Consider the findings and recommendations of the MGT of America Report of 1998, as well as the State Auditor/PCG, Inc. Study.

(5) Consider the impact of mental health system reform on quality of services and patient care and ensure that the Plan provides for ongoing review and improvements to quality of services and patient care.

(6) Ensure that the Plan provides for the active involvement of consumers and families in mental health system reform and ongoing implementation.

(7) Address the need to enhance and improve substance abuse services, including services for the prevention of substance abuse.

(8) Recommend a mental health, developmental disabilities, and substance abuse services benefits package that will provide for basic benefits for these services as well as specific benefits for targeted populations.

(9) Take into account the State's responsibility to enable institutionalized persons and persons at-

risk for institutionalization to receive services outside of the institution in community-based settings in accordance with the United States Supreme Court decision in Olmstead vs. L.C., (1999).

(10) Identify and address issues pertaining to the administration and provision of mental health services to children.

(11) Address issues, problems, strengths, and weaknesses in the current mental health system that are not addressed in the State Auditor/PCG, Inc. Study but that warrant consideration in the development of a reformed mental health system.

(c) Subcommittees. The Committee shall establish one or more subcommittees to consider and develop specific focus areas of the Plan. Each subcommittee shall be the working group for the focus area assigned by the Committee co-chairs. The Committee co-chairs shall appoint the co-chairs and members of each subcommittee from the Committee membership. The Committee co-chairs shall invite representatives from the following to participate as nonvoting members of each subcommittee:

(1) Providers of mental health, developmental disabilities, and substance abuse services.

(2) Consumers of mental health, developmental disabilities, and substance abuse services and family members of consumers of theses services.

(3) State and local government, including area mental health programs.

(4) Business and industry.

(5) Organizations that advocate for individuals in need of mental health, developmental disabilities, and substance abuse services.

Subcommittees shall meet at the call of the subcommittee co-chairs.

The Committee co-chairs shall assign the focus area for each subcommittee. Each subcommittee shall carry out its assignment as directed by the Committee co-chairs and shall provide its findings and recommendations to the Committee co-chairs for final decision by the Committee.

(d) Reports. -- In addition to the report required under subsection (b) of this section, the Committee shall submit the following reports:

(1) To the 2001 General Assembly, upon its convening:

a. A progress report on the development of the Plan required by this section; and
b. An outline of an implementation process for downsizing the four State psychiatric hospitals.

(2) To the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services, and to the Joint Appropriations Committees on Health and Human Services, by October 1, 2001, and March 1, 2002, progress reports on the development and implementation of the Plan.

(3) Interim reports on the development and implementation of the Plan to:
a. The 2001 General Assembly, by May 1, 2002. The report shall include legislative action necessary to continue the implementation of changes to the governance, structure, and financing of the State mental health system as recommended by the Committee in its January, 2001 report to the General Assembly.
b. The 2003 General Assembly, upon its convening.
c. The 2003 General Assembly, by May 1, 2004. The report shall include legislative action necessary to continue phased-in implementation of the Plan.

(4) To the 2005 General Assembly, upon its convening, a final report on the Plan for Mental Health System Reform.

Section 4. Oversight Committee Appointments. -- The Speaker of the House of Representatives and the President Pro Tempore of the Senate shall make appointments to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services established under this act not later than 30 days from the date of adjournment sine die of the 1999 General Assembly. The Committee shall convene its first meeting not later than 15 days after all members have been appointed.

Section 5. Department of Health and Human Services Reports. -- On or before October 1, 2000, and on or before March 1, 2001, the Department of Health and Human Services shall report to the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services, and to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, the

status of the Department's reorganization efforts pertaining to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. The report shall also include efforts underway by the Department to better coordinate policy and administration of the Division of Medical Assistance with policy and administration of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

Section 6. Effective Date. -- This act becomes effective July 1, 2000.

SUMMARY
BILL DRAFT – MENTAL HEALTH SYSTEM REFORM
99-LNZ-219A(4.24.00)

This bill establishes a legislative oversight committee on mental health, developmental disabilities, and substance abuse services, and directs the oversight committee to develop a Plan for Mental Health System Reform.

Section 1. – This section sets out findings of the General Assembly with respect to the need for reforming the current public mental health system.

Section 2. – This section establishes a statutory joint legislative oversight committee on mental health, developmental disabilities, and substance abuse services.

(1) From each chamber, 8 members to include:
Appropriations committee
Chair of DHHS appropriations subcommittee
2 from minority party

(2) 2 year terms beginning on convening of each GA in odd-year. Except, initial term will begin on appointment and end upon convening of 2001 GA.
a. Purpose is to examine systemwide issues affecting the development, financing, administration, and delivery of mental health, developmental disabilities, and substance abuse services, including issuses relating to governance, accountability, and quality of services.
b. Authorization to make ongoing recommendations to GA.
c. Committee organization (appointment of co-chairs; quorum; powers of joint committee conferred by G.S. 120-19.1 through 19.4.)

