RRC Staff Opinion

Please Note: This communication is either 1) only the recommendation of an RRC staff attorney as to action that the attorney believes the Commission should take on the cited rule at its next meeting, or 2) an opinion of that attorney as to some matter concerning that rule. The agency and members of the public are invited to submit their own comments and recommendations (according to RRC rules) to the Commission.

AGENCY: Commission for MH/DD/SAS

RULE CITATION: Rules 10A NCAC 27H .0202, .0203, .0204, .0205, .0206, and .0207

RECOMMENDED ACTION: Approve .0202 and .0207

Object to .0203, .0204, .0205, and .0206

COMMENT:

History

In January of 2014, the Commission for Mental Health, Developmental Disabilities and Substance Abuse Services (Commission for MH/DD/SAS) submitted eight temporary Rules pursuant to Session Law 2013-18. This Session Law amended N.C.G.S. 15A-1002 and gave the Commission for MH/DD/SAS the authority to require completion of training requirements necessary to be certified as a forensic evaluator and also required completion of continuing education. On January 31, 2014, the RRC reviewed the filed temporary Rules at a special meeting. At that time, the RRC objected to several of the Rules for lack of statutory authority. In response, the Commission for MH/DD/SAS requested that the Rules be returned to them.

On December 16, 2016, the Commission for MH/DD/SAS submitted the same eight Rules for review by the RRC at their January 2017 meeting. The period of review was extended on these Rules, and they were ultimately reviewed at the March 16, 2017 RRC meeting. At that time, the RRC objected to Rules .0202, .0203, 0204, .0205, .0206, and .0207 for several reasons, including lack of statutory authority and ambiguity.

In an attempt to cure the objections, the agency has provided rewritten Rules pursuant to G.S. 150B-21.12. In addition to the rewritten Rules, the agency has provided a response to the objections that appears to make further arguments against the objections. It is noted within the rules below where the agency chose not to make changes based upon the objections. Based upon the rewritten Rules and the responses, staff is recommending approval of .0202 and .0207 and objection to .0203, .0204, .0205, and .0206. for the reasons set forth below.

General

In an attempt to meet the objections of the RRC, the Commission has narrowed the scope of the Rules to apply only to forensic evaluators that are being paid through public funds. The rewritten Rules leave much of the oversight and enforcement of these Rules with the LME-MCO. While

staff agrees that the Commission for MH/DD/SAS has the authority to promulgate Rules regarding LME-MCOs pursuant to 122C-191(b), it is unclear to staff how the approval of forensic evaluators pursuant to 15A-1002 falls within the statutory mandates contained therein.

10A NCAC 27H .0202

At its March 16, 2017 meeting, the RRC objected to this Rule, finding that the Commission for MH/DD/SAS lacked the authority to set employment requirements for forensic evaluators. In the rewritten Rule, the agency has narrowed the scope of Rules .0201 through .0207 to only be applicable when a capacity evaluation is ordered through the LME-MCO. Despite the specific mandate contained within 15A-1002 to approve forensic evaluators, it appears as though the Commission for MH/DD/SAS is relying upon their general grant of authority contained within 143B-147 to narrow the scope of their charge to approving only those forensic evaluators that are paid through the public system. Although staff does believe that the Commission has the authority to promulgate Rules regarding all forensic evaluators due to the specific mandate contained within 15A-1002, it is staff's opinion that includes rules dealing exclusively with forensic evaluators paid through public funds.

At the March meeting, the RRC also objected to the Rule as being unclear or ambiguous as it was unclear what the Pre-Trial Evaluation Center was. In its rewritten Rule, the agency has indicated that the Pre-Trial Evaluation Center will be located at Central Regional Hospital in Butner.

Staff is recommending approval of 10A NCAC 27H .0202 as it is staff's opinion that the objections have been met.

10A NCAC 27H .0203

At its March 16, 2017 meeting, the RRC objected to this Rule finding that the Commission for MH/DD/SAS lacked the authority to set employment requirements. As additional language has been added that narrows the scope of these Rules in Rule .0202, staff believes that this objection has been met.

