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Outsourcing Our Children: The Failure to Treat Mental Illness-in-State

Matthew Herr

NOTES AND COMMENTS

OUTSOURCING OUR CHILDREN: THE FAILURE TO TREAT MENTAL ILLNESS IN-STATE

MATTHEW HERR*

INTRODUCTION

Imagine taking your child[1] to the hospital for intensive brain surgery and doctors telling you that his post-operative care will take place in another state. Or imagine your child being turned away from an emergency room that *could* heal her, but *won't*, because she is "too sick" and therefore not as profitable to treat. What if your child could no longer receive her cancer treatment because she turned eighteen? Many North Carolina families, who have children with mental illness, face this kind of reality.

Over the past decade, North Carolina largely privatized its mental health system.[2] One particular type of private provider, psychiatric residential treatment facilities (PRTFs), increasingly dominates inpatient mental health services for children.[3] However, the North Caro-

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1. For the purposes of this paper, "child" means someone who is less than eighteen years old. Eighteen to twenty-one year olds will be referred to categorically. Because certain issues apply to both children and eighteen to twenty-one year olds, "youth" means someone who is under the age of twenty-one, including children. "Adult" means someone who is over twenty-one years old, unless noted to the contrary.

2. *See* An Act to Phase In Implementation of Mental Health Reform at the State and Local Level, §1.15, 2001 N.C. Sess. Laws 2232, 2256(requiring area authorities to contract out the provision of services); *infra* note 3; *See also* NAT'L INST. FOR HEALTH CARE MGMT CHILDREN'S MENTAL HEALTH: AN OVERVIEW AND KEY CONSIDERATIONS FOR HEALTH SYSTEM STAKEHOLDERS 7 (2005). ("[A]s services increasingly are privatized through Medicaid managed care arrangements, the role of public mental health agencies has been diminished.")

3. *See generally* Psychiatric Residential Treatment Facilities for Children Under the Age of 21, N.C. Div. of Med. Assistance Enhanced Mental Health & Substance Abuse Serv., Clinical Coverage Policy No.: 8D-1 (August 1, 2012) [hereinafter Clinical Coverage Policy No.: 8D-1], *available at* http://www.ncdhhs.gov/dma/mp/8D1.pdf. The main exception being acute psychiatric hospitals, the most intense and restrictive kind of psychiatric treatment possible. *See* 10A N.C. ADMIN. CODE 27G.6001 (providing that psychiatric hospitals are "the most intensive and restrictive type of facility for individuals" receiving mental health services). Those are still run by the state. Whitaker School is the only state-run PRTF in North Carolina, although the state runs one other similar program called Wright School. *See NC State Operated Facilities*, NC DHHS (last

lina Administrative Code only allows PRTFs, and similar facilities, to serve youth up to age eighteen.[4] Yet, the Early and Periodic Screening, Diagnosis & Treatment (EPSDT) provision of Medicaid makes the child-adult delineation at age twenty-one.[5] Broadening the states' duty to provide services, EPSDT expressly requires that all EPSDT qualified children under the age of twenty-one receive any and all services medical professionals deem necessary.[6] However, because many of North Carolina's mental health regulations treat eighteen year olds as adults—and "adults"[7] in North Carolina generally suffer from a stark lack of meaningful mental health services[8]—the laws in North Carolina create a bar to Medicaid-eligible eighteen to twenty-one year olds from seeking vital EPSDT services within the state.[9] As for children under the age of eighteen, North Carolina licenses facilities to address either mental health issues or intellectual disability issues, but not both.[10] As a result, complex/hard-to-serve children[11]—less profitable to treat children—often find themselves without appropriate in-state treatment options.[12]

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updated Oct. 14, 2013), http://www.ncdhhs.gov/dsohf/facilitycontacts.htm. The state's remaining PRTFs—upwards of forty at any given time—are all operated by private providers. *See Licensed by the state of North Carolina Department of Health and Human Services-Division of Health Service Regulation*, NC DHHS (last updatedNov. 2013), http://www.ncdhhs.gov/dhsr/data/mhllist.pdf.

4. 10A N.C. ADMIN. CODE 27G.0103(10) (2012); *see also* 10A N.C. ADMIN. CODE 27G.0103(9) (2012) ("'Child' means a minor from birth through 12 years of age."); 10A N.C. ADMIN. CODE 27G.0103(3) (2012) ("'Adolescent' means a minor from 13 through 17 years of age."); 10A N.C. ADMIN. CODE 27G.0103(4) (2012) ("'Adult' means a person 18 years of age or older . . . .").

5. *See* 42 U.S.C. § 1396a(a)(43)A (2006).

6. *See, e.g.*, Assistance Enhanced Mental Health & Substance Abuse Serv., N.C. Div. of Med., Clinical Coverage Policy No.: 8B, at 2 (Nov. 1, 2012) [hereinafter Clinical Coverage Policy No.: 8B], *available at* http://www.ncdhhs.gov/dma/mp/8B.pdf ("IMPORTANT NOTE: EPSDT allows a recipient less than [twenty-one] years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are medically necessary health care services to correct or ameliorate a defect, physical or mental illness, or a [health related] condition.") (emphasis in original omitted).

7. In this context, someone over the age of eighteen.

8. *See infra* Part I.B.

9. *See infra* notes 63–69.

10. *See* Disability Rights NC, Kids Caught in a Double Bind: North Carolina's Failure to Care for Children with Dual Disabilities 3 (2011) [hereinafter KIDS CAUGHT IN A DOUBLE BIND]("The State separates services between Mental Health (MH) and Developmental Disabilities (DD), and the process for getting services for an individual with complex needs is confusing and difficult. Sometimes the services do not exist at all [in-state]."); *see generally* N.C. Div. of Med. Assistance Enhanced Mental Health & Substance Abuse Serv., Clinical Coverage Policies §§ 8A–8D-2, *available at* http://www.ncdhhs.gov/dma/mp/ (for mental/behavior health designated providers); *cf.* N.C. Div. of Med. Assistance Enhanced Mental Health & Substance Abuse Serv., Clinical Coverage Policy 8E [hereinafter Clinical Coverage Policy 8E], *available at* http://www.ncdhhs.gov/dma/mp/ (for intellectual and developmental disability designated providers).

11. For instance, children with dual-diagnoses or who are sexually reactive.

12. *See infra* note 76.

In practice, this leaves North Carolina's eighteen to twenty-one year olds and complex/hard-to-serve children who have severe mental illness with three options: First, they can try to seek in-state inpatient treatment in acute psychiatric hospitals, which may be inappropriately restrictive and therefore against the law.[13] Second, they can go without essential services until they are sick enough to *warrant* acute psychiatric hospitalization—where, once stabilized and discharged, they are back to square-one. Or, as often is the case, they are forced to obtain treatment out of state—often as far away as Florida or Texas—isolating them from their families,[14] excluding them from their communities, and frequently resulting in the state of North Carolina having little-to-no meaningful oversight over their care.[15]

As such, this Article argues three main points. First, under EPSDT, the state has an affirmative duty to ensure that meaningful, comprehensive, and appropriate in-state psychiatric and disability services exist for all qualifying youth under the age of twenty-one.[16] Second, relying on other states to provide North Carolina's youth with essential EPSDT services, which the state is capable of providing itself, violates Medicaid's comparability provisions and out-of-state placement requirements as well as the Americans with Disabilities Act (ADA).[17] Finally, the state has an obligation to ensure that the realities of its mental health system do not belie its policies; while North Carolina may boldly proclaim on paper that out-of-state placement is always a

13. *See* Olmstead v. L. C. by Zimring, 527 U.S. 581, 592, 599–600 (1999).

14. *Cf.* N.C. DEP'T OF HEALTH AND HUMAN SERVS., COMPLIANCE VERIFICATION PROTOCOL FOR CLIENT SPECIFIC, TIME LIMITED OUT-OF-STATE ENROLLMENT FOR RESIDENTIAL SERVICES 3 (Apr. 2002) [hereinafter N.C. COMPLIANCE VERIFICATION PROTOCOL], *available at* http://www.ncdhhs.gov/mhddsas/statspublications/Policy/policy-cf101outofst.pdf (Proclaiming that "support and continuity of family involvement is the first priority"); 10A N.C. ADMIN. CODE 27G §§ .1303(b)(61), .1706(b), .1805(b), .1903(e) (2012) (emphasizing the need for family involvement at all levels of inpatient placement; Susan Stefan, *Accommodating Families: Using the Americans with Disabilities Act to Keep Families Together,* ST. LOUIS U. J. HEALTH L. & POL'Y 135 (emphasizing the need to keep families intact in order to have better outcomes).

15. *See infra* Part I.D.2.

16. Clinical Coverage Policy No.: 8B, *supra* note 6, at 2 ("IMPORTANT NOTE:PSDT allows a recipient less than [twenty-one] years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are medically necessary health care services to correct or ameliorate a defect, physical or mental illness, or a [health related] condition." (emphasis in original omitted)). N.C. DEP'T OF HEALTH AND HUMAN SERVS., EPSDT POLICY INSTRUCTIONS UPDATE (Jan. 11, 2010) [hereinafter N.C. EPSDT POLICY INSTRUCTIONS], *available at* http://www.ncdhhs.gov/dma/epsdt/epsdtpolicyinstructions.pdf ("Under EPSDT, North Carolina Medicaid must make available a variety of individual and group providers qualified and willing to provide EPSDT services.").