Section 3(a),(b) – This section directs the Oversight Committee established in Section 2 to develop a Plan for Mental Health System Reform. Intent is that the reform will be fully implemented by July 1, 2005. Plan must provide for systematic, phased-in implementation of changes to the State's mental health system. In developing Plan, Committee must:

(1) Review and consider findings of State Auditor/PCG, Inc. Study.
(2) Report to 2001 GA on changes to governance, structure, and financing of State's mental system at State and local levels. Report must include specified items.
(3) Study administration, financing, and delivery of DD services. Study must go into greater depth and detail than PCG, Inc. study. Progress report on this study to 2001 GA.
(4) Study feasibility and impact of and best methods for downsizing State's psychiatric hospitals.
(5) Consider impact of reform on quality of services and patient care and ensure that the Plan provides for ongoing review and improvements to quality of services and patient care.
(6) Plan must provide for active involvement of consumers and families in mental health system reform and implementation.
(7) Address need to enhance and improve substance abuse services, including services for prevention of substance abuse.
(8) Recommend a benefits package that will provide for basic mental health, developmental disabilities, and substance abuse services benefits as well as specific benefits for targeted populations.
(9) Take into account the requirements of Olmstead decision.

(10) Identify and address issues pertaining to the administration and provision of mental health, developmental disabilities, and substance abuse services to children.

(11) Address issues, problems, strengths, and weaknesses in the current system that are not addressed in the PCG study but that warrant consideration in the development of a reformed mental health system.

Section 3(c), (d)

Subcommittees

Committee must establish subcommittees to consider and develop specific focus areas of the Plan. Subcommittees must have certain representatives as nonvoting members of the subcommittee.

Reports

Sets reporting requirements for development and implementation of the Plan.

Section 4. – Directs Speaker and President Pro Tempore to appoint members to Oversight Committee not later than 30 days after adjournment sine die of the 1999 GA. Committee must convene its first meeting within 15 days of when all appointments have been made.

Section 5. – DHHS must make certain reports to MHSC and to Oversight Committee.

Section 6. – Act becomes effective July 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S/H D

99-LNZ-209H(2.1.00)
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Restraints in Facilities. Public

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO REGULATE THE USE OF RESTRAINTS, SECLUSION, AND OTHER PROCEDURES IN CERTAIN FACILITIES, TO REQUIRE THE REPORTING OF DEATHS IN CERTAIN FACILITIES AND IMPOSING PENALTIES FOR FAILURE TO REPORT, AND TO AUTHORIZE THE GOVERNOR'S ADVOCACY COUNCIL FOR PERSONS WITH DISABILITIES TO HAVE ACCESS TO INFORMATION ABOUT THE DEATHS.

The General Assembly of North Carolina enacts:

Section 1. (a) G.S. 122C-3 is amended by adding the following new definitions in the appropriate alphabetical order to read:

"**§ 122C-3 Definitions.**

. . .

(13) 'Drug used as a restraint' is a medication used to control behavior or to restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition.

. . .

(18a) 'Isolation time-out' means the removal of a client to a separate unlocked room or area from which the client is physically prevented from leaving.

. . .

(32a) 'Protective device' means intervention

which provides support for or enhances the safety of a client. A 'protective behavioral device' enhances the safety of a self-injurious client. A 'protective medical device' provides support for a medically fragile client.

(32b) 'Restraint' means the limitation of an individual's freedom of movement. In accordance with G.S. 122C-60, 'restraint' includes mechanical restraint and physical restraint, as follows:

1. 'Mechanical restraint' is the restraining of a client with the intent of controlling the client's behavior with mechanical devices. Mechanical devices include cuffs, ankle straps, sheets, or restraining shirts, but not protective devices.
2. 'Physical restraint' means the use of physical holds to limit an individual's movements except those holds required for necessary medical procedures or gentle instructional or physical guiding.
3. 'Planned restrictive intervention' means the use of physical restraint, mechanical restraint, protective behavioral device, seclusion, or isolation time-out as part of a comprehensive treatment plan.

(32c) 'Seclusion' means the isolation of a client in a separate, locked room."

Section 1. (b) G.S. 122C-60 reads as rewritten:

"**§ 122C-60. Use of ~~physical restraints or seclusion.~~ restraints, seclusion, and other procedures.**

~~(a) Physical restraint or seclusion of a client shall be employed only when there is imminent danger of abuse or injury to himself or others, when substantial property damage is occurring, or when the restraint or seclusion is necessary as a measure of therapeutic treatment. All instances of restraint or seclusion and the detailed reasons for such action shall be documented in the client's record. Each client who is restrained or secluded shall be observed frequently, and a written notation of the observation shall be made in the client's record.~~

~~(b) The Commission may adopt rules to implement this section.~~

(a) Except as provided in subsection (b) of this section, a facility may use physical restraint, mechanical restraint, protective behavioral device, isolation time-out, or seclusion of

a client only when there is imminent danger of harm to the client or others.

(b) A facility may use planned restrictive intervention when all of the following are true:

(1) There is current documented evidence based on the client's condition that includes medical and behavioral assessments, which clearly substantiates that serious physical harm to self or others would occur if the planned restrictive intervention were not employed.

(2) The planned restrictive intervention is used as a last resort when less restrictive alternatives have failed.