The RRC also objected to this Rule finding that it was unclear or ambiguous. Specifically, the Rules Review Commission objected as Paragraph (a) contained a reference to an "applicant," but there was no information to say what the "applicant" will need to do to apply to be certified as a forensic evaluator, to whom the applicant will apply, what the application process is, and the timing of the training requirements. In response to the objection, the Commission for MH/DD/SAS has changed the word "applicant" to "individual." Staff believes that this specific objection has been met as it no longer appears to be an "approval" process that requires the forensic evaluator to do anything.

However, the issue now is this Rule seems to create a process whereby the LME-MCO is required to submit the information on behalf of the individual. Specifically, .0203(a)(3), requires that the individual have his or her name submitted by the LME-MCO. It is staff's understanding that this essentially puts the LME-MCO into the shoes of the Commission in determining

whether an individual is suitable for approval to be a forensic evaluator. As such, staff is recommending objection.

It is staff's opinion that requiring the LME-MCO to collect, submit, and verify the information required by the Commission is an improper delegation of authority. Not only does 15A-1002 require the Commission to approve forensic evaluators, 143B-147(d) states that the Secretary shall enforce the Rules of the Commission. If the Commission for MH/DD/SAS wishes to delegate the authority over forensic evaluators, it appears that it would be proper to delegate this authority to the Secretary, not an LME-MCO. As written, this provision appears to be inconsistent with and contradictory to 143B-147(d) and outside of the authority of the Commission for MH/DD/SAS. If it is found that this is a proper delegation of authority, the Rule is still ambiguous as written as it is unclear as to how and where the LME-MCO is to provide this information.

In its March 16, 2017 meeting, the RRC also found that it is unclear how the LME-MCO will determine whether the evaluator has expertise as set forth in Paragraph (b). No additional language has been added to provide clarity; therefore, staff is recommending a continued objection to this provision.

10A NCAC 27H .0204

At its March 16, 2017 meeting, the RRC objected to this Rule finding that the Commission for MH/DD/SAS lacked the authority to promulgate rules regarding the content of the forensic evaluator's report. The Commission for MH/DD/SAS has provided a rewritten Rule that staff believes has met the objection set forth in the March 17, 2017 objection letter. However, in doing so, it is staff's opinion that there is now a clarity issue in (a)(3). As there are multiple statutes and Rules setting forth the "procedures for completing reports", it is unclear what this "law" is. As such, staff is recommending objection to the rewritten Rule for lack of clarity.

10A NCAC 27H .0205

At its March 16, 2017 meeting, the RRC found that the Commission for MH/DD/SAS lacked the statutory authority to promulgate rules regarding LME-MCOs oversight of forensic evaluators. The rewritten Rule as submitted by the Commission still requires oversight by the LME-MCO. The Commission has provided some additional statutory authority; however, for the same reasons set forth above for Rule .0203, it is staff's opinion that this is an improper delegation of authority. As no change was made to this Rule regarding the required oversight by the LME-MCO and because it is staff's opinion that this delegation is contradictory to the statute, staff is recommending a continued objection to the rewritten Rule.

The RRC also objected to the word "sufficient" in (a) finding that the meaning was unclear. In response to the objection, the Commission has changed the wording to "meet the demand." It is staff's opinion that this phrase is still ambiguous as it is unclear what demand is to be met. Staff is recommending a continued objection.

At its March meeting, the RRC also found that (b) was unclear as to how expertise of an evaluator is to be conveyed to the LME-MCO. Rule .0205 indicates that it will be self-reporting by the evaluator; however, Rule .0203 indicates that the LME-MCO is required to determine the expertise of the evaluator. It is unclear whether these two provisions conflict with each other or whether they are different processes. As no changes have been made to this provision in the rewritten Rule, staff is recommending a continued objection.

The RRC also objected to the requirements of a log in (b), finding that this was unclear as written. This issue has been addressed by the Commission; therefore, staff believes that this objection has been met.

10A NCAC 27H .0206

At its March 16, 2017 meeting, the RRC objected to this Rule finding that the Commission for MH/DD/SAS lacked the authority to delegate the termination of certifications to LME-MCOs. In its rewritten Rule, the Commission has shifted the actual termination of the certification to the Division; however, much of the termination responsibilities remain with the LME-MCO. Staff does not believe that this objection has been met and is recommending a continued objection.

