SENATE BILL 630:
Revise IVC Laws to Improve Behavioral Health.

2017-2018 General Assembly

Committee:	Senate Rules and Operations of the Senate	**Date:**	April 26, 2017
Introduced by:	Sens. Hise, Krawiec, Randleman	**Prepared by:**	Augustus D. Willis
Analysis of:	First Edition		Staff Attorney

OVERVIEW: Senate Bill 630 would make changes to the laws on voluntary and involuntary commitment for the mentally ill and substance abusers contained in Chapter 122C (Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985).

[As introduced, this bill was identical to H564, as introduced by Reps. Dobson, S. Martin, Lambeth, Malone, which is currently in House Health.]

CURRENT LAW and BILL ANALYSIS:

Section 1 would make the following definitional changes to Chapter 122C:

- Place the definition of "incapable" contained in G.S. 122C-72 in the definitions portion that applies to the whole of Chapter 122C and distinguishes it from the definition of "incompetent adult."
- Define the term "commitment examiner"
- Define the term "Outpatient treatment physician or center" to establish that LME/MCOs are not outpatient treatment or centers for purposes of outpatient commitment, but rather the LME/MCO's contracted service providers are the "outpatient treatment or center" that a court could order a person to treatment under the outpatient commitment statutes.
- Remove "program director" as a defined term.
- Modify definitions of "incompetent adult," "legally responsible person," and "local management entity."

Section 2 would clarify that when the phrase "client or legally responsible person" is used, and the client is an incapable adult who has not been adjudicated incompetent under Chapter 35A, the duty or right involved would be exercised not by the client, but by a health care agent named pursuant to a valid health care power of attorney or by the client as expressed in a valid advance instruction for mental health treatment. If neither of these documents exist, the bill would specify who the legally responsible person for an incapable adult who has not been adjudicated incompetent would be.

Except for certain exceptions provided by statute, G.S. 122C-52 provides for the confidentiality of information acquired in attending or treating a client. Exceptions include upon order of a court of competent jurisdiction and for the purpose of filing a petition for involuntary commitment.

Section 3 would make technical changes to G.S. 122C-53 (exceptions to client's rights and confidentiality for the client's benefit) and allow facilities to disclose the time and location of a client's admission or discharge to the client's next of kin when the responsible professional determines that such disclosure is in the best interest of the client.

Section 4 would mandate that in cases of clients voluntarily admitted or involuntary committed and facing district court hearings related to admission/discharge to mental health facilities, the client's counsel would receive copies of written results of examinations and other records without the client's consent. Section 4 would also allow an individual who has been a respondent in such a proceeding to get a copy of the court records of the proceeding upon submitting a written request to the clerk of court. The respondent's legally responsible person would have to exercise this right on behalf of the respondent if the respondent is a minor or incompetent adult at the time of the request.

Section 5 would clarify that, even though LME/MCOs (area authorities) are no longer treatment providers, they can continue to share confidential information with providers of behavioral health services ("facilities") and their own contracted providers ("area facilities") without client consent for purposes of coordinating the care and treatment of share clients.

Local Management Entities (LMEs) are responsible for the management and oversight of the public system of mental health, developmental disabilities, and substance abuse services at the community level. The primary functions of an LME are designated in G.S. 122C-115.4(b) and must not be conducted by any other entity unless an LME voluntarily enters into a contract with that entity.

Section 6 would add community crisis services planning as a primary function of LMEs under 122C-115.4(b).

Section 7 would make a technical change to conform with the change made in Section 8 of the bill.

Section 8 would require every LME/MCO to adopt a community crisis services plan to facilitate the implementation of the laws pertaining to involuntary commitment of the mentally ill and substance abusers within the LME/MCO's catchment area. Section 8 would set forth minimum requirements for the community crisis service plan and require the participation of law enforcement agencies, acute care hospitals, magistrates or clerks of court, area facilities with identified commitment examiners and other relevant community partners or stakeholders in the development of the plans.

Section 9 would make conforming and other changes to the laws governing the transfers of clients between 24-hour facilities. Substantive changes would require facilities to notify a client's legally responsible person of the location of transfer and that the transfer is complete in cases where the client is a minor, incompetent adult, or individual with a health care power of attorney who is deemed incapable. This section also makes provisions for transfers between 24-hour facilities and acute care hospitals.

Section 10 would make modification to the law conferring immunity to facilities and facility officials, staff or employees to clarify the entities and persons who are immune. Section 10 would further update the standard required to receive immunity to require that a facility or person "take reasonable measures in good faith under the authority of this Article and is not grossly negligent."

Section 11 would make a conforming change in light of changes that would occur pursuant to Section 19 of the bill.

Generally, a person in need of treatment for mental illness or substance abuse may seek voluntary admission at any facility by presenting themselves for evaluation.

Section 12 would make changes to the laws governing voluntary admissions to clarify that a person's legally responsible person would have to sign an application for evaluation at a facility if the individual is a minor, incapable adult, or incompetent adult and require that information provided in an advance instruction for mental health treatment by the client be reviewed in the evaluation, if applicable. Section 12 would also repeal subsections (e), and (f1) of G.S. 122C-211 to conform with changes made in Section 14.

