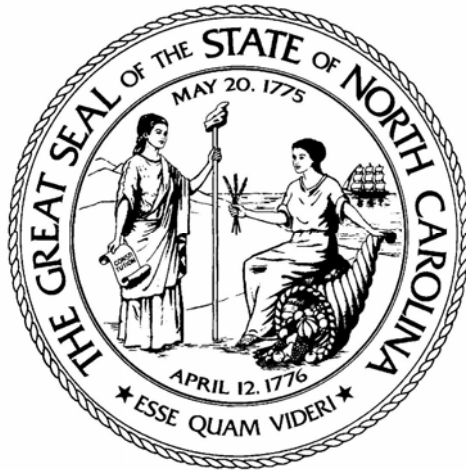


**JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON
MENTAL HEALTH, DEVELOPMENTAL DISABILITIES,
AND SUBSTANCE ABUSE SERVICES**



**REPORT TO THE GENERAL ASSEMBLY
OF NORTH CAROLINA**

January 2005

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January 26, 2005

TO THE MEMBERS OF THE 2005 GENERAL ASSEMBLY

Pursuant to G.S. 120-241 of the North Carolina General Statutes, the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services submits its report to the 2005 General Assembly for the 2005 Regular Session.

Respectfully submitted,

Senator Martin L. Nesbitt, Jr., Co-Chair

Representative Verla Insko, Co-Chair

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PART I

INTRODUCTION

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) is submitting this report to update the 2005 General Assembly on the activities of the LOC during the 2004 interim. Included in this report is the final report on the Plan for Mental Health System Reform as required by Section 3(e)(4) of House Bill 1519, Session Law 2000-83 (See Appendix I); a report on the findings and recommendations for the Alcohol Drug Education Traffic School Program (ADETS) as required by Section 4 of House Bill 1356, Session Law 2004-197 (See Appendix II); and the proceedings of meetings concerning the integration of care for children with multiple service needs as directed by Section 24.2 of Senate Bill 1152, Session Law 2004-161 (See Appendix IV).

The LOC met on September 29, 2004, November 17, 2004, December 17, 2004, January 4, 2005, and January 18, 2005. The DWI/ADETS Advisory Committee met on October 19, 2004, December 14, 2004, and January 4, 2005. The Children's Services Work Group met on November 17, 2004, December 7, 2004, December 16, 2004, January 4, 2005, and January 18, 2005. Committee proceedings are included in this report.

LEGISLATIVE OVERSIGHT COMMITTEE PROCEEDINGS

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services met on five occasions during the 2004 interim. The following is a brief summary of the Committee's proceedings. Detailed minutes and information from each Committee meeting is available in the Legislative Library.

September 29, 2004

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) convened its first meeting of the interim on Wednesday, September 29, 2004 at 10:00 A.M. in Room 544 of the Legislative Office Building.

Kory Goldsmith, Staff Attorney, provided a presentation of enacted legislation concerning Mental Health/Developmental Disabilities/Substance Abuse Services (MH/DD/SAS) issues from the 2004 Session including two bills previously recommended by the LOC: Involuntary Commitment Warrant Clarification and Increase Fees/Qualifications for the DWI Assessments. She also reviewed the studies assigned to the Committee including a study on the Integration of Care for Children with Multiple System Service Needs. She also noted that the Department of Health and Human Services had been directed to study Care for the Mentally Ill in Long Term Care Facilities and the Financing of MH/DD/SA Services.

Jim Klingler, Fiscal Analyst, reviewed the budget provisions from H.B. 1414 – Appropriations Act of 2004 and noted items reduced or funded in the Money Report. He also noted an appropriation of \$10 million to the Mental Health Trust Fund for the purpose of building community capacity and assisting with the mental health reform transition as well as changes in Medicaid policy that allow independent providers to directly enroll with Medicaid for reimbursement for services delivered primarily to non-target populations. Under Special Provisions, Mr. Klingler highlighted the Mental Health Treatment Courts item, which established three pilot mental health treatment courts in three districts.

Kory Goldsmith continued the presentation with a historical overview of mental health reform and the requirements of reform legislation. Ms. Goldsmith reviewed the State and federal context and the General Assembly's response, which included commissioning several studies. In 2000, the General Assembly created the LOC to develop a plan for mental health reform and examine ongoing system-wide issues. Ms. Goldsmith then reviewed HB 381, the reform legislation noting the significant changes in governance at the local level and the State's responsibilities.

Jim Klingler completed the presentation by summarizing what has occurred with reform implementation and identifying the work that remains to be done. He reviewed the *State Plan - Blueprint for Change* developed by DHHS. He explained the steps in creating the Local Management Entities and the Consumer and Family Advisory Councils. He noted that the Consumer Advocacy Program created in HB 381 has never been funded. However, the Division has established the Advocacy and Consumer Services Section.

Significant work remains to complete reform including: implementation of the service array; divestiture of services by LMEs; LME merger and consolidations to reduce from 33 to 20 by January 2007; and allocation of funds to the LMEs. Local business plans will need to be continually assessed. The downsizing and replacement of State institutions is also an ongoing issue.

Mike Moseley, Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH), provided an update on the implementation of reform. Mr. Moseley said that he was committed to visit every LME by January and the Division will hold four town meetings between now and next July to hear concerns and address issues.

Leza Wainwright, DMH Deputy Director, gave a presentation on the changes in the service array. One of the fundamental changes required by the reform legislation was to identify target populations to receive State and State allocated federal funds to ensure funds are used to serve people most in need of services. She identified the criteria for the target populations in adult, child and adolescents in Mental Health, Developmental Disabilities, and Substance Abuse. Ms. Wainwright noted LMEs may use county funding to cover the cost of services for the non-target population. She reviewed the benefit packages, new services for mental health and substance abuse and identified those services to be eliminated.

Ms. Wainwright explained that DHHS contracted with Technical Assistance Collaborative to gather rate information from around the country to help determine service rates for North Carolina. In reviewing the direct enrollment of Service Providers, she gave a brief background, explained Medicaid requirements and enhanced benefits. Continuing, she explained the changes to the LMEs. She addressed changes in the contract and assured members that divestiture of services would not occur until providers were in place. She reviewed the service management functions of an LME explaining the review and approval of the Person Centered Plan and she spoke of "trigger points" that would result in utilization review. She also provided information regarding provider monitoring, enrollment and requirements for endorsement.

Mike Moseley spoke on the status of downsizing the Mental Retardation Centers and the State Psychiatric Hospitals. Mr. Moseley explained the barriers in downsizing the Mental Retardation Centers, including financial resources, provider resources and planning. He explained the urgency of meeting the requirements of the Olmstead decision and the Legislative mandate requiring a reduction each year of 4 percent.

Continuing, Mr. Moseley said the current CAP/MRDD waiver runs through June 2006. Because numerous problems exist with the existing waiver, the new comprehensive waiver targeting those with intense needs is to be submitted to CMS and will be in place by July 1, 2005. It will run concurrently with the current waiver until the current waiver expires. An Independence Plus waiver is also being written to address those with less intense needs who can be served at a lower cost and can be more self-directed. The goal is to submit that waiver request to CMS by July 1, 2005.

Mr. Moseley addressed the downsizing of the psychiatric hospitals. He explained that no acute adult admission beds have closed and none would close until appropriate community alternatives were in place. He said that \$7.7 million from the Mental Health Trust Fund had been allocated to the LMEs to build community capacity, and that \$15.3

million in recurring funds had been transferred from the State hospitals' budgets to the LMEs to fund community mental health services.

Addressing admissions, Mr. Moseley said the attempt to downsize 36 beds by 2005 is offset by an increase in the number of acute care adult admissions. He reviewed data addressing the reasons for the increase and said the Secretary is working with the Hospital Association to try to increase incentives for private hospitals to keep their existing psychiatric beds and to create additional beds.

November 17, 2004

The LOC held its second meeting of the interim on November 17, 2004 at 1:00 P.M. in Room 544 of the Legislative Office Building.

Senator Martin Nesbitt, Co-Chair, gave an update on the Children's Services Work Group informal information session that took place earlier that day. He told members that all the agencies representing children's services were present to discuss collaboration.

Representative Alexander, Co-Chair of the DWI/ADET Advisory Committee, gave a brief report on activities of the committee. She said the committee is studying ADET facilities and the fee structure as directed by legislation passed last Session.

Jim Klingler, Fiscal Analyst, gave an overview of the budget for community mental health, developmental disabilities, and substance abuse services and the allocation of State appropriations. He told members that of the \$1.6 billion in the State's MHDDSAS budget, Medicaid pays 65% of all services delivered in the community. The State appropriates 20% of that amount. He said that just over \$1 billion flows through the area programs with 49% coming from Medicaid. The difference is that the Medicaid funds are paid to direct enrolled Medicaid providers. Given proposed changes to the State Plan, all Medicaid providers will be direct enrolled which will cause significantly more money to flow from the State and the State Medicaid Program to providers and not through the area programs.

Continuing, Mr. Klingler stated that the greatest change in the budget figures had been in the growth of Medicaid payment for services (122%) over the past five years. Mike Moseley, DMH Director, added that in addition to residential treatment services, community based services are a source of growth in the Medicaid program. The issue spawned a number of questions regarding the use and regulation of group homes. Mr. Moseley said Secretary Hooker Odom is overseeing the effort to review the regulatory climate connected to these programs and other residential programs and provider qualifications.

Returning to the funding allocation presentation, Mr. Klingler reviewed the direct State appropriations to the area programs for the delivery of services. He noted that State appropriations are the main source of funding for indigent care and services not covered by Medicaid and that the funds are not equitably distributed across the area programs. Mr. Klingler said that DHHS had been instructed by the General Assembly to report by February 1, 2005 on a revised system for allocating State and federal funds to area mental health authorities.

Mr. Klingler continued by explaining that Medicaid funding presents the largest single source of funding for area programs. The Federal Government pays \$0.631/2 on every dollar expended for Medicaid reimbursable services.

Mr. Klingler reviewed the allocation of State funds and illustrated how they vary across the State per capita and per person served. Finally, he gave some long-term and short-term options for consideration when looking at a new allocation system and questions that should be considered regarding the system. He emphasized the options were simply ways to approach the issue of methodologically infusing more dollars.

Dr. Beth Melcher, Director of the North Carolina Science to Service Project, gave a presentation on the implementation of evidence-based practices for adults with mental illness, a project commissioned by the DMH. She focused on what she believed to be the core of reform – access to services that support people in their lives, their recovery, and that allows them to stay in their communities. Dr. Melcher reviewed federal studies, initiatives, and goals. Evidenced Based Practices offers standardized treatments. She said controlled research has been done on services, with objective outcome measures. She said Evidenced Based Practices offers mental health consumers choices of outcomes from services offered.

Dr. Melcher said information gathered from studies and surveys informed the recommendations compiled into the final report from the North Carolina Science to Service Project. The report is available in its entirety at www.ncs2s.org.

December 17, 2004

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services held its third meeting on Friday, December 17, 2004 at 9:30 A.M. in Room 643 of the Legislative Office Building.

Kory Goldsmith, Committee Counsel, gave an update on the Children's Services information session held on December 16th. Ms. Goldsmith explained that the purpose of the work group meeting had been to make recommendations that would be brought back to the LOC. Representative Insko said that a bill would be drafted and presented to the Child Services Committee on January 4th for review. The bill would then be presented to the LOC on January 18th. Senator Nesbitt reiterated that one issue that continues to be raised is that although there exist collaborative bodies, the key players do not always attend those meetings. He said the consensus from the workgroup was that the Legislature needed to facilitate collaboration.

Dr. Michael Lancaster, DMH Chief of Clinical Policy, gave a presentation on target population. Dr. Lancaster noted that the term "target population" appears in the mental health reform legislation and that it was included because there were not sufficient resources in the State to serve everyone in the State with disabilities. Dr. Lancaster explained the consultative process the Division used for determining the target population. Dr. Lancaster provided estimates regarding the number of persons in the target and non-target populations for mental illness, child mental illness, and substance abuse or drug problems, and compared the number of persons currently served versus those not currently being served.

In adult mental health, using CDC estimates, the Division believes that 260,000 people in the target population are not being served. Of those 20% to 50% are covered by insurance or alternative resources. The remaining 50% are those who should be treated by the public system. The cost would be \$2,300 per case with an additional \$149-\$207 million needed to treat the target population.

Regarding the non-target population, Dr. Lancaster said the criteria indicates those persons may have a diagnosis of mental illness related to anxiety, underlying depression or other disorders. He said that 7% of those currently being served are in the non-target population and that approximately \$11 million had been spent last year to provide services for these individuals.

Senator Dannelly briefed the committee on the DWI/ADET Advisory Committee, noting the Advisory Committee would present final recommendations to the LOC on January 18, 2005.

Mike Moseley, DMH Director, gave an update on system reform. He said that he had recently completed visits to all 15 facilities and 24 of the 33 Local Management Entities. He told members that he would complete the visits by the end of January. Mr. Moseley said the subcommittee of the Physicians Advisory Group for the Division of Medical Assistance (DMA) had made its final recommendations on the service definitions and hopefully DHHS would be able to submit the final State Plan Amendment for new services to the federal government in early January. He continued by saying that DMH had brought providers together from the various disabilities to discuss the associated rates for services. The review should be complete in early January with the final rates being published later that month. He said a comprehensive training program regarding the new service definition has been developed. Mr. Moseley said two major statewide training events are planned in January targeting providers, LMEs, and consumers.

Continuing, Mr. Moseley said a joint work group from the staff of the Division of Vocational Rehabilitation and the Division of MHDDSAS had studied the Adult Developmental Vocational Program System. The group made preliminary recommendations on developmental disabilities in August to the Division Director but the group was asked to go back and expand the scope to include consumers with mental health and substance abuse issues and to give fiscal data showing the cost of their recommendations. This process should be completed in February or March.

Regarding the Child Mental Health Plan implementation, Mr. Moseley said Dr. Lancaster is leading a group that has been working and formulating recommendations and looking at ways to ensure smooth implementation of the new services. He said one issue of particular interest is the placement of children in a residential treatment environment. Alternative treatment must be in place for those in Level 1, Level 2 and Level 3 group homes. The goal is to treat children in the home community with less disruptive, more effective and less costly services. Mr. Moseley noted that group home treatment facilities are Medicaid funded services, so any changes are subject to approval by the Centers for Medicare and Medicaid Services. The Division will present proposed rule changes to the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services at their January meeting. He also said the Secretary is finalizing a regulatory package to be presented to the Legislature during the upcoming Session.

January 4, 2005

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services held its fourth meeting on Tuesday, January 4, 2004 at 1:00 P.M. in Room 643 of the Legislative Office Building.