(3) The planned restrictive intervention has been reviewed, approved and signed by the physician or licensed psychologist prior to implementation by a treatment or planning team. The treatment or planning team shall include all of the following:

a. A physician.

b. A licensed psychologist or a licensed psychological associate.

c. The client or the client's legally responsible person.

d. A client advocate chosen by the client. If the client refuses to choose a client advocate, then the client advocate may be appointed by the facility.

(4) The client or the client's legally responsible person has consented to the plan in writing. If written consent of the legally responsible person cannot be obtained prior to implementation of the procedure, then witnessed verbal consent shall be valid until written consent is obtained but not longer than 30 days. If a client refuses to consent to the plan, then planned restrictive intervention may be used despite refusal by the client or the legally responsible person if the use is in accordance with G.S. 122C-57 and this section.

(5) The plan for use of planned restrictive intervention shall expire on the 90th day after its initial adoption and every 90 days thereafter unless an external review of the planned restrictive intervention plan is conducted within the 90 day period and the review finds that

continued use of the plan or alternative strategies is appropriate. As used in this subdivision, 'external review' is a review conducted by one or more persons or entities knowledgeable of the client population and facility procedures and not employed by the facility.

Within fifteen minutes of initiation, each use of planned restrictive intervention shall be approved by a professional qualified to assess the appropriateness of the planned restrictive intervention. The facility shall review regularly the use of planned restrictive intervention to assess its appropriateness and effectiveness.

(c) The facility shall employ the least restrictive method of restraint, isolation time-out, protective behavioral device, or seclusion applicable to the particular situation. The facility shall end the restraint, isolation time-out, protective behavioral device, seclusion, or planned restrictive intervention when the client is no longer a danger to self or others.

(d) A facility shall obtain the written order of a physician or licensed psychologist within one hour of initiating the use of physical restraint, mechanical restraint, protective behavioral device, seclusion, or isolation time-out. The order must specify duration and the circumstances under which the physical restraint, mechanical restraint, protective behavioral device, seclusion, or isolation time-out may be used. An order for the use of restraint, protective behavioral device, seclusion, or isolation time-out shall not be issued as a standing order or on an as needed basis. The use of planned restrictive intervention as authorized under subsection (b) of this section meets the written order requirements of this subsection.

(e) A facility shall ensure that each client in physical restraint, mechanical restraint, seclusion, or isolation time-out is observed continuously by facility staff. Staff assigned to conduct audio-video observation of a client shall not engage in any activity other than continuous observation of the client. A facility shall ensure that a physical assessment of each client in physical restraint, mechanical restraint, seclusion, or isolation time-out is conducted by a physician, registered nurse, physician assistant, or nurse practitioner within one hour of the initiation of the procedure.

(f) A facility shall not employ restraint and seclusion simultaneously.

(g) A drug used as a restraint:

(1) Shall not be employed for the purpose of discipline, punishment, staff convenience, or as a substitute for adequate staffing, and

(2) Shall not be employed unless required to treat a medical condition.

(h) A facility shall ensure that the following procedures are implemented during the use of restraint, protective behavioral device, seclusion, or isolation time-out:

(1) The client's vital indicators are monitored to assure that the client is conscious, breathing freely, free of physical pain or harm, verbally responsive and motorically in control.

(2) If there is apparent loss or clouding of the client's consciousness or difficulty or interruption in the client's breathing, then the facility shall discontinue the restraints, protective behavioral device, isolation time-out or seclusion and shall immediately seek medical services for the client.

(i) Facilities shall implement policies and practices that emphasize the use of alternatives to restraint, protective device, seclusion, and isolation time-out. Restraints, protective device, seclusion, and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate restraint, protective device, seclusion, and isolation time-out are retrained and have demonstrated competence at least annually.

(j) Facilities shall document each instance of the use of restraint, protective behavioral device, seclusion, and isolation time-out in the client's record. Documentation shall include:

(1) The type of restraint, protective behavioral device, isolation time-out, or seclusion used.

(2) Reasons why the procedure was used, including a description of the event that prompted use.

(3) The time and duration of the procedure.

(4) Use of less restrictive alternatives.

(5) Planning, debriefing, and internal monitoring conducted to eliminate or reduce the probability of incidents that would require use of these procedures.

(6) All assessments, physical examinations, other safety checks, and continuous observations of the client employed during these procedures.

(7) Informed involvement of the client and the client's legally responsible person, if applicable, in planning, debriefing, and assessment concerning these procedures and their alternatives.

(k) Facilities shall collect and analyze data on the use of restraint, planned restrictive intervention, protective behavioral device, isolation time-out, and seclusion. The data shall reflect for each incidence, the type of procedure used, the length of time employed, alternatives considered or employed, and the effectiveness of each procedure or alternative employed. Facilities shall collect and analyze the data on a quarterly basis to monitor effectiveness, determine trends, and take corrective action where necessary. Facilities shall make the data available to the Secretary upon request.

(l) An individual or entity that (i) provides services to individuals who receive services from a facility, (ii) charges the facility or the individual a fee for the services provided, and (iii) is not licensed under Article 2 of this Chapter and not excluded from licensure under G.S. 122C-22, shall comply with the requirements of this section. An individual or entity required to comply with this section shall notify the facility immediately upon the death of an individual receiving services from the individual or entity. The notification shall include the circumstances of the death known to the individual or entity.