In addition, the RRC found that it is unclear what the responsibilities and duties of the LME-MCOs would be in accordance with this Rule. In its rewritten Rule, the Commission for MH/DD/SAS has indicated that the LME-MCO is to notify the Division of offenses for which a certification may be terminated. As such, staff believes that this objection has been met; however, staff believes that a clarity issue now exists with regard to Items (2) and (3) of the rewritten Rule. It is unclear to staff how the LME-MCO is to know whether an individual is no longer a "licensed clinician," as required by 10A NCAC 27H .0203(a)(1). It is also unclear to staff how the LME-MCO is to know whether a forensic evaluator has completed the required training set forth in 10A NCAC 27H .0204 as the Division is responsible for conducting this training. Staff is recommending objection to the rewritten Rule as being ambiguous.

10A NCAC 27H .0207

At its March 16, 2017 meeting, the RRC objected to this Rule finding that the Commission for MH/DD/SAS lacked the statutory authority to specify the requirements of the evaluation report. In its rewritten Rule, the agency has addressed this issue by setting forth the requirements contained within the 15A-1002 and 122C-54. The RRC also found that the Commission for MH/DD/SAS lacked the statutory authority to limit a recommendation by a forensic evaluator for a full evaluation at the Pre-Trial Evaluation Center only if the defendant is charged with a felony. The language has been removed from the Rule; therefore, staff believes that this objection has been met.

As it is staff's opinion that both objections have been met, staff is recommending approval of this Rule.

Cited Statutory Authority

§ 15A-1002. Determination of incapacity to proceed; evidence; temporary commitment; temporary orders.

(a) The question of the capacity of the defendant to proceed may be raised at any time on motion by the prosecutor, the defendant, the defense counsel, or the court. The motion shall detail the specific conduct that leads the moving party to question the defendant's capacity to proceed.

(b) (1) When the capacity of the defendant to proceed is questioned, the court shall hold a hearing to determine the defendant's capacity to proceed. If an examination is ordered pursuant to subdivision (1a) or (2) of this subsection, the hearing shall be held after the examination. Reasonable notice shall be given to the defendant and prosecutor, and the State and the defendant may introduce evidence.

(1a) In the case of a defendant charged with a misdemeanor or felony, the court may appoint one or more impartial medical experts, including forensic evaluators approved under rules of the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services, to examine the defendant and return a written report describing the present state of the defendant's mental health. Reports so prepared are admissible at the hearing. The court may call any expert so appointed to testify at the hearing with or without the request of either party.

(2) At any time in the case of a defendant charged with a felony, the court may order the defendant to a State facility for the mentally ill for observation and treatment for the period, not to exceed 60 days, necessary to determine the defendant's capacity to proceed. If a defendant is ordered to a State facility without first having an examination pursuant to subsection (b)(1a) of this section, the judge shall make a finding that an examination pursuant to this subsection would be more appropriate to determine the defendant's capacity. The sheriff shall return the defendant to the county when notified that the evaluation has been completed. The director of the facility shall direct his report on defendant's condition to the defense attorney and to the clerk of superior court, who shall bring it to the attention of the court. The report is admissible at the hearing.

(3) Repealed by Session Laws 1989, c. 486, s. 1.

(4) A presiding district or superior court judge of this State who orders an examination pursuant to subdivision (1a) or (2) of this subsection shall order the release of relevant confidential information to the examiner, including, but not limited to, the warrant or indictment, arrest records, the law enforcement incident report, the defendant's criminal record, jail records, any prior medical and mental health records of the defendant, and any school records of the defendant after providing the defendant with reasonable notice and an opportunity to be heard and then determining that the information is relevant and necessary to the hearing of the matter before the court and unavailable from any other source. This subdivision shall not be construed to relieve any court of its duty to conduct hearings and make findings required under relevant federal law before ordering the release of any private medical or mental health

information or records related to substance abuse or HIV status or treatment. The records may be surrendered to the court for in camera review if surrender is necessary to make the required determinations. The records shall be withheld from public inspection and, except as provided in this subdivision, may be examined only by order of the court.