Representative Martha Alexander, Co-Chair of the DWI/ADETS Advisory Committee, reviewed the results of the survey of the 54 ADETS. She explained that the survey examined the qualifications of the instructors, class size, cost findings and the cost findings of other states. Based on information compiled from the survey, she reviewed draft legislation that included suggested recommendations by the Advisory Committee. The first recommendation was to increase the fee to the ADET schools from \$75 to \$160. In Section 2 of the draft legislation, individuals providing ADET school instruction must be a Certified Substance Abuse Counselor, a Certified Clinical Addiction Specialist, or a Certified Substance Abuse Prevention Consultant by January 1, 2009. Section 3 recommends that the minimum hours of instruction not be less than 16 hours and that the maximum class size not be more than 20 persons. She indicated that the Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services would have to revise its rules regarding this last recommendation. Representative Alexander explained that Section 4 would contain language pertaining to a quality assurance/outcome study. Staff would include that language after reviewing current laws. She said Section 5 would include appropriated funds to the Department of Health and Human Services but that figure will be determined once the language for Section 4 has been decided.

A motion to adopt the bill for recommendation by the LOC and to authorize staff to add Sections 4 and 5 was approved.

Representative Insko provided an update on the Children's Services Work Group. She explained the group had identified barriers to collaboration, identified existing laws that are in conflict with one another and spoke to the need to develop common language. She said the group first drafted a bill to create a Council in the Executive Branch to meet with the Governor. However, concern that the Council might not meet prompted a second draft mandating the system of care as the State policy for providing services to children. The second draft included principles defining the system of care, and established a tier of work groups. Representative Insko said based on issues that were identified but were not represented in either draft of the bill, staff would develop a third draft securing the support of affected agency heads.

Flo Stein, DMH Chief of Community Policy Management, gave an update on implementation of best practices. Her presentation addressed DMH accomplishments and plans for connecting services to research. She explained that DMH has obtained grants to study best practices in the three areas of disabilities. She referenced the Science to Service Project for Adult Mental Health Services that the LOC heard about earlier this year and said the developmental disabilities best practice framework would be included in the 2005 State Plan. Ms. Stein said North Carolina has one of the most highly developed outcome measurement systems in the country for substance abuse services, and this past year the outcome system was recognized three times in Congress. DMH is working on including developmental disabilities core indicators into a measurement system following the division success in including mental health in the system. Ms. Stein explained that a system of partnership had been established to look at research, to study how practices are being adopted, and to look at new research that might be considered.

That group will give its findings to a Division Advisory Group that will meet twice a year.

Addressing LOC member concerns, Ms. Stein explained the system requires the development of an infrastructure to support the adoption for these practices. The Area Health Education Centers and the University System are in the process of looking at the new service definitions and changing the curriculum to ensure people are prepared.

Mr. Moseley followed by adding that a major systemwide training initiative would begin at the end of January for providers, consumers, LMEs, and family members. Beyond that, a support structure will be in place to offer support as the transition begins and will continue after the new services are implemented.

January 18, 2005

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services held its fifth meeting on January 18, 2004 at 10:30 A.M. in Room 643 of the Legislative Office Building.

Andy Wilson, DMA Senior Eligibility Policy Consultant, provided an update on the policy of suspending Medicaid enrollment for persons committed to institutions. Mr. Wilson explained that the current DMA policy terminates Medicaid services for a person entering a public institution or a person between the ages of 22 and 64 entering an Institution for Mental Disease (IMD) and has been in place since 1978. Although the Centers for Medicare and Medicaid Services (CMS) recently recommended a suspension of services rather than a termination, DMA does not believe the recommendation warrants changing the current policy. Mr. Wilson explained that from DMA's perspective, the Medicaid status for persons in a public institution or an IMD is the same whether terminated or suspended. He further explained the process for reapplication upon discharge, noting the re-evaluation process would take no longer than 45 days. LOC members asked DMA to report back with a plan to shorten the review process and to provide federal and State definitions for "suspension" and "termination."

Mr. Wilson reported on multiple eligibility and waiver options under Medicaid that the State currently does not utilize. He gave 5 examples – TEFRA Children, Medicaid Coverage of the Working Disabled (Medicaid Buy-In), State/County Special assistance for Adults Living at Home, Optional Targeted Low Income Children, and Presumptive Eligibility of Children. The actual cost for incorporating any of these options has not been determined. None of the options would expand coverage to individuals over 20 years of age who are not blind; disabled; pregnant; or the caretakers of children under age 19. LOC members requested that DMA report back with an estimated cost analysis of implementing any of the options.

Coalition 2001 is a coalition representing 50 statewide not-for-profit organizations working together to meet the needs of North Carolinians living with mental illness, developmental disabilities, and the disease of addiction. The Coalition's fiscal priorities for 2005 include increasing the Mental Health Trust Fund by \$20 million with an emphasis on crisis services and a recurring appropriation request of \$134 million which includes \$90 million for community capacity development for those in the target population who are waiting for services. The Committee endorsed the Coalition 2001

proposals and voted to include them in the Oversight Committee report to the General Assembly.

Jim Klingler, Fiscal Analyst, presented two draft bills specifically addressing how to pay for the outcome study of the ADETS program. The first draft contained an appropriation to pay for the outcomes study. The second draft had no appropriation but rather authorized the Department to receive 10% of each fee paid to the ADETS by the offender to cover administrative costs. The Committee approved the second draft and voted to include the bill draft in the LOC Report.

Members then reviewed and approved the LOC's final report on the implementation of the State plan for mental health reform. This report is required by legislation passed during the 2000 Session creating the LOC. The report includes an historical overview for mental health reform, summarizes the provisions of the mental health reform legislation, describes reform implementation, and outlines unfinished business.

Kory Goldsmith, Committee Counsel then explained the bill draft containing the recommendations of the Children's Services Work Group. After discussion, the LOC approved the bill with some modifications and moved to include it in the LOC report.

The Committee approved the draft report with recommended changes and instructed staff to incorporate the draft report into a final report to the 2005 General Assembly.

PART II

FINAL REPORT ON THE PLAN FOR MENTAL HEALTH REFORM

As required under S.L. 2000-83, Sec. 3 (e)(4)

I. Introduction

During the mid to late-1990's, North Carolina's public mental health system faced significant challenges. There were 40 Area Authorities Statewide, but several programs were experiencing severe financial difficulties and even bankruptcy. Newspaper articles chronicled deaths in State mental health facilities and State psychiatric hospitals were in danger of losing federal funds due to severe staffing shortages and record-keeping violations. The General Assembly responded by commissioning several studies (State Auditor/PCG Studies) of the State psychiatric hospitals and the Area mental health programs. The State Auditor/PCG Studies found that:

- the governance and funding structures of area authorities did not promote accountability to local governments or to the State;
- the use of State hospital inpatient beds in North Carolina was significantly higher than in peer group states;
- the accessibility and quality of clinical assessment varied widely across the State;
- services for acute substance abuse were lacking across the State;
- the role of State hospitals with regard to area programs was not clear;
- the system suffered from a lack of clarity about what it was trying to accomplish;
- the State spent a large percentage of its funds on State hospitals and clients covered under certain lawsuits, making it difficult to provide services to other individuals; and
- the State served a greater proportion of its developmentally disabled clients in large, State-operated residential centers than was the national norm and did not utilize the Medicaid waiver program to pay for community services to the extent other states did.

Contemporaneous with these studies and findings, the United States Supreme Court issued the Olmstead decision clarifying the States' responsibilities towards certain institutionalized individuals. The Court held that States have an obligation to provide community-based treatment for persons with mental disabilities when treatment officials determine that community placement is appropriate, the affected person does not oppose community-based treatment, and the placement can be reasonably accommodated taking into account available resources.

In response to these studies and court decisions, the General Assembly passed HB 1519 (S.L. 2000-83) (See Appendix I). In that legislation, the General Assembly found that:

- (1) State and local governments were not effectively or efficiently using available resources to provide mental health, developmental disabilities, and substance abuse services across the State;
- (2) Effective implementation of State policy to assist individuals with mental illness, developmental disabilities, and substance abuse problems required a

standard system of services to identify, assess and meet client needs within available resources;

(3) The findings of the studies and federal court decisions compelled the State to consider significant changes in the operation and utilization of the State psychiatric services;

(4) State and local funds for mental health, developmental disabilities, and substance abuse services must be stabilized and increased over time to ensure that the purposes of mental health reform system are achieved; and

(5) Reform should begin immediately and focus on correcting system inefficiencies, inequities in service availability, deficiencies in funding and accountability, and improving services to citizens.

That same legislation created the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC). The LOC was charged with examining, on a continual basis, the system-wide issues affecting the development, financing, administration, and delivery of mental health, developmental disabilities, and substance abuse services, including issues related to governance, accountability and quality of services. The LOC was also charged with developing a Plan for Mental Health System Reform (Plan) to provide for the systematic, phased-in implementation of changes to the State's mental health system. The LOC was directed to make interim reports on the development and implementation of the Plan to the General Assembly upon its convening in 2001, in May 2002, upon the convening of the 2003 General Assembly, in May 2004, and a final report upon the convening of the 2005 General Assembly. This report constitutes the LOC's final Report on the Plan for Mental Health System Reform.

II. Contents of the Plan for Mental Health System Reform

HB 1519 directed the LOC to develop a Plan for Mental Health System Reform addressing a wide variety of issues including:

- the findings and recommendations of the State Auditor's/PCG studies;
- the administration and delivery of developmental disability services;
- the feasibility and impact of downsizing the State's psychiatric hospitals;
- the impact of reform on the quality of mental health services;
- increasing consumer and family involvement in reform and implementation;
- enhancing and improving substance abuse services;
- inclusion of a basic package of service benefits as well as specific benefits for targeted populations;
- examination of the State's responsibility under Olmstead to allow institutionalized persons to receive services in community-based settings;
- mental health services to children; and
- whether to implement a contested case hearings procedure for applicants and recipients of mental health, developmental disabilities, and substance abuse services.

The LOC's first task, however, was to report to the 2001 General Assembly regarding changes that should be made to the governance, structure, and financing of the State's mental health system at the State and local level. In response to this requirement, the LOC created five subcommittees and commissioned independent studies on developmental disabilities and substance abuse services. The LOC also worked during the 2001 Session to draft and pass reform legislation.

III. Reform Legislation

During the 2001 Regular Session, the LOC introduced HB381 – An Act to Phase in Implementation of Mental Health System Reform at the State and Local Level (S.L. 2001-427). In its enacted form, the legislation made significant policy changes addressing issues of State and local governance, increasing accountability, and emphasizing community-based services that are consumer driven. It established the requirement that State and local governments provide, within available resources, certain core services including: screening, assessment, referral, crisis services, service coordination, consultation, prevention, and education. It shifted the role of local public mental health, developmental disability, and substance abuse agencies from that of direct service providers to one of managing and coordinating services delivered by private providers. The legislation also established a Consumer Advocacy Program to operate at the State and local levels.¹ It also directed the LOC to conduct an in-depth review of current State funding allocation methods and disparities and make recommendations no later than May 1, 2002.²

The legislation also charged the Secretary of the Department of Health and Human Services (Secretary) with developing a State Plan to implement reform that included:

- (1) the mission and vision for the State mental health, developmental disability, and substance abuse system;
- (2) the protection of client rights and consumer involvement;
- (3) the provision of services to targeted populations including criteria for targeted populations;
- (4) a description of core services available to all individuals;
- (5) service standards;
- (6) a uniform portal process; and
- (7) strategies and schedules to eliminate disparities in allocation of State funding across programs by January 1, 2007.

It also clarified the State's role as articulated in the powers and duties of the Secretary. These include:

- Review and approve local business plans;
- Oversight of area authorities, county programs and providers of public services;
- Development of a unified system of services to be provided in local programs, State facilities and private providers;
- Monitoring fiscal and administrative practices of area authorities and county programs;
- Adopting rules for enforcement of clients rights; ensuring the State Reform Plan is coordinated with Medicaid State Plan and North Carolina Health Choice; and
- Suspending funding and assuming service delivery or management functions of an area authority or county program that is not providing minimally adequate services to persons in need in a timely manner.

¹ The General Assembly has not, to this point, appropriated the funds to implement this program.

² The LOC created a subcommittee to study this issue, but has not made any final recommendations to the General Assembly.

In addition, the Secretary is directed to develop a plan to reduce the number of area authorities and county programs to 20 by no later than January 1, 2007.

The legislation also significantly clarified the counties' role in the provision of mental health, developmental disabilities, and substance abuse services. County Commissioners are given the authority to choose the governance structure for area programs (area authorities or county programs), dissolve an area authority, approve the hiring of area authority and county program directors, approve the program budget, and approve the local business plan. The legislation allowed the creation of interlocal agreements for multi-county programs to provide for a targeted minimum population of 200,000 or a targeted minimum number of five counties served by the program. It also required counties, through an area authority or county programs, to develop a business plan to guide the management and delivery of public services at the local and State level. The business plan must address the development of a provider network based upon consumer choice and fair competition. Finally, area authorities and county programs would contract with other providers for the provision of services unless otherwise approved by the Secretary

IV. Olmstead Implementation and other 2001 Budget Provisions

The 2001 Appropriations Act (SB 1005, S.L. 2001-424) contained provisions related to the State's Olmstead obligations. It directed the Department of Health and Human Services (Department) to develop policies to provide appropriate services in the least restrictive environment to persons receiving mental health, developmental disabilities or substance abuse services in Adult Care Homes. It required the Department to develop plans to transition residents with Olmstead plans in State Mental Retardation Centers to appropriate community programs and to downsize the Centers. It also directed the Department to develop plans to construct a replacement for the Dorothea Dix Hospital and provide for the transition of patients to the new facility, to the community, or to other long-term care facilities, as appropriate.

The 2001 Appropriations Act also created G.S. 143-15D, The Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services and Bridge Funding Needs (MH Trust Fund). The MH Trust Fund is an interest bearing, nonreverting special trust fund. The moneys in the fund may be used only to:

- Provide start-up funds and operating support for community treatment alternatives for individuals in State institutions.
- Facilitate the State's compliance with the Olmstead decision.
- Facilitate reform of the mental health, developmental disabilities, and substance abuse service system.
- Provide bridge funding to maintain appropriate client services during transitional periods as a result of facility closures.
- Construct, repair, and renovate State facilities.

The General Assembly shifted \$3 million dollars from an existing fund and added another \$47.5 million to the MH Trust Fund.³

V. Reform Implementation

³ Later in the same fiscal year, the Governor seized \$37.5 million in response to the State Budget crisis.

During the past four years, the Department of Health and Human Services (Department) has worked with the area and county mental health programs and other affected parties to develop and execute mental health reform.

The State Plan - G.S. 122C-102 directs the Department to develop a plan for implementing the new mental health reform law. In November 2001, the Secretary released the *State Plan 2001: a Blueprint for Change* (State Plan), which would be the central document for implementation and education regarding the future of North Carolina's mental health system. In subsequent years, the Department has updated the State Plan annually.

As directed in HB 381, the Department included in the State Plan a method for transforming the area and county mental health programs from primarily service delivery organizations to service management organizations. The State Plan created a process by which counties would decide on their form of local governance. Once established, each public community mental health program would be referred to as a Local Management Entity (LME). LME is not a statutory term, and it identifies the purpose of the public agency rather than describing its governance structure. While a county could be part of an Area Authority, a single County Program, or part of an interlocal agreement, the function of these organizations as LMEs would be the same.