17. *See generally* Americans with Disabilities Act of 1990, Pub.L. 101-336, 104 Stat. 327 (July 26, 1990), codified as amended at 42 U.S.C.A. §§12101–12213 (2009); *Olmstead*, 527 U.S. at 592, 599–600 (1999) (interpreting the ADA as requiring that psychiatric treatment be conducted in the least restrictive environment possible and have the aim of reintegrating patients back into their communities); *see also 42* U.S.C. § 1396a(a)(10)(B) (2006); *see also* 42 C.F.R. § 431.52(b) (2012).

measure of last resort, in reality it is the de facto treatment plan for many North Carolina youth.[18] The status-quo is not tenable. Not only does it put the state at risk of litigation,[19] it harms North Carolina's youth who have severe mental illness, it harms their families, and it harms the state as a whole.

This Article follows in three parts. Part I provides an overview of the state's mental health reform effort and the creation of privatized PRTFs for children's mental health services. Part II outlines and analyzes the legal issues and inconsistencies in North Carolina's mental health system for youth. Finally, Part III suggests several reforms that North Carolina should implement, including the adoption of an evidence-based approach to treatment, which has been proven to work in other states.

I. NORTH CAROLINA'S FAILED MENTAL HEALTH REFORM EFFORT

A. *The Origins of Mental Health Reform*

As recently as the 1970s, people with mental illness and developmental disabilities regularly were warehoused in large, state-run institutions that looked more like prisons than places to receive treatment. People were restrained forcibly for long periods of time, while others wallowed in their own filth.[20] These institutions were not just places for the violent and criminally insane; they were places where children and adults with conditions such as autism, Down syndrome, cerebral palsy, and epilepsy were segregated from society.[21]

Thanks to the work of advocacy groups and the intrepid investigative reporting of journalists like Geraldo Rivera, this injustice finally came to light.[22] In the decades that followed, people with disabilities and their advocates fought hard to obtain appropriate, deinstitutional-

18. *See* N.C. COMPLIANCE VERIFICATION PROTOCOL *supra* note 14, at 3 (Proclaiming that "all appropriate in-state [treatment] options [must be] exhausted prior to requesting out-of-state placement[ ]," for any of North Carolina's children with mental illness and that "[i]n-state placement for the support and continuity of family involvement is the first priority, with [out-of-state] placements as the last option").

19. *See Olmstead*, 527 U.S. at 591 n.5 (1999) (private right of action under ADA); *see also* Blessing v. Freestone, 520 U.S. 329, 340–41 (1997) (private right of action under Medicaid, generally); Doe v. Kidd, 501 F.3d 348, 355 (4th Cir. 2007) (same); *see also* Pashby v. Cansler, 279 F.R.D. 347, 354 (2011) (private right of action under Medicaid comparability provision, 42 U.S.C. § 1396a(a)(10)(B) (2006)); *see also* Antrican v. Buell, 158 F. Supp. 2d 663, 672 (E.D.N.C. 2001) aff'd sub nom. Antrican v. Odom, 290 F.3d 178 (4th Cir. 2002) (private right of action under Medicaid EPSDT provisions, 42 U.S.C. § 1396a(a)(43) (2006)).

20. *See* Geraldo Rivera – The P&A System, http://www.youtube.com/watch?v=CRA7sX_FYSCY.

21. *See id.*

22. *See id.* (highlighting Mr. Rivera's 1972 investigative report on the conditions at Willowbrook State School in New York).

ized treatment, as well as something that those without disabilities take for granted every day: dignity.

This work culminated in the 1999 landmark ruling, *Olmstead v. L. C. by Zimring*,[23] where the United States Supreme Court, in interpreting the ADA, enshrined the following principles in disability jurisprudence: First, the "community integration" mandate requires that a fundamental goal of mental illness and disability treatment—particularly inpatient treatment—must be to reintegrate the people receiving those treatments back into their communities.[24] Second, the "least restrictive treatment" mandate requires that mental health and disability treatment must be conducted in the least restrictive—medically necessary—setting possible.[25] And third, while the ADA may not require a particular "standard of care" for mental health or disability services rendered, states cannot discriminate "with regard to the services they in fact provide."[26]

In response to *Olmstead*, then-Governor Easley and the North Carolina General Assembly entered into, what facially appeared to be, a comprehensive mental health reform effort.[27] They created a Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS) as part of a complete "paradigm shift" in the provision of MH/DD/SA services.[28] Specifically, the state emphasized the need for a locally controlled, community-based service model and found that "[m]any of the individuals currently [receiving inpatient treatment], *in all levels of care, could be treated in community-based services if such services were available.*"[29] Moreover, the state "recognized that [many] individuals

23. 527 U.S. 581, 592 (1999).

24. *Id.*

25. *Id.* at 599–600.

26. *Id.* at 603 n.14.

27. *See generally* An Act to Establish the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and to Direct the Oversight Committee to Develop a Plan to Reform the State System for Mental Health, Developmental Disabilities, and Substance Abuse Services, §1, 2000 N.C. Sess. Laws 473, 473("The General Assembly finds that . . . recent federal court decisions, compel the State to consider significant changes in the operation and utilization of State psychiatric hospital services.").

28. *See id.*; Ralph Campbell Jr., State Auditor, Transmittal letter to The Honorable James B. Hunt, Jr., Governor to Members of the North Carolina General Assembly, Secretary H. David Bruton, NC DHHS, & Citizens of the State of North Carolina (Mar 31, 2000), *in* STUDY OF STATE PSYCHIATRIC HOSPITALS AND AREA MENTAL HEALTH PROGRAMS (Apr. 1, 2000) [hereinafter N.C. STUDY OF STATE PSYCHIATRIC HOSPITALS], *available at* http://www.ncauditor.net/EPSWeb/Reports/Performance/PER-0184.pdf.

29. N.C. STUDY OF STATE PSYCHIATRIC HOSPITALS, *supra* note 28; *see also* An Act to Establish the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and to Direct the Oversight Committee to Develop a Plan to Reform the State System for Mental Health, Developmental Disabilities, and Substance Abuse Services, 2000 N.C. Sess. Laws 473, 473 ("[T]he "Study of State Psychiatric Hospitals and Area Mental Health Programs . . . present[s] a comprehensive blueprint for reform of the State's

who [have] serious mental illnesses would be unable to 'live successfully in the community without [appropriate] services, support, and guidance.' "[30]

On a practical level, the Governor and the General Assembly promised to close "about half the beds in state mental hospitals," pool the leftover money into a mental health trust fund, and then use that fund to provide comprehensive and community-based mental health services to North Carolinians.[31] By 2001, half of those beds were closed.[32] North Carolina's laws no longer referred to people with disabilities as having "problems," but instead as "individuals with needs for . . . services . . . [that will] maximize their quality of life."[33] It seemed as though North Carolina was on its way to realizing meaningful mental health reform.

B. *North Carolina's Failed Mental Health Reform Effort for People Over the Age of Eighteen*

Unfortunately, what appeared to be the foundation of a laudable mental health reform effort turned out to be a plan that was "poorly designed and even more poorly implemented."[34] The institutional beds *were* being closed, but almost no community-based services were implemented to replace them.[35] Instead, the Governor and the Gen-

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mental health system . . . [and] the General Assembly endorses [its] findings . . . .") (emphasis added).

30. Complaint by Disability Rights NC to the United States Department of Justice on behalf of Individuals with Mental Illness living in Adult Care Homes in North Carolina (July 22, 2010) [hereinafter Adult Care Home Complaint] (quoting N.C. DEP'T. HEALTH & HUMAN SERVS., STATE PLAN 2001: A BLUEPRINT FOR CHANGE 2, 16 (Nov. 30, 2001)).

31. Michael Biesecker, *Feds Probing North Carolina's Mental Health System*, NEWS & OBSERVER, Nov. 25, 2010, *available at* http://www.newsobserver.com/2010/11/25/825089/feds-probing-mental-health.html ("North Carolina legislators approved an ambitious reform plan aimed at bringing the state's mental health system into compliance with Olmstead by downsizing state hospitals and launching new community treatment programs through private companies."); *see* An Act to Phase In Implementation of Mental Health Reform at the State and Local Level, §1.7(b), 2001 N.C. Sess. Laws 2237, 2237-40. ("[Before the closure of any state institution,] [t]he Secretary shall . . . [p]resent a plan . . . [that] shall address specifically how patients will be cared for after closure, how support services to community-based agencies and outreach services will be continued . . . .").

32. *See* Biesecker, *supra* note 31.

33. An Act to Phase in Implementation of Mental Health System Reform at the State and Local Level, §1.1, 2001 N.C. Sess. Laws 2232, 2233.

34. Chris Fitzsimon, *Mental health reform 2.0*, NORTH CAROLINA POLICY WATCH, Jun. 9, 2008 http://www.ncpolicywatch.com/cms/2008/06/09/mental-health-reform-20/ (last visited Nov. 28, 2013)(using data complied by the N.C. Justice Ctr.). .

