ARTICLE 44

Mental Health Services

by Mark F. Botts

In North Carolina public services for the treatment of mental illness, developmental disabilities, and substance abuse are a shared responsibility of the state and local governments. Both levels of government provide and fund services, and both make policies governing service provision. However, state government dominates the policy arena and allocates the majority of funds spent on services. In turn, public services are delivered primarily at the community level through a network of service providers managed and monitored by local governments or units of local government called *area authorities* (the short term used for area mental health, developmental disabilities, and substance abuse authorities) and *county programs* (the short term used for county mental health, developmental disabilities, and substance abuse programs).

Area authorities and county programs are the governance and administrative structures available to counties for carrying out their legal responsibility to provide publicly funded mental health, developmental disabilities, and substance abuse (MH/DD/SA) services. Although the North Carolina General Assembly has designated and defined these

ISBN 978-1-56011-541-0. This article was last updated in 2006.

structures, determined their powers and duties, and their relationship to county government, it is up to each county to choose a particular structure, establish it either singly or jointly with other counties, approve its business plan, fund it, and monitor its performance.

This article discusses the functions of area authorities and county programs, their governing structure, and their relationship to county and state government. The article also addresses the populations served by area authorities and county programs and the primary sources of revenue used to pay for services.

Historical Development

Only in recent history has local government in North Carolina adopted a significant treatment role in mental health care. In the eighteenth and nineteenth centuries, county governments sometimes confined persons with mental disabilities in poorhouses or jails, but this was solely a custodial function undertaken to protect property or public safety from the dangers, real or perceived, posed by persons believed to be possessed by demons. Confinement for curative or treatment purposes did not begin until 1856, when the General Assembly, concerned about the abuse and neglect endured by persons indefinitely confined in local facilities and influenced by the emerging belief that mental disabilities could be cured if treated in the right environment, opened the first "State Hospital for the Insane," now Dorothea Dix Hospital in Raleigh. By 1914, North Carolina had opened two more state hospitals and a state facility for persons with mental retardation. Due to the limited capacity of state institutions, however, many people with mental disabilities remained confined to local poorhouses and jails.

During the first half of the twentieth century state government continued to take primary responsibility for mental health services. Nevertheless, there was a growing interest in the development of local mental health care facilities that could intervene with preventive treatment before confinement in a state institution was necessary. Charlotte and Winston-Salem, in the forefront of this movement, each established a local mental health clinic in the 1930s. But most counties did not have the financial resources or substantive expertise to develop mental health clinics. Federal funding spurred further development of community-based services when Congress passed the National Mental Health Act in 1946.[1] By 1959, North Carolina had utilized this funding to establish eleven community mental health clinics and psychiatric services in eight county departments of health.

Despite the federal incentives to develop community mental health care, North Carolina continued to focus on state-operated institutions, spending money to improve existing state facilities and adding a fourth mental hospital in 1947 and three more mental retardation centers between 1958 and 1963. Ironically, this expansion occurred during a period of increasing dissatisfaction—both in North Carolina and in the rest of the nation—with the institutional model of mental health care, one that relied on prolonged or permanent confinement of the mentally ill in huge, crowded hospitals. Revelations of inhumane treatment at some state institutions, advocacy for community services by parents of mentally retarded children, and new drug therapies for mental illness contributed to a national movement to reduce the traditional emphasis on state institutions in favor of community-based services intended to fulfill the institutional functions of mental health treatment, medical care, nutrition, recreation, social contact, and social control, without excessive restrictions on personal liberty.

The watershed event in the movement to reform mental health care came in 1963, when President Kennedy proposed,[2] and Congress passed, the Community Mental Health Centers Act (CMHCA),[3] which authorized federal funding for the construction of community mental health clinics. The level of funding available provided a powerful incentive to states to implement federal mental health policy, a policy that emphasized the responsibility of communities and local governments. The North Carolina General Assembly responded immediately by authorizing local communities to establish and operate mental health clinics as a joint undertaking with state government, which would

1. Pub. L. No. 487, 60 Stat. 421 (1946).

2. John F. Kennedy, *President's Messages: Mental Illness and Mental Retardation*, H.R. Doc. No. 58, at 1468. (1963). 109 Cong. Rec. 1744.

3. Title II of Pub. L. No. 88-164 (1963).

Table 44-1. *Number and Percentage of Persons Served by Community Mental Health Programs and State Institutions in North Carolina, Fiscal Years 1960–61 to 2004–5*

	Persons Receiving Institutional Care		Persons Receiving Community-Based Care		Total Persons Served
Fiscal Year	Number	Percentage of total	Number	Percentage of total	Number
1960–61	23,327	74	8,196	26	31,523
1970–71	30,019	32	63,791	68	93,810
1980–81	25,658	13	171,712	87	197,370
1993–94	21,825	9	225,167	91	246,992
2004–05	24,840	7	330,083	93	354,923

Note: The figures for state-operated institutions include psychiatric hospitals, mental retardation centers, alcohol and drug abuse centers, specialized nursing facilities, and residential programs for children. The 2004-5 figure for community-based care is an unduplicated headcount, whereas that year's figure for institutional care is a "duplicated headcount," meaning that it includes people who were counted more than once if they had more than one distinct admission event. The duplicated headcount for community services is 337,676 in 2004–5.

Sources: Data for fiscal years 1960-61, 1970-71, and 1980-81 derived from the *Strategic Plan 1983–1989*, Vol. I, Quality Assurance Section, N.C. Division of Mental Health, Mental Retardation, and Substance Abuse Services (Raleigh, N.C.: NCDMHMRSAS, 1981), 39. Fiscal year 1993-94 figures from Deborah Merrill, Data Support Branch, N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, memorandum to author, 8 December 1994. Data for fiscal year 2004-5 from *Transformation: A Commitment to Make a Difference*, Annual Report for the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (Raleigh, N.C.: NCDMHDDSAS, 2005).

develop a plan for establishing community outpatient clinics, administer federal grants, set standards for clinic operations, and appropriate state funds for community services.[4]

In the two decades that followed the passage of the CMHCA, Congress enacted a series of laws that expanded federal support to include funding for clinic staff and operations, ensuring that federal appropriations would continue to influence the development of mental health care at the state and local level. In North Carolina, as in other states, federal policy achieved the twin goals of reducing the proportion of mental health clients receiving treatment in state hospitals while expanding the number of persons receiving mental health services in the community. By 1980, 740 federally funded community mental health centers were serving areas comprising roughly one-half of the nation, and approximately 3 million persons received services annually. The number of inpatients in state mental hospitals across the nation, which had peaked at 560,000 in 1955, decreased to 160,000 by 1977, and to about 120,000 in 1986, a decline of almost 80 percent since 1955.[5]

North Carolina's experience matched the national trend as the percentage of public-sector MH/DD/SA clients served by state institutions declined dramatically between 1961 and 1981, from 74 to 13 percent of the total persons severed. By fiscal year 2004–5, state psychiatric hospitals, mental retardation centers, alcohol and drug treatment centers, and other state-operated institutions accounted for only 7 percent of admissions to the public-sector system, with the remainder of admissions, 93 percent, occurring at community-based facilities (See Table 44-1). The relative decline in institutional care, however, appears related more to the dramatic increase in the number of persons served by commu-

4. 1963 N.C. Sess. Laws ch. 1166; former Sections 122-35.1 through -35.12 of the North Carolina General Statues (hereinafter G.S.).

5. Rebecca T. Craig and Barbara Wright, *Mental Health Financing and Programming* (National Conference of State Legislatures, 1988): 7. Other factors contributing to the deinstitutionalization included legal decisions restricting the involuntary commitment of persons to psychiatric hospitals and federal funding policies that motivated the transfer of some patients to Medicaid-supported nursing homes.

nity programs—from 8,196 in 1961 to 330,083 in 2005—than to any decrease in the actual number of persons served at state institutions, as state institutional admissions held steady with 24,840 persons served in 2005 compared to 23,327 in 1961. The greatest legacy of the development of community-based services, therefore, is not so much the deinstitutionalization of disabled individuals as it is the expansion of services to populations not previously served.

Although the federal government repealed the CMHCA in 1981,[6] North Carolina's current mental health system—local governmental entities created specifically for the purpose of ensuring the coordination and delivery of community-based mental health services pursuant to state policy, oversight, and financial support—is founded squarely upon a vision of the community as the locus of care, the original goal of the CMHCA and its legislative progeny. Further, the basic governance and administrative structure of the current system continues to demonstrate fidelity to the CMHCA, as it remains relatively unaltered since the 1977 General Assembly required counties to establish, either singly or jointly with other counties, local agencies (area authorities) responsible for managing community-based mental health services and accountable to a locally appointed governing board.[7]

While the public agencies responsible for services continue to operate under the same basic system of governance, their functions changed dramatically in 2001, when the North Carolina General Assembly changed the role of area authorities from one of directly providing services to clients to one of managing and monitoring care that is provided by others. Among other key features, the 2001 Act to Phase In Implementation of Mental Health System Reform at the State and Local Level[8] required the consolidation of area authorities from 39 local agencies to a target of 20 by January 1, 2007; called for a plan to target or limit public resources to the most severely disabled in the most integrated community setting possible; and, in an attempt to solicit greater involvement of county government in area authority affairs, required counties to develop, review, and approve a "business plan" for the management and delivery of mental health, developmental disabilities, and substance abuse services.[9] The 2001 system reform act also expanded the kinds of administrative units or structures that counties can use to perform their local government functions related to MH/DD/SA services, described in detail below.

The reform legislation produced the system operating today, which continues to evolve as state and local governments attempt to implement the legislation and as new legislation is adopted to respond to the unforeseen consequences of the 2001 act.[10] It is worth noting, however, that in spite of the numerous changes made by the system reform act of 2001, including changes to the role of local government, the basic features spurred by the CMHCA—local government responsibility for a community-based system of services funded largely with state appropriations and provided in accordance with state policy—remain to this day.