Under the previous community system, area and county programs delivered a full range of services and also contracted for the delivery of services. Additionally, the area and county programs were responsible for coordinating and managing the quality and quantity of services in the community. As directed in HB 381, the State Plan set about removing these overlapping roles. LMEs were primarily intended to be management entities. Public services delivered directly by the area and county programs would be divested to private providers through the creation of qualified provider networks.

In managing services, the LMEs would be expected to perform a series of functions not previously expected of the Area and County Programs. These responsibilities include:

- Identifying the client base within each LME's catchment area;
- Understanding the need for community-based services and identifying service gaps;
- Developing a qualified provider network (now called a Provider Community);⁴
- Contracting with qualified providers;⁵ and
- Approving the service plans for individual clients.⁶

Establishing the LMEs - In order to achieve this transformation from service provider to LME, the State Plan established a process and schedule for certifying newly created LMEs. This process included the statutory requirement that counties develop business plans for implementing and operating the reformed community system.

⁴ In building a network, LMEs would qualify providers that meet the State's service standards and assist providers to meet service standards, especially for newly established services.

⁵ LMEs are expected to design performance contracts tied to service outcomes, and LMEs will monitor and enforce those contracts.

⁶ If a service plan is approved by an LME, the LME is responsible for monitoring the client's outcomes to see if the service plan is appropriate.

According to the State Plan, counties would work together to develop one business plan for each proposed LME. The local business plan would describe characteristics of the LME's catchment area, including the client base and service gaps. The local business plan would also address specifics regarding the LME's operation. Specifically, G.S. 122C-115.2 required that the local business plans include:

- Planning – Identifying service gaps and strategies for addressing those gaps, equitably delivering services in an efficient manner, and establishing a means for public input.
- Developing a Provider Network – Including service development, performance contracting, and provider monitoring.
- Service Management – Implementing a uniform portal for accessing services, monitoring the level and appropriateness of services, and monitoring the use of state institutions.
- Financial Management and Accountability – The operations of the LME itself, as well as, the operation of the provider network.
- Evaluation – Establishing capacity for self-evaluation to determine whether the LME is meeting state outcome standards.
- Collaboration – Identifying methods for collaborating with other service systems to enhance client care.
- Access – Guaranteeing the availability of core and targeted services for clients.

Once a local business plan is submitted, the Secretary is responsible for certifying the plan. Once certified, the LME is officially established and operational. The local business plan has a lifespan of three years, and then a new plan must be submitted. LMEs and the Department annually negotiate performance contracts addressing changes in the LME's service environment.

The State Plan contemplated full transformation to the LME system by July 1, 2003. As of this Final Report, the number of area and county authorities has been reduced from 39 to 33 programs. Of the 33 programs, 29 are certified LMEs. All but four area and county programs have completed the transformation to LME. The delay has several causes. Many counties required assistance and direction from the Department to complete their local business plans, which slowed the transformation process. Also, the State Plan and G.S. 122C-115.1 limit the size of an LME to a catchment area of at least 200,000 population or five counties and HB 381 directs the Secretary to develop a plan for the reduction of the number of area and county programs to 20 statewide by July 1, 2007. Many counties have been negotiating with the Department to meet these requirements. Of the four uncertified programs, two programs may join existing LME's, while the remaining two are working with the Department to determine their organizational structure.

Consumer and Family Advisory Committees – In order to address the consumer involvement requirements of HB 381, the State Plan directed the LMEs to create Consumer and Family Advisory Committees (CFAC). Each CFAC is composed of individuals who are consumers or family members of consumers in the LME for each of the major disability groups. The CFAC advises the LME on all aspects of LME operations as well as the development and operation of the local service system. The State Plan required that a CFAC be in place and approve the LME's local business plan as a condition of LME certification. The expectation is that the CFAC will meet regularly and play a prominent role in the LME's decision-making process. In addition to the local

CFACs, a State-level CFAC has been established to inform the Department regarding operations of the mental health, developmental disability, and substance abuse service system.

Target Populations – As a matter of policy, G.S. 122C-2 prioritizes the spending of State funds for targeted populations. The State Plan identifies and defines those targeted populations. While all citizens of North Carolina would have access to certain core services, more intensive services and supports would be made available to persons with significant and chronic needs.

Core services include screening, assessment, referral, crisis services, service coordination, consultation, prevention, and education. As implemented, these core services are also known as the Basic Benefits Package. The Enhanced Benefits Package is being developed and will move the system away from basic outpatient services to a system of intensive, home-based, cross-disciplinary, agency delivered services. The Enhanced Benefit Package will be available to those individuals who meet one or more of the target population criteria.

The use of State funds and non-Medicaid federal funds is restricted to deliver only the core/basic services to the general population and the enhanced services to the target populations. HB 381 authorizes the counties to use their funds to provide specialized services to persons who do not meet any of the target population definitions. Implementation of the target population definitions occurred July 1, 2004.

Divestiture of Services – G.S. 122C-141 no longer authorizes an area and county authority to continue as a service provider. Instead, area and county authorities are expected to contract with private and other public providers to deliver services (Qualified Provider Network). Services delivered under the new system should address the issues of access, availability of qualified private and public providers, consumer choice, and fair competition.

The State Plan directed the LMEs to include a divestiture plan in their local business plans, with the intention that divestiture of area and county authority services would occur over a number of years. While each LME is at a different stage in divestiture, the process of contracting out services is happening rapidly, and in many cases, well ahead of schedule. This rapid divestiture of services does raise the question of whether the necessary components are in place to address existing services gaps in the community. In particular, the Department is still working to implement the new array of services.

HB 381 does allow the Secretary to waive all or part of the divestiture requirements for an LME if the LME demonstrates that the divestiture of services would greatly harm access.

New Array of Services – The Department is in the process of implementing a new array of services that will comprise both the Basic Services Package and the Enhanced Services Package. The rationale behind the new service array is that the service definitions would be science-based (e.g. evidence based practices, best practices, and emerging best practices). Not only did the service need to be demonstrably effective, but effective for the defined populations that will be served in the reformed system. The process of establishing the new service array also identified and removed those services,

which have been shown to be ineffective or potentially harmful to consumers. The Department is also seeking to make greater use of the Medicaid program, within existing state law, to fund mental health, developmental disability, and substance abuse services.

Another purpose for creating the new service array is to create one seamless set of definitions for services that are reimbursed both by the Medicaid Program and through State funds.

This effort to establish a new array of services and a seamless set of service definitions requires that the Department submit an amendment to the Medicaid State Plan through the Center for Medicare/Medicaid Services in the United States Department of Health and Human Services (CMS). This submission is scheduled to occur in January 2005. The expectation is that the new services will be in place on July 1, 2005.⁷ Once the service array is in place, providers will be able to render services and be reimbursed for services that are not currently available in North Carolina.

Implementation of the new service array will be the first phase in establishing new services for North Carolina. The Department will make changes to the service array as it identifies service definitions and rates for new and existing services that are determined to be appropriate for persons in the target population. For instance, the Department is currently working on the implementation of the Child Mental Health Plan, which will likely result in service changes for that population.

Institution Downsizing and Replacement – In response to the Olmstead decision, investigations by the United States Department of Justice, and the State Auditors/MGT Studies, the General Assembly and the Department have recognized the State's past reliance on institutionalized care for consumers. In addition to work being performed to increase community service capacity, the State has taken steps to reduce the capacity of institutions to deliver services. These initiatives include:

- Olmstead planning for long-term residents of the State's psychiatric hospitals, MR Centers, and privately run Intermediate Care Facilities for the Mentally Retarded (ICF-MR).
- Downsizing the State's psychiatric hospitals from 1788 beds statewide to 934 beds by fiscal year 2006-07. While the targeted number of beds and the deadline for downsizing have not changed, progress towards those goals has slowed significantly, and in some cases come to a halt.
- Reduction in the number of State-operated psychiatric hospitals from four to three. In 2003, HB 684 (S.L. 2003-314) authorized the financing of the construction of a new psychiatric hospital in Granville County to replace both Dorothea Dix and Umstead Hospitals. In December 2003, the Department received bids for the construction of the new hospital. The hospital is expected to open in late 2007.
- In 2002, SB 1217 (S.L. 2002-159) directed the Department to plan for the replacement of Broughton and Cherry psychiatric hospitals. That initial planning is complete, but construction will not occur until the General

⁷ The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services plans to provide training and education regarding the new services to LMEs, providers, and consumers during the period between the submission of the amendment and the anticipated date the new services will become effective.

Assembly authorizes the financing to build those two new hospitals. The principle on any indebtedness is estimated at \$166 million for both projects.

- In 2004, the General Assembly budgeted \$3.5 million of Mental Health Trust Fund monies to fund the expansion of the Alcohol and Drug Abuse Treatment Centers to provide more detoxification services.

Division Reorganization – In 2001, the General Assembly directed the Department to reorganize the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (SB 1005; S.L. 2001-424). The State Plan provided guidance for the reorganization, which was completed in July 2003. The reorganization eliminated disability silos and organized the Division around function (e.g. Community Policy, State Operated Facilities, and Administrative Support). Within each Section, personnel were arranged into cross-disability teams to address operations from a broad perspective. The reorganization also reduced the number of Division sections and layers of management.

The reorganization also established the Advocacy and Consumer Services Section. The purpose of the Section is to oversee State facility advocacy, customer service, rights, and empowerment, and to communicate with local CFACs. The Section Chief reports directly to the Secretary. While the Department has implemented the Advocacy and Consumer Services Section, it has not received funding for nor implemented the Consumer Advocacy Program created in HB 381.

VI. Unfinished Business

Implementing the Service Array – Service definitions and rates have been developed, but the Medicaid State Plan amendment has not been submitted to the CMS. Assuming prompt approval by CMS, the new services will become effective July 1, 2005. Even with new services in place, the Department may still need to develop specialized services for many target population clients.

With the new service array largely designed, the Department can resume the Service Cost Model project. This project could provide the service delivery system the information needed to estimate the types and costs of services for a particular community. LMEs can soon use the new service package and cost model to begin planning the composition of their provider communities. From this work, service gaps should emerge and highlight for State leaders future policy and resource priorities. This work of assessing accurate community capacity is just beginning.

In addition to the new service array, the Department is requesting two new waivers from CMS for the Community Alternatives Program for the Mentally Retarded and Developmentally Disabled (CAP-MR/DD). The first waiver is a complete rewrite of the existing CAP-MR/DD Waiver. Among the many changes is the removal of the per person cap on funded services. The intent is to provide greater flexibility in funding service plans for individuals in the program. The second waiver, also known as the Independence Waiver, will allow consumers to manage their own services. The first CAP MR/DD waiver will be submitted in January 2005 and the Independence Waiver will be submitted a year later.

Divestiture of Services – Divestiture is happening rapidly, and the LMEs are expected to manage the divestiture in conjunction with the other processes of reform. Until the new service array is in place, many providers may be reluctant to commit to

delivering the kinds of services that will be required in the future. The LMEs and the Department will need to be cognizant of the sequencing involved in divesting while implementing other aspects of reform.

LME Certification, Mergers, and Consolidations – All but four area and county authorities are certified LMEs. The Department continues to work with the respective counties to reach the point where every county belongs to a certified LME. For the LMEs that are certified, the process of organizing and transforming may not be done. There are currently 33 authorities, and there is a statutory requirement to reduce that number to 20 by 2007. The Secretary is scheduled to deliver to the LOC a plan for this consolidation by January 15, 2005, but at this time, it is not clear what the final arrangement will look like.

Allocation of State Funds to the LME's – There currently exists no transparent formula or methodology for allocating State funds to the LMEs. The Department allocates State funds to the LMEs based on historical expenditures by the LMEs and area and county programs that as created disparities in funding levels. The General Assembly directed the LOC (in HB 381) and the Department (in HB 381 and the 2004 Appropriations Act) to design a new allocation system. This new system should be transparent and based on service need. The Department is scheduled to report on a proposed system in February of 2005.

Downsizing and Replacing the Institutions – In managing the State institutions, the Department is faced with a series of tasks. In order to resume the downsizing plan for the psychiatric hospitals, the Department will need to work with the LMEs to develop sufficient community capacity to serve long-term residents of the hospitals. In addition to replacing Dix and Umstead Hospitals, the General Assembly will need to address whether to finance the replacement of Broughton and Cherry Hospitals. The Department has been directed by the General Assembly to reduce the state-operated MR Centers by 4% in each of the past four fiscal years. The Department has not complied with these legislative requirements, but is currently focused on transitioning residents to the community based on Olmstead plans. Reliance on residential services in the MR Centers remains an issue for the General Assembly and the Department to address. The Department will complete the current expansions of the Alcohol and Drug Abuse Treatment Centers (ADATCs), and must also assess future needs and potential additional expansions of the ADATCs.

VII. Conclusion

Reform of the State's public system for individuals in need of mental health, developmental disabilities, and substance abuse services has been a monumental undertaking. It has required enormous effort at the State and local levels with support and input by consumers, families, and providers. While reform will not be fully implemented by July 1, 2005, it appears that significant mechanisms of reform are in place and others are scheduled for implementation in the very near future. The LOC will continue to monitor reform implementation and will report its findings and recommendations periodically to the General Assembly.

PART III

DWI/ADETS ADVISORY COMMITTEE

The DWI/ADETS Advisory Committee was appointed by the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) to prepare findings and recommendations pursuant to HB 1356. HB 1356 directed the LOC to undertake a study of Alcohol and Drug Education Traffic School (ADETS) program as follows:

“The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Services shall study the programs offered by ADETS providers to clients who must complete ADET school to receive a certification of completion of a substance abuse program. The study should include information on the qualifications of ADETS instructors, class size, the average duration of a program, the average cost of ADETS, and the adequacy of the fee paid to the ADETS provider by a client for a required ADETS course. The Committee must report its findings and any recommended legislation to the 2005 Regular Session of the 2005 General Assembly.”

In September 2004, LOC Co-Chairs Senator Martin Nesbitt and Representative Verla Insko appointed Senator Charlie Dannelly and Representative Martha Alexander as Co-Chairs to the DWI/ADETS Advisory Committee. The LOC Co-Chairs also appointed Senator Austin Allran and Representative John Sauls as Committee members. Senator Nesbitt and Representative Insko appointed other committee members from a list of representative stakeholders.

The DWI/ADETS Advisory Committee convened its first meeting on October 19, 2004 and developed the scope of work and study method. With assistance of staff from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS), a survey of ADETS, including a cost study, was completed in December. The DWI/ADETS Advisory Committee deliberated on the findings and made initial recommendations at its December 14, 2004 meeting, at which time the Committee also reviewed and approved the revised ADETS instructor curriculum. A draft bill was reviewed and approved on January 4, 2005 as recommendation to the LOC. A bill summary and fiscal impact analysis for the proposed legislation have been prepared and are included in this report. (See Appendix III)

METHOD OF STUDY

Currently there are 54 Alcohol and Drug Education Traffic Schools in North Carolina, serving the first offender of Driving While Impaired (DWI), with a blood alcohol content level of 0.14 or below, and substance abuse assessment not identifying a substance abuse disability.