35. Biesecker, *supra* note 31. ("[T]he Easley administration closed about half the beds in state mental hospitals, although the planned community treatment system was not in place. The governor and legislators then raided the trust fund set up to pay for mental health reform to close a hole in the state budget."). The few community-based services that did exist, were often wasteful and of questionable efficacy. For instance, community-based "providers" employed a workforce — ninety-eight percent of which had only a high school education — primarily to take

eral Assembly "raided" the state's suddenly-full mental health trust fund in order to fill gaps in the state budget. [36] As a result, many of the former residents of North Carolina's psychiatric hospitals found themselves on the streets with no meaningful services or supports.[37] And the pattern continued. In 2007 alone, nearly 1,200 mental health patients were discharged to homeless shelters.[38]

With nowhere else to go, many former residents found themselves warehoused again, this time in adult care homes, places designed for the frail or elderly, not for the treatment of severe mental illness.[39] Adult care home staff members were ill-equipped to handle this influx and the severity of residents' conditions; when residents experienced psychotic delusions, sometimes people died.[40] Squalor and filth returned to the institutional setting and pervaded many of the adult care homes.[41] This continued until 2010 when the United States Department of Justice learned of the situation, threatened to take action against the state, and forced North Carolina into lengthy settlement negotiations.[42] Those negotiations resulted in a settlement agreement, signed in August 2012, which cost North Carolina $287 million.[43]

However, since the settlement agreement, North Carolina has primarily focused its energy on closing adult care homes that contain "too many" people with mental illness, lest the state be forced to pay for the residents' treatment without the assistance of federal Medicaid

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clients shopping or to the movies, all the while charging North Carolina taxpayers $61 per hour. Pat Stith & David Raynor, *Mental-Health Changes Aimed to Improve Community Treatment, but Providers Took Clients Shopping, Swimming and to Movies for $61 an Hour*, NEWS & OBSERVER, Feb. 24, 2008 [hereinafter *Providers Took Clients Shopping*], *available at* http://www.inthepublicinterest.org/article/reform-wastes-millions-fails-mentally-ill. That is what constituted "community-based services" in North Carolina. In all, the state wasted $400 million on this venture. Pat Smith & David Raynor, *Reform Wastes Millions, Enriches Providers, Fails to Serve Mentally Ill*, NEWS & OBSERVER, Feb. 24, 2008, *available at* http://media2.newsobserver.com/static/content/pdf/disorder.pdf. On some years, less than 5% of those funds were spent on services that might actually keep people out of mental institutions. *Providers Took Clients Shopping*.

36. Biesecker, *supra* note 31.

37. *See* Fitzsimon, *supra* note 34.

38. *Id.*

39. *See* Licensing of Homes for the Aged and Infirm, 10A N.C. ADMIN. CODE 13F (2012); Licensing of Family Care Homes, 10A N.C. ADMIN. CODE 13G (2012); *see also* Adult Care Home Complaint, *supra* note 30; DISABILITY RIGHTS NC, TRAPPED IN A FRACTURED SYSTEM: PEOPLE WITH MENTAL ILLNESS IN ADULT CARE HOMES (Aug2010), *available at* http://www.disabilityrightsnc.org/sites/default/files/Trapped%20in%20a%20Fractured%20System.pdf.

40. *See* Adult Care Home Complaint, *supra* note 30, Summary of Findings, at 12–15.

41. *Id.*, Adult Care Home Facility Summaries, at 1–22.

42. Lynn Bonner, *State Reaches Agreement with Feds Over Treatment of Mentally Ill*, NEWS & OBSERVER, Aug. 23, 2012, *available at* http://www.newsobserver.com/2012/08/23/2287472/state-reaches-agreement-with-feds.html?story_link=email_msg#storylink=cpy.

43. *Id.*

dollars.[44] And similar to the psychiatric hospital downsize of 2001, the state has neglected to implement any meaningful community-based services to fill the service gap after these facilities are closed.[45] Just as in 2001, these former residents find themselves at risk of having nowhere to go.[46] Generally, with a continued lack of comprehensive community-based mental health services in place, anyone over eighteen faces a stark lack of intensive mental health services in North Carolina.

C. *"Best Practices" Is Not Synonymous with "Evidence-Based"*

Unfortunately, the failure does not end there. Throughout the 1990s, the medical/mental health community began to notice disconnects between treatment methodologies and outcomes.[47] In response, doctors began to focus on the inextricable link between data-driven treatment and successful outcomes. This shift in thinking resulted in the adoption of "evidence-based" practices.[48] Its most notable feature: data.[49] In order for a treatment to be deemed "evidence-based," a treatment's efficacy has to be supported by peer-reviewed, reproducible, empirical data. In the mental health arena, it is the "gold standard" for treatment.[50]

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44. *See* TARA LARSON, N.C. DIV. OF MED. ASSISTANCE, MEDICAL CARE ADVISORY COMMITTEE UPDATE ON PERSONAL CARE SERVICES & INSTITUTION OF MENTAL DISEASE 17–32 (Sept. 7, 2012), *available at* http://www.ncdhhs.gov/dma/mcac/20120907%20MCAC%20PCS%20and%20IMD.pdf; *Adult Care Home Plan for N.C. Under Way*, WINSTON-SALEM J (July 26, 2012, 2:40 PM), http://www.journalnow.com/news/local/article_cd7825d1-e504-5152-ab32-c666a5c08a61.html; Martha Quillin, *NC Screening Process for Mental Illness has Slowed Placements*, NEWS & OBSERVER (Nov. 3, 2013), *available at* http://www.newsobserver.com/2013/11/03/3339213/screening-process-for-mental-illness.html. When a facility has been identified as being an Institute for Mental Disease ("IMD"), all of the residents in that facility lose their Medicaid funding as long as they continue to reside in that facility. *See* NAT'L ALLIANCE ON MENTAL ILLNESS ("NAMI"), BACKGROUND INFORMATION ON IMD EXCLUSION, http://www.nami.org/Template.cfm?Section=March9&Template=/ContentManagement/ContentDisplay.cfm&ContentID=44050.

45. *See supra* notes 27–38; Mandy Locke, *Mentally Ill in N.C. Could Face Loss of Homes*, NEWS & OBSERVER, Aug. 14, 2012, *available at* http://www.newsobserver.com/2011/08/14/141189z3/mentally-ill-could-face-loss-of.html#storylink=cpy.

46. *See id.*

47. *See, e.g.*, Paul Kettlewell, Service and Science: A powerful Combination (June 21, 2002), *available at* http://www.apadivisions.org/division-31/publications/articles/pennsylvania/kettlewell.pdf.

48. JEREMY H. HOWICK, THE PHILOSOPHY OF EVIDENCE-BASED MEDICINE 15 (2011); *see also* Kathleen S. Oman, Christine Duran, & Regina Fink, *Evidence-Based Policy and Procedures: An Algorithm for Success* 38 J. NURSING ADMIN. 47, 48–49 (2008) (discussing quality of evidence).

49. U.S. DEP'T. HEALTH AND HUMAN SERVS., SCIENCE TO SERVICE: IMPLEMENTING EVIDENCE-BASED MENTAL HEALTH SERVICES 5–6 (2005) [hereinafter U.S. SCIENCE TO SERVICE REPORT], *available at* http://www.namhpac.org/PDFs/01/sciencetoservice.pdf.

50. PAMELA S. HYDE, SECRETARY, ET AL., N.M. HUMAN SERVS. DEP'T., TURNING KNOWLEDGE INTO PRACTICE: A MANUAL FOR BEHAVIORAL HEALTH ADMINISTRATORS AND PRACTITIONERS ABOUT UNDERSTANDING AND IMPLEMENTING EVIDENCE-BASED PRACTICES 49 (Fall

By 2005, the United States Substance Abuse and Mental Health Services Administration (SAMHSA) had developed free toolkits for states, which provide comprehensive, step-by-step guidance on setting up and implementing evidence-based practices.[51] Furthermore, research has shown that these toolkits are immensely helpful in actually implementing an evidence-based system of care.[52] Most providers are able to achieve a high rate of compliance with evidence-based program parameters within twelve months of their adoption.[53]

The timing of this general movement towards evidence-based practices and the beginnings of North Carolina's mental health reform effort might have seemed serendipitous, had the state actually adopted an evidence-based model for its mental health service system. Of course, at the time, the state proclaimed that it would.[54] It even created a widely circulated science to service blueprint for implementing comprehensive evidence-based practices throughout North Carolina.[55] Unfortunately, that blueprint was quietly scrapped.[56] Instead,

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2003), *available at* http://www.acmha.org/content/reports/EBPManual.pdf (internal quotations omitted).

51. *See* U.S. SCIENCE TO SERVICE REPORT, *supra* note 49, at 26–27; *see, e.g.*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., GETTING STARTED WITH EVIDENCE-BASED PRACTICES: ASSERTIVE COMMUNITY TREATMENT, *available at* http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345. And North Carolina was aware of these toolkits at the time they were being developed. *See The Implementation Toolkits*, N.C. SCI. TO SERV. PROJECT, https://web.archive.org/web/20050326043649/http://www.ncs2s.org/td_background_toolkit.shtml (accessed by searching http://www.ncs2s.org/td_background_toolkit.shtml in the Internet Archive index).