(b1) The order of the court shall contain findings of fact to support its determination of the defendant's capacity to proceed. The parties may stipulate that the defendant is capable of proceeding but shall not be allowed to stipulate that the defendant lacks capacity to proceed. If the court concludes that the defendant lacks capacity to proceed, proceedings for involuntary civil commitment under Chapter 122C of the General Statutes may be instituted on the basis of the report in either the county where the criminal proceedings are pending or, if the defendant is hospitalized, in the county in which the defendant is hospitalized.

(b2) Reports made to the court pursuant to this section shall be completed and provided to the court as follows:

(1) The report in a case of a defendant charged with a misdemeanor shall be completed and provided to the court no later than 10 days following the completion of the examination for a defendant who was in custody at the time the examination order was entered and no later than 20 days following the completion of the examination for a defendant who was not in custody at the time the examination order was entered.

(2) The report in the case of a defendant charged with a felony shall be completed and provided to the court no later than 30 days following the completion of the examination.

(3) In cases where the defendant challenges the determination made by the court-ordered examiner or the State facility and the court orders an independent psychiatric examination, that examination and report to the court must be completed within 60 days of the entry of the order by the court.

The court may, for good cause shown, extend the time for the provision of the report to the court for up to 30 additional days. The court may renew an extension of time for an additional 30 days upon request of the State or the defendant prior to the expiration of the previous extension. In no case shall the court grant extensions totaling more than 120 days beyond the time periods otherwise provided in this subsection.

(c) The court may make appropriate temporary orders for the confinement or security of the defendant pending the hearing or ruling of the court on the question of the capacity of the defendant to proceed.

(d) Any report made to the court pursuant to this section shall be forwarded to the clerk of superior court in a sealed envelope addressed to the attention of a presiding judge, with a covering statement to the clerk of the fact of the examination of the defendant and any conclusion as to whether the defendant has or lacks capacity to proceed. If the defendant is being held in the custody of the sheriff, the clerk shall send a copy of the covering statement to the sheriff. The sheriff and any persons employed by the sheriff shall maintain the copy of the covering statement as a confidential record. A copy of the full report shall be forwarded to defense counsel, or to the defendant if he is not represented by counsel. If the question of the defendant's capacity to proceed is raised at any time, a copy of the full report must be forwarded to the district attorney, as provided in G.S. 122C-54(b). Until such report becomes a public record, the full report to the court shall be kept under such conditions as are directed by the court, and its contents shall not be revealed except

as directed by the court. Any report made to the court pursuant to this section shall not be a public record unless introduced into evidence. (1973, c. 1286, s. 1; 1975, c. 166, ss. 20, 27; 1977, cc. 25, 860; 1979, 2nd Sess., c. 1313; 1985, c. 588; c. 589, s. 9; 1989, c. 486, s. 1; 1991, c. 636, s. 19(b); 1995, c. 299, s. 1; 1995 (Reg. Sess., 1996), c. 742, ss. 13, 14; 2013-18, s. 1.)

Part 4. Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services.

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

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

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

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

(c) Certified copies of written results of examinations by physicians and records in the cases of clients voluntarily admitted or involuntarily committed and facing district court hearings and rehearings pursuant to Article 5 of this Chapter shall be furnished by the facility to the client's counsel, the attorney representing the State's interest, and the court. The confidentiality of client information shall be preserved in all matters except those pertaining to the necessity for admission or continued stay in the facility or commitment under review. The relevance of confidential information for which disclosure is sought in a particular case shall be determined by the court with jurisdiction over the matter.

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

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

(d2) The record of involuntary commitment for inpatient or outpatient mental health treatment or for substance abuse treatment required to be reported to the National Instant Criminal Background Check System (NICS) by G.S. 14-409.43 shall be accessible only by the sheriff or the sheriff's designee for the purposes of conducting background checks under G.S. 14-404 and shall remain otherwise confidential as provided by this Article.

(e) Upon the request of the legally responsible person or the minor admitted or committed, and after that minor has both been released and reached adulthood, the court records of that minor made in proceedings pursuant to Article 5 of this Chapter may be expunged from the files of the court. The minor and his legally responsible person shall be informed in writing by the court of

the right provided by this subsection at the time that the application for admission is filed with the court.

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

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

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

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

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

§ 122C-115.4. Functions of local management entities.