Based on the FY 2003 data on the Certificate of Completion (DMH-508R), of a sample of 21,670 individuals who completed DWI services during 2002-2003, 23 percent of them completed the ADETS program. The program consists of a minimum of 10 hours of education, in a class no larger than 35 persons, over a 3-day period, at a fee of \$75 charged to the offenders. ADETS is an educational and intervention program, and the first program beyond assessment for first-time DWI offenders.

The study is intended to address the following:

- (a) ADETS instructor qualifications
- (b) Class size
- (c) Fee

To capture as much data as feasible within a short time frame for the study, a telephone survey was employed, using a standardized survey questionnaire. An important aspect of the study addresses the cost of services, using a cost-finding model to collect all costs associated with ADETS program. The cost findings are based on the survey model used in the 2003 study of DWI assessment fee, which included administration, personnel for conducting instructions, fixed maintenance costs, and other business-related expenses.

In addition, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services has begun to revamp the ADETS curriculum, which was reviewed and endorsed by the DWI/ADETS Advisory Committee.

The Study was carried out during November 2004, and initial findings were reported to the DWI/ADETS Advisory Committee at the December meeting.

FINDINGS AND RECOMMENDATIONS

General Findings:

The telephone survey of 54 ADETS providers yielded a 93 percent response rate. Chief findings are described below:

1. Instructor qualifications:

Out of 57 ADETS instructors surveyed and interviewed, 47 percent are certified with the North Carolina Substance Abuse Professional Certification Board (NCSAPCB). Of the remaining 53 percent, 12 have a Master's degree, 3 a Bachelor's degree, 2 are Certified Substance Abuse Counselors (CSAC) interns, 1 is CSAC, 4 have associate degrees, and 9 have a high school degree. It should be noted that the high school-degree instructors have 10 years or more experience in the substance abuse field.

2. ADETS Class size:

There is a wide range of class sizes, from 3 to 35, with a mean at 14. Most class sizes fall in the range of 20 to 25.

3. Cost findings:

- Current fee is \$75, or \$7.5 per hour.
- Mean cost/10 hour ADETS class/15 students=\$84.12
- Median cost=\$75.30
- Range of cost from Eastern rural (\$35.19) to Western rural (\$126.69) showed the difference in infrastructure cost

Other neighboring states were surveyed for comparison purposes:

South Carolina=\$500 for 16 hours

Georgia=20 hours for \$195 plus a matriculation fee of \$15

Tennessee=12 hours for a range of \$75 to \$125

Florida=12 hours for \$195

West Virginia=18 hours for \$250

Virginia=20 hours for a range of \$300 to \$400

Recommendations:

- 1. Effective January 1, 2009, all ADETS instructors must obtain certification in Substance Abuse Counselor, or Clinical Addiction Specialist, or Substance Abuse Prevention Consultant from the North Carolina Substance Abuse Professional Certification Board in order to qualify.**

Currently, the administrative requirements for ADETS instructors contain the following:

- Student practicum
- Pre-certification training
- Training and experience: (1) Bachelor's degree in a human services field with substance abuse course work and a practice or internship in a substance abuse program; or (2) graduation from a four year college or university and one year experience in a substance abuse field; or (3) graduation from high school or equivalent and three years experience in a substance abuse field, two of which must be at the level of a substance abuse worker; or (4) an equivalent combination of training and experience.
- References (2)
- Registration with NCSAPCB

The change in increased qualification is appropriate for improved quality and changes in curriculum and teaching method.

- 2. The ADETS fee be changed from \$75 to \$160 while increasing the minimum hours from 10 to 16, and requiring class size to be no more than 20.**

The substance abuse professional field has long supported a more interactive teaching approach with a focus on personal, life goal development for the student, so that each first-time committed DWI offender may learn to avoid further problems with substance abuse. Such a systems approach teaching requires a smaller class size, and more intensive individual and small group interaction.

The question of efficacy of ADETS is of primary concern to the Advisory Committee. Currently there is no data bank tracking individuals who have completed the ADETS program. There is a need to incorporate outcome study of ADETS into the Division's overall quality assurance efforts.

To support these changes in participating in outcome study, class size, teaching approach, and curriculum hours, \$160 is an appropriate fee increase from \$75, a per hour rate of \$10, an increase of \$2.50 from the existing hourly rate of \$7.50.

- 3. DMHDDSAS be directed to perform outcome study.**

Currently there is no statewide data available that can track the movements of a DWI offender throughout contact with assessment, education and treatment.

The Division will be required to perform a biannual outcome study as part of its quality assurance program. There will be equivalent increase in state appropriation to accomplish this task.

DWI/ADETS ADVISORY COMMITTEE PROCEEDINGS

October 19, 2004

The first DWI/ADETS Advisory Committee meeting was convened by Co-Chairs, Representative Martha Alexander and Senator Charlie Dannelly. In attendance were: Senator Charlie Dannelly, Co-Chair; Representative Martha Alexander, Co-Chair; Senator Austin Allran, Representative John Sauls, Ann Christian, Dale Kirkley, Phillip Mooring and Sandy Pearce. Offering staff support were: Dr. Alice Lin, LOC Project Manager; Spencer Clark, Michael Eisen, Jennifer Resnick and Jason Reynolds from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS) and Shawn Parker, Kory Goldsmith and Jim Klinger, Legislative staff and Rennie Hobby, LOC staff.

Representative Alexander described the committee as advisory in nature, providing recommendations to the Joint Oversight Committee on MHDDSAS, which may propose changes to the General Assembly. The charge to this subcommittee is to make findings and recommendations to the LOC for appropriate actions.

Dr. Lin provided an overview of the DWI subcommittee work performed in 2003 that became the genesis for this committee work. HB 1356 and its charge to the LOC to review certification requirements and fees for ADETS providers were walked through, and a scope of work for the subcommittee suggested.

Representative Alexander challenged the committee to review improved responses from the surveyed ADETS. Given the number of ADETS (54 statewide), the study approach should ensure a high response rate.

Mr. Eisen provided a summary of ADETS programs, including the criteria for students of ADETS, and curriculum of the instruction, class size, and current provider network. He emphasized the program as an early intervention program, targeting first-time offender, and is different from a treatment program where the DWI offenders have already been diagnosed as having substance abuse disorder.

Senator Allran expressed an interest in outcome studies. Mr. Eisen replied that while the 2001 data did show that intervention reduced the number of re-arrests, but there is no longitudinal data to ascertain results overtime. Mr. Clark indicated that with the increased DWI assessment fees, it would become feasible to review minimally recidivism rate.

The committee adjourned following an establishment of a timetable for the study. Two more meetings will be convened, to review preliminary findings and recommendations, and to finalize recommendations to the LOC.

December 14, 2004

DWI/ADETS Advisory Committee Co-Chair Senator Charlie Dannelly convened the meeting. Representative Martha Alexander had a schedule conflict. In attendance were Senator Charlie Dannelly, Co-Chair; Senator Austin Allran, Representative John Sauls, Ann Christian, Dr. Robert Foss, Dale Kirkley, Phillip Mooring and Sandy Pearce.

Offering staff support were: Dr. Alice Lin, LOC Project Manager; Spencer Clark, Michael Eisen, Jennifer Resnick and Jason Reynolds from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS) and Shawn Parker, Kory Goldsmith, Legislative staff and Rennie Hobby, LOC staff.

Dr. Lin reported on the initial survey of ADETS providers and indicated that a response rate of 93 percent was reached using a telephone survey method. The same cost-finding model used in the 2003 DWI assessment study was used for this study as well.

Mr. Eisen provided the group with detailed survey findings and preliminary options for recommendations pursuant to HB 1356. Much discussion about the ADETS instructor qualifications ensued. The members of the committee deliberated at length the pros and cons of changing the qualifications, and the implications for qualify of teaching. Academic credentials and work experiences were considered equally important in the instruction. In the end, there was consensus to support ADETS instruction qualifications closely linked to statewide certification through North Carolina Substance Abuse Professional Certification Board, while grandfathering in existing ADETS providers, given the positive findings of existing qualifications.

Mr. Eisen also described the proposed changes to the current ADETS curriculum. He underscored the systems approach and interactive teaching. The new curriculum is posted at website <http://www.nctasc.net/html/adets/index.htm>.

The committee supported a preliminary recommendation for a rate increase from \$75 to \$125 with an increase of class hours from 10 to 16, and a decrease of class size from up to 35 to no more than 20.

January 4, 2005

Representative Martha Alexander convened the meeting of the DWI/ADETS Advisory Committee. In attendance were Senator Charlie Dannelly, Phillip Mooring, Sandy Pearce, Dale Kirkley, Ann Christian, and Tammy Kernodle. Staff in attendance were Dr. Alice Lin, Shawn Parker, Tim Hover, and Ann Faust; Spencer Clark, Michael Eisen, and Jennifer Resnick from the DMHDDSAS.

Dr. Lin gave a summary of the discussion from December and preliminary recommendations from the DWI/ADETS Advisory Committee, noting that the group needed to finalize its recommendations at today's meeting.

Representative Alexander shared with the group some of the comments she has received from constituents about qualifications and wondered why Certified Substance Abuse Prevention Consultant is not considered a viable qualification. Spencer Clark replied that upon further discussion with the Certification Board, there was consensus that this title should be added to the qualification. Phillip Mooring confirmed that this discussion took place following the December 14 meeting.

Senator Dannelly suggested that the ADETS fee be raised from \$125 to \$200, as a deterrent to the first-time offenders. Alice Lin reminded the group that the \$125 fee did not represent any increase since it is based on prorated increase from 10 hours to 16 hours of instructor on an initial fee of \$75. However, there are sufficient reasons to raise the fee given the increased qualification, new teaching approach, and change in class size. Phillip Mooring also noted that with the outcome study, there would be cost implication for the

providers. Several individuals recommended a change of fee to either \$150 or \$160. The group settled on \$160 for a minimum of 16 hours, thus rounding off the hourly rate at \$10.

The effective date for new qualifications and the proposed grandfather clause were discussed. Representative Alexander referred to the DWI assessment bill as an example of dealing with the qualification issue, in that all providers are required to qualify under the new rules, but given sufficient time to come into compliance. The group adopted this approach and recommended an effective day of January 1, 2009 for compliance by all ADET providers. Spencer Clark indicated that the late effective date would not compromise the quality of the existing instruction, given the positive survey findings of instructor qualifications.

The inclusion of outcome study was discussed. Representative Alexander suggested using existing statute to incorporate the outcome study into existing quality assurance efforts by the Division.

As this is the last meeting of the Advisory Committee, the Co-Chairs thanked the members for their participation. A revised draft bill will be circulated among the members. The Co-Chairs will present the subcommittee's findings and recommendations to the Oversight Committee on January 4, 2005.

DWI /ADETS ADVISORY COMMITTEE MEMBERS

For HB 1356

Joint Legislative Oversight Committee on MH/DD/SAS
2004

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PART IV

CHILDREN'S SERVICES WORK GROUP

November 17, 2004

The Co-Chairs of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) convened an informal information session regarding collaboration of services to children with multiple service needs on November 17, 2004, in Room 421 of the Legislative Office Building.

LOC staff gave an overview of structures for collaboration at the State Level. The Co-Chairs then received brief presentations from the State Superintendent of Public Instruction (DPI), the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH), the Director of the Division of Social Services (DSS), the State Health Director (DPH), the Secretary of the Department of Juvenile Justice and Delinquency Prevention (DJJDP), and a Court Management Specialist from the Administrative Office of the Courts (AOC) regarding existing collaborative programs and barriers to collaboration.

The Co-Chairs of the State Collaborative then explained the history, makeup, and accomplishments of the organization. The State Collaborative is based on the system of care principles and provides a neutral place where those who implement programs for children can share information, receive training, and evaluate progress.

LOC staff provided an overview of three different examples of local collaboration: the Comprehensive Treatment Services Program (CTSP), which is the successor to the Willie M. Program; the Comprehensive Community Mental Health Services Program for Children and Families (a federal grant program); and the Juvenile Crime Prevention Councils.

Staff then presented the results of a survey of the local collaboratives created under the CTSP and federal grant programs. He summarized the responses to a variety of questions regarding the organizations, their commonalities, differences, and needs. The survey responses identified both positive outcomes and continued barriers to collaboration.

Chairs representing three types of local community collaboratives then spoke. Durham County Local Collaborative offered the perspective of a CTSP-established collaborative. Chatham County provided information on the federal Comprehensive Community Mental Health Services Program for Children and Families. The Wayne County Juvenile Crime Prevention Council presented the perspective of a JCPC.

The group raised several items of concern including: low attendance at meetings and agency roles. The Co-Chairs asked the participants to return in December to continue the discussions.

December 7, 2004

The Co-Chairs of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) convened the second meeting of the Children's Services Work Group in Room 421 of the Legislative Office Building.

LOC Staff explained that after the last meeting, the participants had been asked to identify three barriers to collaboration and provide specific solutions. Staff then compiled those responses. The barriers included: 1) lack of leadership or clear policy directive; 2) multiple/conflicting legislative policy directives; 3) lack of accountability; 4) lack of database with cross-agency information about which children are being served by which agencies; 5) resources; 6) agencies can not share information about individual children receiving multiple services, 7) lack of or uneven distribution of appropriate treatment programs and residential placements; 8) children who are subject to both abuse/neglect and delinquency petitions may not receive appropriate services; 9) lack of training in how to collaborate; and 10) communication. A variety of solutions were then discussed including the establishment of a State-level Advisory Council with broad representation to oversee all agencies, shared funding and resources, and to make recommendations to the Legislature. Another suggestion was that legislative staff could meet and share information and encourage collaboration between Legislative committee chairs. Others suggested that incentives would help improve collaboration.

Other critical components included: the importance of having families represented at the table; prevention; a review of collaborative efforts in other states; reviewing structures that could be eliminated or consolidated; blended funding and training; using common outcomes with protocols in order to preserve confidentiality; and a study commission that could look at the issues over several months.

Senator Nesbitt asked the work group participants to get together again and develop a proposal.

December 16, 2004

The Co-Chairs of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) convened the third informal session of the Children's Services Work Group on December 16, 2004, in Room 605 of the Legislative Office Building.

LOC staff explained that the Co-Chairs' charge was for the Work Group to determine if there was consensus on whether to recommend the creation of a high level advisory group to provide guidance and direction on the issue of coordination and cross collaboration. The Work Group affirmed its consensus to recommend the creation of a high level group to provide leadership and direction for collaboration. Staff then reviewed information provided by Susan Robison, a consultant with the National Conference of State Legislators¹ regarding issues to consider when developing a state

¹ Draft of *Organizational Strategies for Improving Human Services: Moving From Restructuring to Reform*.

structure for increased collaboration. These issues included the purpose, composition, accountability, scope and scale of the structure.