(m) The Commission shall adopt rules to implement this section. Rules adopted by the Commission shall address the following:

(1) Requirements for the external review of planned restrictive interventions on a regular basis to assess appropriateness and effectiveness.

(2) Qualifications necessary for professionals that assess the appropriateness of the planned restrictive intervention.

(3) Staff training and competence in:

a. The use of positive behavioral supports.

b. Communication strategies for defusing and de-escalating potentially dangerous behavior.

c. Monitoring vital indicators.

d. Administration of CPR.

e. Debriefing with client and staff.

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

g. Other areas designed to ensure the safe and appropriate use of restraints, protective devices, isolation time-out, and seclusion.

(4) Time limits on and renewal of:

a. Written orders for the use of restraint, protective devices, isolation time-out, and seclusion, and

b. Reauthorization of planned restrictive intervention by a treatment or planning team.

(5) Time frames for physical assessment of a client who is in restraint, protective behavioral device, isolation time-out, or seclusion.

(6) Collection, analysis, and use of data by facilities pursuant to subsection (k) of this section.

(7) Any other matters relating to the use of restraints, protective devices, isolation time-out, and seclusion of clients.

(n) The Department may investigate complaints and inspect a facility at any time to ensure compliance with this section."

Section 2. (a) G.S. 131D-10.2 is amended by adding the following new definitions in the appropriate alphabetical order to read:

"**§ 131D-10.2. Definitions.**

. . .

(7a) 'Drug used as a restraint' is a medication used to control behavior or to restrict the child's freedom of movement and is not a standard treatment for the child's medical or psychiatric condition.

. . .

(10a) 'Physical restraint' means physically holding a child who is at imminent risk of harm to self or others until the child is calm.

. . .

(14) 'Time-out' means the removal of a child to a separate unlocked room or area from which a child is not physically prevented from leaving."

Section 2. (b). Article 1A of Chapter 131D of the General Statutes is amended by adding the following new section to read:

"**§ 131D-10.5A. Use of restraints and time-out in residential child-care facilities.**

(a) A residential child-care facility may employ physical restraint and time-out. A drug used as a restraint:

(1) Shall not be employed for the purpose of discipline, punishment, staff convenience, or as a substitute for adequate staffing, and

(2) Shall not be employed unless required to treat a medical condition.

(b) A residential child-care facility may employ physical restraint of a child only when there is imminent risk of harm to the child or others. In employing physical restraint the facility shall use the least restrictive method of physical restraint applicable to a particular situation and the facility shall end the physical restraint when there is no longer imminent risk of harm to the child or others. Before employing physical restraint the facility shall take into consideration the medical condition of the child and any medications the child may be taking.

(c) The residential child-care facility shall record in an incident log and shall document in the child's record all instances of physical restraint and the detailed reasons for the use of physical restraint by the facility. Documentation of instances of physical restraint shall include all of the following:

(1) The type of physical restraint used.

(2) The time and duration of the physical restraint.

(3) Less restrictive alternatives to the physical restraint that were considered.

(4) Evidence of planning and debriefing to reduce the probability of incidents that would require use of physical restraint.

(d) During the entire period of time that a child is under physical restraint in a residential child-care facility, the facility shall ensure that the child is observed continuously by facility staff. The facility shall include in the child's record a notation of the observation.

(e) Physical restraint of a child in a residential child-care facility may be employed only by staff who have been trained and have demonstrated competence in the safe and appropriate use of physical restraints, the alternatives, and techniques to identify and defuse potential emergency situations. Training shall also include monitoring of vital indicators, administration of CPR, and debriefing with staff and the child restrained. All staff employing restraint shall be trained and demonstrate competence annually.

(f) A residential child-care facility may use time-out only if the child in time-out is within hearing and visual distance of staff and the length of time-out is appropriate to the child's age and development.

(g) The Commission shall adopt rules on the use of physical restraint and time-out in residential child-care facilities and shall establish personnel requirements of staff employed in these facilities."

Section 3. (a). G.S. 131D-2 is amended by adding the following new subdivisions in the appropriate alphabetical order to read:

"**§ 131D-2. Licensing of adult care homes for the aged and disabled.**

(a) The following definitions will apply in the interpretation of this section:

. . .

(1e) 'Chemical restraint' means a psychopharmacologic drug that is used for discipline or convenience and not required to treat medical symptoms.

~~(1e) 'Compensatory agent' means a spouse, relative, or other caretaker who lives with a resident and provides care to a resident.~~

(11a) 'Restraint' means the restriction of an individual's freedom of movement. 'Restraint' includes physical holds and physical restraints, as follows:

a. 'Physical hold' means physically holding an individual to limit the individual's movements except when required for necessary medical procedures or gentle instructions or physical guiding.

b. 'Physical restraint' means the application of a physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily which restricts the resident's freedom of movement or normal access to the resident's body."