Section 13 would make conforming changes to the laws pertaining to discharges from facilities after voluntary admission.

Section 14 would add a new Part 2A to Article 5 of Chapter 122C entitled "Voluntary Admissions and Discharges; Incapable Adults; Facilities for Individuals with Mental Illness and Substance Use Disorder." These new laws would provide for the voluntary admission of "incapable adults" pursuant to an advance instruction for mental health treatment or the authority of a health care agent named in a valid health care power of attorney.

Section 15 would require applications for admission of minors in the case of voluntary admissions to facilities for the mentally ill and substance abusers to be in writing.

Section 16 would make a conforming change in light of the requirement imposed pursuant to Section 15 of the bill.

Section 17 would make a clarifying change to the laws dealing with voluntary admissions and discharges for incompetent adults to specify that those laws apply only to adults who are adjudicated incompetent, and not to "incapable adults" as defined by Section 1 of the bill.

When an incompetent adult is voluntarily admitted to a 24-hour facility where they will be subjected to the restrictions on freedom of movement, a hearing is required in the district court of the county in which the facility is located.

Section 18 would impose the following requirements pertaining to the judicial review of the voluntary admission of an incompetent adult:

- Prior to admission, the facility would be required to provide the incompetent adult and legally responsible person with written information on the procedures for the court review of the admission and the procedures for discharge.
- Within 24 hours after the admission, the facility would be required to notify the clerk of court that the incompetent adult has been admitted and that a hearing for concurrence in the admission must be scheduled. The notice would be required to include the names and addresses of the legally responsible persona nd responsible professional as well as a copy of the legally responsible person's written application for evaluation or admission and the facility's evaluation of the incompetent adult.
- After finding the statutory requirements have been met, the court may not set the length of the authorized admission for longer than 90 days.

Section 19 would make a number of changes to the statutes dealing with custody and transportation in situations where a person is being involuntarily committed. Section 19 would specify that transportation between counties for a first examination must be provided by the county where the respondent is taken into custody. The bill would authorize LME/MCOs, in addition to counties and cities, to designate personnel other than law enforcement to carry out parts of the custody and transportation process. The bill further clarifies the limitations and conditions on the use of force against a respondent and specifically exempts acute care hospitals and general hospitals when the use of force is governed by rules for accreditation by an accrediting body that reviews entities and individuals working there for compliance. Section 19 would also declare that the person designated to provide transportation for respondents in involuntary commitment situations must consent to being the designated person, or the agency that employs the person must consent.

Section 20 would make conforming changes to add "commitment examiner" to the persons who may treat respondents in involuntary commitment proceedings.

Section 21 would make a technical change.

Section 22 would make changes to the laws dealing with involuntary commitment proceedings when the person making an affidavit for involuntary commitment is a commitment examiner. Section 22 would provide for the electronic transmission of an affidavit to the court, and impose a requirement that the affiant document and file the examination findings with the affidavit, and impose requirements in instances where the commitment examiner is recommending outpatient treatment. Section 22 also would clarify that the examiner who performs a second examination pursuant to G.S. 122C-266 must not be the same commitment examiner who executed the affidavit and relieve commitment examiners and facilities and persons involved in the holding of a patient involuntarily pending a petition for, and issuance of, a custody order.

Section 23 would make changes to the laws pertaining to the special emergency procedures for individuals who need immediate hospitalization as a part of involuntary commitment proceedings. Section 23 would allow for temporary detention of a respondent if a 24-hour facility is not immediately available or appropriate to treat the respondent's condition. Section 23 would also provide for a procedure in instances where a commitment examiner finds a person meets the criteria for inpatient commitment, but does not require immediate e hospitalization to prevent harm to themselves or others.

Section 24 would amend the laws on the duties of law enforcement officers upon the initial examination of a respondent in an involuntary commitment. Without unnecessary delay after assuming custody, the individual providing transportation must take the respondent to an area facility identified by the LME/MCO in the community crisis plan for the respondent to be examined. If a facility identified in the plan or one of its commitment examiners is not available, or if there is no area facility identified in the plan, the transporter must take the respondent to an acute care hospital identified by the LME/MCO in the community crisis services plan. If no identified facility or acute care hospital is available, the transporter must take the respondent to any commitment examiner available in a private hospital or clinic, general hospital, or State facility for the mentally ill.

Section 24 would impose criteria for area facilities identified by LME/MCOs as sites for conducting initial examinations and provide that the responsible professional at a site of first examination may transfer a respondent to an acute care hospital. In cases where the commitment examiner finds that the respondent is mentally ill and a danger to self or others, Section 24 would impose a requirement that the transporter take the respondent to a 24-hour facility within 6 hours. Currently, in cases where a 24-hour facility is not available, a respondent may be temporarily restrained for up to seven days while waiting for a facility to become available. Section 24 would expressly provide that a commitment examiner could initiate a new involuntary commitment proceeding prior to the expiration of the seven day period, if the respondent meets the applicable criteria.