Work Group members also reviewed conceptual information provided by the State Collaborative illustrating what a collaborative structure might look like including state, regional and local levels with possible functions and suggestions of what could be done at those different levels.

After a brief discussion, the consensus of the group was to recommend the creation of a Council made up of Department heads that would report to the Legislature, with subcommittees to study issues and report to the Council.

Issues suggested by the group for consideration included: legislative staff overseeing and communicating activities of various Legislative committees dealing with children's issues; annual progress report on interagency collaboration, housing the Council in the Department of Administration with staff; creation of Study Commission to look at what the Council will address; and solutions to funding.

Representative Insko ended the discussion by directing staff to prepare a bill draft and email it to the workgroup members.

January 4, 2005

The Co-Chairs of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services convened the fourth meeting of the Children's Services Work Group on January 4, 2005, in Room 643 of the Legislative Office Building.

LOC staff reviewed draft legislation entitled *Council on Children, Youth and Families*. The bill draft included language stating the intent of the legislation was to improve the well being of children, youth and families, to support collaboration between State and local agencies, to make more effective use of resources and programs, and to streamline service delivery. The bill also recognized that services are most effective when outlined in a system of care and that even though agencies are making significant progress in collaboration and coordination of services, there is a need to focus State-level policy in order to provide support, remove barriers, and more fully implement these goals. The bill created a Council on Children, Youth and Families made of the Governor, the Chief Justice, agency heads and a parent of an at-risk child. The language does not allow for "designees" to attend Council meetings. The Council would meet on a quarterly basis to study and make recommendations on ways to improve services to children and would make annual reports to the General Assembly.

LOC staff also reviewed an alternative draft bill entitled *System of Care for Children and Families*. It would establish System of Care as State policy for the provision of services to at-risk children. The bill defined a system of care as child and family centered, strengths-based, community-based, and culturally competent. The bill provided for shared responsibilities among child-serving agencies and parameters of the creation of a system of care work group. The work group would compile information from State and local agencies and would report semi-annually to the Council on its findings and recommendations. The Council would then report to the General Assembly.

Members of the work group, attending legislators and the Co-Chairs identified a number of concerns including: the make-up of the Council; adding a division level group between the work group and the Council; consulting the Governor and Executive agency heads; addressing overlap and duplication of existing collaborative bodies; identifying issues that can be addressed immediately and issues needing more in-depth study; whether including a statutory statement regarding system of care would create an entitlement; measuring accountability; including prevention; whether issues could be addressed by bringing agency heads together informally for discussions; absence of private sector participation; balancing at-home care against removing children from their homes; and whether the terminology included abused, delinquent, and neglected children.

January 18, 2005

The Co-Chairs of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) convened the fifth meeting of the Children's Services Work Group on January 18, 2005, in Room 605 of the Legislative Office Building.

The Work Group discussed and approved draft legislation that included the following provisions: codified intent language using terms associated with system of care; creation of an agency-level work group to study administrative barriers to collaboration and make recommendations to an independent study commission; an independent study commission to look at issues related to collaborative bodies and whether to adopt system of care as a State policy; and a legislative staff work group. The Work Group asked the LOC Co-Chairs to carry the recommendations to the LOC.

PART V

ENDORSEMENT OF COALITION 2001 PROPOSALS

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services endorses the proposal offered by Coalition 2001 (See Appendix VI).

APPENDIX I

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 1999

SESSION LAW 2000-83
HOUSE BILL 1519

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,

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. – 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 cochairs of the House of Representatives Appropriations Subcommittee on Health and Human Services.

c. At least two members of the minority party.

(c) Terms. – 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 reelection or are not reelected 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 cochair 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 cochairs.

(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.(a) Plan for Mental Health System Reform. – 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 Reform" 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.

Section 3.(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.

Section 3.(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.
- (12) Consider whether the State shall implement a contested case hearings procedure for applicants and recipients of mental health, developmental disabilities, and substance abuse services.

Section 3.(d) 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 cochairs. The Committee cochairs shall appoint the cochairs and members of each subcommittee from the Committee membership. The Committee cochairs shall invite representatives from the following to participate as nonvoting members of each subcommittee:

- (1) Providers of mental health, developmental disabilities, substance abuse, long-term care, and other appropriate providers.
- (2) Consumers of mental health, developmental disabilities, and substance abuse services and family members of consumers of these 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 cochairs.

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

Section 3.(e) 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.

In the General Assembly read three times and ratified this the 30th day of June, 2000.

s/ Marc Basnight
President Pro Tempore of the Senate

s/ James B. Black
Speaker of the House of Representatives

s/ James B. Hunt, Jr.
Governor

Approved 2:55 p.m. this 5th day of July, 2000

APPENDIX II

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003**

**SESSION LAW 2004-197
HOUSE BILL 1356**

AN ACT TO ENACT THE RECOMMENDATIONS OF THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES TO INCREASE THE QUALIFICATIONS OF PERSONS WHO WILL BE ELIGIBLE TO ADMINISTER SUBSTANCE ABUSE ASSESSMENTS, TO INCREASE THE FEE PAID BY DWI OFFENDERS FOR SUBSTANCE ABUSE ASSESSMENTS, TO STUDY THE MINIMUM QUALIFICATIONS OF INDIVIDUALS CONDUCTING ALCOHOL AND DRUG EDUCATION TRAFFIC SCHOOLS, AND TO STUDY THE FEE PAID BY DWI OFFENDERS FOR EDUCATION OR TREATMENT SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-142.1 is amended by adding a new subsection to read:

"(b1) Persons Authorized to Conduct Assessments. – The following individuals are authorized to conduct a substance abuse assessment under subsection (b) of this section:

- (1) A Certified Substance Abuse Counselor (CSAC), as defined by the Commission.
- (2) A Certified Clinical Addiction Specialist (CCAS), as defined by the Commission.
- (3) A Substance Abuse Counselor Intern who is supervised by a Certified Clinical Supervisor (CCS), as defined by the Commission, and who meets the minimum qualifications established by the Commission for individuals performing substance abuse assessments.
- (4) A person licensed by the North Carolina Medical Board or the North Carolina Psychology Board.
- (5) A physician certified by the American Society of Addiction Medicine (ASAM)."

SECTION 2. G.S. 122C-142.1(b1), as enacted in Section 1 of this act, reads as rewritten:

"(b1) Persons Authorized to Conduct Assessments. – The following individuals are authorized to conduct a substance abuse assessment under subsection (b) of this section:

- (1) A Certified Substance Abuse Counselor (CSAC), as defined by the Commission.
- (2) A Certified Clinical Addiction Specialist (CCAS), as defined by the Commission.
- ~~(3) A Substance Abuse Counselor Intern who is supervised by a Certified Clinical Supervisor (CCS), as defined by the Commission, and who meets the minimum qualifications established by the Commission for individuals performing substance abuse assessments.~~
- (4) A person licensed by the North Carolina Medical Board or the North Carolina Psychology Board.
- (5) A physician certified by the American Society of Addiction Medicine (ASAM)."

SECTION 3. G.S. 122C-142.1(f) reads as rewritten:

"(f) Fees. – A person who has a substance abuse assessment conducted for the purpose of obtaining a certificate of completion shall pay to the assessing agency a fee of ~~fifty dollars (\$50.00)~~ one hundred dollars (\$100). A person shall pay to a treatment facility or school a fee of seventy-five dollars (\$75.00). If the defendant is treated by an area mental health facility, G.S. 122C-146 applies after receipt of the seventy-five dollar (\$75.00) fee.

A facility that provides to a person who is required to obtain a certificate of completion a substance abuse assessment, an ADET school, or a substance abuse treatment program may require the person to pay a fee required by this subsection before it issues a certificate of completion. As stated in G.S. 122C-146, however, an area facility may not deny a service to a person because the person is unable to pay.

An area facility shall remit to the Department five percent (5%) of each fee paid to the area facility under this subsection by a person who attends an ADET school conducted by the area facility. The Department may use amounts remitted to it under this subsection only to support, evaluate, and administer ADET schools."

SECTION 4. Section 2 of S.L. 2003-396 reads as rewritten:

"SECTION 2. The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services shall study the programs offered by assessing agencies to clients who must obtain a substance abuse assessment and a certification of completion of a substance abuse program. The study should include information on the type of testing provided by an agency, the certification requirements for persons conducting alcohol and drug education traffic schools, the treatment offered by an agency, the average duration of a program, the average cost of treatment, the rates of recidivism, and the adequacy of the fee paid to the assessing agency by a client for a required substance abuse assessment, assessment and the adequacy of the fee paid to the treatment facility or school by a client for receiving treatment or education. The Committee must report its findings and any recommended legislation to the ~~2004 Regular Session of the 2003-2005~~ General Assembly."

SECTION 5. Section 1 of this act becomes effective October 1, 2005, and applies to substance abuse assessments conducted on or after that date. Section 2 becomes effective October 1, 2008, and applies to substance abuse assessments conducted on or after that date. Section 3 becomes effective October 1, 2004, and applies to substance abuse assessments administered on or after that date. The remainder of this act is effective when it becomes law.

In the General Assembly read three times and ratified this the 9th day of July, 2004.

s/ Beverly E. Perdue
President of the Senate

s/ James B. Black
Speaker of the House of Representatives

s/ Michael F. Easley
Governor

Approved 12:33 p.m. this 17th day of August, 2004

APPENDIX III

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005**

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BILL DRAFT 2005-RGfz-2 [v.15] (1/10)

**(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/20/2005 12:15:13 PM**

Short Title: ADET School/Fee/Qualis. Increase.

(Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

1
2 AN ACT TO INCREASE THE FEE PAID BY DWI OFFENDERS FOR ATTENDING
3 AN ALCOHOL AND DRUG EDUCATION TRAFFIC SCHOOL, TO INCREASE
4 THE AMOUNT REMITTED FROM THE FEE BY AN AREA FACILITY TO
5 THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO INCREASE
6 THE QUALIFICATIONS OF PERSONS WHO WILL BE ELIGIBLE TO
7 PROVIDE ADET SCHOOL INSTRUCTION, TO DIRECT THE COMMISSION
8 ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND
9 SUBSTANCE ABUSE SERVICES TO MODIFY THE RULES REGARDING THE
10 NUMBER OF INSTRUCTIONAL HOURS AND MAXIMUM ADET SCHOOL
11 CLASS SIZE, AND TO REQUIRE THE DEPARTMENT TO ESTABLISH AN
12 OUTCOMES EVALUATION STUDY ON THE EFFECTIVENESS OF
13 SUBSTANCE ABUSE SERVICES AS RECOMMENDED BY THE JOINT
14 LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH,
15 DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

16 The General Assembly of North Carolina enacts:

17 **SECTION 1.** G.S. 122C-142.1(f) reads as rewritten

18 "(f) Fees. – A person who has a substance abuse assessment conducted for the
19 purpose of obtaining a certificate of completion shall pay to the assessing agency a fee
20 of one hundred dollars (\$100). A person shall pay to a ~~treatment facility or~~ school a fee
21 ~~of seventy five dollars (\$75.00).~~ one hundred sixty dollars (\$160.00). A person shall pay
22 to a treatment facility a fee of seventy-five dollars (\$75.00). If the defendant is treated
23 by an area mental health facility, G.S. 122C 146 applies after receipt of the seventy five
24 dollar (\$75.00) fee.

25 A facility that provides to a person who is required to obtain a certificate of
26 completion a substance abuse assessment, an ADET school, or a substance abuse

1 treatment program may require the person to pay a fee required by this subsection
2 before it issues a certificate of completion. As stated in G.S. 122C 146, however, an
3 area facility may not deny a service to a person because the person is unable to pay.

4 An area facility shall remit to the Department ~~five percent (5%)~~ fifteen percent
5 (15%) of each fee paid to the area facility under this subsection by a person who attends
6 an ADET school conducted by the area facility. The Department may use amounts
7 remitted to it under this subsection only to support, evaluate, and administer ADET
8 schools."

9 **SECTION 2.** G.S. 122C-142.1 is amended by adding a new subsection to
10 read:

11 "(d1) Persons Authorized to Provide Instruction. – Beginning January 1, 2009,
12 individuals who provide ADET school instruction as a Department authorized ADETS
13 instructor must have at least one of the following qualifications:

- 14 (1) Certified Substance Abuse Counselor (CSAC), as defined by the
15 Commission.
- 16 (2) Certified Clinical Addiction Specialist (CCAS), as defined by the
17 Commission.
- 18 (3) Certified Substance Abuse Prevention Consultant (CSAPC), as defined
19 by the Commission."

20 **SECTION 3.** The Commission on Mental Health, Developmental
21 Disabilities And Substance Abuse Services shall revise its rules regarding the number of
22 instructional program hours and the class size for ADET school. The minimum
23 program hours of instruction shall not be less than 16 hours. The maximum class size
24 shall not be more than 20 participants.

25 **SECTION 4.** G.S. 122C-142.1 is amended by adding a new subsection to
26 read:

27 "(j) The Department shall establish an outcomes evaluation study on the
28 effectiveness of substance abuse services provided to persons who obtain a certificate of
29 completion under G.S. 20-17.6 as a condition for restoration of a drivers license. The
30 findings of the study shall be reported every two years to the Joint Legislative
31 Commission on Governmental Operations. The Department shall submit an initial
32 report on the findings of the study to the Commission no later than December 31, 2007
33 and shall submit a report to the Commission every two years following that date."

34 **SECTION 5.** Section 1 becomes effective when the rules adopted under
35 Section 3 of this act become effective and shall apply to fees charged for ADET school
36 instruction that commences on or after that date. The remainder of this act is effective
37 when it becomes law.



BILL DRAFT: ADET School/Fee/Qualifs. Increase

BILL ANALYSIS

Committee: D.W.I./ADET Advisory Committee for
Legislative Oversight Committee-
MH/DD/SAS

Date: January 18, 2005

Version: 2005-RGfz-2[v.13]

Introduced by:
Summary by: Kory Goldsmith, Tim Hovis
Committee Counsels

SUMMARY: *The bill increases the fee charged for an alcohol and drug education traffic (ADET) school, increases the qualifications for certain persons providing ADET instruction, and increases the percentage of the fee remitted by an area facility to the Department to fund an ongoing outcomes evaluation study of substance abuse services. The bill also directs the Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services (Commission) to revise its rules regarding the amount of ADET instructional time and maximum class size.*

CURRENT LAW: A person is guilty of impaired driving (DWI) if he or she drives a motor vehicle on any public vehicular area while under the influence of an impairing substance or with a blood alcohol concentration (BAC) of 0.08 or more. G.S. 20-138.1. Upon conviction of a DWI offense, the Department of Motor Vehicles (DMV) must immediately revoke the offender's drivers license. G.S. 20-17(a). DMV may not restore the license unless it receives a certificate of completion indicating that the offender has undergone a substance abuse assessment and either completed an ADET school or a substance abuse treatment program. G.S. 20-17.6.