(a) Local management entities are responsible for the management and oversight of the public system of mental health, developmental disabilities, and substance abuse services at the community level. An LME shall plan, develop, implement, and monitor services within a specified geographic area to ensure expected outcomes for consumers within available resources.

(b) The primary functions of an LME are designated in this subsection and shall not be conducted by any other entity unless an LME voluntarily enters into a contract with that entity under subsection (c) of this section. The primary functions include all of the following:

(1) Access for all citizens to the core services and administrative functions described in G.S. 122C-2. In particular, this shall include the implementation of a 24-hour a day, seven-day a week screening, triage, and referral process and a uniform portal of entry into care.

(2) Provider monitoring, technical assistance, capacity development, and quality control. If at anytime the LME has reasonable cause to believe a violation of

licensure rules has occurred, the LME shall make a referral to the Division of Health Service Regulation. If at anytime the LME has reasonable cause to believe the abuse, neglect, or exploitation of a client has occurred, the LME shall make a referral to the local Department of Social Services, Child Protective Services Program, or Adult Protective Services Program.

(3) Utilization management, utilization review, and determination of the appropriate level and intensity of services. An LME may participate in the development of person centered plans for any consumer and shall monitor the implementation of person centered plans. An LME shall review and approve person centered plans for consumers who receive State-funded services and shall conduct concurrent reviews of person centered plans for consumers in the LME's catchment area who receive Medicaid funded services.

(4) Authorization of the utilization of State psychiatric hospitals and other State facilities. Authorization of eligibility determination requests for recipients under a CAP-MR/DD waiver.

(5) Care coordination and quality management. This function involves individual client care decisions at critical treatment junctures to assure clients' care is coordinated, received when needed, likely to produce good outcomes, and is neither too little nor too much service to achieve the desired results. Care coordination is sometimes referred to as "care management." Care coordination shall be provided by clinically trained professionals with the authority and skills necessary to determine appropriate diagnosis and treatment, approve treatment and service plans, when necessary to link clients to higher levels of care quickly and efficiently, to facilitate the resolution of disagreements between providers and clinicians, and to consult with providers, clinicians, case managers, and utilization reviewers. Care coordination activities for high-risk/high-cost consumers or consumers at a critical treatment juncture include the following:

a. Assisting with the development of a single care plan for individual clients, including participating in child and family teams around the development of plans for children and adolescents.
b. Addressing difficult situations for clients or providers.
c. Consulting with providers regarding difficult or unusual care situations.
d. Ensuring that consumers are linked to primary care providers to address the consumer's physical health needs.
e. Coordinating client transitions from one service to another.
f. Conducting customer service interventions.
g. Assuring clients are given additional, fewer, or different services as client needs increase, lessen, or change.
h. Interfacing with utilization reviewers and case managers.
i. Providing leadership on the development and use of communication protocols.
j. Participating in the development of discharge plans for consumers being discharged from a State facility or other inpatient setting who have not been previously served in the community.

(6) Community collaboration and consumer affairs including a process to protect consumer rights, an appeals process, and support of an effective consumer and family advisory committee.

(7) Financial management and accountability for the use of State and local funds and information management for the delivery of publicly funded services.

(8) Each LME shall develop a waiting list of persons with intellectual or developmental disabilities that are waiting for specific services. The LME shall develop the list in accordance with rules adopted by the Secretary to ensure that waiting list data are collected consistently across LMEs. Each LME shall report this data annually to the Department. The data collected should include numbers of persons who are:

a. Waiting for residential services.

b. Potentially eligible for CAP-MRDD.

c. In need of other services and supports funded from State appropriations to or allocations from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, including CAP-MRDD.

Subject to all applicable State and federal laws and rules established by the Secretary and the Commission, nothing in this subsection shall be construed to preempt or supersede the regulatory or licensing authority of other State or local departments or divisions.

(c) Subject to subsection (b) of this section and all applicable State and federal laws and rules established by the Secretary, an LME may contract with a public or private entity for the implementation of LME functions designated under subsection (b) of this section.

(d) Except as provided in G.S. 122C-124.1 and G.S. 122C-125, the Secretary may neither remove from an LME nor designate another entity as eligible to implement any function enumerated under subsection (b) of this section unless all of the following applies:

(1) The LME fails during the previous consecutive three months to achieve a satisfactory outcome on any of the critical performance measures developed by the Secretary under G.S. 122C-112.1(33).