Overview of Today's Local Service System

Administrative Units

Every county, with the exception of Wake and Mecklenburg counties, must provide mental health, developmental disabilities, and substance abuse services through either an area authority or county program (G.S. 122C-115(a)). The area authority and county program each may serve either a single county or multiple counties, giving counties four options to choose from for administering public services on the local government level: a single-county area authority, a multicounty area authority, a single-county program, or a multicounty program. In lieu of the area authority and county program, any county that operates under the county-manager form of government and has at least 425,000

6. The Omnibus Budget and Reconciliation Act of 1981, Pub. L. No. 97-35, Title IX § 901, 42 U.S.C. § 300x.

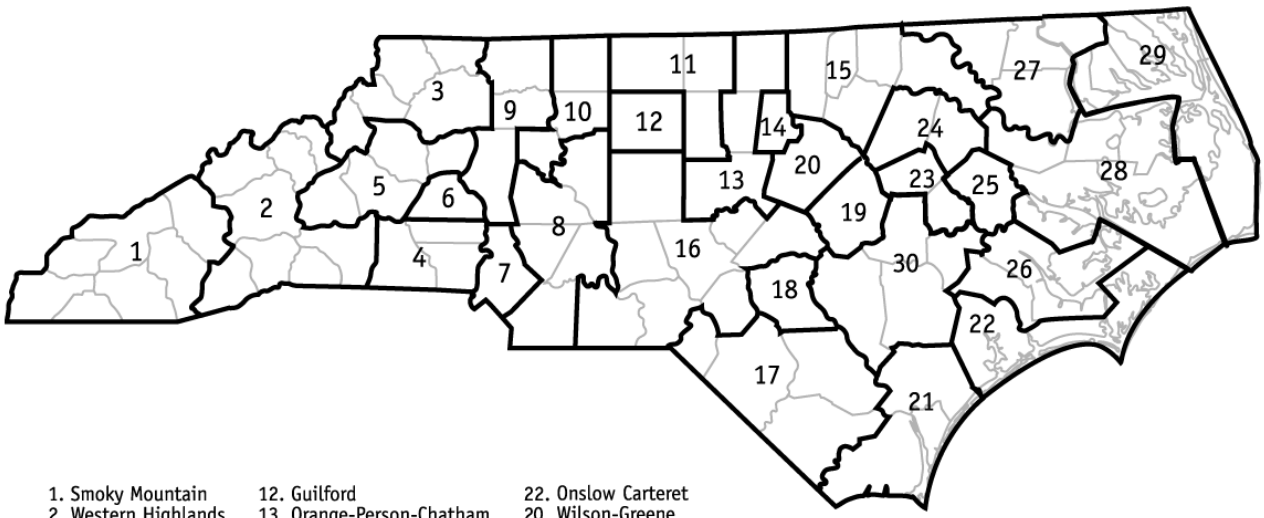
7. 1977 N.C. Sess. Laws ch. 568; former G.S. 122-35.35 to -35.57.

8. S.L. 2001-437.

9. The 2001 legislation and some of the factors precipitating its adoption are described in greater detail in Mark F. Botts, "2001 Legislation Affecting Mental Health, Developmental Disabilities, and Substance Abuse Services," *Mental Health Law Bulletin*, No. 7, March 2002.

10. See S.L. 2006-142 (An Act to Make Changes with Respect to the Implementation Mental Health Reform) and S.L. 2006-66, sections 10.28 and 10.32.

Figure 44-1. *North Carolina Mental Health, Developmental Disabilities, and Substance Abuse Programs*



1. Smoky Mountain
2. Western Highlands
3. New River
4. Pathways
5. Foothills
6. Catawba
7. Mecklenburg
8. Piedmont
9. Crossroads
10. CenterPoint
11. Alamance-Caswell-Rockingham
12. Guilford
13. Orange-Person-Chatham
14. Durham
15. Five County
16. Sandhills
17. Southeastern Regional
18. Cumberland
19. Johnston
20. Wake
21. Southeastern
22. Onslow Carteret
20. Wilson-Greene
24. Edgecombe-Nash
25. Pitt
26. Neuse
27. Roanoke-Chowan
28. Tideland
29. Albemarle
30. Eastpointe

people has the authority to establish a consolidated human services agency (G.S. 153A-77). Only Wake and Mecklenburg counties meet the population threshold for establishing a consolidated human services agency.

Each of the five organizational options for providing services has a different governing structure prescribed by statute and varies in the degree to which its administration is integrated into county government. As a general rule, an area authority operates more independently of county government than a county program or consolidated human services agency. (The area authority, county program, and consolidated human services agency are described separately below in sections with those titles.)

Today there are 30 local governmental entities responsible for community services in North Carolina: 28 area authorities, one county program, and one consolidated human services agency (see Figure 44-1). Ninety-eight of North Carolina's one hundred counties administer local mental health services through an area authority. The vast majority of these counties—ninety-two—participate in a multicounty area authority; only six counties participate in a single-county area authority. Among the two counties not participating in an area authority, Pitt County operates a single county program, and Wake County has exercised its statutory authority to consolidate the administration and delivery of mental health, social services, and public health services into a consolidated human services agency.[11]

Service Areas

The geographic area served by the area authority or county program is called its catchment area. As one might expect given the range of options available to counties, catchment areas vary widely in geographic size and popula-

11. While both Wake and Mecklenburg counties meet the statutory conditions for establishing a consolidated human services agency, only Wake operates such a program. Mecklenburg county has exercised other authority under G.S. 153A-77 that permits the board of county commissioners to become the governing body for the area authority, thereby substituting itself for the more independent "area board" that would otherwise govern the area authority. While Mecklenburg is unique in this respect, its mental health program is still an area authority.

tion (see Figure 44-1). Some area authorities cover relatively small populations spread over large rural areas of the state. For example, the Smoky Mountain Center area authority serves a population of 185,588 spread over seven of the state's westernmost counties—Cherokee, Clay, Macon, Jackson, Haywood, Swain, and Graham—while Tideland Mental Health Center serves five eastern counties—Martin, Beaufort, Washington, Tyrrell, and Hyde—with a combined population of 93,894. On the other hand, some catchment areas include large urban populations concentrated in smaller geographic areas, as is the case with the Mecklenburg and Guilford area authorities, which serve populations of 805,291 and 443,753, respectively.

The 2001 mental health system reform act directed the Secretary of the Department of Health and Human Services (DHHS) to develop a catchment area consolidation plan that reduced the number of area authorities and county programs, at that time 39 in number, to "no more than a target of 20" by January 1, 2007.[12] Although some area authorities merged as a result of the Secretary's plan—the Western Highlands and Sandhills area authorities each grew to eight counties in size—other merger initiatives stalled.[13] As of July 1, 2006, there were still 30 entities. To force further consolidation of area authorities and county programs into fewer and larger programs, the 2006 General Assembly amended the mental health laws to require that the catchment area of an area authority or county program contain either a minimum population of 200,000 or a minimum of six counties.[14] Because the 2006 law requires DHHS, beginning July 1, 2007, to reduce by ten 10 percent annually the state funding for administrative functions to any area authority or county program that does not comply with these catchment area requirements, it is anticipated that affected counties will choose to consolidate their programs to meet the new threshold for catchment area size.

Populations Served

Area authorities and county programs arrange and monitor care and treatment for mental illness, developmental disabilities, and substance abuse. As discussed further in this section, individuals that meet specific *target population* criteria or who are *Medicaid-eligible*, may qualify for publicly funded MH/DD/SA services. In addition all citizens are permitted access to *core services*.

Mental illness covers a group of illnesses, including both emotional and cognitive disorders, characterized by alterations in thinking, mood, or behavior associated with stress or impaired functioning, or both. Examples include depression that results in mood disturbance and attention deficit hyperactivity disorder that creates changes in behavior or the ability to concentrate. Evidence of mental illness may include perceptual difficulties, delusions, visual and auditory hallucinations and impairments in personal, social, and occupational functioning. For children, the common term is "emotional disturbance." Schizophrenia and related illnesses, affecting a small percentage of the population, are considered the most expensive and debilitating of the mental illnesses. Depression, on the other hand, is more common; a major cause of suicide, it frequently goes unrecognized and untreated, particularly in elderly populations.

The term *developmental disabilities* includes severe physical, cognitive, and mental impairments that appear before age twenty-two (unless caused by traumatic head injury), are likely to continue indefinitely, and produce substantial functional limitations in three or more of the following major areas of life activities: self-care, learning, mobility, language, capacity for independent living, self-direction, and economic self-sufficiency. Depending on severity, developmental disabilities may include mental retardation, epilepsy, autism, and cerebral palsy. The term also includes delayed cognitive, physical, or communication and social-emotional development in children.

Substance abuse is the use of drugs or alcohol in a dangerous, self-defeating, or destructive way and to a degree that produces impaired personal, social, or occupational functioning. An individual who engages in substance abuse has difficulty controlling his or her use, even though the use may be sporadic. Persons engaging in substance abuse and who might receive community-based services include injecting drug users, substance abusing women with children, DWI offenders, persons involved in the criminal justice system, those under investigation or supervision by child

12. S.L. 2001-437.

13. For example, the separate Wilson-Greene and Edgecombe-Nash area authorities reconsidered their planned consolidation when it appeared they would garner significantly less state funding for administrative functions if they went through with their consolidation plan. In addition, a proposed merger of the Tidelands and Roanoke-Chowan area authorities failed to materialize after considerable time and effort was expended planning the merger.

14. S.L. 2006-66, section 10.32(c) (amending G.S. 122C-115).

protective services, and those whose substance abuse involves recurring episodes of habitual use requiring assisted detoxification.

Simply suffering from mental illness, substance abuse, or a developmental disability, does not qualify an individual for receiving publicly-funded, community-based MH/DD/SA services. Due to limited public resources, the primary focus of the publicly-funded system, particularly since the redesign that began in 2001, is to provide services to individuals with the most severe disabilities. Central to reform is the goal that public resources be used to allow people with the most severe disabilities to function and receive services in their community and to reduce as much as possible the public system's reliance on expensive institutional care.[15] To meet this goal, DHHS has established target populations defined by specific diagnostic and functional criteria along with unique individual circumstances. These include several specific sets of criteria for each of the major age and disability categories: children with mental illness, adults with mental illness, adults suffering from addictive disorders, substance abusing youth or those at risk of engaging in substance abuse, and adults and children with developmental disabilities.