52. Gregory J. McHugo, et al., *Fidelity Outcomes in the National Implementing Evidence-Based Practices Project*, 58 Psychiatric Servs. 1279, 1282, Figure 1 (2007).

53. *Id.*

54. *See infra* note 55.

55. N.C. SCIENCE TO SERVICE CONSORTIUM, BRIDGING SCIENCE AND SERVICE: A PLAN TO IMPLEMENT EVIDENCE-BASED PRACTICES FOR ADULTS WITH MENTAL ILLNESS IN NORTH CAROLINA'S PUBLIC MENTAL HEALTH SYSTEM (2004) [hereinafter N.C. SCIENCE TO SERVICE BLUEPRINT], *available at* https://web.archive.org/web/20050908030913/http://www.ncs2s.org/ (accessed by searching http://www.ncs2s.org in the Internet Archive index); *see also* Letter from Beth Melcher, Project Director, N.C. Science to Service Consortium, to Michael Moseley Director, Div. MH/DD/SAS (Aug. 2, 2004), *available at* https://web.archive.org/web/20050908030913/http://www.ncs2s.org/ (accessed by searching http://www.ncs2s.org in the Internet Archive index) (presenting the N.C. SCIENCE TO SERVICE BLUEPRINT to the director of N.C. MH/DD/SAS); JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES, REPORT TO THE GENERAL ASSEMBLY OF NORTH CAROLINA at 6 (2005) [hereinafter N.C. OVERSIGHT COMMITTEE REPORT], *available at* http://ncleg.net/Library/studies/2005/nr25.pdf (informing the General Assembly of Dr. Melcher's presentation of the N.C. SCIENCE TO SERVICE BLUEPRINT to the joint legislative oversight committee).

56. The N.C. OVERSIGHT COMMITTEE REPORT, *supra* note 55, at 6, indicates that the N.C. SCIENCE TO SERVICE BLUEPRINT "is available in its entirety" on the North Carolina Science to Service Consortium website, www.ncs2s.org. However, this website no longer exists. After an extensive internet search, the author was unable to find a publicly available copy of this report on any active websites. In fact, since January 2005, the Oversight Committee has not mentioned the N.C. SCIENCE TO SERVICE BLUEPRINT in its minutes even once.

since 2001, the state has incorporated into its service definitions only *one* evidence-based intensive mental health treatment.[57] Most notably, for the purposes of this paper, that treatment can be utilized only by people over the age of twenty-one.[58]

In lieu of adopting evidence-based models of treatment, the state adopted an alternative term to describe its services: "best practices."[59] Although, "[t]he terms 'best practice' and 'evidence-based practice' are often used interchangeably," they are not the same thing.[60] "Best practices" is loosely defined and, in some respects, has some praiseworthy ideas behind it.[61] However, what is *missing* under the "best practices" model—in stark contrast to an evidence-based one—is the requirement that treatments be proven to work.[62] In North Carolina, a "treatment" can be full of good intentions, but otherwise completely ineffectual, and still be considered a "best practice." Because of the lack of data, almost every sanctioned mental health service in North Carolina could fall into this category.

57. N.C. Div. of Med. Assistance Enhanced Mental Health & Substance Abuse Serv., Clinical Coverage Policy No.: 8A at 68 [hereinafter Clinical Coverage Policy No.: 8A], *available at* http://www.ncdhhs.gov/dma/mp/8A.pdf (describing Assertive Community Treatment Teams). The state has also adopted something called "multisystemic therapy," although it is geared towards juvenile delinquents. *See id.* at 48. Therapeutic foster care is also evidence-based, but takes place in "family setting homes" and is minimally restrictive. *See* U.S. SCIENCE TO SERVICE *supra* note 49, at 40; N.C. Div. of Med. Assistance Enhanced Mental Health & Substance Abuse Serv., Clinical Coverage Policy No.: 8D-2 at 6 [hereinafter Clinical Coverage Policy No.: 8D-2], *available at* http://www.ncdhhs.gov/dma/mp/8D2.pdf ("Level II therapeutic foster care providers are licensed under Division of Social Service (131-D) as family setting homes."); *cf. infra* notes 63–66 and corresponding text (outlining levels of treatment restrictiveness).

58. Clinical Coverage Policy No.: 8A, *supra* note 57, at 6 (indicating that Assertive Community Treatment Teams can only be utilized by people "[a]ge 21+").

59. *See, e.g.*, N.C. GEN. STAT. §122C-102 (2011) ("The State Plan shall include . . . promotion of best practices . . . .") ("evidence-based" practices are mentioned nowhere in N.C. GEN. STAT. §122C); Press Release, NC DHHS, DHHS Secretary Gets Support in Revamping Future of Mental Health Care (Jan. 7, 2011) ("'We will concentrate our efforts and our resources on providing tested and proven "best practices" of mental health, developmental disability and substance abuse treatment' ") (quoting Lanier M. Cansler, NC DHHS Secretary), *available at* http://www.ncdhhs.gov/pressrel/2011/2011-01-07-cabha.htm.

60. *Definitions*, N.C. EVIDENCE BASED PRACTICES CTR., http://www.ncebpcenter.org/index.php?option=com_content&view=article&id=48&Itemid=49 (last visited Nov. 28, 2013).

61. *See infra* notes 160–73.

62. *Emerging Practices*, U. KAN. SCH. SOC. WELFARE, https://web.archive.org/web/20120412095145/http://www.socwel.ku.edu/mentalhealth/projects/Emerging/index.shtml ("[A] true evidence-based practice . . . [is supported by at least] five published scientifically rigorous studies using consistent dependent variables.") (accessed by searching http://www.socwel.ku.edu/mentalhealth/projects/Emerging/index.shtml in the Internet Archive index); *Evidence-Based Practices*, VT. DEP'T MENTAL HEALTH, http://mentalhealth.vermont.gov/ebp ("'Evidence-based' stands in contrast to approaches that are based on tradition, convention, belief, or anecdotal evidence.").

D. *North Carolina's Failed Mental Health Reform Effort for Children*

1. The Rise of PRTFs

During the initial reform effort, North Carolina emphasized the need to provide local area programs with "flexibility" to provide as many community-based services as possible to children with mental illness.[63] The state also created a graduated service structure for children's inpatient treatment consisting of five levels, each more restrictive than the last:

> Level I is a low to moderate structured and supervised environment level of care provided in a family setting . . . Level II is a moderate to high structured supervised environment level of care provided in a group home . . . or a family setting [such as therapeutic foster care[64]] . . . Level III is a highly structured and supervised environment level of care in a program setting only . . . Level IV is a level of care provided in a physically secure, locked environment in a program setting.[65]

Finally, psychiatric hospitalization is "designed to provide treatment for individuals who have acute psychiatric problems . . . and is the most intensive and restrictive type of facility for individuals."[66]

Of the five different levels of treatment, only Level I is specifically identified as "targeted" to treat "children under age [twenty-one]."[67]

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63. *See* N.C. STUDY OF STATE PSYCHIATRIC HOSPITALS, *supra* note 28, Section II. Mental Health and Substance Abuse Structure, Services and Finances at 95 ("[F]lexibility in funding [would allow local area programs] the latitude to develop services for children and adolescents that were preventative, school or home based, and tailored to individual needs . . . These are exactly the types of services that are needed, especially if the state wants to reduce its reliance on state hospitals and other high cost residential facilities."); *see also* An Act to Establish the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and to Direct the Oversight Committee to Develop a Plan to Reform the State System for Mental Health, Developmental Disabilities, and Substance Abuse Services, 2000 N.C. Sess. Laws 473, 473 ("[T]he "Study of State Psychiatric Hospitals and Area Mental Health Programs" . . . present[s] a comprehensive blueprint for reform of the State's mental health system . . . [and] the General Assembly endorses [its] findings . . . .").

64. Clinical Coverage Policy No.: 8D-2, *supra* note 57, at 6 ("Level II therapeutic foster care providers are licensed under Division of Social Service (131-D) as family setting homes.").

65. NC DHHS, STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT MEDICAL ASSISTANCE PROGRAM, ATTACHMENT 3.1-A.1, 15A.19-20 (May 1980), *available at* http://www.ncdhhs.gov/dma/plan/sp.pdf.

66. 10A N.C. ADMIN. CODE 27G.6001. For purposes of this paper, someone who requires this highest and most restrictive level of care will be referred to as needing "acute" treatment. Someone who still requires intensive mental health services, but not yet at a psychiatric hospital level of care, will be referred to as requiring "non-acute" treatment.

67. Clinical Coverage Policy No.: 8D-2, *supra* note 57, at 14 ("[Level I treatment] is a service targeted to children under age [twenty-one], which offers a low to moderate structured and supervised environment in a family setting . . . ."). However, the PRTF service definition does acknowledge they are supposed to be serving youth through age twenty-one. *See* Clinical Coverage Policy No.: 8D-1, *supra* note 3, at 1 ("PRTF services are available to Medicaid recipients under [twenty-one] years of age.").