(2) The Secretary provides focused technical assistance to the LME in the implementation of the function. The assistance shall continue for at least three months or until the LME achieves a satisfactory outcome on the performance measure, whichever occurs first.

(3) If, after three months of receiving technical assistance from the Secretary, the LME still fails to achieve or maintain a satisfactory outcome on the critical performance measure, the Secretary shall enter into a contract with another LME or agency to implement the function on behalf of the LME from which the function has been removed.

(e) Notwithstanding subsection (d) of this section, in the case of serious financial mismanagement or serious regulatory noncompliance, the Secretary may temporarily remove an LME function after consultation with the Joint Legislative Oversight Committee on Health and Human Services.

(f) The Commission shall adopt rules regarding the following matters:

(1) The definition of a high risk consumer. Until such time as the Commission adopts a rule under this subdivision, a high risk consumer means a person who has been assessed as needing emergent crisis services three or more times in the previous 12 months.

(2) The definition of a high cost consumer. Until such time as the Commission adopts a rule under this subdivision, a high cost consumer means a person whose treatment plan is expected to incur costs in the top twenty percent (20%) of expenditures for all consumers in a disability group.

(3) The notice and procedural requirements for removing one or more LME functions under subsection (d) of this section.

(g) The Commission shall adopt rules to ensure that the needs of members of the active and reserve components of the Armed Forces of the United States, veterans, and their family members are met by requiring:

(1) Each LME to have at least one trained care coordination person on staff to serve as the point of contact for TRICARE, the North Carolina National Guard's Integrated Behavioral Health System, the Army Reserve Department of Psychological Health, the United States Department of Veterans Affairs, the Division of Adult Correction, and related organizations to ensure that members of the active and reserve components of the Armed Forces of the United States, veterans, and their family members have access to State-funded services when they are not eligible for federally funded mental health or substance abuse services.

(2) LME staff members who provide screening, triage, or referral services to receive training to enhance the services provided to members of the active or reserve components of the Armed Forces of the United States, veterans, and their families. The training required by this subdivision shall include training on at least all of the following:

a. The number of persons who serve or who have served in the active or reserve components of the Armed Forces of the United States in the LME's catchment area.

b. The types of mental health and substance abuse disorders that these service personnel and their families may have experienced, including traumatic brain injury, posttraumatic stress disorder, depression, substance use disorders, potential suicide risks, military sexual trauma, and domestic violence.

c. Appropriate resources to which these service personnel and their families may be referred as needed. (2006-142, s. 4(d); 2007-323, ss. 10.49(l), (hh); 2007-484, ss. 18, 43.7(a)-(c); 2007-504, s. 1.2; 2008-107, s. 10.15(cc); 2009-186, s. 1; 2009-189, s. 1; 2011-145, s. 19.1(h); 2011-185, s. 6; 2011-291, s. 2.45; 2012-66, s. 2; 2012-83, s. 43.)

§ 122C-191. Quality of services.

(a) The assurance that services provided are of the highest possible quality within available resources is an obligation of the area authority and the Secretary.

(b) Each area authority and State facility shall comply with the rules of the Commission regarding quality assurance activities, including: program evaluation; utilization and peer review; and staff qualifications, privileging, supervision, education, and training. These rules may not nullify compliance otherwise required by Chapter 126 of the General Statutes.

(c) Each area authority and State facility shall develop internal processes to monitor and evaluate the level of quality obtained by all its programs and services including the activities prescribed in the rules of the Commission.

(d) The Secretary shall develop rules for a review process to monitor area facilities and State facilities for compliance with the required quality assurance activities as well as other rules of the Commission and the Secretary. The rules may provide that the Secretary has the authority to determine whether applicable standards of practice have been met.