Generally, to receive community-based services paid for by appropriations from the state general fund an individual must fall within the target population for their age and disability category. For example, while many children may suffer from mild mental illness, the state's target population criteria generally focus on children with *serious* emotional disturbance (SED).[16] Children with SED—which may include anxiety disorders, disruptive behavior disorders, depression, substance abuse, or eating disorders—are seriously affected in their ability to develop and function normally at school, at home, or with peers, and typically require mental health and other services during childhood and in many cases throughout their lives.[17] Often these children require placement out of the home or are at risk of out-of-home placement, and without treatment and support children with SED are more likely to be expelled from school, drop out of school, become pregnant during adolescent, commit suicide, or be convicted of a crime.[18]

Those individuals eligible for Medicaid and with a condition that meets "medical necessity" for a particular service as defined by the federal Centers for Medicare and Medicaid Services are entitled to receive services whether or not they meet the specific criteria of the target populations. Since the majority of funding to support public MH/DD/SA services—both community-based services and state institutional care—is derived from Medicaid receipts (61% or 1.42 billion, which includes federal dollars and state and county shares), the state's federally-approved service definitions for Medicaid-reimbursable MH/DD/SA services largely determine who receives services and the kinds of services provided, as the state strives to define state-funded target population services in a way is consistent with the State Medicaid Plan. In addition, the limited state and county funding available to address the needs of individuals who are not Medicaid eligible and who have no third party insurance coverage creates a challenge for local governments and drives the state policy that targets state and local funds to the most severely disabled.

People falling outside the state's target populations or who are not Medicaid-eligible can receive *core services* as needed. Core services include screening, assessment, and referral to providers and community organizations, as well

---

15. Legal developments also contributed to renewed emphasis on this goal. The most recent example is *Olmstead v. L.C.*, 527 U.S. 581, 119 S. Ct. 2176, 144 L.Ed. 2d 540 (1999), where the U.S. Supreme Court held that the unnecessary segregation of individuals with mental disabilities in institutions could constitute discrimination based on disability, in violation of the Americans with Disabilities Act. After the ruling, states believed they risked litigation if they did not develop a comprehensive plan for moving qualified persons from psychiatric hospitals to less restrictive settings at a reasonable pace. North Carolina developed its *Olmstead Plan* for individuals institutionalized for 60 or more days in state psychiatric institutions, developmental disabilities centers, and community-based intermediate care facilities for persons with mental retardation. The plan includes a process for assessing individuals to determine the services and supports needed to return them to the community and discharging them from institutional care where appropriate.

16. National estimates indicate that 20 to 28 percent of children in the United States suffer from a mild mental health disorder, and 5 to 6 percent suffer form a serious emotional disturbance. *Child Mental Health Plan*. North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. Updated March 2004.

17. *Family Impact Seminar*, "Children's Mental Health: Strategies for providing high quality and cost-effective care," p. 10, Center for Child and Family Policy, Terry Sanford Institute of Public Policy, Duke University North Carolina Family (May 17, 2006).

18. *Id*.

as emergency or "crisis" services. The screening, assessment, and referral process also serves as a portal of entry to community services for individuals who are eligible for Medicaid or who meet the state's target population criteria. Core services also include indirect or universal services such as education, consultation, and prevention activities intended to increase knowledge about mental illness, developmental disabilities, and addictive disorders.

In 2004–5 the publicly-funded, community-based system served 330,083 people. Of these, the system served 246,652 persons with mental illness, 17,787 persons with developmental disabilities, and 65,644 with substance abuse diagnoses.[19] Among those receiving services for mental illness (75 percent of all persons served), 174,366 were adults and 72,286 were children. Of the individuals receiving services for developmental disabilities (5 percent), 12,062 were adults and 5,725 were children. Among persons receiving services for substance abuse (20 percent), 63,181 were adults and 2,463 were children. (To compare the number of persons served in each of the three major disability categories with the level of funding committed to the three disabilities, see "Distribution of Revenue" in this article.)

Service Provision

An area authority, county program, or consolidated human services agency must contract with other *qualified* agencies or institutions for the provision of services and may itself provide services to clients only if it seeks and obtains the approval of the Secretary of DHHS (G.S. 122C-141). A provider is qualified to contract with an area authority, county program, or consolidated human services agency if it meets the provider qualifications as defined by rules adopted by the Secretary.

The area authority, county program, or consolidated human services agency is responsible for assuring that all services, whether provided directly or under contract, meet the standards for services specified in state statutes and regulations (G.S. 122C-141, -142). A standard contract, adopted by the Secretary of DHHS, must be used when contracting with qualified providers for the provision of MH/DD/SA services. To enable the authority, program, or agency to adequately monitor provider performance and service outcomes, the standard contract requires service providers to provide timely data regarding the clients served, the services provided, and the resulting outcomes for clients.

Most contracted providers of MH/DD/SA services are private organizations. However, an area authority, county program, or consolidated human services agency may contract with public providers, as long as the public provider is qualified. For example, Rockingham County contracts with the Alamance-Caswell-Rockingham area authority to provide services to the area authority's clients. In addition, two or more counties may enter into an interlocal agreement under Article 20 of General Statutes Chapter 160A to jointly operate a public provider of MH/DD/SA services. The five counties participating in the New River area authority have formed a joint county provider agency to provide services to New River area authority clients after the New River area authority completes its anticipated merger with the Smoky Mountain Center authority. When contracting with a public provider, the area authority, county program, or consolidated human services agency must not unfairly favor the public provider over private providers when negotiating and monitoring contracts (G.S. 122C-141).[20]

Government Functions

Before the enactment of the 2001 mental health reform act, area authorities were permitted to provide services directly to clients using their own staff, or they could contract with other persons, organizations, or agencies to provide services to clients. Every area authority utilized both means of service provision, and most area authorities employed a large number of personnel with either clinical or case management skills who were devoted to providing services directly to clients. Since the enactment of the 2001 act, however, area authorities and county programs may provide

---

19. *North Carolina Area Programs Annual Statistics and Admission Report Fiscal Year 2005,* Data Operations Branch, North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (Raleigh, N.C.: NC Department of Health and Human Services, (January 2005), 17, Table V. The disability of clients is based on their primary diagnosis, as some clients may have diagnoses in more than one disability category. The report counts a client just one time during the fiscal year regardless of the number of admissions a client may have.

20. Although a county providing services through a consolidated human services agency may contract with both public and private providers of services, it may not contact with a provider agency created by two or more counties through an interlocal agreement under Article 20 of G.S. Chapter 160A.

only a few services directly to clients, such as screening and referral services, and must now manage consumer care by delivering the bulk of services through a network of other private or public providers. (The terms "client" and "consumer" are used interchangeably throughout this article, as they are in the General Statutes.)

To mark this change in function and organizational identity—from service provider in direct contact with clients to a manager, monitor, and, to some degree, payer of services provided by others—most people affiliated with the public system, including policy makers and administrators, use the catch-all reference *local management entities* or its acronym, *LMEs*, to refer to the local government entities responsible for mental health, developmental disabilities, and substance abuse services. Although widely used, these terms, and the functions they denote, remained uncodified until the 2006 General Assembly defined the terms "local management entity" and "LME" as a means for referring collectively to area authorities, county programs, and consolidated human services programs based on their common functional responsibilities (G.S. 122C-3(20b)).[21]

Local management entities are responsible for the management and oversight of the public system of MH/DD/SA services at the community level (G.S. 122C-115.4). LMEs must plan, develop, implement, and monitor services within their catchment area to ensure expected outcomes for consumers of services within available resources. This broad management and oversight responsibility includes the following primary functions:

1. *Access.* The LME must implement procedures for citizens to access services and, in particular, for the LME to respond to the need for emergency or "crisis" services. These procedures must include a screening, triage, and referral (STR) process available 24 hours a day, seven days a week. STR serves as a portal of entry to community services for individuals who are eligible for Medicaid or who meet the state's target population criteria. All citizens, however, may use STR (a "core service") to access service providers, community organizations, or crisis services (G.S. 122C-2).
2. *Provider development and management.* The LME must ensure available, qualified providers to deliver quality services in the LME's catchment area. The LME must endorse a provider (determine that it is qualified under state rules to deliver services), before the provider may provide services to LME clients.[22] The LME must then monitor provider performance and service outcomes in accordance with state standards, provide technical assistance to providers, and develop the service capacity of the LME's provider network, which could include recruiting new providers as necessary.
3. *Service authorization and utilization.* For each consumer of services paid for with state funds (not Medicaid) the LME must determine both eligibility for services and the appropriate level and intensity of services given the severity of the consumer's illness or disability (utilization management and review). This includes review and approval of the consumer's person-centered plan, an individualized plan of expected services and service outcomes developed by the consumer or his legally responsible person with the assistance of system professionals. For consumers in the LME's catchment area who receive Medicaid services, service authorization is limited to a review of the consumer's person-centered plan concurrent with the review performed by the fiscal agent conducting utilization control activities on behalf of the state. The LME must also authorize the utilization of state psychiatric hospitals or other state facilities and determine eligibility requests for individuals requesting services under the Medicaid Community Alternatives Program for the Mentally Retarded/Developmentally Disabled.
4. *Care coordination and quality management.* This function involves the periodic monitoring of individual consumer services to determine whether the consumer's person-centered plan is being implemented and is effective. It includes the initiation of and participation in the development of required modifications to person-centered plans for high risk and high cost consumers in order to achieve better client outcomes or equivalent outcomes in a more cost-effective manner. Monitoring effectiveness requires reviewing client outcomes data supplied by the provider, making direct contact with consumers, and reviewing consumer charts.
5. *Community collaboration and consumer affairs.* This function involves implementing a process to protect consumer rights, including an appeals process, and supporting an effective consumer and family advisory

21. S.L. 2006-142, section 4.

22. To ensure that community service providers have appropriate qualifications before providing services paid for with Medicaid funds, the Division of MH/DD/SA Services established a process in April 2005 that requires an LME to endorse a provider before it enrolls with the DHHS Division of Medical Assistance.

committee. It also includes collaborating with other local service systems to ensure access and coordination of services at the local level (G.S. 122C-115.2).

6. *Financial management and accountability.* The LME must carry out business functions in an efficient and effective manner and manage resources dedicated to public services—and information related to the delivery of services—in a manner that is accountable to state and local government funding sources.

An area authority, county program, or consolidated human services agency may contract with a public or private entity to carry out the primary LME functions. The entity contracting to perform the functions on behalf of the LME is subject to the same state and federal laws, obligations, and standards that the LME would have to meet if it were performing the functions itself.