An offender is eligible to attend an ADET school if the offender's substance abuse assessment does not identify a substance abuse disability, the offender has no prior DWI convictions and the offender had a BAC of 0.14 or less at the time of the offense. The fee for attending ADET school is \$75. (The fee for substance abuse treatment depends upon the level and extent of treatment provided, with the minimum fee being \$75.) G.S. 122C-142.1(f) and G.S. 122C-146.

The curriculum for ADET school is established by the Commission. It consists of not less than 10 hours of instruction to be delivered in class sessions that may not exceed 3 hours in length. The maximum class size is 35 persons. In order to be certified to provide ADET school instruction; a person must be a high school graduate (or equivalent); have a working knowledge of alcohol, other drugs and traffic safety issues; demonstrate skills by teaching all aspects of ADET classes; and apply to the Division of MH/DD/SAS – DWI Services for certification. 10A NCAC 27G.3801.

BILL DRAFT

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BILL ANALYSIS:

Section 1 amends G.S. 122C-142.1(f) to increase the ADET school fee from \$75 to \$160. This section also increases the percentage of this fee remitted by an area facility to the Department of Health and Human Services from 5% to 15%. This increased amount will be used to fund the outcomes evaluation study set forth in Section 4 of the bill.

Section 2 amends G.S. 122C-142.1 by creating a new subsection regarding the qualifications for persons providing ADET school instruction. Beginning January 1, 2009, persons who provide instruction as a Department authorized ADETS instructor must be either a Certified Substance Abuse Counselor (CSAC), a Certified Clinical Addiction Specialist (CCAS) or a Certified Substance Abuse Prevention Consultant (CSAPC).

Section 3 directs the Commission to revise its rules regarding ADET school instructional time and class size. The minimum program hours must not be less than 16 hours (an increase of at least 6 hours over the current minimum). The maximum class size shall not be more than 20 persons (a decrease of at least 15 students from the current maximum).

Section 4 of the bill requires the Department to establish an ongoing outcomes evaluation study on the effectiveness of substance abuse services. The findings of the study must be reported every three years to the Joint Legislative Commission on Governmental Operations. An initial report must be submitted to the Commission no later than December 31, 2007.

BACKGROUND: In 2003, the General Assembly directed the Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) to study a number of issues related to the substance abuse assessments required under G.S. 122C-142.1. In 2004, the LOC recommended that the substance abuse assessment fee be increased from \$50 to \$100 and that certain qualifications be required of persons who conduct the assessments. The LOC also recommended that there should be further study regarding the certification requirements for persons conducting ADET schools and the adequacy of the fee paid to the school. The General Assembly adopted the assessment fee and assessor qualification changes and charged the LOC with the additional study. S.L. 2004-197. This bill draft reflects the recommendations of the LOC on these issues.

Effective Dates: The fee increase becomes effective when the revised rules become effective and applies to ADET courses commenced on or after that date. The ADET school instructor qualifications become effective January 1, 2009. The remainder of the act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2005

FISCAL ANALYSIS MEMORANDUM

[This confidential fiscal memorandum is a fiscal analysis of a draft bill, amendment, committee substitute, or conference committee report that has not been formally introduced or adopted on the chamber floor or in committee. This is not an official fiscal note. If upon introduction of the bill you determine that a formal fiscal note is needed, please make a fiscal note request to the Fiscal Research Division, and one will be provided under the rules of the House and the Senate.]

DATE: January 21, 2005

TO: Joint Legislative Oversight Committee for Mental Health, Developmental Disabilities, and Substance Abuse Services

FROM: Jim Klingler
Fiscal Research Division

RE: 2005-RGfz-2 ADET School /Fees / Qualifications Increase

FISCAL IMPACT					
	Yes (X)	No ()	No Estimate Available ()		
	<u>FY 2005-06</u>	<u>FY 2006-07</u>	<u>FY 2007-08</u>	<u>FY 2008-09</u>	<u>FY 2009-10</u>
REVENUES					
Local Mgt. Entities	\$50,720	\$50,720	\$50,720		
DMH/DD/SAS	\$57,661	\$57,661	\$57,661	\$57,661	\$57,661
EXPENDITURES					
Local Mgt. Entities	See Assumptions and Methodology: The additional cost associated with establishing the minimum number of class hours and maximum class size could not be estimated				
DMH/DD/SAS	\$57,661	\$57,661	\$57,661	\$57,661	\$57,661
PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED: Department of Health and Human Services and Local Management Entities					

EFFECTIVE DATE: Sections 1, 3, & 4 – Effective once the bill is enacted; Section 2 – January 1, 2009

BILL SUMMARY: The following is a summary of bill draft 2005-RGfz-2 (13th Edition):

Section 1 – Amends G.S. 122C-142.1(f) to increase the fee a DWI offender pays for Alcohol and Drug Education Traffic Schools (ADET Schools). The current fee is set in statute at \$75.00, and this bill draft would increase the fee amount to \$160.00. Of the fee charged to the DWI Offender, 5% is currently remitted to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS). The proposed bill changes the remittance from 5% to 10%. This section becomes effective once the bill becomes law and the Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services (the Commission) adopts rules.

Section 2 – Establishes in the statute the qualifications necessary for a person to administer an ADET class. At a minimum, the instructor must be a Certified Substance Abuse Counselor, a Certified Clinical Addiction Specialist, or a Certified Substance Abuse Prevention Consultant. The Commission defines these certifications. This section becomes effective on January 1, 2009.

Section 3 – Directs the Commission to revise its rules regarding minimum hours of instruction and class size for the ADET schools. The new minimum will be 16 hours and no more than 20 participants per class. This section becomes effective when the bill becomes law.

Section 4 – Directs the Department of Health and Human Services (DHHS) to perform an ongoing outcomes study of the Certificates of Completion program. This study would include evaluating DWI assessments, ADET schools, and treatment services for DWI offenders as they seek Certificates of Completion. DHHS would deliver the first report by December 31, 2007 and report every two years afterward.

ASSUMPTIONS AND METHODOLOGY: The following assumptions were made in performing this fiscal analysis:

- 16 Area and County Authorities, referred to in the document as local management entities (LME's), currently provide ADET schools as a direct service.
- While all 16 LME's will divest their ADET schools as part of mental health reform, this divestiture will occur over the next three years.
- For the purpose of this analysis, the LME's are assumed to retain their ADET schools for the next three years.
- The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) will receive the full 10% remittance that the Division is authorized to take under statute. The increased remittance would be used to fund the outcomes study required in Section 4 of the proposed bill.
- The number of DWI offenders that enroll in ADET schools is assumed to remain constant at FY 2003-04 levels.

Impacts of the Fee Increase

By increasing the fee charged to DWI offenders from \$75.00 to \$160.00, ADET school providers will see an overall increase in revenues. These providers include 16 local management entities (LME's), which manage the delivery of community mental health, developmental disabilities, and substance abuse services. In order to determine the likely increase in revenue for the LME's, DHHS provided data on the number of persons served through LME ADET schools in FY 2003-04. Assuming that the number of ADET students remains relatively constant, the expected increase in revenue for the LME's should remain constant for the next two to three years.

This revenue increase for the LME's is affected by the current mental health system reform that DHHS is implementing. reform, the

divest of their and contract for with private and providers. As a next three years, currently schools will need

Increased Revenues to LME's in FY 2005-06	
Persons Served by LME's FY 2003-04	663
Current Fee per Person	\$75
Proposed Fee per Person	\$160
Fee Difference per Person	\$85
Less the 10% Charge by DMH/DD/SAS	\$76.50
Estimated Revenue Increase for LME's	\$50,720

As part of LME's must direct services those services other public result, within the the 16 LME's providing ADET to contract for

those services. This analysis assumes that revenues for the LME's providing ADET schools will remain constant until FY 2008-09, and at that time, the LME's will no longer administer the ADET schools directly. The following chart shows the estimated revenue increase for the LME's in FY 2005-06:

In addition to the revenue impact to the LME's, DMH/DD/SAS would also experience an increase in revenues. According to G.S. 122C-142.1, the Division has the authority to receive up to 5% of each fee paid by the DWI offender for ADET services. The increase in the fee will result in an increased amount of dollars remitted to DMH/DD/SAS. In addition to the fee increase, the proposed bill increases the percentage that is remitted to DMH/DD/SAS from 5% to 10%. The following chart describes the anticipated impact of the remittance and fee changes for the Division:

Increased Revenues for DMH/DD/SAS	
Persons Served in all ADETS FY 2003-04	4707
Current Fee per Person	\$75.00
Estimated Current Revenue for All Providers	\$353,025
Percentage Increase Remitted to DMH/DD/SAS	5%
Increased Revenue to DMH/DD/SAS for the current fee	\$17,651
Propose Fee per Person	\$160.00
Difference from Increased Fee	\$85
Estimated Revenue Increase for All Providers	\$400,095
Fee Percentage Remitted to DMH/DD/SAS	10%
Estimated Revenue Increase for DMH/DD/SAS from the Increased Fee	\$40,010
Total Revenue Increase for DMH/DD/SAS	\$57,661

Impacts to Expenditures

Sections 2 and 3 may impact the expenditures of any or all providers of ADET school services. Section 2 establishes in statute the instructor requirements for persons who administer the ADET classes. For any provider that hires instructors that do not meet this requirement, an additional expense would be incurred in hiring higher qualified instructors or purchasing training for existing instructors. Considering that the 16 LME's that current administer ADET schools will divest of those schools within the next three years, section 2 will not apply. The instructor standards will not go into effect until 2009, after the LME's will have divested of these services. No expenditure impact is expected for the LME from this section.

Section 3 requires the ADET school providers to deliver classes that are at least 16 hours long and have no more than 20 persons per class. For ADETS that are not in compliance, the minimum number of class hours could result in increased costs for additional instructor time. In addition, the maximum number of students could result in the need for more class space and/or additional classes. This provision would become effective in FY 2005-06, so an impact to LME expenditures is possible. This analysis does not estimate the expenditure impact to LME's. It is unclear whether any LME's are delivering ADET classes that are not in compliance with Section 3 of this draft bill.

Section 4 directs DHHS to perform an outcome study of the Certificate of Completion program. This study would be ongoing, and DHHS would be required to report to the Legislature every two years. According to DMH/DD/SAS, the cost of this study would be \$150,000 in the first year and \$125,000 in subsequent years. As conceived by DMH/DD/SAS, this study would involve creating web-based method for providers to enter records for DWI offenders. This web-based system would allow DMH/DD/SAS to track outcomes for DWI offenders in the Certificate of Completion program and track the performance of providers. Absent an appropriation for such a system, the Division might incur fewer expenses through a paper-based system. This fiscal analysis assumes that the Division will perform a study equal in cost to the revenues available for the study. These revenues are collected through the 10% remittance on each ADET school fee paid by DWI offenders. This analysis assumes annual expenditures totaling \$57,661 for the outcome study.

SOURCES OF DATA: Department of Health and Human Services

TECHNICAL CONSIDERATIONS: None

APPENDIX IV

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003**

**SESSION LAW 2004-161
SENATE BILL 1152**

AN ACT CONCERNING STUDIES AND OTHER PURPOSES.

The General Assembly of North Carolina enacts:

PART I. TITLE

SECTION 1. This act shall be known as "The Studies Act of 2004".

....

PART XXIV. JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES STUDIES

SECTION 24.1. The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services may study the topics listed in this part and report its findings, together with any recommended legislation, to the 2005 General Assembly upon its convening.

SECTION 24.2. Integration of care for children with multiple system service needs (S.B. 262 – Foxx, Allran, Dannelly, Lucas, Purcell; H.B. 169 – Insko) – The Committee shall conduct a comprehensive review of the State's system of care for children with multiple system service needs. The purpose of the comprehensive review is to determine the extent to which children who need services from multiple State and local agencies in this system are or are not receiving those services in a timely manner, the effectiveness of the services provided, the potential long-term impact on the children, their families, and State and local resources of not providing all services in a timely and cost-effective manner, and to make detailed recommendations on the system changes necessary to address the problems identified as quickly as possible. Recommendations on system changes shall include programmatic and funding changes, and an analysis and estimate of implementation costs and projected cost-savings to the State in future years. In order to ensure a dedicated focus and appropriate expertise for the comprehensive review, the Committee shall convene a task force to conduct the review. The task force shall be comprised of the cochairs of the Oversight Committee, the Joint Legislative Education Oversight Committee, the Joint Legislative Corrections, Crime Control, and Juvenile Justice Oversight Committee, the Joint Legislative Health Care Oversight Committee, and other individuals appointed by the cochairs of the Oversight Committee upon recommendation of the other members of the task force.

In conducting its review, the task force shall consider thoroughly all of the following:

- (1) State-of-the-art approaches to services to children with multiple system service needs as the basis of reform in North Carolina.
- (2) Evidence-based best practices in North Carolina and elsewhere for potential systemwide adoption.

- (3) Barriers to access for developing a uniform access process to implement a "no wrong door" policy such that children and families may enter any service access point but will be afforded seamless access to all necessary services.
- (4) Initiatives taken or under consideration in other states to ensure a unified approach to system services, including the feasibility of establishing a funding consortium for pooling resources of all involved agencies in order to streamline access to the system by children and involvement in the system by service providers.
- (5) Ways to improve the multidisciplinary identification and evaluation of children's multiple service needs and the communication of those needs to all appropriate service providers.
- (6) The extent to which children currently in the juvenile justice system have not received adequate and appropriate educational, mental health, or other health services, and the reasons why the children have not been adequately served.
- (7) Information from the Department of Public Instruction and other organizations showing the number of children who have been suspended or expelled from public school, the reasons for the suspension or expulsion, the number of these children who have received alternative placements to ensure that they are being adequately and appropriately served by State and local service systems.
- (8) Necessary changes to North Carolina service systems involving mental health, developmental disabilities, and substance abuse services, social services, education services, juvenile justice, and other related service systems that will enable these systems to work together to ensure effective and timely access to services for children and their families.

The Oversight Committee, subject to the provisions of G.S. 120-32.02, may hire a consultant to assist the task force in its comprehensive review. The Oversight Committee shall establish interim and final reporting time lines for the consultant's findings and recommendations, and, subject to the requirements of this section, for meetings and reports of the task force.

APPENDIX V

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005

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BILL DRAFT 2005-RCz-9 [v.7] (1/14)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/24/2005 9:58:15 AM

Short Title: Coordination of Children's Services/Study.

(Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO IMPROVE THE COORDINATION OF SERVICES TO CHILDREN,
YOUTH AND FAMILIES BY CREATING CHILDREN'S SERVICES WORK
GROUPS, BY ESTABLISHING AN INDEPENDENT STUDY COMMISSION TO
MAKE RECOMMENDATIONS ON HOW TO ELIMINATE BARRIERS TO
COLLABORATION BETWEEN AND AMONG CHILD-SERVING AGENCIES,
AND TO MAKE AN APPROPRIATION AS RECOMMENDED BY THE JOINT
LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH,
DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. The General States are amended by adding a new Chapter to
read:

"Chapter 143C

"Coordination of Children's Services.