(e) For purposes of peer review functions only:

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

(2) The proceedings of a quality assurance committee, the records and materials it produces, and the material it considers shall be confidential and not considered public records within the meaning of G.S. 132-1, " 'Public records' defined," and shall not be subject to discovery or introduction into evidence in any civil action against a facility or a provider of professional health services that results from matters which are the subject of evaluation and review by the committee. No person who was in attendance at a meeting of the committee shall be required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of the committee or as to any findings, recommendations, evaluations, opinions, or other actions of the committee or its members. However, information, documents or records otherwise available are not immune from discovery or use in a civil action merely because they were presented during proceedings of the committee, and nothing herein shall prevent a provider of professional health services from using such otherwise available information, documents or records in connection with an administrative hearing or civil suit relating to the medical staff membership, clinical privileges or employment of the provider. Documents otherwise available as public records within the meaning of G.S. 132-1 do not lose their status as public records merely because they were presented or considered during proceedings of the committee. A member of the committee or a person who testifies before the committee may be subpoenaed and be required to testify in a civil action as to events of which the person has knowledge independent of the peer review process, but cannot be asked about the person's testimony before the committee for impeachment or other purposes or about any opinions formed as a result of the committee hearings.

(3) Peer review information that is confidential and is not subject to discovery or use in civil actions under this section may be released to a professional

standards review organization that contracts with an agency of this State or the federal government to perform any accreditation or certification function, including the Joint Commission on Accreditation of Healthcare Organizations. Information released under this subdivision shall be limited to that which is reasonably necessary and relevant to the standards review organization's determination to grant or continue accreditation or certification. Information released under this subdivision retains its confidentiality and is not subject to discovery or use in any civil actions as provided under this subsection, and the standards review organization shall keep the information confidential subject to this section. (1977, c. 568, s. 1; 1979, c. 358, s. 1; 1983, c. 383, s. 1; 1985, c. 589, s. 2; 1989 (Reg. Sess., 1990), c. 1053, s. 1; 1998-212, s. 12.35C(d); 1999-222, s. 1; 2004-149, s. 2.7.)

§ 143B-147. Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services – creation, powers and duties.

(a) There is hereby created the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services of the Department of Health and Human Services with the power and duty to adopt, amend and repeal rules to be followed in the conduct of State and local mental health, developmental disabilities, substance abuse programs including education, prevention, intervention, screening, assessment, referral, detoxification, treatment, rehabilitation, continuing care, emergency services, case management, and other related services. Such rules shall be designed to promote the amelioration or elimination of the mental illness, developmental disabilities, or substance abuse problems of the citizens of this State. Rules establishing standards for certification of child care centers providing Developmental Day programs are excluded from this section and shall be adopted by the Child Care Commission under G.S. 110-88. The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services shall have the authority:

(1) To adopt rules regarding the

a. Admission, including the designation of regions, treatment, and professional care of individuals admitted to a facility operated under the authority of G.S. 122C-181(a), that is now or may be established;

b. Operation of education, prevention, intervention, treatment, rehabilitation and other related services as provided by area mental health, developmental disabilities, and substance abuse authorities, county programs, and all providers of public services under Part 4 of Article 4 of Chapter 122C of the General Statutes;

c. Hearings and appeals of area mental health, developmental disabilities, and substance abuse authorities as provided for in Part 4 of Article 4 of Chapter 122C of the General Statutes; and

d and e. Repealed by Session Laws 2001-437, s. 1.21(a), effective July 1, 2002.

f. Standards of public services for mental health, developmental disabilities, and substance abuse services.

(2) To adopt rules for the licensing of facilities for the mentally ill, developmentally disabled, and substance abusers, under Article 2 of Chapter 122C of the General Statutes. These rules shall include all of the following:
   a. Standards for the use of electronic supervision devices during client sleep hours for facilities licensed under 10A NCAC 27G. 1700 or any related or subsequent regulations setting licensing standards for such facilities.
   b. Personnel requirements for facilities licensed under 10A NCAC 27G. 1700, or any related or subsequent regulations setting licensing standards for such facilities, when continuous electronic supervision that meets the standards established under sub-subdivision a. of this of this subdivision is present.

(3) To advise the Secretary of the Department of Health and Human Services regarding the need for, provision and coordination of education, prevention, intervention, treatment, rehabilitation and other related services in the areas of:
   a. Mental illness and mental health,
   b. Developmental disabilities,
   c. Substance abuse.
   d. Repealed by Session Laws 2001-437, s. 1.21(a), effective July 1, 2002.