The terms "area authority," "county program," and "consolidated human services agency" continue to denote specific and distinct governance and administrative structures available to a county or group of counties for carrying out local management entity functions. Therefore, despite the popular tendency to substitute the term "LME" for all references to the area authority, county program, or consolidated human services agency, local government officials and those working with them must know the more specific statutory reference for the LME serving their county—area authority, county program, or consolidated human services agency—to understand the relationship of that entity to their county government. Area authorities, county programs, and the consolidated human service program are discussed separately below.

The Area Authority

Governance

Area Board Composition and Appointment

Each area authority is governed by an area board that exercises specific powers and duties enumerated in the General Statutes of North Carolina. These statutes also prescribe the method of appointment and composition of the area board (G.S. 122C-118.1). Generally, an area board must have no fewer than eleven and no more than twenty-five members, with the size determined by the boards of county commissioners of the counties served by the area authority. However, a multicounty area authority consisting of eight or more counties and serving a catchment area with more than 500,000 people may have up to thirty area board members.

In a single-county area, the board of county commissioners appoints the members of the area board. In a multicounty area authority, each board of county commissioners within the catchment area is authorized to appoint one commissioner as a member of the area board; these commissioner members then appoint the remaining area board members. Boards of county commissioners within a multicounty area authority may depart from this prescribed appointment process by adopting a joint resolution setting forth a different method of appointment or allocation of appointment authority among participating counties. If the boards of county commissioners for a multicounty area authority exercise this option, the manner of appointment must be indicated in the area authority's business plan that is reviewed and approved by the commissioners.

Area board membership must include two individuals with financial expertise, an individual with expertise in management or business, and a person representing the interests of children. One board member may concurrently fill up to two required categories of membership if the member has the qualifications or attributes of the two categories of membership. The entity authorized to appoint board members must "take into account" citizen participation and representation of the disability groups when making appointments. However, no more than 50 percent of the members of the area board may be composed of the following representatives: a physician; a clinical professional from the field of mental health, developmental disabilities, or substance abuse; a family member—or individual from a citizens' organization composed primarily of consumers or their family members—who represents the interests of persons with mental illness, developmental disabilities, or substance abuse; and an openly declared consumer who is mentally ill, developmentally disabled, or in recovery from addiction.[23]

23. Before July 10, 2006, *at least* 50 percent of the members of the area board had to be composed of a physician, a clinical professional, three consumers of services, and three family members of consumers, guaranteeing that at least half the board members would be appointed from these constituent groups. S.L. 2006-142 amended G.S.122C-118.1 to provide that *no more* than

Commissioner members on the area board serve in an ex officio capacity for a term concurrent with their term as county commissioners. Other area board members serve three-year terms, and no member may serve more than two consecutive terms.[24] Area board members may be removed with or without cause by the person or group authorized to initially appoint the member. If a vacancy occurs on the area board before the end of the term, the person or group who initially filled the seat must choose a replacement within 90 days to complete the remainder of the unexpired term.

Area board members elect the area board chair, who may be a commissioner member of the area board, to serve a one-year term (G.S. 122C-119). The area board must meet at least six times per year. Meetings are called either by the board chair or by three or more members who have given written notice to the chair.

The area board must establish a finance committee that meets at least six times per year to review the financial strength of the area authority. This committee must have at least three members, two of whom have expertise in budgeting and fiscal control. One of the area board members who is an individual with financial expertise, or any county finance officer serving on the board, must serve on the finance committee as an ex officio member. All other finance officers of counties participating in a multicounty area authority may serve on the finance committee as ex officio members.

Alternative Governing Body

In the special case of a county with at least 425,000 people, the board of county commissioners, through adoption of a resolution after a public hearing, may choose to become the governing body for the area authority (G.S. 153A-77). In this event, the powers and duties of the area board become the responsibility of the board of county commissioners. Under this law, the board of county commissioners for Mecklenburg County has abolished the area board, board of health, and board of social services, and assumed governing authority over these human service agencies.

Powers and Duties of the Area Board

The area authority is governed by an area board that exercises specific powers and duties enumerated in the General Statutes of North Carolina. The area board must rely on the area director and staff to carry out many of the tasks associated with these legal responsibilities, thus limiting the level of direct board involvement in the operation of the area authority. But some legal responsibilities, including the adoption of certain policies mandated by law, require direct action by the board. For example, the area board must appoint an area director, develop an LME business plan, adopt an annual budget, and establish a finance committee, client rights committee, and consumer and family advisory committee. Moreover, as the governing body for the area authority, the area board bears ultimate responsibility for the execution of all powers and duties conferred by law on the area authority.

Some board duties, expressed in broad general terms, can be viewed as encompassing many of the more discrete duties listed below. For example, the board is legally responsible for ensuring, within available resources, the provision of mental health, developmental disabilities, and substance abuse services to citizens in the catchment area (G.S. 122C-2, -117). This responsibility directly relates to the local management entity functions of ensuring that qualified providers of services are available and that citizens have a way to access these providers. In another broadly-stated charge, statutory law requires the area board to do what is necessary to ensure the provision of services: to engage in comprehensive planning, budgeting, implementing, and monitoring of community-based services (G.S. 122C-117). Again, this broad language subsumes many of the duties listed below and relates to the primary management functions of the area authority. For example, the duty to monitor services is related to the local management entity functions of care coordination and quality management, which include monitoring the effectiveness of person centered plans.

A relatively recent responsibility of the area board, related to the goals of the 2001 mental health system reform act, is the responsibility to develop an *LME business plan* for the management, delivery, and oversight of community services (G.S. 122C-117, 122C-115.2). This plan must be in effect for at least three years and address how the area authority will carry out its local management entity functions, including how it will ensure the quality of services and

---

50 percent of the board may be composed of the these representatives. The effect of the amendment is that there appears to be no requirement, as there was previously, that board membership include the foregoing representatives, although the entity authorized to appoint board members must continue to "take into account" citizen participation and representation of the disability groups when making appointments.

24. S.L. 2006-142 added language to G.S. 122C-118.1(d) that says board members serving as of July 1, 2006, may remain on the board for one additional term. The apparent effect of the added language is that a board member serving his or her second term as of July 1, 2006, could be appointed for a third consecutive term, in spite of the general two-term limit.

measure their effectiveness. The LME business plan must be submitted for approval to the board or boards of county commissioners for the area authority before being submitted to the Secretary of DHHS for approval.

Services. In addition to generally ensuring the provision of services to clients in the area authority's catchment area, board responsibilities in the area of services include the power and duty to

- Determine the needs of the area authority's clients (G.S. 122C-117).
- Ensure the provision of services to clients committed to the custody of the Department of Juvenile Justice and Delinquency Provision (DJJDP), and coordinate with DHHS and DJJDP the provision of services to clients through local and state facilities (G.S. 122C-117).
- Enter into contracts for the provision of services (G.S. 122C-141).
- Assure that services meet state standards and are of the highest possible quality, and develop procedures for monitoring and evaluating the level of quality of services (G.S. 122C-117, 122C-191).
- Recommend to the board of county commissioners the creation of local program services (G.S. 122C-117).
- Submit to DHHS and the board of county commissioners quarterly service delivery reports that assess the quality and availability of services within the area authority's catchment area and an annual report assessing progress toward implementing service plans and goals and achieving outcomes (G.S. 122C-117).

Client rights and consumer affairs. The area board has the duty to

- Establish a local consumer and family advisory committee to advise the area authority on its planning and management of community services (G.S. 122C-170).
- Establish a client rights committee that monitors services for compliance with client rights, reports annually to the area board, and establishes review procedures for client grievances
- Perform public relations and community advocacy functions (G.S. 122C-117).

Budget and finance. In the area of budget and fiscal control, the area board must

- Establish a finance committee that meets at least six times a year to review the financial strength of the area authority (G.S. 122C-119).
- Develop and maintain an annual budget as required by the Local Government Budget and Fiscal Control Act (G.S. 122C-117, 122C-144.1).
- Submit its budget to the board of county commissioners and the county manager (G.S. 122C-117). A single-county area authority submits its proposed budget to the county as part of the county's budget process. The multicounty area authority submits its approved budget to the participating counties for informational purposes.
- Submit quarterly reports on the financial status of the area authority to the county finance officer for each participating county, who in turn submits the reports to the board of county commissioners at its next regularly scheduled meeting
- Prepare annual financial statements that set out the financial position of the area authority as of the end of the fiscal year and the financial results of operations during the course of the year (G.S. 159-34).
- Appoint a budget officer (multicounty programs only) to serve at the pleasure of the area board (G.S. 159-9).[25] The *county* budget officer serves the *single-county* area authority.
- Appoint a finance officer (multicounty programs only) unless the area director appoints the finance officer. The finance officer may be appointed by either the area board or the area director to serve at the pleasure of the appointing board or director. (G.S. 159-24) The *county* finance officer serves the *single-county* area authority.

25. G.S. 122C-121 charges the area director with developing the area authority budget for review by the area board. Because this is a budget officer responsibility under G.S. 159-11, one might conclude that the area director, by virtue of holding that position, is the budget officer for the area authority and the area board need not appoint a budget officer. Yet, the duty to develop the budget for area board review, like other duties expressed in G.S. 122C-121, applies to both multicounty and single-county area directors, and the budget officer for a single-county area authority is the county budget officer, as a single-county area authority is considered a department of the county for budget and fiscal control. Thus, it is not entirely clear that the area director's budget duty expressed in G.S. 122C-121, by itself, relieves the mutlticounty area board of the duty, set forth in G.S. 159-9, to appoint a budget officer. Of course, the multicounty area board could choose to impose the duties of budget officer on the area director.

- Have an independent certified public accountant complete an annual audit for submission to the Local Government Commission in conformance with the Local Government Budget and Fiscal Control Act (G.S. 122C-144.1).
- Enter into a memorandum of agreement (performance contract) with the Secretary of DHHS for the purpose of ensuring that state funds are used in accordance with priorities expressed in the area authority's business plan (G.S. 122C-115.2(d)).
- Prepare fee schedules for services and make reasonable efforts to collect reimbursement for the costs of services from individuals or entities able to pay, including insurance companies or other third parties who cover patient costs (G.S. 122C-146).