"§ 143C-1. Intent; purpose.

It is the intent of the General Assembly to (i) improve the safety and well-being of North Carolina's children, youth and families, (ii) support collaboration between State, regional and local agencies that deliver services to children, youth and families (iii) make more effective use of existing federal, State, and local resources and programs for children, youth, and families, and (iv) streamline service delivery, fill service gaps, and eliminate duplication of services for children, youth, and families.

The Department of Health and Human Services, the Department of Juvenile Justice and Delinquency Prevention, the Department of Public Instruction, the Administrative Office of the Courts and other affected State agencies share responsibility and accountability to assure effective collaboration among State and local agencies to improve outcomes for children and their families leading to full participation in their communities and schools."

1 **SECTION 2.** (a) The General Assembly recognizes that services to children,
2 youth and families are most effective when they are child and family centered, strengths
3 based, community based, use multidisciplinary approaches, use evidence based
4 practices when appropriate, and recognize and respect cultural differences. These
5 practices can be successfully implemented only where there is significant and ongoing
6 collaboration and coordination between multiple public agencies. The General
7 Assembly also recognizes that while agencies are making significant progress towards
8 implementing these practices, there is also a need to focus State level policy in order to
9 provide support, remove barriers, and more fully implement these goals.

10 (b) There is established a children's services work group. It shall be located in
11 the Department of Administration for budgetary and staffing purposes only. The
12 Secretary of the Department of Health and Human Services, the Secretary of the
13 Department of Juvenile Justice and Delinquency Prevention, the Chair of the State
14 Board of Education, the Superintendent of Public Instruction, and the Chief Justice of
15 the Supreme Court shall each designate at least one representative to serve on the work
16 group from among the programs, divisions or departments under that administrator's
17 control that provide services to children and youths. Each administrator named in the
18 preceding sentence shall also appoint to serve on the work group at least one parent of a
19 child or youth who has or is at risk for behavioral, social, health, or safety problems or
20 academic failure, at least one member of a local collaborative body, and at least one
21 private sector service provider. The Chair of the State Board of Education and the
22 Superintendent of Public Instruction may make joint appointments.

23 (c) The work group shall meet at least monthly. The first meeting of the work group
24 shall occur not less than 30 days after the effective date of this Section. The
25 Department of Health and Human Services, the Department of Juvenile Justice and
26 Delinquency Prevention, the Department of Public Instruction and the Administrative
27 Office of the Courts shall, in this order and on a rotating basis, host the monthly
28 meetings of the work group. The Department of Administration shall provide staff and
29 clerical support to the work group.

30 (d) The work group shall:

31 (1) Identify common outcome measures for child-serving agencies that can be
32 used for monitoring the safety, health, and well-being of North Carolina's children,
33 youth and families, including preventative measures.

34 (2) Identify strategies for funding flexibility between State and local agencies,
35 including shared funding streams and the removal of financial and bureaucratic
36 barriers.

37 (3) Develop a common service terminology to be used across child-serving
38 agencies that is appropriate and assists collaboration and coordination.

39 (4) Make recommendations regarding the creation of a shared database to
40 track population and program outcomes information while protecting individual
41 confidentiality.

42 (5) Develop mechanisms that would allow agencies to share information
43 about individual children receiving multiple services. Any recommendations must
44 take into account confidentiality requirements and be voluntary on the part of the

1 party receiving services and time-limited. The mechanisms may address intake,
2 assessment and release procedures.

3 (6) Examine State and local training needs for implementing increased
4 coordination and collaboration.

5 (7) Study other issues the work group determines would improve
6 coordination and collaboration between child-serving agencies.

7 (e) A majority of the work group shall constitute a quorum for the transaction of
8 business.

9 (f) Any member of the Council who is not an officer or employee of the State
10 shall receive per diem and necessary travel and subsistence in accordance with the
11 provisions of G.S. 138-5.

12 (g) Upon the approval of the Secretary of the Department of Health and Human
13 Services, the Secretary of the Department of Juvenile Justice and Delinquency
14 Prevention, the Chair of the State Board of Education, the Superintendent of Public
15 Instruction, and the Chief Justice of the Supreme Court, the work group shall submit its
16 findings and recommendations to the Coordination of Children's Services Study
17 Commission created under Section 4 of this act. The work group shall submit an interim
18 report no later than December 15, 2005, and a final report no later than April 15, 2006.
19 The reports shall specify those recommendations that may be implemented without
20 statutory changes and those that would require statutory authorization.

21 If the General Assembly has not adjourned by those dates, or if the membership of
22 the Study Commission has not been appointed, the work group shall submit its reports
23 to the Joint Legislative Education Oversight Committee, the Joint Legislative
24 Corrections, Crime Control, and Juvenile Justice Oversight Committee, the Joint
25 Legislative Health Care Oversight Committee, and the Joint Legislative Oversight
26 Committee on Mental Health, Developmental Disabilities, and Substance Abuse
27 Services.

28 The work group shall expire upon the filing of the final report.

29 **SECTION 3.** The Directors of the Bill Drafting, Research, and Fiscal
30 Research Divisions of the General Assembly shall establish a children's services work
31 group comprised of the legislative staff assigned to subject areas or agencies involving
32 the child-serving programs administered by the Department of Health and Human
33 Services, the Department of Juvenile Justice and Delinquency Prevention, the
34 Administrative Office of the Courts and the Department of Public Instruction.

35 The work group shall: (i) monitor the proceedings of the children's service work
36 group created under Section 2 of this act; (ii) provide information to legislators and
37 legislative bodies regarding the recommendations of the work group and methods by
38 which the General Assembly may implement those recommendations; and (iii) provide
39 a mechanism to improve coordination, collaboration and education regarding children's
40 services across State and local agencies among legislative staff.

41 This Section shall expire upon the convening of the 2009 General Assembly.
42 However, this shall in no way limit the Division Directors' authority to direct legislative
43 staff to continue to implement the purposes of this Section.

1 **SECTION 4.** (a) There is created the Coordination of Children's Services
2 Study Commission ("Commission"). The Commission shall consist of 18 members
3 appointed as follows:

4 (1) Nine members appointed by the Speaker of the House of
5 Representatives as follows:

6 a. Five members of the House of Representatives, of whom at
7 least one shall also serve on the House Health and Human Services
8 Appropriations subcommittee, at least one shall also serve on the
9 House Education Committee, at least one shall also serve on the
10 House Health Committee, and at least one shall also serve on a
11 House Judiciary Committee; and

12 b. Four members of the public including a district court judge,
13 a member of a local collaborative body, a private sector service
14 provider, and a parent of a child who has or is at risk for
15 behavioral, social, health, or safety problems or academic failure.

16 (2) Nine members appointed by the President Pro Tempore of the Senate
17 as follows:

18 a. Five members of the Senate of whom at least one shall also
19 serve on the Senate Health and Human Services appropriations
20 Subcommittee, at least one shall also serve on the Senate Education
21 Committee, at least one shall also serve on the Senate Health
22 Committee, and at least one shall also serve on a Senate Judiciary
23 Committee; and

24 b. Four members of the public including a parent of a child
25 who has or is at risk for behavioral, social, health, or safety
26 problems or academic failure, a child who has or is at risk for
27 behavioral, social, health, or safety problems or academic failure, a
28 member of a local board of education, and a member of a board of
29 county commissioners.

30 The Speaker of the House of Representatives shall appoint a cochair and the
31 President Pro Tempore of the Senate shall appoint a cochair for the Commission. The
32 Commission may meet at any time upon the joint call of the cochairs. Vacancies on the
33 Commission shall be filled by the same appointing authority as made the initial
34 appointment.

35 (b) The purpose of the Commission is to study and recommend changes to
36 improve collaboration and coordination between agencies that provide services to
37 children, youth and families with multiple service needs. The Commission's
38 recommendations shall include mechanisms for establishing clear State leadership,
39 consistent policy direction, and increased accountability at the State and local level. As
40 part of its work, the Commission shall:

41 (1) Identify existing State, regional and local collaborative bodies (including
42 their charges, scopes of authority and accountability requirements) that have been
43 created by legislation, administrative rule or agency policy and that are charged with
44 serving, protecting, or improving the well-being of North Carolina's children, youth

1 and families. Once it has identified the collaborative bodies, the Commission shall
2 consider how they could be consolidated, reorganized or eliminated in order to
3 improve their effectiveness and accountability, increase the likelihood that key
4 players will actively participate, and reduce unnecessary duplication of effort. The
5 Commission shall also consider the creation of a mechanism for coordination and
6 communication between the State and local collaborative bodies, incentives for
7 collaboration, clarification of roles among agencies, and ways to monitor the extent
8 to which groups are collaborating.

9 (2) Study the practices of agencies currently implementing a system of care
10 platform of practices and make recommendations regarding whether to adopt those
11 practices State-wide and across child-serving agencies as the preferred mechanism
12 for providing services to children, youth and families. In examining this issue, the
13 Commission shall identify those State and local agencies that are currently
14 implementing practices that are consistent with a system of care, those States that
15 have implemented system of care as a state-wide policy initiative, and the extent to
16 which system of care is cost effective.

17 The Commission shall also examine the following principles that are associated
18 with a system of care and determine whether to recommend the adoption of a State
19 policy that reflects these principles:

- 20 a. Services for children should promote success, safety and
21 permanence.
- 22 b. Services should be child- and family-centered giving priority to
23 keeping children with their families, in their home school and community.
- 24 c. Services should actively promote early identification and
25 intervention.
- 26 d. Services should be designed to protect the rights of children.
- 27 e. Services shall be integrated and comprehensive, addressing the
28 child's physical, educational, social, and emotional needs through a single
29 Child and Family Team.
- 30 f. Services shall be outcomes-accountable and tied to a unified Child
31 and Family Plan.
- 32 g. Agency resources and services shall be shared and coordinated.
- 33 h. Services shall be provided as close to home as appropriate in the
34 least restrictive setting consistent with what is known to be effective.
- 35 i. Services shall be culturally competent.
- 36 j. Services shall address the unique strengths, needs and potential of
37 each child and family, and shall be sufficiently flexible to meet highly
38 individualized child and family needs.
- 39 k. Management of the child serving system is a responsibility shared
40 among all public and private child-serving agencies that should be held
41 collectively accountable for outcomes.

42 In reviewing these or any other principles, the Commission shall determine
43 whether they articulate goals that are measurable and if not, determine whether they
44 could be modified to reflect measurable goals.

1 (3) Receive and study the recommendations contained in the reports
2 submitted by the work group created in Section 2 of this act and determine whether
3 to recommend any of the statutory proposals.

4 (4) Study any other issues the Commission determines would improve
5 coordination and collaboration between child-serving agencies.

6 (c) Upon approval of the Legislative Services Commission, the Legislative
7 Services Officer shall assign professional and clerical staff to assist in the work of the
8 Commission. Clerical staff shall be furnished to the Commission through the offices of
9 the House of Representatives and Senate Supervisors of Clerks. The Commission may
10 meet in the Legislative Building or the Legislative Office Building upon the approval of
11 the Legislative Services Commission. The members of the Commission, while in the
12 discharge of official duties, may exercise all the powers provided under the provisions
13 of G.S. 120-19 through G.S. 120-19.4, including the power to request all officers,
14 agents, agencies, and departments of the State to provide any information, data, or
15 documents within their possession, ascertainable from their records, or otherwise
16 available to them, and the power to subpoena witnesses. Members of the Commission
17 shall receive per diem, subsistence, and travel allowances at the rate established in
18 G.S. 120-3.1, 138-5, or 138-6 as appropriate.

19 (d) The Commission shall submit an interim report to the 2006 Regular Session
20 of the 2005 General Assembly that contains its recommendations, and legislative
21 proposals. It shall submit a final report to the 2007 Regular Session of the 2007 General
22 Assembly. Upon the earlier of the filing of its final report or the convening of the 2007
23 General Assembly, the Commission shall terminate.

24 **SECTION 5.** There is appropriated from the General Fund to the
25 Department of Administration the sum of one hundred ten thousand dollars
26 (\$110,000.00) for the 2005-2006 fiscal year to carry out the provisions of this act.

27 **SECTION 6.** Section 5 of this act becomes effective July 1, 2005. The
28 remainder of the act is effective when it becomes law.



BILL DRAFT: Coordination of Children's Services/Study

BILL ANALYSIS

Committee:	Joint Legislative Oversight Committee on MH/DD/SAS	Introduced by:	
Date:	January 26, 2005	Summary by:	Kory Goldsmith Committee Counsel
Version:	2005-RCZ-9[v.7]		

SUMMARY: *The bill creates Chapter 143C entitled "Coordination of Children's Services". It states that the intent of the General Assembly is to improve services to children, support collaboration between agencies, make more effective use of resources, and streamline service delivery. It also states that child-serving agencies share responsibility and accountability for improving outcomes for children and families. In addition, the bill also creates a children's services work group housed in the Department of Administration, a work group for legislative staff assigned to child servicing agencies and subject areas, and study commission on the coordination of children's services.*

CURRENT LAW: There are a number of entities created at the State level that are charged with overseeing services to children, youth and families. However, these groups tend to be charged with issues related to specific populations or services, such as prevention of juvenile delinquency (the Governor's Advisory Council on Juvenile Justice and Delinquency Prevention), early childhood development (Partnership for Children), or education (the Education Cabinet). There are also numerous local collaborative entities that reflect their State-level counterparts, such as the Juvenile Crime Prevention Councils. However, there is no governmental entity charged with the over-arching responsibility of coordinating children's services across age, agencies and disciplines.

The need for coordination and collaboration is recognized and is being implemented by many agencies under Memorandums of Agreement or Memorandums of Understanding (MOAs or MOUs). For example, the Department of Health and Human Services (DHHS), the Department of Public Instruction (DPI), the Department of Juvenile Justice and Delinquency Prevention (DJJDP), and the Administrative Office of the Courts (AOC) have entered into a MOA regarding the Comprehensive Treatment Services Program (CTSP) for children at-risk for institutionalization or other out of home placement. The MOA is required by law and must exist before CTSP funds can be made available (S.L. 2001-424, Sec. 21.60.(d)). Similarly, DHHS may not allocate CTSP funds at the local level until an MOA between the local counterparts of these agencies is in place. MOAs and MOUs also exist between DPI and DHHS regarding the provision of services to exceptional children, between DJJDP and local mental health programs regarding residential services to at-risk children in need of mental health and substance abuse treatment, and between local local mental health programs and

county departments of social services regarding their roles in providing for the safety, permanency and well-being of children.

BILL ANALYSIS:

Section 1 adds a new Chapter 143C entitled "Coordination of Children's Services". It states that it is the intent of the General Assembly to improve the well-being of North Carolina's families and children, support collaboration between agencies, make more effective use of existing resources and streamline service delivery. It also states that DHHS, DJJDP, DPI, AOC and other affected State agencies share responsibility and accountability to assure effective collaboration among State and local agencies to improve outcomes for children and their families leading to full participation in their schools and communities.