Finally, rather than require a commitment examiner to provide notice directing a respondent for whom outpatient treatment is recommended to appear for treatment, Section 24 would require the commitment examiner to notify the LME/MCO that the respondent is being recommended for outpatient treatment. The LME/MCO would then be responsible for scheduling an appointment with the center and provide contact information for the center. The commitment examiner would then be required to provide the respondent with information on the center and notify the outpatient treatment center and send a copy of their examination report to the center.

Section 25 would acknowledge that physicians and eligible psychologists are qualified to perform the commitment examinations required for involuntary commitment for the mentally ill and substance abusers. The bill would then eliminate the ability of the Secretary of DHHS to waive certain requirements pertaining to the first examinations of respondents by commitment examiners, and instead

allow the Secretary to individually certify an expanded list of professionals, including licensed professional counselors, nurse practitioners, and physicians assistants, to perform first commitment examinations. The bill would allow for these certifications to be renewed every three years upon completion of a refresher training program approved by the Department. The requirement that the LME document the availability of a physician to provide backup support would be repealed, and the Department would be required to submit a list of certified first commitment examiners to the Chief District Court Judge of each judicial district and maintain a current list of certified first commitment examiners on its website.

Sections 26 and 27 would make conforming changes.

Section 28 would add a requirement for the physician who performs the required examination upon a respondent's arrival at a 24-hour facility as part of an involuntary commitment proceeding. If a physician finds that the respondent meets the criteria for outpatient commitment and release from the facility pending a hearing, the physician who performed the examination would be required to contact the LME/MCO that serves the county in which the respondent resides to inform them that the respondent is being recommended for outpatient commitment. The LME/MCO would then be required to identify and schedule an appointment with a proposed outpatient treatment center and provide the commitment examiner with the name, address and phone number of the center and the date and time of the scheduled appointment.

Section 29 would make a conforming change.

Section 30 would amend the statutes pertaining to district court hearings for inpatient commitment to impose a requirement that respondents who are temporarily detained and subject to a series of successive custody orders be given a hearing within 10 days of the day the respondent is taken into custody under the most recent custody order. Section 30 also makes provisions for hearings to be held by audio and video transmission between the treatment facility and courtroom provided certain requirements are met.

Section 31 would amend the laws that set forth the dispositions a district court can make after hearings in involuntary commitment matters to impose requirements on courts ordering outpatient commitment. When a respondent is being held at 24-hour facility pending a district court hearing based on the facility's finding that the respondent is dangerous to self or others and recommended for inpatient commitment, before the court releases such a respondent under an order of outpatient commitment, Section 31 requires the 24-hour facility to identify for the court an available outpatient treatment provider that has participated in discharge planning and scheduled an outpatient appointment for the respondent.

Section 32 would make a conforming change.

Section 33 would amend the laws pertaining to affidavits for involuntary commitment of substance abusers when the affiant is a commitment examiner to bring substance abuse involuntary commitments in line with those for the mentally ill. Section 33 would include a release of civil and criminal liability similar to that added for mentally ill treatment providers in Section 22 for facilities and their employees provided that they were acting in accordance with statute.

Section 34 would make conforming changes.

Section 35 would amend the laws on the duties of law enforcement officers upon the initial examination of a respondent in an involuntary commitment for substance abuse to reflect the changes made in Section 24 of the bill pertaining to the duties of law enforcement officers in the context of involuntary commitments for the mentally ill.

Section 36 would make technical changes.

Section 37 would make technical and conforming changes to the statutes pertaining to second examinations for the commitment of substance abusers and would require the findings of the second examiner, along with the facts upon which the findings are based, to be sent to the clerk of superior court.

Section 38 would amend the statutes pertaining to district court hearings for commitment for substance abusers to impose a requirement that respondents who are temporarily detained and subject to a series of successive custody orders be given a hearing within 10 days of the day the respondent is taken into custody under the most recent custody order. The bill would also provide for the respondent to waive the requirement that he or she be personally present for the hearing and for the use of audio video technology to conduct hearings similar to that provided for in Section 30 of the bill.

Section 39 would amend the law on dispositions in cases where courts order commitment of substance abuser respondents to impose the same requirements Section 31 imposes on courts ordering outpatient commitment for mentally ill respondents.

Sections 40-44 would make technical and conforming changes.

Section 45 would require each LME/MCO to submit to the Department of Health and Human Services a copy of its current community crisis services plan as would be required under this bill by the earlier of (i) 12 months after the date the Department receives notification that the federal Centers for Medicaid and Medicare has approved all necessary waivers and State Plan amendments for Medicaid and NC Health Choice transformation, or (ii) six months prior to the date the Department actually initiates capitated contracts with Prepaid Health Plans for the delivery of Medicaid and NC Health Choice services.

EFFECTIVE DATE: Section 45 would become effective when it becomes law. The remainder would become effective December 1, 2017, and apply to proceedings initiated on or after that date.

**UNC School of Government Attorney Mark F. Botts contributed substantially in the preparation of this summary*