Coincidentally, Level I treatment also is the only treatment level not specifically covered in 10A N.C. ADMIN. CODE 27G, which contains regulations for each of the other five treatment levels.[68] Otherwise, the North Carolina Administrative Code expressly limits Level II–IV facilities to serving children and adolescents only until the age of eighteen.[69]

In 2005, the state introduced a sixth level of care, which is more restrictive than Level IV facilities but less restrictive than psychiatric hospitals: PRTFs.[70] Here too, although the federal government designed PRTF treatment was to serve youth through age twenty-one, North Carolina regulations limit in-state PRTFs to serving children only until they turn eighteen.[71] In light of the earlier distinction between "evidence-based" practices and "best practices," it is pertinent to note that PRTF treatment does not meet even the marginal criteria to be considered a "best practice."[72]

Subsequently, the state has begun phasing out Level III and IV facilities.[73] This essentially bifurcated inpatient-level mental health ser-

68. *See* 10A N.C. ADMIN. CODE 27G (2012).

69. *See* 10A N.C. ADMIN. CODE 27G §§ .1301(a), .1303(a), .1303(d) (2012) (requiring that Level II facilities only serve "children and adolescents" as defined in 10A N.C. ADMIN. CODE 27G.0103 (2012), thus until they turn 18, although "[i]f an adolescent has his 18th birthday while receiving treatment in a residential facility, he *may* continue in the facility for six months or until the end of the state fiscal year, whichever is longer") (emphasis added); *see also* 10A N.C. ADMIN. CODE 27G §§ .1301(b), .1701(a), .1706(e) (2012) (regarding Level III and Level IV facilities, with the same age restrictions).

70. *See* Psychiatric Residential Treatment for Children and Adolescents, 10A N.C. ADMIN. CODE §§ 27G.1901–.1903 (Nov. 1, 2005); *Psychiatric Residential Treatment Facility Services (PRTF)*; Psychiatric Residential Treatment Services, Eliada Homes, http://www.eliada.org/programs/treatment/prtf ("Eliada Homes, Inc. opened the first Psychiatric Residential Treatment Facility program, in western North Carolina in 2006, beginning with one 9 bed cottage for adolescent females."). The N.C. ADMIN. CODE describes Level IV treatment as being geared towards children and adolescents who require "treatment in a staff secure setting" where, inter alia, "staff are required to be awake during client sleep hours," 10A N.C. ADMIN. CODE 27G.1701, while PRTF treatment is geared towards "children or adolescents who do not meet criteria for [a psychiatric hospital level of] care, but do require supervision and specialized interventions on a 24-hour basis," 10A N.C. ADMIN. CODE 27G.1901. *See generally* Clinical Coverage Policy No.: 8D-1, *supra* note 3. However, the first PRFT was not actually created until 2006.

71. 10A N.C. ADMIN. CODE 27G.1901(b) (2012) (regarding PRTF's only serving "children and adolescents" as defined in 10A N.C. ADMIN. CODE 27G.0103 (2012), thus until they turn 18, but notably there is no option for extending treatment "for six months [after a resident's eighteenth birthday] or until the end of the state fiscal year" like there is in Level II-IV facilities); *cf.* Clinical Coverage Policy No.: 8D-1, *supra* note 3, at 1 ("PRTF services are available to Medicaid recipients under [twenty-one] years of age.").

72. *See infra* note 209 (discussing a recent study by the United States Department of Health and Human Services, which demonstrated that replacing community-based services for institutionalization in PRTFs resulted in better outcomes for youth and only cost a third as much).

73. *See* NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE, LME ROLE IN THE CLOSURE OF LEVEL III AND LEVEL IV GROUP HOME FACILITIES STATEWIDE, *available at* http://www.ncdhhs.gov/dma/provider/budgetinitiative/LMERoleGroupHomeClosure.pdf ("[NC DHHS] shall report on its plan for transitioning children out of Level III and Level IV group homes.").

vices for children in North Carolina. And although the stated purpose of this effort is to encourage the utilization of "community based services," intensive, evidence-based community-based services do not exist for North Carolina's children.[74] Furthermore, there is no mention of phasing out PRTFs as part of this effort. The de facto result is that children who require more than minimally restrictive settings increasingly will be institutionalized in extremely restrictive PRTF facilities.[75] And because PRTFs are essentially allowed to cherry-pick which children they serve, as children with less-intensive needs fill up the PRTFs, complex/hard-to-serve children can find themselves without any in-state treatment options.[76]

As for the children who *do* find PRTF placements, as soon as they turn eighteen, they too are either dropped from the system or forced out-of-state in order to continue with the exact same level of treatment they were already receiving. Of course, before a youth is allowed to seek out-of-state placement, that youth has to apply to, and be rejected from, every PRTF in the state—even from facilities where he or

74. *See id.*

75. In fact, while rates of child institutionalization are generally decreasing on a national level, these rates for North Carolina's children are skyrocketing. *See* KIDS CAUGHT IN A DOUBLE BIND *supra* note 10, at 2

76. Compounding the issue is the fact that North Carolina draws a fairly bright-line distinction between mental health providers and intellectual disability providers. *See id.* at 3 ("The State separates services between Mental Health (MH) and Developmental Disabilities (DD), and the process for getting services for an individual with complex needs is confusing and difficult. Sometimes the services do not exist at all [in-state]."); Telephone interview with Becky Fields, former clinical director, F.A.C.T. Specialized Services (Level III Facility) (Jan. 23, 2013); *see also* North Carolina Clinical Coverage Policies §§ 8A–8D-2, *available at* http://www.ncdhhs.gov/dma/mp/ (for mental/behavior health designated providers); *cf.* Clinical Coverage Policy 8E, *supra* note 9 (for intellectual disability designated providers). Any given provider can be one or the other, but not both. *See* North Carolina Clinical Coverage Policies §§ 8A–8D-2, *available at* http://www.ncdhhs.gov/dma/mp/ (for mental/behavior health designated providers); *cf.* Clinical Coverage Policy 8E, *supra* note 9 (for intellectual disability designated providers). *But cf.* MURDOCK CENTER, http://www.murdochcenter.org (a state-run Intermediate Care Facility for individual with Mental Retardation ("ICF/MR") that provides some dual-diagnosis services. However, this service can be time limited. *See* Telephone Interview with Mother of a Dually-Diagnosed Child in the Eighteen to Twenty-one Age Range (Jan. 25, 2013) (noting that her child quickly regressed once he had to stop receiving services at the Murdock Center after only a year). This disconnect creates a significant barrier to providers attempting to treat complex/hard-to-serve children. *See* Telephone Interview with Becky Fields. Even Michael Watson, former Deputy Secretary of NC DHHS acknowledged that state regulations "discourage facilities from accepting high-risk patients." Lynn Bonner, *Report Rips N.C. Over Mentally Ill Kids*, NEWS & OBSERVER, Jan, 12, 2012, *available at* http://www.newsobserver.com/2012/01/12/1771229/report-rips-nc-over-mentally-ill.html. Generally, "mental health" providers cannot bill for developmental disability services, and "intellectual disability" providers cannot bill for mental health services. *See* Telephone Interview with Becky Fields. The expense of hiring additional staff to bridge the gap must come out of the providers' own profits. *Id.* That is why it generally does not happen and why "North Carolina has only one in-state specialty provider to treat [children] with . . . dual diagnoses." *Id.*; KIDS CAUGHT IN A DOUBLE BIND, *supra* note 9, at 3. As such, placement in a PRTF is often as close to "appropriate" services as many complex/hard-to-serve children can get in-state.

she does not satisfy the age or gender requirements.[77] Furthermore, this process can take weeks or even months.[78] For a family whose child is in crisis, this can be devastating.[79]

2. North Carolina Lacks Comprehensive Oversight Over Its Children's Care Once They are Placed Out-of-State

Under North Carolina's current treatment system, once children with severe mental illness turn eighteen, or become "too complicated" to treat, their in-state treatment options essentially vanish. Their families' only remaining recourse is to seek treatment in another state or

77. Telephone Interview with Becky Fields, *supra* note 76; *see e.g.*, MeckLINK Behavioral Healthcare, Provider Hot Sheet, *available at* http://charmeck.org/mecklenburg/county/AreaMentalHealth/ForProviders/Hot%20Sheets/12312012HotSheet.pdf ("If you are pursuing admission to an out-of state PRTF facility, written denial letters from *all* in-state PRTF facilities must be obtained prior to [submitting your request] . . . ." (emphasis added)).

78. *See* GERALD AKLAND & ANN AKLAND, WAKE COUNTY, NATIONAL ALLIANCE ON MENTAL ILLNESS, STATE PSYCHIATRIC HOSPITAL ADMISSION DELAYS IN NORTH CAROLINA, JANUARY-JUNE 2010 2 (Aug. 6, 2010); Telephone Interview with Becky Fields, *supra* note 76.

79. The state's heavy reliance on privatized PRTFs also has created some major problems during treatment. Of the approximately forty licensed PRTFs in North Carolina, only one is run by the state. See *supra* note 3; NC State Operated Facilities, NC DHHS, http://www.ncdhhs.gov/dsohf/facilitycontacts.htm. Although the state runs one other similar program called Wright School. Notably, the Department of Public Instruction ("DPI") provides the residents of this state-run PRTF with a public school education, where course credit is transferrable upon discharge. *Whitaker PRTF*, NC DHHS, http://www.ncdhhs.gov/dsohf/services/whitaker.htm, ("[C]hildren [at Whitaker School] are entitled to a free and appropriate public education under North Carolina law.").