Personnel. In addition to appointing the area director, the board must

- Evaluate annually the area director for performance based on criteria established by the board and the Secretary of DHHS.
- Establish a salary plan that sets the salaries for area authority employees in conformance with the State Personnel Act. Approval of the plan by the county commissioners is not required unless the salary plan for a single-county area authority exceeds the county's salary plan, or the salary plan for a multi-county area authority exceeds the highest paying salary plan of any county in that area (G.S. 122C-156).
- Adopt and enforce a professional reimbursement policy that (1) requires fees for services provided directly by the area authority be paid to the area authority (not to its employees); (2) prohibits area employees from providing on a private basis services that require the use of area program resources and facilities; and (3) allows area employees to accept dual compensation and dual employment only if they first obtain the written permission of the area authority (G.S. 122C-157).

In addition to the powers listed above, the area board also may contract for the purchase, lease, or lease-purchase of personal property, including equipment necessary for the operation of the area authority (G.S. 122C-147). The area board has the authority to lease real property and, with county commissioner approval, may purchase real estate. The area board may purchase life insurance, health insurance, or both for the benefit of all or any class of area authority officers or employees as part of their compensation (G.S. 122C-156). In addition, the area board may enter into a contract to insure the area authority, board members, and employees against civil liability for damages caused by the actions of agents, board members, or employees of the area authority when acting within the course of their duties or employment (G.S. 122C-152, -153, -142).

The board also has implicit authority to enter into other contracts necessary to carry out its duty to provide services. Other contracts that might be necessary to area authority functions include contracts for the construction and repair of facilities and contracts for professional or other services not directly related to client services.

Finally, the area board is required to establish informal dispute resolution procedures for (1) persons who claim the area authority's failure to comply with state laws adversely affected their ability to participate in planning or budgeting processes, (2) clients or contractors who claim the area authority acted arbitrarily and capriciously in reducing funding for services, (3) contractors who claim that the area authority did not act within applicable law when imposing a particular requirement, and (4) contractors who claim that the area authority imposed a requirement that substantially compromises the their ability to fulfill the contract (G.S. 122C-151.3, -151.4).

Area Director

The area director is an employee of the area board and serves as the administrative head of the area authority. The area director appoints and supervises area authority employees, implements area board programs and policies, administers area authority services in compliance with state law, acts as a liaison between the area authority and DHHS, and provides information and advice to the board of county commissioners through the county manager (G.S. 122C-121). In addition, the area director must develop the budget for the area authority for review by the area board.

The area director is appointed by the area board, subject to the approval of the boards of county commissioners of each county participating in the area authority, except that one or more boards of county commissioners may waive the authority to approve the appointment (G.S. 122C-117(7)). The appointment must be based on the selection of a search committee of the area board that includes consumer members of the area board, a county manager, and a county commissioner.

Unless specifically waived by the Secretary of DHHS, area directors must have a master's degree, management experience, and other related experience. Any area director hired after January 1, 2007, must meet the job classifications adopted for area director by the Office of State Personnel (G.S. 122C-120.1).

Personnel Administration

Personnel administration for area authority employees must be conducted in accordance with the State Personnel Act and the rules and policies of the North Carolina State Personnel Commission (G.S. 122C-154). These rules and policies govern position classification, qualifications, recruitment, promotion, dismissal, compensation, personnel records, and nepotism (employment of relatives). For example, area authorities must use a competitive recruitment process that selects employees based on a relative consideration of the applicants' skills, knowledge, and abilities. Employees who have satisfactorily completed a probationary and/or trainee appointment may not be demoted, suspended, or dismissed except for "just cause" or reduction in force.[26]

The area board is authorized, but not required, to purchase life insurance and health insurance for the benefit of all or any class of area authority officers or employees as part of their compensation. Other fringe benefits for officers and employees may also be provided (G.S. 122C-156).

Budget and Fiscal Control

Like all other local governments and public authorities, the area authority's budgeting and fiscal management must be administered according to the Local Government Budget and Fiscal Control Act (G.S. 159), which prescribes a general system for adopting and administering a budget. This means that area authorities must operate under a balanced annual budget ordinance. Except for funds used for certain purposes, all moneys received or expended by the area authority—whether federal, state, local, or private in origin—must be spent in accordance with the budget ordinance.

Although both single-county and multicounty area authorities are local political subdivisions of the state with the power to exercise independent governing authority on many matters, a single-county area authority is considered a department of the county in which it is located for purposes of budget and fiscal control. Thus, the single-county area authority must present its budget for approval of the county commissioners in the manner requested by the county budget officer, and its financial operations must follow the budget set by the county commissioners in the county's budget ordinance. By contrast, the multicounty area authority—considered a *public authority* for purposes of the Local Government Budget and Fiscal Control Act—is not a part of the budgeting and accounting system of any county, but is responsible for its own budgeting, disbursing, accounting, and financial management under the direction of a budget officer appointed by the area board and a finance officer appointed by the area director or board.

Notwithstanding these distinctions, the statutory obligation of the area board to consider and approve a budget for the area authority does not vary according to the authority's single- or multi-county status. All area boards have the power and duty to engage in budgeting. Even though the county has ultimate authority over the budget decisions for a single-county area authority, the single-county area board should set whatever policy is necessary for the preparation of the area program's budget request, as well as consider and approve the budget to be submitted to the county.

Each area authority also must complete and submit an annual independent audit to the Local Government Commission. Under the audit requirement, an independent certified public accountant examines the area authority's accounting records and other evidence supporting its financial statements to provide independent verification that the financial statements are credible and can be relied upon. This is called a *financial audit*. The accountant also conducts a *compliance audit* to determine whether the area authority has complied with requirements for receiving federal or state financial assistance.

Multi-county area programs are responsible for contracting for their own auditing. However, because a single-county area program is considered a department of the county for purposes of budget and fiscal control, the county is responsible for including the single-county area program in the county's audit process. The area boards for both single and multi-county areas, however, have a need for the information produced by the audit and a duty to follow up on the auditor's findings and recommendations.

26. These and other rules applicable to area authority employees are found in title 25, subchapter 1I of the North Carolina Administrative Code.

The County Program

Instead of choosing an area authority, a county may choose to administer services through a county program for mental health, developmental disabilities, and substance abuse services (G.S. 122C-115.1). And, as with an area authority, a county may choose to operate a single county program or participate in a multicounty program. In either case, however, the county program's catchment area, as with area authority catchment areas, must contain either a minimum population of 200,000 or a minimum of six counties by July 1, 2007, unless the program is willing to sustain a 10 percent annual reduction in state funding.[27] Before establishing a county program, the board of county commissioners for the county or counties planning to operate the program must hold a public hearing with notice published at least 10 days before the hearing.

Single-County Program

A single county program is considered a department of the county for all purposes, with a county program director appointed by the county manager. The county program director must meet the same job qualifications and classifications that apply to area directors. Employees appointed by the single county program director are employees of the county (whereas employees under the direct supervision of an area authority director are employees of the area authority). Unlike the single-county area authority, the single county program is governed by the board of county commissioners, but the board of county commissioners must appoint an advisory committee that meets the compositional requirements for area boards and reports to the county manager.

Multicounty Program

Counties may operate a multicounty program to administer mental health, developmental disabilities, and substance abuse services by entering into an interlocal agreement with one or more other counties pursuant to Article 20 of G.S. Chapter 160A. Under these statutes counties appear to have a number of organizational options that range from establishing a joint agency governed by a separate board to having several counties contracting for one county to administer the program on behalf of all participating counties. Any interlocal agreement must provide for (1) the adoption and administration of the program budget in accordance with G.S. Chapter 159, (2) the appointment of a program director to manage the service system in accordance with the program's business plan and monitor the provision of services for compliance with the law, (3) the appointment of an advisory committee whose membership conforms to the membership requirements for area boards, (4) designation of a county manager to whom the advisory committee must report, and (5) compliance with the provisions of G.S. Chapter 122C and rules of the Secretary and the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services. The appointment of the program director and employment of county program staff will be as agreed upon in the interlocal agreement, but the program director must meet the same job qualifications and classifications that apply to area directors.

27. The 2006 legislative enactment setting the minimum size for an area authority or county program catchment area, codified at G.S. 122C-115, conflicts with a pre-existing size requirement for multicounty programs codified at G.S. 122C-115.1. The latter requires counties entering into an interlocal agreement for a multicounty program to have a combined population of 200,000, consistent with the 2006 law, or to have a five-county catchment area, one less than the six-county requirement in the 2006 law. The 2006 law, however, clearly applies to all area authorities and county programs, including multicounty programs. The fact that the pre-existing requirement, applicable only to multicounty programs, was not changed to conform to the 2006 amendment to G.S. 122C-115 is likely the result of an oversight, as this author, who followed the legislation, can recall no committee discussion that indicated any intent other than to require all catchment areas to meet the same minimum size requirements. Therefore, in the opinion of this author, it would be prudent to assume that the General Assembly did not intend to create a separate size requirement for multicounty programs.

The Consolidated Human Services Agency

A county with at least 425,000 people that operates under the county-manager form of government may choose to administer services through a consolidated human services agency rather than an area authority or county program. By adoption of a resolution after a public hearing, the board of county commissioners for the county may consolidate the administration and delivery of health services, social services, and area authority services under the control of the county manager and a consolidated human services board (G.S. 153A-77). In broad outline, this consolidated human services option, which Wake County has chosen, has four main features. It permits the board of county commissioners to do the following:

1. Consolidate human services in the county (mental health services, social services, and public health services) under the direct control of a human services director appointed and supervised by the county manager
2. Create a consolidated human services board that includes representatives of professional and constituent groups specified by statute
3. Create a consolidated county human services agency having the authority to carry out the functions of the local health department, the county department of social services, and the area authority
4. Assign other county human services functions to be performed by the consolidated human services agency, under the direction of the human services director, with policy-making authority granted to the consolidated human services board as determined by the board of county commissioners.

A consolidated human services agency is a department of the county, whereas an area authority is a local political subdivision of the state (G.S. 122C-116). The primary differences between a consolidated human services agency and the more independent area authority relate to these agencies' respective authority to make decisions regarding personnel matters and client services. Unlike the area authority, a consolidated human services board may recommend, but not establish, client services. Further, a consolidated human services board has no independent authority to enter into contracts for the provision of client services (a power held by the governing boards of single- and multicounty area authorities). Only if specifically authorized by the county board of commissioners may a consolidated human services agency enter into contracts; otherwise, the county board of commissioners holds the authority to contract on behalf of the consolidated human services agency.