Section 2 begins by stating that the General Assembly recognizes that services to children, youth and families are most effective when they are child and family-centered, strengths-based, community-based, use multidisciplinary approaches, use evidence-based practices when appropriate, and recognize cultural differences. It also recognizes that agencies have made significant progress with collaboration, but there is also a need for State-level leadership to provide support, remove barriers and more fully implement the goals.

The legislation goes on to create a children's services work group. The work group is made up of appointees designated by the Secretaries of DHHS and DJJDP, the Superintendent of Public Instruction and the Chair of the State Board of Education, and the Chief Justice of the Supreme Court. The appointees consist of agency employees, parents of at-risk children, members of local collaborative bodies, and private providers.

The work group will be housed in the Department of Administration for budgetary and administrative purposes only. The DOA shall provide administrative and clerical support. The work group shall meet at least monthly, with each of the named agencies hosting the meetings on a rotating basis. The work group is charged with studying and making recommendations on specific issues that have been identified as barriers to interagency collaboration. These include:

- Identifying common outcome measures to monitor child health, safety and well-being;
- Identifying flexible funding strategies;
- Developing a common service terminology;
- Making recommendations regarding the creation of a shared database to track outcomes;
- Making recommendations regarding a mechanism for sharing individual information among agencies while protecting confidentiality; and
- Examining State and local training needs.

Subject to the approval of the various agency heads, the work group will make a interim report no later than December 15, 2005, and a final report no later than April 15, 2006. The reports will come to the Coordination of Children's Services Study Commission (if it is constituted), or the Oversight Committees for Education, Mental Health, Health, and Juvenile Justice and Delinquency Prevention. The work group will terminate upon the submission of its final report.

Section 3 directs the Directors of the Bill Drafting, Research, and Fiscal Research Divisions of the General Assembly to create a children's services work group comprised of the legislative staff who are assigned to subject areas or agencies involving child-serving programs administered by DHHS, DJJDP, DPI, and AOC. The work group shall monitor the work of the agency work group created under Section 2 of the bill, provide information to legislators regarding the recommendations of that work group, and create a mechanism for better coordination and information regarding children's services among legislative staff. The legislative staff children's services work group will expire upon the convening of the 2009 General Assembly.

Section 4 creates the Coordination of Children's Services Study Commission (Commission). The Commission shall consist of 18 members, 9 appointed by the President Pro Tempore of the Senate and 9 appointed by the Speaker of the House of Representatives.

The President Pro Tempore's appointees will include five legislators, at least one of whom also serves on the Senate Health and Human Services Appropriations Subcommittee, at least one of whom also serves on the Senate Education Committee, at least one of whom also serves on the Senate Health Committee, and at least one of whom also serves on a Senate Judiciary Committee. The four public members appointed by the President Pro Tempore will include a parent of a child who has or is at risk for behavioral, social, health, or safety problems or academic failure, a child who has or is at risk for behavioral, social, health, or safety problems or academic failure, a member of a local board of education, and a member of a board of county commissioners.

The Speaker's appointees will include five legislators, at least one of whom also serves on the House Health and Human Services Appropriations Subcommittee, at least one of whom also serves on the House Education Committee, at least one of whom also serves on the House Health Committee, and at least one of whom also serves on a House Judiciary Committee. The four public members appointed by the Speaker include a district court judge, a member of a local collaborative body, a private sector service provider, and a parent of a child who has or is at risk for behavioral, social, health, or safety problems or academic failure.

The purpose of the Commission is to study and recommend changes to improve collaboration and coordination between agencies that provide services to children, youth and families with multiple service needs, including mechanisms for establishing clear State leadership, consistent policy direction, and increased accountability at the State and local level. The Commission shall:

- look at conflicting and overlapping collaborative entities and make recommendations regarding their consolidation, reorganization or elimination;

- examine agencies that are implementing a system of care as the model for delivering services and determine whether to adopt a system of care across agencies as the preferred method of service delivery in the State; and
- review the recommendations of the children's services work group.

The Commission shall submit an interim report to the 2006 Regular Session of the 2005 General Assembly, and a final report upon the convening of the 2007 General Assembly. The Commission shall terminate upon the filing of its final report.

Section 5 appropriates \$110,000 from the General Fund to DOA for the 2005-2006 fiscal year to carry out the provisions of the act.

Section 5 becomes effective July 1, 2005. The remainder of the act becomes effective when the act becomes law.

BACKGROUND: The Studies Act of 2004 directed the co-chairs of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) to study the integration of care for children with multiple service needs. S.L. 2004-161, Sec. 24.2. After numerous meetings with agency heads, the co-chairs of the State Collaborative, and representatives from several local collaboratives (work group), LOC co-chairs brought the work group's recommendations to the LOC for review. The LOC included the substance of those recommendations in this bill draft.

APPENDIX VI



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COALITION 2001 FUNDING REQUEST

2005 SESSION OF THE N.C. GENERAL ASSEMBLY

January 2005

I.	TRUST FUND REQUEST	\$20,000,000
a.	Crisis Services	
b.	Children's Services	
c.	Bridge/Start-up Funding to Develop Community Capacity to Those in the target Population.	
II.	RECURRING APPROPRIATION REQUEST	\$134, 000,000
a.	Supported Employment/Long-term Vocational Support Services	\$6,000,000
b.	Crisis Services	\$5,000,000
c.	Children's Services	\$8,500,000
d.	Community Capacity Development for Those in the Target Population Who are Waiting for Services	\$90,000,000
e.	Residential Services	\$19,000,000
f.	Specialty Appropriation Requests (Deaf MI, DDTI, Family Support)	\$5,500,000
III.	MEDICAID MATCH STATEMENT	
IV.	INFLATIONARY ADJUSTMENT STATEMENT	

COALITION 2001

2005 FUNDING REQUEST TO THE NC GENERAL ASSEMBLY

Coalition 2001 is composed of 48 statewide, not-for-profit organizations representing families, consumers, advocates and providers that work in the areas of mental health, developmental disabilities, and substance abuse services. This Coalition has been in existence since 1991 and has helped bring awareness of and funding to the community MH/DD/SA system in North Carolina. The 2005 budget request continues the Coalition's appropriations advocacy to assure provision of services to the hundreds of thousands of North Carolinians affected by these disabilities.

Coalition 2001 is seeking to address funding needs that are both one-time and recurring in nature and that deal with the impact of the Olmstead decision, Medicaid, and inflationary issues. Additionally, Coalition 2001 has researched the number of individuals affected by these requests, their service needs and their accompanying economic impact, and has developed this funding request based on this research. Coalition 2001 has also taken into account the issue of MH/DD/SAS reform as a major component of its funding priorities.

Coalition 2001, whose motto is "It's just good business", seeks to fulfill the promise that the state of North Carolina has made to its citizens that experience mental illness, developmental disabilities, and substance abuse problems by addressing the major areas of need across a broad spectrum of services at a time of great change.

I. APPROPRIATION REQUEST FOR TRUST FUND/NON-RECURRING ITEMS \$20,000,000

The following are three umbrella areas that are critical to the success of reform, and the success of individuals affected by mental illness, developmental disabilities, and substance abuse problems.

- A. Crisis Services** - including those that are mobile and community based along a continuum that serves both children and adults affected by these disabilities in order to prevent institutionalization.
- B. Children's Services** - These vital services are needed throughout a system of care approach for children that face these three disability areas. These are services that are preventative, provide for early intervention, and are community focused.
- C. Bridge/Start-Up Funding for Community-based Services to Those in the Target Population Who are Unserved or Underserved** - These crucial programs and services are essential for moving individuals into the community in accordance with the Olmstead decision and for the success of MH/DD/SAS reform and for the well being of adults and children that experience mental illness, developmental disabilities, and substance abuse problems throughout the state. This also includes essential training for providers, LMEs, family members, and consumers.

II. Recurring Appropriation

\$134,000,000

A. Supported Employment: Long Term Vocational \$6,000,000

Support Services

Coalition 2001 is seeking funding in the amount of \$6,000,000 to be used for long-term vocational support services for individuals with mental illness, developmental disability, and substance abuse problems. Supported employment is nationally recognized as an evidence-based practice with significantly positive results that helps turn individuals into productive, tax paying members of society thus moving them off of disability roles and, most importantly, allowing them to live the lives they desire for themselves and their families. This initiative would provide assistance to more than 10,000 individuals across the state on a regular basis.

B. Crisis Services \$5,000,000 (\$2.500,000 DD, \$2.500,000 mental health)

As the MH/DD/SA system in N.C. continues to focus on supporting people with disabilities to live in their home communities, the availability of adequate crisis services is essential. Whether living in their own home or in a supported living environment in the community, some individuals with severe disabilities will need crisis support. This type of support may be delivered in a variety of ways, including mobile response (support coming to the individual), and/or community based services which are delivered out of the home. The purpose is to prevent unnecessary institutionalization, which will help the state adhere to the requirements of MH/DD/SA reform as well as the Olmstead Decision. For DD services, it is envisioned that these crisis services would be provided through four strategically located crisis centers across the state that would provide professionally delivered crisis services to children and adults experiencing developmental disabilities. For mental health, the funds would be used to enhance existing services and expand services in conjunction with existing response centers, such as local crisis units and inpatient centers as well as emergency rooms and others.

C. Children Services \$8,500,000

Coalition 2001 is seeking funding for comprehensive kids MH/DD/SA services at the community level. These funds would be designed around developmental disability early intervention services (\$1,000,000), expansion of the Mental Health System of Care Initiative (\$2,500,000), as well as multi-systemic therapy and intensive in-home services in the area of substance abuse (\$5,000,000). Each of these would be community-based with the intent of preserving in-home residential placement avoiding institutionalizations.

D. Community Capacity Development for Those in the \$90,000,000 Target Population Who are Waiting for Services

Coalition 2001 is deeply concerned about the lack of available community services for those within the target population. Currently, there are tens of thousands of

citizens who are waiting for initial services to begin, as well as thousands of others that are waiting for additional services. Funds would go to services such as intensive outpatient and comprehensive outpatient treatment programs for those in the area of substance abuse, ACT, community support and interdisciplinary dual diagnosis teams for mental health. Also, CAP/ DD Medicaid funds are needed to allow North Carolina to draw down additional funds to reduce the DD waiting lists. Additionally, DD waiting list funds are needed for those that are not waiver program eligible.

E. Residential Services

\$19,000,000

This key area is designed to provide support and programming to allow individuals to stay in their own home within their own community, and to keep them from ending up in a more costly, long-term care or state facility which is often a great distance away from their home.

1. Housing Support - This crucial funding is to provide needed operational dollars to support a range of group and supportive living programming at the community level for persons affected by mental illness, developmental disabilities and/or substance abuse problems. An example of where this support would be utilized is DDA group homes. DDA group homes provide a stable living environment for individuals with developmental disabilities in communities throughout North Carolina. Most of these homes were originally built utilizing HUD funds with a legislative appropriation for services. The service funds have been eroding, compromising the ability for people to successfully live in communities. This funding will allow for people to continue to live successfully in these homes. (\$15,000,000)

2. Special Assistance/Rental Assistance - This appropriation request is to expand the innovative pilot program for special assistance and to add additional rental assistance funding on top of that for others who would not be eligible to receive special assistance. (\$4,000,000)

F. Specialty Appropriation Requests

\$5,500,000

1. Deaf/MI funds: This \$2,500,000 will allow the state to continue to be in compliance with its 504 B Settlement Agreement with the NC Association for the Deaf. It also would continue to provide crucial community based services to the resident of N.C. who experience mental illness and are also deaf by providing a full range of services including out-patient, psychosocial rehabilitation, ACTT, case management, and more with the proper use of interpreting/translating services.

2. DDTI Funds: This \$1,000,000 would allow the Developmental Disabilities Training Institute to continue to provide core training for staff on DD Best Practice. It would also allow DDTI to provide stipends to allow staff to attend the training more easily.

3. First in Families/Family Support: This \$2,000,000 request would assist First in Families, which is North Carolina's family support program for families with people with developmental disabilities. These programs, which are now in many of the LMEs, are for relatively small, one time grants to support families to keep their

children at home. It also provides LMEs the ability to leverage other funding sources for needed services.

III. STATEMENT ON MEDICAID MATCH

Services funded by Medicaid are a critical part of our MH/DD/SAS system. North Carolina's favorable federal/state match ration makes it good business for our state to utilize, indeed optimize, Medicaid to provide services that are appropriate for people in the target population.

Though North Carolina utilizes Medicaid funding extensively, we should continue to look for ways to enhance services funded by the Medicaid program. With increasing pressure at the federal level to control the growth of Medicaid, now is the time for North Carolina to take full advantage of this program for our citizens.

IV. STATEMENT ON INFLATIONARY INCREASES

Coalition 2001 supports the Division of Medical Assistance and the DMH/DD/SAS in establishment of a standardized rate methodology for determination of reasonable costs for reimbursement to providers for Medicaid and state funded services. The determination should include a historical inflation factor as a part of the calculation for determining new rates for services and for annual adjustment for inflation. All providers should be required to file annual cost reports to the Division of Medical Assistance or DMH/DD/SAS for all services they provide.

COALITION 2001 MEMBER ORGANIZATIONS

January 2005

The Arc of North Carolina
Addiction Professionals of North Carolina
Alcohol/Drug Council of North Carolina
Autism Society of NC
Brain Injury Association of NC
Carolina Legal Assistance
Coalition for Persons Disabled by Mental Illness
Developmental Disabilities Consortium
Durham Council on Alcohol and Drug Abuse
Easter Seals UCP North Carolina
Epilepsy Foundation of NC
Family Alternatives, Inc.
Governor's Advocacy Council for Persons with Disabilities
Governor's Institute on Alcohol & Substance Abuse
Mental Health Association – NC
Mental Retardation Association of NC
NAMI – NC
National Association of Social Workers – NC Chapter
NC Assistive Technology Project
North Carolina Association for Addiction Residential Facilities
North Carolina Association for Behavioral Analysis
North Carolina Association for Behavioral Health Care
North Carolina Association for Marriage & Family Therapy
North Carolina Association Rehabilitation Facilities
North Carolina Association of the Deaf
North Carolina Child Advocacy Institute
North Carolina Community Sentencing Association
North Carolina Community Support Providers Council
North Carolina Council for Community Programs
North Carolina Council on Developmental Disabilities
North Carolina Deaf-Blind Associates
North Carolina Depression and Bi-Polar Support Alliance
North Carolina Employee Assistance Professionals Association
North Carolina Guardianship Association
NC Interagency Coordinating Council
North Carolina International Association of Psychosocial Rehabilitation Services
North Carolina Mental Health Consumers' Organization
North Carolina Nurses Association
North Carolina Psychiatric Association
North Carolina Psychological Association
NC Psychological Foundation
North Carolina Recreation Therapy Association
NC TASH
Partnerships in Assistive Technology
Self Advocates of NC
Substance Abuse Federation
VOICES for Addiction Recovery