Section 3. (b). Article 1 of Chapter 131D of the General Statutes is amended by adding the following new section to read:

"**§ 131D-4.8. Use of restraint.**

(a) Adult care homes may use restraints only when the resident has medical symptoms that warrant the use of restraints, and when alternatives to restraints have failed. An adult care home shall not use restraints for the purpose of discipline or

convenience. When using restraints, the facility shall use the least restrictive restraint that provides safety. Adult care homes shall develop and implement policies and procedures in the use of alternatives to restraints and in the care of residents who are restrained. The policies and procedures shall include:

(1) The implementation of a systemic and gradual process for reducing physical restraint time by the use of alternatives.

(2) Development of an assessment and care plan for each resident with medical symptoms that warrant the use of restraints. Except in emergency situations, a resident shall not be restrained until the assessment and care plan have been developed.

(3) A process for providing residents information that the resident's right to participate in the resident's care and treatment includes the right to accept or refuse physical restraint. Information shall enable the resident or the resident's representative to make an informed choice about the use of restraints, including negative outcomes, benefits, and alternatives to restraints. If the resident is incapable of making decisions, the information shall be provided to the resident's representative. A resident's representative shall not assent to the use of restraints for discipline or staff convenience or when the restraint is not necessary to treat the resident's medical symptoms.

(4) Other policies and procedures pertaining to the use of restraints and alternatives to restraints necessary to comply with rules adopted by the Medical Care Commission.

(b) Except in emergency situations where there is risk of harm to the resident or others, adult care homes shall not use physical restraints without a written order from a physician. The order shall specify the medical need for the restraint, the type of physical restraint to be used, the circumstances under which the restraint may be used, and the time intervals the restraint must be checked and removed. Adult care homes may employ physical holds of a resident only in an emergency where there is risk of harm to the resident or others. In emergency situations, adult care homes may use restraints for not longer than one hour until a physician is contacted or the resident is transferred to a medical facility.

(c) Adult care homes shall record in an incident log and shall document in the resident's record all instances of restraints employed and the detailed reasons for the use of restraints. Documentation of instances of restraints shall include all of the following:

(1) Medical symptoms warranting the use of restraint.
(2) The type of restraint used.
(3) The time and duration of the restraint.
(4) Alternatives to restraint that were provided and the resident's response.
(5) The resident's behaviors and care provided during the use of restraints.
(6) Evidence of planning by the adult care home to reduce the probability of incidents that would require the use of restraint.

(d) Restraints may be employed only by staff who have been trained and validated for competence by a registered nurse in the proper use of restraints, alternatives to restraints, and techniques to identify and defuse potential emergency situations. Adult care homes shall ensure that staff authorized to employ restraints are validated annually by a registered nurse as competent in the use of restraints and are required to complete annually a refresher course in the use of restraints and alternatives to restraints. The Commission shall adopt rules establishing minimum training and curriculum requirements for the use of restraints and alternatives to restraints.

(e) Adult care homes shall not use chemical restraint.

(f) As used in this section, a resident's representative is a person designated under G.S. 131D-22.

(g) The Medical Care Commission shall adopt rules to implement this section. The rules shall be at least as protective of residents of adult care homes as State and federal laws, rules, and regulations governing the use of physical restraints in nursing homes."

Section 4. Article 2 of Chapter 122C of the General Statutes is amended by adding the following new section to read:

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

(a) A facility shall notify the Secretary immediately upon the death of any client of the facility. The Secretary may assess a civil penalty of not less than five hundred dollars ($500) and not more than one thousand dollars ($1,000) against a facility that fails to notify the Secretary of a death and the circumstances surrounding the death known to the facility. Each day of a continuing violation of this subsection is a separate

violation. Chapter 150B of the General Statutes governs the assessment of a penalty under this section. A civil penalty owed under this section may be recovered in a civil action brought by the Secretary or the Attorney General. The clear proceeds of the penalty shall be remitted to the State Treasurer for deposit in accordance with State law.

(b) Upon receipt of notification from a facility in accordance with subsection (a) of this section, the Secretary shall notify the Governor's Advocacy Council for Persons with Disabilities that a person with a disability has died. The Secretary shall provide the Council access to the information about each death reported, including information resulting from any investigation of the death by the Department and from reports received from the Chief Medical Examiner pursuant to G.S. 130A-385. The Council shall use the information in accordance with its powers and duties under G.S. 143B-403.1. and applicable federal law and regulations.

(c) If the death of a client of a facility occurs within seven days of the use of restraint, protective behavioral device, seclusion, or isolation time-out, the Secretary shall initiate immediately an investigation of the death.

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

(e) Nothing in this section abrogates State law pertaining to the confidentiality of information provided to the Secretary or the Council under this section. In carrying out the requirements of this section, the Secretary and the Council shall adhere to State and federal requirements of confidentiality applicable to the information received under this section. A facility or provider that makes available confidential information in accordance with this section and with State and federal law is not liable for the release of the information."

Section 5. G.S. 130A-385 is amended by adding the following new subsection to read:

"(f) If a death occurred in a facility licensed subject to Article 2 or Article 3 of Chapter 122C of the General Statutes, or Articles 1 or 1A of Chapter 131D of the General Statutes, and the deceased was a client or resident of the facility or a recipient of facility services at the time of death, then the Chief Medical Examiner shall forward a copy of the medical examiner's report to the Secretary of Health and Human Services within 30 days of receipt of the report from the medical examiner."