In the privatized PRTFs, this is not necessarily the case. *See* Complaint by Disability Rights NC on Behalf of Children with Mental Illness/Developmental Disabilities Placed in Private Psychiatric Residential Treatment Facilities (May 11, 2012) [hereinafter PRTF Complaint]; *cf.* 10A N.C. ADMIN. CODE 27G .1903(f) (2012) ("Children or adolescents residing in a PRTF shall receive educational services through a facility-based school."). According to a recent complaint by Disability Rights NC, children in many privatized PRFTs receive virtually no education. *See* PRTF Complaint, at 7–9. Where they do, the education is often minimal and not age-appropriate, and any "credits" that they earn do not transfer. Id. This is because the facilities, DPI, and the North Carolina Department of Health and Human Services ("NC DHHS") are in an ongoing stalemate over who is responsible for educating children in privatized PRTFs, in spite of an explicit statutory directive to resolve the issue. Id. at 5–7, 9–11; see An Act to Require the State Board of Education and Department of Health and Human Services to Determine Responsibility for Children with Disabilities Places in Private Psychiatric Residential Treatment Facilities by Public Agencies Other Than Local Educational Agencies, 2008 N.C. Sess. Laws 698, 698–99 ("The State Board of Education and Department of Health and Human Services shall jointly meet and make a determination as to which public agency is responsible for providing special education and related services . . . for children with disabilities who are placed in private psychiatric residential treatment facilities . . . ."). In the meantime, children receiving PRTF services are being set up for failure after discharge. Fortunately, the North Carolina General Assembly may take a more active role in resolving this matter. *See* A Bill to be Entitled An Act To Provide for the Education of Children in Private Psychiatric Residential Treatment Facilities, H.B. 831, 2013 Sess. (N.C. 2013), available at http://www.ncleg.net/Sessions/2013/Bills/House/PDF/H831v3.pdf. The bill passed a second reading almost unanimously in July of this year. See *House Bill 831, Ed. Services for Children in PRTFs*, N.C. GEN. ASSEMBLY, http://www.ncleg.net/gascripts/BillLookUp/BillLookUp.pl?BillID=H831&Session=2013.

to go without essential services.[80] When seeking the former, North Carolina places the burden for finding and acquiring out-of-state PRTF placements on county-level Managed Care Organizations (LME-MCOs)[81] and families.[82] Once youth are placed out-of-state, the state relies on LME-MCOs to continue overseeing their care.[83] Unfortunately, this only "sometimes" happens,[84] which is not entirely surprising given that the state does not have an enforcement mechanism to ensure LME-MCOs' compliance with this duty.[85] As a result, North Carolina's children are falling through the cracks once they get shipped out of state for treatment.[86]

E. *Even Amid Failure, Meaningful Mental Health Reform is Still Within Reach*

As it stands today, North Carolina's mental health reform effort is generally viewed as a failure—even the recently retired secretary of NC DHHS has declared that the "[r]eform [effort] is over."[87] What

80. *See supra* notes 13–15 and corresponding text.

81. Previously known as Local Management Entities ("LME"s), which are in the process of transitioning into Managed Care Organizations ("MCO"s) as part of the state's ongoing reform effort. *See generally* Anna North & Jay Taylor, presentation to NC Providers Council Conference, LME/MCO Challenges with Managed Care: Addressing the Challenge Together (Nov. 5, 2011), *available at* http://www.ncproviderscouncil.org/Portals/ncproviderscouncil.org/NC%20Tides-LME-MCO%20Challenges%20with%20Managed%20Care-Jay%20Taylor.pdf. Sometimes, they collectively are referred to as "LME-MCO"s.

82. COMPLIANCE VERIFICATION PROTOCOL *supra* note 14 at 5.

83. *See id.* at 4 ("On-going [utilization review] is also conducted by the AP / LME with active case management involvement."); Interstate Compact on Mental Health, N.C. GEN. STAT. §122C-361 (2011) (defining interstate compact responsibilities only in terms of contracting "party states"); *cf.* Interstate Compact on the Placement of Children, N.C. GEN. STAT. §§ 7B-3800–06 (2011) (codifying North Carolina's interstate compact on out-of-state *adoptions*, which includes "a party state officer or employee thereof; a subdivision of a party state, or officer or employee thereof; a court of a party state; a person, corporation, association, charitable agency or other entity which sends, brings, or causes to be sent or brought any child to another party state" among those who might be responsible for a child's welfare during and after placement).

84. Telephone interview with high-ranking MH/DD/SAS official (Jan. 18, 2013) [hereinafter MH/DD/SAS Interview] (acknowledging that continued oversight by LME-MCOs only "sometimes" occurs); Telephone interview with Iris Green, Senior Attorney, Kid's Team, Disability Rights NC (Jan. 24, 2013); *see, e.g.*, KIDS CAUGHT IN A DOUBLE BIND *supra* note 10, at 3 (noting an instance where a child was transferred to a PRTF in Virginia, at which point "the North Carolina LME stopped participating in [the child's] continued treatment and discharge planning").

85. MD/DD/SAS Interview, *supra* note 84.

86. Telephone interview with Iris Green, *supra* note 84.

87. Michael Biesecker, *Mental Health Rules Remade*, NEWS & OBSERVER, Jan. 8, 2011, *available at* http://www.newsobserver.com/2011/01/08/906666/mental-health-rules-remade.html (quoting Lanier Cansler, Secretary of Health and Human Services); *see* Bonner, *supra* note 76 (outlining "horror stories" from families trying to obtain mental health services for their children"); Tom Campbell, *Let's Take the Time to Get Mental Health Reform Right*, HERALD SUN (Nov. 15, 2013, 10:10 AM), http://www.heraldsun.com/opinion/opinioncolumnists/x2082481972/Let-s-take-the-time-to-get-mental-health-reform-right (noting that "North Carolina's 2001 mental health 'reforms' have been a disaster"); *see generally* NAMI WAKE COUNTY, INDICA-

started off as a move towards a cost-effective, community-based model of care, instead resulted in a doubling down on restrictive inpatient treatment and the state abdicating its responsibilities to many of its youth.

Fundamental, meaningful reform is needed now, more than ever. If North Carolina were to implement comprehensive, evidence-based, community-based services—similar to the services that it promised over a decade ago—many of these problems would solve themselves. Other states have done it, expediently and with resounding success.[88] To that end, the potential of North Carolina's mental health reform effort is still within reach.

II. Analysis of Legal Issues of Not Providing Appropriate In-State Services

The primary thesis of this Article is that North Carolina's mental health system for youth violates numerous federal laws and the state's own policies. One must first know how something is broken before one can fix it. The proceeding section examines the laws and policies being violated by North Carolina's mental health system for youth.

A. *North Carolina's Violation of Medicaid Provisions*

The purpose of Medicaid is to help people who are poor and/or disabled receive appropriate medical care.[89] Medicaid aims to provide "safe, effective, efficient, patient-centered, high quality and equitable care to all enrollees."[90] In contrast to *Olmstead*'s interpretation of the ADA, "the Medicaid Act clearly mandates that states provide a certain level and quality of . . . care."[91] In this context, North Carolina has violated (1) Medicaid's EPSDT provisions with regard to both complex/hard-to-serve children and eighteen to twenty-one year olds; (2) Medicaid's comparability provision with regard to eighteen to twenty-one year olds; and (3) Medicaid's out-of-state placement requirements generally.

TORS OF THE IMPACT OF NORTH CAROLINA'S "MENTAL HEALTH REFORM" ON PEOPLE WITH SEVERE MENTAL ILLNESS (OCT. 7, 2008), *available at* http://www.nami-wake.org/files/NAMI_Wake_Indicators_Report.pdf.

88. *See infra* Part III.

89. *See* 42 U.S.C. § 1396 (2006); Harris v. McRae, 448 U.S. 297, 301 (1980) ("The Medicaid program was created . . . for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons.").

90. *Quality of Care*, MEDICAID.GOV, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care.html (last visited Nov. 28, 2013).

91. Antrican v. Odom, 290 F.3d 178, 191 (4th Cir. 2002), *cert. denied* Odom v. Antrican 537 U.S. 973 (2002) (discussing a case regarding a lack of Medicaid funded dental services.); *cf. Olmstead*, 527 U.S. at 603 n.14.

1. Medicaid's EPSDT Provisions

Although Medicaid has many restrictions on the kinds of services available to adults over the age of twenty-one, the bar is much lower for Medicaid recipients who are under twenty-one years old. [92] Under EPSDT, federal law requires that states cover any and all "services, products, or procedures for Medicaid beneficiaries under [twenty-one years] of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a [health] condition."[93] Furthermore, while mental health treatment under Medicaid is optional for states generally, EPSDT is an entitlement.[94]

North Carolina recognizes that "EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems."[95] And although North Carolina laudably aims to provide these medically necessary treatments in the most "economic mode" possible,[96] the state also recognizes that the treatment made available by the state must be "similarly efficacious to the [treatment] requested by the [youth]'s physician, . . . [and that it] does not limit the [youth]'s right to a free choice of providers."[97]

EPSDT creates an affirmative duty for states to provide their youth with a "full panoply" of EPSDT services. [98] North Carolina also de-

92. N.C. EPSDT POLICY INSTRUCTIONS, *supra* note 16, at 2 ("EPSDT makes short-term and long-term services available to recipients under [twenty-one] years of age without many of the restrictions Medicaid imposes for services under a waiver OR for adults (recipients [twenty-one] years of age and over." (emphasis omitted)); *Id.* ("Medicaid cannot impose any waiting list and must provide coverage for corrective treatment for recipients under [twenty-one] years of age."); *Id.* ("A child under [twenty-one] years of age financially eligible for Medicaid is entitled to receive EPSDT services without any monetary cap provided the service meets all EPSDT criteria . . . .").