(4) To review and advise the Secretary of the Department of Health and Human Services regarding all State plans required by federal or State law and to recommend to the Secretary any changes it thinks necessary in those plans; provided, however, for the purposes of meeting State plan requirements under federal or State law, the Department of Health and Human Services is designated as the single State agency responsible for administration of plans involving mental health, developmental disabilities, and substance abuse services.

(5) To adopt rules relating to the registration and control of the manufacture, distribution, security, and dispensing of controlled substances as provided by G.S. 90-100.

(6) To adopt rules to establish the professional requirements for staff of licensed facilities for the mentally ill, developmentally disabled, and substance abusers. Such rules may require that one or more, but not all staff of a facility be either licensed or certified. If a facility has only one professional staff, such rules may require that that individual be licensed or certified. Such rules may include the recognition of professional certification boards for those professions not licensed or certified under other provisions of the General Statutes provided that the professional certification board evaluates applicants on a basis which protects the public health, safety or welfare.

(7) Except where rule making authority is assigned under that Article to the Secretary of the Department of Health and Human Services, to adopt rules to implement Article 3 of Chapter 122C of the General Statutes.

(8) To adopt rules specifying procedures for waiver of rules adopted by the Commission.

(9) To adopt rules establishing a process for non-Medicaid eligible clients to appeal to the Division of Mental Health, Developmental Disabilities, and Substance

Abuse Services of the Department of Health and Human Services decisions made by an area authority or county program affecting the client. The purpose of the appeal process is to ensure that mental health, developmental disabilities, and substance abuse services are delivered within available resources, to provide an additional level of review independent of the area authority or county program to ensure appropriate application of and compliance with applicable statutes and rules, and to provide additional opportunities for the area authority or county program to resolve the underlying complaint. Upon receipt of a written request by the non-Medicaid eligible client, the Division shall review the decision of the area authority or county program and shall advise the requesting client and the area authority or county program as to the Division's findings and the bases therefor. Notwithstanding Chapter 150B of the General Statutes, the Division's findings are not a final agency decision for purposes of that Chapter. Upon receipt of the Division's findings, the area authority or county program shall issue a final decision based on those findings. Nothing in this subdivision shall be construed to create an entitlement to mental health, developmental disabilities, and substance abuse services.

(10) The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services shall develop and adopt rules by December 1, 2013, to require forensic evaluators appointed pursuant to G.S. 15A-1002(b) to meet the following requirements:

a. Complete all training requirements necessary to be credentialed as a certified forensic evaluator.

b. Attend annual continuing education seminars that provide continuing education and training in conducting forensic evaluations and screening examinations of defendants to determine capacity to proceed and in preparing written reports required by law.

(b) All rules hereby adopted shall be consistent with the laws of this State and not inconsistent with the management responsibilities of the Secretary of the Department of Health and Human Services provided by this Chapter and the Executive Organization Act of 1973.

(c) All rules and regulations pertaining to the delivery of services and licensing of facilities heretofore adopted by the Commission for Mental Health and Mental Retardation Services, controlled substances rules and regulations adopted by the North Carolina Drug Commission, and all rules and regulations adopted by the Commission for Mental Health, Mental Retardation and Substance Abuse Services shall remain in full force and effect unless and until repealed or superseded by action of the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services.

(d) All rules adopted by the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services shall be enforced by the Department of Health and Human Services.

(e) The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services shall by December 1, 2013, adopt guidelines for treatment of individuals who are involuntarily committed following a determination of incapacity to proceed and a referral pursuant to G.S. 15A-1003. The guidelines shall require a treatment plan that uses best practices in an effort to restore the individual's capacity to proceed in the criminal matter. (1973, ch. 476, s. 129; 1977, c. 568, ss. 2, 3; c. 679, s. 1; 1981, c. 51, s. 1; 1983, c. 718, s. 5; 1983 (Reg. Sess., 1984), c. 1110, s. 6; 1985, c. 589, ss. 47-54; 1985 (Reg. Sess., 1986), c. 863, s. 33; 1989, c. 625, s. 23; 1991, c.

309, s. 1; 1993, c. 396, s. 6; 1997-443, s. 11A.118(a); 2001-437, s. 1.21(a); 2005-276, s. 10.35(a); 2009-187, s. 1; 2009-490, s. 6; 2013-18, ss. 9, 10.)