As for personnel, the director of a consolidated agency is appointed, dismissed, and supervised by the county manager, whereas the director of the area authority (area director) is an employee of the area board. Further, the personnel of a consolidated agency are subject to county personnel policies and may be appointed only upon approval of the county manager. In contrast, employees of the area authority are appointed by the area director and are subject to the State Personnel Act.

With the exception of the differences noted above, the consolidated human services board and its human services director have many of the same powers and duties conferred by law upon the area board and area director, respectively (G.S. 153A-77(d) and (e); G.S. 122C-127(a)).[28]

The Role of Consumers and Families

Local Consumer and Family Advisory Committee

Every area authority, county program, and consolidated human services agency must establish a Consumer and Family Advisory Committee (CFAC) to advise the local management entity on its planning and management of the local MH/DD/SA service system (G.S. 122C-170).[29] Specifically, the CFAC must

28. Because this section of the material describes only the primary differences between the human services agency and the area authority, the reader is advised to consult the actual text of G.S. 153A-77 if a complete comparison of board and director powers and duties for the two agencies is required.

29. Although G.S. 122C-170 refers only to area authorities and county programs, and not consolidated human services agencies, among the primary functions prescribed in G.S. 122C-115.4 for local management entities is support of an effective consumer and family advisory committee. "Local management entity" is defined to include a consolidated human services

1. Review, comment on, and monitor the implementation of the LME business plan;
2. Identify service gaps and underserved populations;
3. Make recommendations regarding the service array and monitor the development of additional services;
4. Review and comment on the area authority or county program budget;
5. Participate in all quality improvement measures and performance indicators; and
6. Submit to the State CFAC findings and recommendations regarding ways to improve the delivery of services

The director of the area authority, county program, or consolidated human services agency must provide to the CFAC support staff sufficient to assist the CFAC in implementing the its duties. Staff assistance must include the provision of data for the identification of service gaps and underserved populations, training to review and comment on business plans and budgets, implementation of procedures to allow the CFAC participation in quality monitoring, and technical advice on rules of procedure and applicable laws.

The CFAC is comprised exclusively of adult consumers of MH/DD/SA services and family members of consumers of services. Each of the three disability groups—people with mental illness, developmental disabilities, or substance abuse—must be represented on the CFAC, and membership must represent as closely as possible the racial and ethnic composition of the catchment area. Member terms are for three years, and no member may serve more than two consecutive terms.

The law requires the CFAC to be self-governing and self-directed, indicating the legislative intent that it act independently of the LME staff and board, albeit with staff support, much like LME staff might support the LME board by providing needed information and logistical support. Each CFAC must adopt bylaws that govern the selection and appointment of its members, their number and terms of service, and other procedural matters. At the request of either the CFAC or the governing board of the area authority or county program, the CFAC and governing board must execute an agreement that identifies the roles and responsibilities of each party, the channels of communication between the CFAC and local board, and a process for resolving disputes between the parties.

State Committee

The law also establishes the State Consumer and Family Advisory Committee (State CFAC) to advise DHHS and the General Assembly on the planning and management of the state's public MH/DD/SA services system (G.S. 122C-171). This twenty-one-member body, composed exclusively of adult consumers of MH/DD/SA services and family members of consumers of services, must:

1. Review, comment on, and monitor the implementation of the State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services;
2. Identify service gaps and underserved populations;
3. Make recommendations regarding the service array and monitor the development of additional services;
4. Review and comment on the State budget for mental health, developmental disabilities, and substance abuse services;
5. Participate in all quality improvement measures and performance indicators;
6. Receive the findings and recommendations of local CFACs regarding ways to improve the delivery of mental health, developmental disabilities, and substance abuse services; and
7. Provide technical assistance to local CFACs in implementing their duties.

Like the local CFAC, the State CFAC must be a self-governing and self-directed organization, and the Secretary must provide sufficient staff to assist the State CFAC in implementing its duties. The assistance must include data for the identification of service gaps and underserved populations, training to review and comment on the State Plan and departmental budget, procedures to allow participation in quality monitoring, and technical advice on rules of procedure and applicable laws.

---

program. Further, G.S. 153A-77(d) and (e) provide that the powers and duties of the area board and area director are conferred on the consolidated human services agency board and its director unless otherwise specified. Based on these statutes, one may conclude that the area authority's duty to establish and assist a CFAC applies equally to the consolidated human services agency and its director.

The County's Role

As noted earlier, the board or boards of county commissioners participating in an area authority appoint, and may remove, area board members, whereas the board of county commissioners for a single-county program or consolidated human services agency is the governing body for the local management entity. This does not mean, however, that area authorities have no relationship with county government or that the administration of the area authority is not sometimes linked to county governance. Rather, the state has granted a limited but significant role to county government by providing for county responsibility and involvement in certain area authority matters. Further, all counties have certain responsibilities related to their local management entity, regardless of whether that entity is an area authority, county program, or consolidated human services agency.

The first three topics below—business planning, funding, and oversight—apply to each county's relationship to its local management entity, regardless of whether that entity is an area authority, county program, or consolidated human services agency. The fourth topic, service provision, applies to area authorities and county programs, but not a consolidated human services agency. The succeeding three topics—property, budget and fiscal control, and personnel—apply only to those counties whose local management entities are area authorities.

Business Planning

Each county, through its area authority or county program, must develop, review, and approve a business plan for the management and delivery of services and submit the plan for the approval of the North Carolina Secretary of Health and Human Services (G.S. 122C-115.2). The business plan must remain in effect for at least three years and address implementation of local management entity functions and other topics specified by statute. For example, the plan must address the resources available and needed within the local area to prevent out-of-community placements, collaboration with other local service systems to ensure access to and coordination of services, and planning for services that identifies gaps in services and methods for filling those gaps. The legislation also requires that local service planning involve key stakeholders and that the identification of resources available and needed to prevent out-of-community placements include input from other pubic agencies in the community.

Because counties generally have less direct control over the governance and management of area authorities, particularly multicounty area authorities, than they do over the county program or consolidated human services agency, and because most counties have chosen to provide services through a multicounty area authority, the periodic renewal of the business plan provides most counties one of the few opportunities to be significantly involved in the area authority's or county program's planning for service provision, financial management and accountability, and collaboration with other local government service systems. Each local management entity must implement its business plan for the next three-year cycle beginning July 1, 2007.

Funding

Counties are required to appropriate funds to support the LME serving their catchment area (G.S. 122C-115(b)). (See section on "Financing Community Services.") Counties must not reduce county appropriations and expenditures for current operations and on-going services of area authorities and county programs because of revenues available from state-allocated funds, client fees, or area authority or county program fund balances (G.S. 122C-115(d)). Counties may reduce county appropriations from the amount previously appropriated for one-time or non-recurring special needs of the area authority or county program. While this "non-supplant" restriction on reductions in county appropriations for ongoing services limits the ability of boards of commissioners to reduce appropriations to area authorities in response to the availability of funding from other sources, counties may allocate little or no new county money to area authority programs that receive substantial amounts of "new" revenue from other sources.

Oversight

To facilitate county oversight of the community-based service system, area authorities and county programs must make regular reports to their participating board or boards of county commissioners regarding the area authority's or county program's financial health and service capacity. These reports, which must be in a format prescribed by the

participating county or counties, include quarterly financial reports,[30] quarterly service delivery reports that assess the quality and availability of services within the area authority's or county program's catchment area, an annual progress report assessing the implementation of local service plans, and any ad hoc reports requested by the participating board or boards of county commissioners (G.S. 153A-453, G.S.122C-117, G.S. 122C-115.1).

Service Provision

G.S. 122C-141 authorizes area authorities and county programs to contract with any provider, public or private, that meets the provider qualifications under rules adopted by the Secretary. Most contracted providers of MH/DD/SA services are private incorporated organizations, but a few are public entities. A county may be a provider of MH/DD/SA services to a local management entity, including the area authority or county program that it participates in. If two or more counties enter into an interlocal agreement under Article 20 of General Statutes Chapter 160A to be a public provider of MH/DD/SA services, before an area authority or county program may enter into a contract with such an entity the area authority or county provider must adopt a conflict of interest policy that applies to all provider contracts so that it does not give unfair advantages to the public provider. In addition, the interlocal agreement must provide that any liabilities of the public provider must be paid from its unobligated surplus funds and that if those funds are not sufficient to satisfy the indebtedness, the remaining indebtedness must be apportioned to the participating counties. A county that provides MH/DD/SA services through a consolidated human services agency may not be a provider of services under G.S. 122C-141. [31]

Property

Generally the authority to purchase and hold title to real property used by an area authority is vested in the county where the property is located. However, this authority may be delegated to the area authority by the board or boards of county commissioners of all the counties within the area authority's catchment area (G.S. 122C-147). Further, an area authority may not finance or acquire real or personal property by means of an installment contract under G.S. 160A-20 without the approval of the board or boards of county commissioners for the counties constituting the catchment area. The area board for both single-county and multi-county areas, however, has the authority to purchase personal property, including equipment necessary to the operations of the area authority, and to lease personal and real property (G.S. 122C-147).

Budget and Fiscal Control

Because a single-county area authority is considered a department of the county for purposes of the Local Government Budget and Fiscal Control Act (G.S. 159), its administration is linked to county administration in ways not characteristic of the more independent multi-county authorities. The single-county area authority must present its budget for approval of the county commissioners in the manner requested by the county budget officer, and its financial operations must follow the budget set by the county commissioners in the county's budget ordinance. The ability of the board of county commissioners to approve the budget of single county area authorities gives the commissioners a substantial role in determining the budget, the scope of services available to county residents, and the number of personnel positions that the area authority may have.

---

30. Reports are to be submitted to the county finance officer for each participating county, who in turn submits the reports to the board of county commissioners at its next regularly scheduled meeting. If the report is not submitted within 30 days of each quarter of the fiscal year, the clerk of the board of county commissioners must notify the area director and area finance officer that the report has not been submitted as required.