93. Clinical Coverage Policy No.: 8D-2, *supra* note 57, at 1 (emphasis omitted); *see* 42 U.S.C. § 1396a(a)(43) (2006).

94. NAMI, STATE MENTAL HEALTH CUTS: A NATIONAL CRISIS 9 (2011), *available at* http://www.nami.org/Content/NavigationMenu/State_Advocacy/State_Budget_Cuts_Report/NAMIStateBudgetCrisis2011.pdf ("All Medicaid mental health services for children and adults fall into the optional category, with the exception of Early Periodic Screening Diagnosis and Treatment (EPSDT) for children.").

95. Clinical Coverage Policy No.: 8D-2, *supra* note 57, at 1; *see* N.C. EPSDT POLICY INSTRUCTIONS, *supra* note 16, at 2 ("Medicaid . . . must provide coverage for corrective treatment for recipients under [twenty-one] years of age.").

96. *Cf.* N.C. EPSDT POLICY INSTRUCTIONS, *supra* note 16, at 2 ("A *child* under [twenty-one] years of age financially eligible for Medicaid is entitled to receive EPSDT services without any monetary cap provided the service meets all EPSDT criteria . . . .").

97. Clinical Coverage Policy No.: 8D-2, *supra* note 56, at 1 ("Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician . . . and the determination does not limit the beneficiary's right to a free choice of providers.")

98. N.C. EPSDT POLICY INSTRUCTIONS, *supra* note 16, at 4.

clares that EPSDT "[p]rocedures, products, and services . . . are covered when they are medically necessary and . . . *no equally effective and more conservative or less costly treatment is available statewide*," provided that they are not simply "intended for the convenience of the recipient, the recipient's caretaker, or the provider."[99] In other words, EPSDT specifically is geared for the provision of novel, medically necessary services.[100]

Granted, on its face, Medicaid only requires states to either "provid[e]" or "arrang[e] for" EPSDT services, not necessarily create them.[101] However, the driving factor behind the *kind* of EPSDT services that the state is obligated to "provid[e]" or "arrang[e] for" is this: medical necessity. Were a treating physician to determine that it was medically necessary to treat a youth's mental health needs in-state—for the continuity of family and community involvement—then North Carolina should be obligated to "provid[e]" and "arrang[e] for" those services. To that end, North Carolina's EPSDT guidelines require that the state "*make available* a variety of individual and group providers qualified and willing to provide EPSDT services" in-state.[102]

There is little case law regarding an affirmative duty on states to actually create services under Medicaid, generally. Some courts that have addressed the issue, particularly with regard to adults over twenty-one, have largely responded in the negative.[103] However, these

99. Clinical Coverage Policy No.: 8D-1, *supra* note 3, at 2.

100. *See* NAMI CENTER FOR PUBLIC REPRESENTATION, STATE EFFORTS TO LIMIT EPSDT SERVICES PURSUANT TO MEDICAID'S REASONABLE STANDARDS PROVISION (Apr. 2005), *available at* http://www.nami.org/Content/ContentGroups/Policy/Issues_Spotlights/Medicaid/factsheet_state_limits_on_EPSDT.pdf ("While States possess the discretion not to provide any of the twenty optional services for adults, they cannot decline to offer mandatory services. However, since this distinction is irrelevant for children pursuant to the EPSDT mandate of the Act, States cannot invoke their discretionary authority under [Medicaid's reasonable standard's provision, 42 U.S.C. §1396a(a)(17),] to refuse to provide a particular form of non-experimental treatment for children,"). Unfortunately, this is exactly what North Carolina is doing. *See e.g.* N.C. EPSDT POLICY INSTRUCTIONS, *supra* note 16, at 2 ("A child under [twenty-one] years of age financially eligible for Medicaid is entitled to receive EPSDT services without any monetary cap provided the service meets all EPSDT criteria . . . ."); *cf. id.* at 4 (North Carolina provided EPSDT services must not be "experimental/investigational"); *cf. also infra* Part III (regarding the superior efficacy of implementing an evidence-based service system, which requires testing new services against old ones so that outmoded services will not be used in perpetuity) By prohibiting the provision of "experimental/investigational" services, the state essentially is banning new, cost effective, and more effective services from being created.

101. *See* 42 U.S.C. 1396a(a)(43) (2006).

102. N.C. EPSDT POLICY INSTRUCTIONS, *supra* note 16, at 4 ("Under EPSDT, North Carolina Medicaid must *make available* a variety of individual and group providers qualified and willing to provide EPSDT services.") (emphasis added).

103. O'Bannon v. Town Court Nursing Center, 447 U.S. 773, 785 (1980) (regarding due process claims over closure of a facility that was de-certified, holding that "[Medicaid only] gives recipients the right to choose among a range of qualified providers") (not addressing EPSDT); Bruggeman v. Blagojevich, 324 F.3d 906, 911 (7th Cir. 2003) ("As for the right to obtain a needed medical service from a provider 'who undertakes to provide him such services,' the aim

cases did not address the issue of EPSDT compliance or there being a complete lack of a particular provider or service type in-state, but rather whether (1) a particular facility (among many qualified facilities) was certified to provide services; (2) services already provided in-state were convenient enough to adult Medicaid recipient's residences; or (3) the purpose of a state's behavioral plan was violated by out-of-state placement in the instant case, largely under due process grounds.

Courts *have* recognized that a complete absence of a vital service in-state is unacceptable under Medicaid.[104] The funding and provision of Medicaid services to recipients must be "reasonable and adequate."[105] With regard to eighteen to twenty-one year olds, North Carolina has arbitrarily singled out a particular class of Medicaid recipients and denied them access to specific Medicaid services in the state.[106] Complex/hard-to-serve children in North Carolina face more of a de facto bar to services.[107] Forcing North Carolina's youth to choose from a

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is to give the recipient a choice among available facilities, not to require the creation or authorization of new facilities.") (internal citation omitted) (not addressing EPSDT). One unpublished case from Connecticut did address a minor being sent out-of-state for services. *See* M.K. V. Sergi, 554 F. Supp. .2d 175, 181 (D. Conn. 2008) (not addressing EPSDT). Here, the child's mother had surrendered custody of her child with special needs in order for him to receive treatment. *Id.* at 188. The state placed child in out-of-state service program, the mother objected to this placement, and she brought suit as next friend of her son. *Id.* at 181. The court denied plaintiff's due process claim that, because of the out-of-state placement, the child "lost the chance to develop a healthy relationship with his family," on the grounds that this did not implicate a property interest. *Id.* at 187. Additionally, the court found that the plaintiff had "not produced any evidence that [the Connecticut Department of Children and Families] employed "criteria or methods of administration" that had the purpose or effect of substantially impairing accomplishment of the objectives of its [intensive child behavioral health] program." *Id.* at 199. Specifically, although out-of-state placement may have hurt the child's relationship with his family, the court held that the placement itself was not discriminatory because "the ADA [does not] impose on the States a 'standard of care' for whatever medical services they render, or that the ADA requires the States to 'provide a certain level of benefits to individuals with disabilities.' " *Id.* at 198 (quoting *Olmstead* at 603 n.14) (internal quotations omitted). However, the court did acknowledge that "'States must adhere to the ADA's nondiscrimination requirement with regard to the services they in fact provide.' " *Id.* (quoting *Olmstead* at 603 n.14) (internal quotations omitted).

104. *See, e.g.*, W. Virginia Univ. Hospitals, Inc. v. Casey, 885 F.2d 11, 23-24 (3d Cir. 1989) aff'd, 499 U.S. 83, 111 S. Ct. 1138, 113 L. Ed. 2d 68 (1991) (admonishing against "state budgetary restraints [and] chauvinistic policies designed to curb access to" treatment) ("[A] state's reimbursement rates may not be so low as to compel the closing of a dangerous number of hospitals or of a single medically important hospital, and thus compel medicaid recipients to travel an unreasonable distance to obtain medical care. *See* H.R.Rep. No. 158, 97th Cong., 1st Sess. 294 (expressing concern that rates not be so low as to discourage hospitals from treating medicaid patients)").

105. *Id.* at 23-24; *See* 42 U.S.C. 1396a(a)(13)(A) (2006).