Section 6. Article 1A of Chapter 131D of the General Statutes is amended by adding the following new section to read:

"**§ 131D-10.6B. Report of death.**

(a) A facility licensed under this Article shall notify the Department immediately upon the death of any resident of the facility. The Department may assess a civil penalty of not less than five hundred dollars ($500) and not more than one thousand dollars ($1,000) against a facility that fails to notify the Department of a death and the circumstances surrounding the death known to the facility. Each day of a continuing violation of this subsection is a separate violation. Chapter 150B of the General Statutes governs the assessment of a penalty under this section. A civil penalty owed under this section may be recovered in a civil action brought by the Department or the Attorney General. The clear proceeds of the penalty shall be remitted to the State Treasurer for deposit in accordance with State law.

(b) Upon receipt of notification from a facility in accordance with subsection (a) of this section, the Department shall notify the Governor's Advocacy Council for Persons with Disabilities that a person with a disability has died. The Department shall provide the Council access to the information about each death reported to the Council, including information resulting from any investigation of the death by the Department, and from reports received from the Chief Medical Examiner pursuant to G.S. 130A-385. The Council shall use the information in accordance with its powers and duties under G.S. 143B-403.1. and applicable federal law and regulations.

(c) If the death of a resident of the facility occurs within seven days of the use of physical restraint the Department shall initiate immediately an investigation of the death.

(d) Nothing in this section abrogates State law pertaining to the confidentiality of information provided to the Department or the Council under this section. In carrying out the requirements of this section, the Department and the Council shall adhere to State and federal requirements of confidentiality applicable to the information received under this section. A facility or provider that makes available confidential information in accordance with this section and with State and federal law is not liable for the release of the information."

Section 7. Article 3 of Chapter 131D of the General Statutes is amended by adding the following new section to read:

"**§ 131D-34.1. Report of death of resident.**

(a) An adult care home shall notify the Department of Health and Human Services immediately upon the death of any resident of

that occurs in the adult care home or that occurs within 24 hours of the resident's transfer to a hospital. The Department may assess a civil penalty of not less than five hundred dollars ($500) and not more than one thousand dollars ($1,000) against a facility that fails to notify the Department of a death and the circumstances surrounding the death known to the facility. Each day of a continuing violation of this subsection is a separate violation. Chapter 150B of the General Statutes governs the assessment of a penalty under this section. A civil penalty owed under this section may be recovered in a civil action brought by the Department or the Attorney General. The clear proceeds of the penalty shall be remitted to the State Treasurer for deposit in accordance with State law.

(b) Upon receipt of notification from an adult care home in accordance with subsection (a) of this section, the Department of Health and Human Services shall notify the Governor's Advocacy Council for Persons with Disabilities that a person with a disability has died. The Department shall provide the Council access to the information about each death reported, including information resulting from any investigation of the death by the Department and from reports received from the Chief Medical Examiner pursuant to G.S. 130A-385. The Council shall use the information in accordance with its powers and duties under G.S. 143B-403.1. and applicable federal law and regulations.

(c) If the death of a resident of the adult care home occurs within seven days of the use of physical restraint or physical hold the Department shall initiate immediately an investigation of the death.

(d) Nothing in this section abrogates State law pertaining to the confidentiality of information provided to the Department or the Council under this section. In carrying out the requirements of this section, the Department and the Council shall adhere to State and federal requirements of confidentiality applicable to the information received under this section. A facility or provider that makes available confidential information in accordance with this section and with State and federal law is not liable for the release of the information."

Section 8. This act becomes effective January 1, 2001.

SUMMARY
BILL DRAFT – 99-LNZ-209H(2.1.00)
RESTRAINTS IN FACILITIES

This bill provides for regulating the use of restraints, seclusion, and other procedures in MH/DD/SAS facilities, in residential child care facilities, and in adult care homes. The bill also requires that the same facilities report all deaths occurring in the facility to DHHS, and imposes a penalty for failure to report.

MH/DD/SAS Facilities

Section 1(a). This section amends G.S. 122C-3 to define 5 new terms pertaining to restraints, seclusion, and other procedures.

Section 1(b). This section rewrites the current law on the use of restraints and seclusion, G.S. 122C-60. The proposed law pertains to the use of the following restraint procedures: restraint, seclusion, isolation time-out, protective devices, and drugs used as a restraint. The proposed law does the following:

- Provides that restraint procedures may only be used when there is **imminent danger of harm** to the client or others. G.S. 122C-60(a).
- **Exception** to the imminent danger circumstance is the use of planned restrictive intervention. A facility **may** use planned restrictive intervention under specified conditions. G.S. 122C-60(b). Within 15 minutes of use of planned restrictive intervention, there must be an assessment as to appropriateness of the use. Facility must review regularly its use of planned restrictive intervention. G.S. 122C-60(b).
- Facility must employ **least restrictive method** of restraint procedures, and must end the procedure when the client is no longer a danger to self or others. G.S. 122C-60(c).
- Facility must obtain **written order of a physician or licensed psychologist within one hour** of initiating restraint procedure. Order must specify duration. Order may not be issued on an "as needed" basis. Use of planned restrictive intervention in accordance with G.S. 122C-60(b) satisfies the written order requirement. G.S. 122C-60(d).
- Facility must conduct **continuous observation of client in restraint.** If observation is by audio-video, observer may not be engaged in any other activity. There must be a **physical assessment** of each client in restraint. Assessment must be conducted by a physician, RN, physician assistant, or nurse practitioner **within one hour** of initiation of the procedure. G.S. 122C-60(e).
- Facility may not employ restraint and seclusion simultaneously. G.S. 122C-60(f).
- Drug used as a restraint may not be employed for the purpose of discipline, punishment, staff convenience, or as a substitute for adequate staffing, and may not be used unless it is required to treat a medical condition. G.S. 122C-60(g).
- Facility must ensure that certain procedures are conducted to ensure the health and safety of the client who is in restraint. G.S. 122C-60(h).
- Facility must implement policies and practices that emphasize the use of **alternatives** to restraint. Restraints may only be employed by staff who have been **trained** and **demonstrate competence** annually. G.S. 122C-60(i).
- Facilities must **document use of restraints** in the client record. Documentation must include specified information. G.S. 122C-60(j).

- Facilities must **collect and analyze data on the use of restraint procedures.** Data must be made available to DHHS upon request. G.S. 122C-60(k)
- Requirements apply not only to facilities but to entities or individuals who are not "facilities" as defined in G.S. 122C-3 but who provide services to individuals who receive services from a facility, and who charge the individual or the facility a fee for providing the service. G.S. 122C-60(l).
- Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services must **adopt rules** to implement the law. Areas of rule-making authority are specified. G.S. 122C-60(m).
- DHHS may investigate complaints and inspect a facility at any time to ensure compliance with the law. G.S. 122C-60(n).

Residential Child Care Facilities

Section 2(a). This section amends the law pertaining to residential child care facilities. It adds 3 new definitions to G.S. 131D-10.2.

Section 2(b). This section regulates the use of restraint and time-out procedures in residential child care facilities. The restrictions are as follows:

- Authorizes use of physical restraint and time-out, as defined. Prohibits drug used as a restraint for discipline, punishment, staff convenience, or as substitute for adequate staffing. G.S. 131D-10.5A.(a)
- Physical restraint only when there is **imminent risk of harm** to the child or others. Facility must use least restrictive method and must end the restraint when imminent risk has ended. Facility must take into consideration the medical condition of the child and any medications the child is taking. G.S. 131D-10.5A(b)
- Facility must **record use of restraint in an incident log.** Documentation must be as specified. G.S. 131D-10.5A(c).
- Facility must **observe child in restraint** during entire time of restraint. Must be a notation of the observation in the child's record. G.S. 131D-10.5A(d)
- Restraint may only be employed by staff who are **trained and have demonstrated competence** annually. G.S. 131D-10.5A(e)
- Facility may only use time-out if the child is within hearing and visual distance of staff and length of time-out is appropriate. G.S. 131D-10.5A(f)
- Social Services Commission adopts rules. G.S. 131D-10.5A(g)

Adult Care Homes

Section 3(a). Adds definitions to G.S. 131D-2 (licensing). Definitions distinguish between "physical restraint" and "physical hold".

Section 3(b).

- ACH may use restraints only when medical symptoms warrant use of restraints and when alternatives have failed. Restraints may not be used for discipline or convenience. Least restrictive method must be used. ACH must develop and implement policies and procedures as specified. G.S. 131D-4.8(a).
- ACH may not use restraints without written order of physician except in emergency situations. Emergency use may only be for one hour until a physician is contacted or resident is transferred to a medical facility. G.S. 131D-4.8(b).

- ACH must record use of restraints in incident log and resident's record. Documentation must include specified information. G.S. 131D-4.8(c).
- Restraints may only be employed by staff who are trained and demonstrate competence annually. Training must be by an RN. G.S. 131D-4.8(d)
- ACH may not use chemical restraint. G.S. 131D-4.8(e).
- Medical Care Commission adopts rules. G.S. 131D-4.8(g).

Sections 4-7. These sections pertain to the reporting requirements for each of the three facilities (MH/DD/SAS, Residential Child Care, Adult Care Homes). The requirements are the same for each facility. They are as follows:

- Notify Secretary of DHHS immediately upon death of a client in the facility. Failure to notify may result in $500-$1,000 civil penalty. G.S. 122C-31(a); G.S. 131D-10.6B(a); G.S. 131D-34.1(a).
- Upon receipt of notice from facility, DHHS notifies Governor's Advocacy Council. DHHS must provide Council with access to information about the death. Council uses information in accordance with its authority under State and federal law. G.S. 122C-31(b); G.S. 131D-10.6B(b); G.S. 131D-34.1(b).
- If death occurs within 7 days of use of restraint procedures, DHHS must immediately initiate an investigation of the death. G.S. 122C-31(c); G.S. 122C-131D-10.6B(c); G.S. 131D-34.1(c).
- State and federal law protecting confidentiality of information applies to information provided by facility. G.S. 122C-31(e); G.S. 122C-131D-10.6B(d); G.S. 131D-34.1(d).
- Chief Medical Examiner must forward copy of reports made by the medical examiner pertaining to death of resident of facility. G.S. 130A-385(f).