31. Specifically, G.S. 122C-141(d) provides that a county that administers services through a consolidated human services agency cannot join with other counties under Article 20 of G.S. Chapter 160A to be a provider of services to an LME. This language does not prohibit such a county from forming, on its own, a provider agency to contract with one or more LMEs. Thus, while the intent of the statute probably was to prohibit such counties from creating a qualified public provider, it does not establish a clear and absolute prohibition. Further, a consolidated human services agency may seek a waiver under G.S. 1226-141(a) to provide services directly to clients in the agency's capacity as an LME.

The county for a single-county area authority has responsibility for fiscal management and may require all disbursements, receipts, and financial management of the area authority to be handled by the county's finance officer. The county, however, may designate a deputy finance officer for the area authority to disburse money (sign checks) and to pre-audit obligations, such as contracts and purchase orders, to ensure that the budget ordinance for the county contains an appropriation authorizing the obligation and that a sufficient amount remains in the appropriation to meet the obligation. This officer could be an employee of the area authority.

As part of the county budget preparation for each year, the single-county area authority must transmit to the county budget officer an estimate of the financial requirements of the area program (expenditure requests and revenue estimates) in a form prescribed by the county budget officer. In addition, a report on the revenues and expenditures for the previous and current years must be prepared, a task sometimes completed by the county finance officer. Although not required by law, budget requests may include program goals or objectives that address anticipated concerns of the county budget officer and the board of county commissioners. Local policy may also require or advise that single-county program officials, like heads of county departments, meet with the county budget officer to review departmental or program requests and attend governing board meetings to review the proposed budget.

By contrast, the multi-county area authority is not a part of the budgeting and accounting system of any county, but is responsible for its own budgeting, disbursing, accounting, and financial management under the direction of a budget officer and finance officer appointed by the area board. Nevertheless, because all counties must appropriate funds to the area authority serving their county, boards of commissioners in counties served by multi-county area authorities, though they do not adopt or administer the area authority budget, do shape or influence the budget when determining the level of county appropriations for area authority services. To keep counties apprised of the multicounty authority's budget policy and financial status, the multicounty area authority must submit its approved budget and annual audit to the participating boards of county commissioners for informational purposes (G.S. 122C-117).

Personnel

Employees under the direct supervision of the area authority are area employees, not county employees. Nonetheless, county personnel policies may apply to area employees in certain circumstances, and counties may pursue statutory options to bring the personnel administration of a single-county authority within the county personnel system. The degree to which county personnel policies may regulate area employees depends, in part, on whether the area authority is a single-county or multi-county authority and, in part, on whether a county affirmatively acts to exert authority over area employees.

In the case of a single-county area authority, the board of county commissioners may prescribe for area employees rules governing annual leave, sick leave, hours of work, holidays, and the administration of the pay plan, if these rules are adopted for county employees generally [G.S. 126-9(a); G.S. 153A-94]. The State Personnel Act also appears to grant the same authority to counties that comprise the catchment area of a *multi-county* authority, but the respective boards of county commissioners would have to jointly exercise this authority and apply the rules to their respective county employees. The county rules must be filed with the state personnel director in order to supersede any rules adopted by the State Personnel Commission.

The county served by a single-county area authority has the option of bringing area employees within the county system of personnel administration. If the board of county commissioners establishes and maintains a personnel system for all county employees and that system is approved by the State Personnel Commission as being substantially equivalent to the state's personnel system for area authority employees, then the county personnel system will cover employees of the area authority (G.S. 126-11). In this case, employees covered by the county system would be exempt from the State Personnel Act, but the provisions on equal opportunity for employment and compensation would continue to apply. In order for the county personnel system to be deemed substantially equivalent, it would have to meet the State Personnel Commission's basic requirements for recruitment, selection, advancement, classification, compensation, suspension, dismissal, and affirmative action.

As for multi-county area authorities, county governments have no independent authority to substitute a substantially equivalent personnel system for the state rules of personnel administration.

The State's Role in Community Services

The primary state government actors are the Department of Health and Human Services; the North Carolina legislature —as a body and through its Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services; and a rulemaking body called the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services.

Administration

The Department of Health and Human Services, through its Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, is the state agency responsible for enforcing state regulations and statutes governing the operation of area authorities, county programs, and consolidated human services agencies (G.S. Ch. 143B; G.S. 122C-111 and -112). DHHS also allocates and administers federal and state funds designated by the General Assembly for community services, enforces requirements for federal and state aid, and adopts rules governing the accreditation of local programs and the expenditure of local management entity funds. Recently, the Secretary of DHHS has been charged also with standardizing the processes related to local management entity functions, developing and implementing performance measures for evaluating how well LMEs perform their functions, and providing to LMEs ongoing and focused technical assistance on the implementation of LME functions.

In 2001 the General Assembly enacted legislation requiring DHHS to develop and implement a State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services that, among other things, sets out the vision and mission of the publicly-funded service system (G.S. 122C-102). The State Plan is a strategic plan for the organization and use of state and local resources that identifies specific goals for DHHS and local management entities to achieve over a three-year period, benchmarks for determining whether progress is being made toward those goals, and the data that will be used to measure that progress. The subjects that must be measured for improvement are access to services, consumer-focused outcomes, systems efficiency and effectiveness, quality management systems, and the promotion of best practices.[32]

The Division of MH/DD/SA Services is directly responsible for operating fifteen facilities for persons in need of twenty-four-hour treatment or residential services: four psychiatric hospitals, five developmental centers (also called "mental retardation centers"), three alcohol and drug abuse treatment centers, two specialized facilities for children and adolescents, and a special care center for adults in need of mental health and nursing care services. Local management entities use the state-operated institutions to provide services that are unavailable as yet in the community or cannot practically be carried out in each individual community.

Policymaking

In 2000 the General Assembly created the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) and charged it with developing a plan to reorganize the public system of mental health, developmental disabilities, and substance abuse services based on recommendations of the State Auditor.[33] After much study and deliberation by its subcommittees, the LOC introduced a mental health reform bill intended to address, among other things, such issues as the governance of local service systems, the quality of services, and consumer and family involvement in oversight of the system. The bill ultimately adopted by the General

32. Best practices are services that, according to scientifically defensible evaluation and research, have demonstrated effectiveness and positive outcomes for consumers and their families.

33. S.L. 2000-83. In 1998 and 1999 the General Assembly directed the Office of State Auditor to coordinate a comprehensive study of the state psychiatric hospitals and area authorities. (S.L. 1998-212, section 12.35A; S.L. 1999-237, section 11.36.) The State Auditor examined the relationship of the state psychiatric hospitals to community mental health programs, as well as how those components interact with and relate to area authorities and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. On April 1, 2000, the State Auditor released the "Study of State Psychiatric Hospitals and Area Mental Health Programs," which made numerous findings and recommendations related to the governance, financing, organizational structure, and service delivery systems of area authorities and the Division of MH/DD/SAS.

Assembly is known as the mental health system reform act of 2001.[34] In 2006 the LOC recommended and the General Assembly adopted legislation modifying the 2001 act, including changes to clarify the respective powers and duties of state and local government with regard to public services.

The sixteen member LOC is charged with examining, on a continuing basis, system wide issues affecting the development, financing, administra2tion, and delivery of mental health, developmental disability, and substance abuse services, including issues relating to the governance, accountability, and quality of those services (G.S. 120-240). The committee must make ongoing recommendations to the General Assembly on ways to improve the quality and delivery of services and to maintain a high level of administrative effectiveness and efficiency at the state and local levels. In conducting its examination, the committee must study the budget, programs, administrative organization, and policies of DHHS to determine ways in which the General Assembly may encourage improvement in services to North Carolinians.

Rulemaking

The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services is the state body authorized to adopt, amend, and repeal rules governing the delivery of mental health, developmental disabilities, and substance abuse services (G.S. 143B-147 through -150). Appointed by the governor and the General Assembly, the twenty-six-member commission is made up of persons with a special interest in these services, including representatives of area authorities, professionals in the field, and representatives of clients of services. Commission rules set standards for the management and operation of area authorities and their contract agencies, the use of federal funds according to federal requirements, and the licensing of public and private facilities that provide mental health, developmental disabilities, and substance abuse services. The rules that pertain specifically to area authorities are intended to ensure that area authorities and their contract agencies provide adequate and appropriate services, and each area authority must demonstrate compliance with the rules by periodically being reviewed and accredited by the state or an accrediting body acting under the auspices of the state

Financing Community Services

Sources of Revenue

Funding for community-based services totaled $1.74 billion in 2005–6, or about 74.5 percent of the total money spent from all sources on MH/DD/SA services in North Carolina ($2.34 billion).[35] The other 25.5 percent went to state-operated institutions (24 percent) and state office administration and management (1.5 percent). Not all of the funding for community-based services goes to LMEs. For example, much of the Medicaid money spent on MH/DD/SA services is paid directly to providers who have agreed to take LME referrals following an endorsement process where the LME determines they are qualified to serve Medicaid-eligible clients. LMEs are responsible for evaluating the general performance of these providers and monitoring the effectiveness of each client's care.

Revenue to support community services comes from a variety of sources, including the state general fund, federal block grants, special purpose grants from the federal government and private foundations, county appropriations, client fees, Medicaid receipts, and other third party receipts such as private insurance. When looking at the sources of revenue for community services, two things become clear. First, the system serves primarily, though not exclusively, individuals who are eligible for Medicaid. Second, the largest source of revenue for providing services to individuals who are not eligible for Medicaid and have no third party insurance coverage is the state general fund.

Medicaid receipts are the largest single source of revenue for community-based services, amounting to roughly $1.14 billion, or 66 percent of all revenue (see Table 44-2). This figure includes the federal share and a portion of the state share of Medicaid. State general fund appropriations, the next largest source of revenue, accounted for $352 million, or roughly 20 percent of all revenue for community services. Federal block grants and other receipts allocated by the Division provided approximately $82 million in revenues.

---

34. S.L. 2001-437 (H 381).

35. *Overview of DMHDDSAS Total System Funding*, a chart prepared by Philip Hoffman, North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (Nov. 18, 2005).

Table 44-2. *Revenues by Source for Community-Based MH/DD/SA Services: Amount and as a Percentage of Total Revenues, Fiscal Year 2004–5*

Type of Revenue	Amount in Millions ($)	Percentage of Total
State General Fund	352	20
Medicaid	1,143	66
Federal Block Grant/Other	82	5
County	109	6
Other	56	3
Total	1,742	100

Source: N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Chart, Overview of DMHDDSAS Total System Funding, prepared by Phillip Hoffman (Raleigh, N.C.: NC DMHDD-SAS, November 18, 2005).

Counties must, and cities may, appropriate funds to support the LME serving their catchment area (G.S. 122C-115(b)). In addition, G.S. 122C-2 provides that the furnishing of services through a public system centered in area authorities and county programs "requires the cooperation and financial assistance of counties, the State, and the federal government." Nevertheless, county appropriations comprise a very small percentage of total revenues. County appropriations funded through property tax proceeds or other local revenues comprise $109 million, or roughly 6 percent of the total revenues committed to community-based services.

Because area authorities do not have the power to levy taxes, their ability to generate revenue is limited. Client receipts other than Medicaid, such as insurance and client fees, provide some revenue, but this, too, is limited, as no person may be refused services because of an inability to pay (G.S. 122C-146). Yet the law also requires area authorities to collect reimbursement for services to the extent that clients are able to pay. Client fees for services, while a small source of revenue, are nevertheless important. In Table 44-2, the category designated "other" includes fees from clients and private insurance and represents $56 million or 3 percent of total revenues committed statewide to community-based services. The revenue generated by an area authority or county program through the collection of fees may be used only for the fiscal operation or capital improvements of LME programs and may not be used as a justification for reducing or replacing the budgeted commitment of county tax revenue (G.S. 122C-146).

Distribution of Revenues

When looking at the distribution of revenue, one can look at the allocation of revenues according to the three major disability categories, how state funds are distributed among the 30 local management entities, and how funds are allocated between community services and institutional care.

The revenues listed in Table 44-2 for community-based services were allocated among the three disability groups as follows: $639 million for mental health services (75 percent of persons served), $744 million for developmental disabilities services (5 percent of persons served), and $118 million for substance abuse services (20 percent of persons served). Another $241 million went to community services but were not budgeted in a disability specific manner.

Because revenues for community services from each source, as depicted in Table 44-2, are based on state-wide figures representing the combined revenues of all local management entities, the percentages depicted do not represent the experience of a particular LME. For example, state appropriations from the state general fund are unevenly distributed among the local management entities. As shown in Table 44-3, while the state level of funding for community-based services amounted to $37.20 per person in fiscal year 2005–6, the distribution of these funds to local management entities ranged from $24.39 per capita for Mecklenburg County to $56.80 per capita for the Tideland Area Authority.

Similarly, the level of county support for community services varies from LME to LME. As depicted in Table 44-4, county funds budgeted for mental health services in fiscal year 2004–5 ranged from $53.39 per capita for the Mecklenburg area authority to $1.03 per capita for the six-county Albemarle area authority. When viewed on a state per capita basis, county funds budgeted for mental health services amounted to $12.54 per person. (It must be noted that Table 44-4 represents county funds budgeted, not actually spent, in 2005–6. Local management entities do not always receive and expend all of the funds budgeted to them by their respective counties, although most do.)

While the development of community services over the past four decades may have kept the incidence of state institutional admissions from rising (see, Table 44-1 and the discussion in "Historical Development," above), institutional care still garners a disproportionate share of the public resources devoted to MH/DD/SA services. For example, while

Table 44-3. *2005–6 State General Fund Appropriations to Local Management Entities for State-Funded (Non-Medicaid) Community Services (Excludes Funding to LMEs for Administrative Functions), Rank Ordered from Highest to Lowest Per Capita Funding*

LME	State Funding	Population	Per Capita Funding
Tideland	5,368,401	94,511	56.80
OPC	11,353,723	219,384	51.75
Roanoke-Chowan	3,781,332	76,385	49.50
Pitt	6,795,927	143,158	47.47
Wilson-Greene	4,608,237	97,729	47.15
Neuse	5,526,598	117,614	46.99
Five County	10,760,210	230,590	46.66
Western Highlands	21,456,995	486,018	44.15
Southeastern Regional	11,035,225	253,778	43.48
Alamance-Caswell-Rock.	11,209,536	258,766	43.32
Smoky Mountain	7,954,991	183,644	43.32
Pathways	15,544,426	363,562	42.76
Sandhills	21,786,529	515,227	42.29
New River	6,987,484	166,517	41.96
Piedmont	27,524,606	657,107	41.89
Edgecombe-Nash	5,968,222	145,140	41.12
Eastpointe	11,979,907	292,708	40.93
Albemarle	4,805,225	127,430	37.71
Durham	9,131,524	243,322	37.53
Foothills	9,160,066	250,358	36.59
Southeastern	10,932,657	308,552	35.43
Crossroads	8,809,705	251,318	35.05
Guilford	14,864,345	446,189	33.31
Catawba	4,913,605	151,169	32.50
CenterPoint	13,322,967	411,590	32.37
Cumberland	9,148,011	315,122	29.03
Onslow-Carteret	6,370,402	223,855	28.46
Wake	19,914,357	744,024	26.77
Johnston	3,742,858	145,240	25.77
Mecklenburg	19,264,694	789,940	24.39
TOTALS	324,022,765	8,709,947	37.20

Note: Based on July 1, 2005, populations. Totals include $26.5 million in funding for "cross area service programs." These are programs that are funded within an LME's allocation but that serve a multi-LME or statewide population.
Source: N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Chart, *LME Service Allocations: Per Final SFY 06 Allocation Letter Distributed on September 30, 2005* (Raleigh, N.C.: NC DMHDDSAS), available online at http://www.dhhs.state.nc.us/mhddsas/budget/index.htm and the link entitled "Area Program Division Per Capita Funding—SFY 06."

TABLE 44-4. *County General Funds Budgeted to Area Programs in 2005–6*

Area Program	County General Funds	County General Funds Per Capita	Per Capita Rank
Mecklenburg	42,178,375	53.39	1
Durham	7,138,918	29.34	2
Guilford	10,444,680	23.41	3
CenterPoint	6,816,059	16.56	4
Cumberland	4,581,053	14.54	5
Wake	10,045,411	13.50	6
Pitt	1,594,588	11.14	7
Alamance-Caswell	2,837,635	10.97	8
Orange-Person-Chatham	2,262,353	10.31	9
Johnston	1,400,195	9.64	10
Catawba	1,228,882	8.13	11
Southeastern	2,275,654	7.38	12
Pathways	2,110,018	5.80	13
New River	925,287	5.56	14
Wilson-Greene	438,544	4.49	15
Sandhills	2,246,778	4.36	16
Piedmont	2,721,924	4.14	17
Eastpointe	1,210,000	4.13	18
Tideland	372,916	3.95	19
Edgecombe-Nash	560,732	3.86	20
Crossroads	912,284	3.63	21
Five County	834,608	3.62	22
Roanoke-Chowan	261,115	3.42	23
Onslow-Carteret	698,000	3.12	24
Smoky Mountain	515,216	2.81	25
Western Highlands	1,340,780	2.76	26
Neuse	308,090	2.62	27
Southeastern Regional	72,917	2.03	28
Foothills	392,578	1.57	29
Albemarle	131,217	1.03	30
Total	**109,253,645**		
Statewide Per Capita		**12.54**	

Source: N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Chart, *County General Funds: SFY 05 Budgeted and Actual and 06 Budgeted.* (Raleigh, N.C.: NC DMHDDSAS), available online at http://www.dhhs.state.nc.us/mhddsas/budget/index.htm and the link entitled "County General Funds in Area Programs: SFY 05 Budget/Actual and SFY 06 Budget."

only 7 percent of all admissions to the public-sector system are to the state-operated institutions, institutional care garners 25 percent of all money spent on services. Further, due to diminished community capacity in some service areas following the implementation of the 2001 reform legislation, acute care admissions at state psychiatric hospitals have actually risen since 2002.[36] And, while Table 44-1 shows that the number of persons receiving community-based care grew by more than 100,000 between 1994 and 2005, the number increased by only 15,777 between 2001, the time the reform legislation was enacted, and 2005.[37] As a result, increasing community capacity in ways that reduce communities' reliance on institutional care while simultaneously transferring resources from existing state services to local governments for building community service remains an ongoing goal of administrators and policymakers at the state and local government levels.

Additional Resources

Botts, Mark F. *Mental Health Law Bulletin,* "2006 Legislation Affecting Mental Health Developmental Disabilities, and Substance Abuse Services," Chapel Hill, N.C.: School of Government, University of North Carolina at Chapel Hill, No. 10, November, 2006.

NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, *State Plan 2006: An Analysis of State Plans 2001–2005*, Raleigh, N.C.: NC Department of Health and Human Services.

Center for Child and Family Policy, *Family Impact Seminar,* "Children's Mental Health: Strategies for Providing High Quality and Cost-effective Care," edited by Nam Douglass, Jenni Owen, Lisa J. Berlin, Durham, N.C.: Terry Sanford Institute of Public Policy, Duke University, May 17 2006.

Botts, Mark F. *Mental Health Law Bulletin,* "2001 Legislation Affecting Mental Health Developmental Disabilities, and Substance Abuse Services," Chapel Hill, N.C.: School of Government, University of North Carolina at Chapel Hill, No. 7, March, 2002.

Botts, Mark F., and Ingrid M. Johansen. "Mental Health, Developmental Disabilities, and Substance Abuse Services." In *State and Local Government Relations in North Carolina*, 2d ed. Liner, Charles D., ed. Chapel Hill, N.C.: Institute of Government, University of North Carolina at Chapel Hill, 1995.

Lawrence, David M. *Local Government Finance in North Carolina,* 2d ed. Chapel Hill, N.C.: Institute of Government, University of North Carolina at Chapel Hill, 1990, especially chapter 5.

Mark F. Botts is a School of Government faculty member who specializes in mental health law.

36. *Annual Statistical Report North Carolina Psychiatric Hospitals Fiscal Year 2005,* Data Operations Branch, North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (Raleigh, N.C.: NC Department of Health and Human Services, (January 2005), 4, Graph 1.

37. *Transformation: A Commitment to Make a Difference*, Annual Report for the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (Raleigh, N.C.: NC Department of Health and Human Services, State Fiscal Year July 1, 2004 through June 30, 2005), 12.