Section 8. Act becomes effective January 1, 2001.

STATE LEGISLATIVE COMMISSION ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES 1999-2001

MEMBERSHIP LIST

Pro Tem's Appointments

Sen. Jim W. Phillips, Sr., Co-Chair
400 Western Boulevard
Lexington, NC 27295
(336) 248-5021
email – Jimp@ms.ncga.state.nc.us

Sen. Robert Carpenter
29 Admiral Drive
Franklin, NC 28734
(828) 524-5009
email – Robertc@ms.ncga.state.nc.us

Sen. Charlie Dannelly
3167 Dawnshire Avenue
Charlotte, NC 28216
(704) 392-1227
fax – (919) 733-5253
email – Charlied@ms.ncga.state.nc.us

Mr. George Jones
1103 West Queen Street
Edenton, NC 27932
(252) 482-3986
fax – (252) 482-8899

Sen. Jeanne Lucas
620 Legislative Office Building
Raleigh, NC 27601-2808
(919) 733-4599
fax – (919) 715-5815
fax – (919) 683-1792
email – Jeannel@ms.ncga.state.nc.us

Sen. R. L. Martin
P.O. Box 387
Bethel, NC 27812
(252) 825-4361
fax – (252) 825-4361
email – Bobm@ms.ncga.state.nc.us

Pro Tem's Appointments (Cont'd)

Sen. William Martin
411 Legislative Office Building
Raleigh, NC 27601
(919) 715-3042
fax – 715-3043
email – Billm@ms.ncga.state.nc.us

Sen. William Purcell
1301 Dunbar Drive
Laurinburg, NC 28352
(910) 276-7328
fax – (910) 276-7323
email – Williamp@ms.ncga.state.nc.us

Mr. Rhett Raynor
P.O. Box 458
400 W. Broad Street
Dunn, NC 28335
(910) 892-4266
fax – (910) 892-5158
email – raraynor@nceye.net

Speaker's Appointments

Rep. Verla Insko, Co-Chair
1323 Legislative Building
Raleigh, NC 27601
(919) 733-5775
email – Verlai@ms.ncga.state.nc.us

Rep. Martha Alexander
1625 Meyers Park Drive
Charlotte, NC 28207
(704) 365-3841
fax – (704) 365-2889
email – marthaa@ms.ncga.state.nc.us

Rep. Lanier Cansler
14 Laurel Summit
Asheville, NC 28803
(828) 274-5080
fax –(828) 277-2499
email – lanier@partnersmedical.com

Speaker's Appointments (Cont'd)

Rep. James Crawford, Jr.
P.O. Box 5144
Henderson, NC 27536
fax – (252) 492-3383
email – Jimcr@ms.ncga.state.nc.us

Rep. Beverly Earle
312 South Clarkson Street
Charlotte, NC 28202
(704) 333-7180
fax – (704) 372-1994
email – Beverlye@ms.ncga.state.nc.us

Rep. Wayne Goodwin
P.O. Box 1533
Rockingham, NC 28380
(910) 997-6799
fax – (910) 997-7676
email – wayneg@ms.ncga.state.nc.us

Rep. Edd Nye
P.O. Box 8
Elizabethtown, NC 28337
(910) 862-3679
email – Eddn@ms.ncga.state.nc.us

Ms. Mary Wakeford
507 Hillsboro Road
Carrboro, NC 27510-1227
(919) 967-5553
fax – (919) 969-8515
email – wakeford@netpath.net

Ms. Loria Williams
Warren County Manager's Office
P.O. Box 619
Warrenton, NC 27589
(252) 257-3115
fax – (252) 257-5971

Governor's Appointments

Dr. Patrice Alexander
Champion International Corp.
P.O. Box 580
Roanoke Rapids, NC 27870
(252) 533-6256
fax – (252) 533-6401
email – alexap@champint.com

Mr. Dale Armstrong
Brynn Marr Hospital
192 Village Drive
Jacksonville, NC 28546
(910) 577-1400
email – dcarmstrong@aol.com

Ms. Sally Cameron
N.C. Psychological Association
1004 Dresser Court, Suite 106
Raleigh, NC 27609
(919) 872-1005
fax – (919) 872-0805
email – ncpasallyc@interpath.com

Mr. Jeffrey Plyler
445 Spring Street
Albemarle, NC 28001

Staff

COUNSEL: Gann Watson
Suite 401, Legislative Office Bldg.
Raleigh, NC 27601
(919) 733-6660
email – Gannw@ms.ncga.state.nc.us

FISCAL: Karen Hammonds-Blank
Suite 619, Legislative Office Bldg.
Raleigh, NC 27601
(919) 733-4910
email – Karenh@ms.ncga.state.nc.us

COMMISSION ASST: Ruth Fish
1219 Legislative Building
Raleigh, NC 27601
(919) 733-5776
fax – (919) 715-7586
email – saundersla@ms.ncga.state.nc.us