106. *See supra* Part I.D.1

107. *See id.*

trifecta of bad treatment options in lieu of the state paying for appropriate in-state services is neither reasonable nor adequate.[108]

Nonetheless, the inherent limits on states' duties when providing Medicaid services to adults only underscores the extent to which the introduction of EPSDT upends the playing field. When courts are presented with the question of whether EPSDT imposes a duty on states to "provide intensive community-based mental health services to youth with [mental illness] and their families that would enable the youth to reside at home or in the community," a resounding chorus has answered in the affirmative.[109]

In *Collins v. Hamilton*, the Seventh Circuit held that a state violated EPSDT in refusing to provide in-state PRTF services, even though alternative inpatient services were available.[110] Notably, the court focused not on whether other services *might* be able to replace a needed EPSDT service, but rather whether a state failed to provide *any* particular EPSDT services.[111] Furthermore, *Emily Q. v. Bonta* held that EPSDT requires the state to provide the "full scope" of mental health services to children who, without those services, would otherwise be locked in institutions.[112] Here, at least, the *Bonta* ruling suggests that replacing outmoded inpatient treatment with meaningful community-based alternatives would nonetheless satisfy EPSDT provisions.

As for the extent to which EPSDT can require the creation of in-state services, *Kirk v. Houstoun* held that Pennsylvania violated the EPSDT provisions by failing to create, and promptly implement, EPSDT services to qualifying children at the county—let alone

108. *See generally supra* notes 13–15 and corresponding text (regarding these youth's only options being to (a) go without essential services; (b) go without essential services until they are sick enough to warrant psychiatric hospitalization; or (c) seek treatment in another state).

109. DEP'T OF HEALTH AND HUMAN SERVS., PUBLIC FINANCING OF HOME AND COMMUNITY SERVICES FOR CHILDREN AND YOUTH WITH SERIOUS EMOTIONAL DISTURBANCES: SELECTED STATE STRATEGIES 14 (June 2006), *available at* http://aspe.hhs.gov/daltcp/reports/2006/youthSED.pdf (citing Perkins, J., & Strickland, S., *Early and Periodic Screening, Diagnosis & Treatment Case Docket-Mental and Behavioral Health Services*, National Health Law Program (July 2004) *available at* http://www.healthlaw.org/images/stories/epsdt/200407-EPSDT-mh-docket.pdf. *But cf.* Okla. Chapter of Am. Acad. of Pediatrics v. Fogarty, 472 F.3d 1208, 1215 (10th Cir. 2007) ("[EPSDT] requires a state Medicaid plan to pay for all such medical services, not, as plaintiffs suggest, to directly provide them.").

110. Collins v. Hamilton, 349 F.3d 371, 373 (7th Cir. 2003) ("[State law provided that] residential placement in a PRTF is not covered, even if a child is diagnosed as needing such placement by an EPSDT provider . . . By excluding all PRTFs, [the state] does not cover services associated with residential placement, even if that placement occurs in a residential treatment ward of a psychiatric hospital.").

111. *See id.*; *see also* Rosie D. v. Romney, 410 F. Supp. 2D 18, 53 (D. Mass. 2006) ("The fact that Defendants provide some services does not relieve them of the duty to provide all necessary services with reasonable promptness." (citation omitted)).

112. Emily Q. v. Bonta, 208 F. Supp. 2d 1078, 1083, 1086–87, 1102–03 (C.D. Cal. 2001) (permanent injunction).

state—level.[113] *Antrican v. Odom*, a North Carolina case heard before the Fourth Circuit, looked at the provision of in-state dental services, and held that EPSDT requires states to not only provide, but create, accessible EPSDT services throughout the state.[114] Here, the court recognized the existence of in-state dentists who could provide EPSDT services.[115] However, the plaintiff children often had to "travel two hours each way to utilize [these EPSDT] services . . . ."[116] On these facts alone, the Fourth Circuit denied the state's motion to dismiss.[117] The mere existence of other in-state dentists was insufficient to plainly satisfy EPSDT requirements. Had the state argued that—rather than actually ensure a sufficient supply of dental providers in North Carolina—it would be willing to pay to send the plaintiff children to another state for appropriate dental care, it quite likely would have been laughed out of court. And unlike intensive mental health treatment, dental services do not even implicate the same issues of community integration and social isolation.

Finally, in *Rosie D. v. Romney*, a district court in Massachusetts held that a state's failure to provide adequate EPSDT services violates EPSDT provisions and the "reasonable promptness" prong of the Medicaid Act.[118] Here, EPSDT qualified children demonstrated the medical necessity of receiving particular services—some of them community-based—that did not currently exist in Massachusetts.[119] The state had decided that the requested services were "experimental" and therefore declined to provide them. However, in no uncertain terms, the court emphasized the importance of EPSDT services and admonished that "[the state] cannot . . . justify denying [Medicaid qualified] children access to necessary treatment by citing barriers [it has] chosen to erect in [its] own system of treatment."[120]

The issue comes down to this: while the Medicaid statute generally refers to "furnishing" services, EPSDT imposes a far greater duty on

113. *See* Kirk T. v. Houstoun, 2000 WL 830731, *1 (E.D. Pa. 2000).

114. *See* Antrican v. Odom, 290 F.3d 178, 182, 191 (4th Cir. 2002), *cert. denied* Odom v. Antrican, 537 U.S. 973 (2002) ("[T]he Medicaid Act clearly mandates that a State provide a certain level and quality of dental care."); *see also* Westside Mothers v. Haveman, 289 F.3d 852 (6th Cir.), cert denied, Haveman v. Westide Mothers 537 U.S. 1045 (2002) (on a similar claim); *cf.* Bruggeman v. Blagojevich, 324 F.3d 906, 911 (7th Cir. 2003) (where the state was not obligated to create services closer the home communities of *adult* Medicaid recipients).

115. *Id.*

116. *Antrican*, 290 F.3d at 182.

117. *Id.* at 191.

118. Rosie D. v. Romney, 410 F. Supp. 2d 18, 53 (D. Mass. 2006) ("Because Defendants have failed to meet the substance of the EPSDT mandate, they have not satisfied Congress' command to provide services with 'reasonable promptness.' "); *see* 42 U.S.C. § 1396a(a)(8) (2006); *see also* Boulet v. Cellucci, 107 F.Supp.2d 61, 79 (D. Mass. 2000).

119. *Rosie D,* 410 F. Supp. 2d at 23.

120. *Id.* at 53 n.12.

the state.[121] It requires North Carolina to "make available a variety of . . . qualified and willing" providers who can provide the "full panoply" of EPSDT services to all Medicaid eligible youth under the age of twenty-one.[122] It also requires the state to pay for any and all medically necessary services for these youth regardless of cost.[123] Here, North Carolina has failed to meet these obligations under EPSDT.

With regard to complex/hard-to-serve children, there may be rare instances when a particular child's condition is so unique and extreme that only an out-of-state specialist can effectively treat him or her. However, North Carolina policy clearly states that "[out-of-state] placement will only be considered for youth who have: Co-occurring disabilities, which may include but are not limited to medical problems, that are *so* complex that *only* an [out-of-state] facility, with *specialty programming* meets their needs . . . ."[124] This cannot be generalized to *every* complex/hard-to-serve child. To analogize the medical field, a child suffering from a rare eye disorder might have to travel across state lines in order to see the only specialist in the country who treats that condition. However, this exceptional circumstance would not justify forcing all children with complex ocular disorders to seek out-of-state providers. Similarly, there may be case-specific instances of children needing highly-specialized treatment out-of-state for exceedingly rare mental conditions. But this is entirely distinct from accommodating the predictable spectrum of need for most complex/hard-to-serve children. As such, North Carolina children who are born with both mental illness and intellectual disabilities should not be summarily sentenced out-of-state for treatment.

2. Medicaid's Comparability Provision

North Carolina has also violated Medicaid's comparability provision. This provision is fairly straightforward: "[t]he Medicaid Act requires that comparable medical assistance be provided to individuals with comparable needs."[125] It "is violated when [certain Medicaid] re-

121. *See* 42 U.S.C. 1396a(a)(11) (2006).

122. *See* N.C. EPSDT POLICY INSTRUCTIONS *supra* note 16, at 4.

123. *Id.* at 2 ("A child under [twenty-one] years of age financially eligible for Medicaid is entitled to receive EPSDT services without any monetary cap provided the service meets all EPSDT criteria . . . ."); *see Rosie D.*, 410 F. Supp. 2d at 23.

124. N.C. COMPLIANCE VERIFICATION PROTOCOL, *supra* note 14, at 3 (emphasis added).

125. Pashby v. Cansler, 279 F.R.D. 347, 354 (2011) (citing 42 U.S.C. § 1396a(a)(10)(B) (2006)); *see* 42 U.S.C. § 1396a(a)(10)(B) (2006) ("[M]edical assistance made available to any [qualified] individual . . . shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual."). 42 U.S.C. § 1396a(a)(10)(B) (2006) is implemented through 42 C.F.R. § 440.230 (2012), which states as follows:

(b) Each [covered Medicaid] service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.

cipients are treated differently than others where each has the same level of need."[126] For instance, in *Pashby v. Cansler*, the Fourth Circuit issued a preliminary injunction against North Carolina, where the state restricted the eligibility criteria for certain services in personal home settings, but not in adult care home settings, even though both populations had similar needs.[127] This scheme placed the people living in their homes "at risk of segregation, in the form of [laws that favor their] institutionalization . . . ."[128] As a result, the court found that the state violated Medicaid's comparability, and enjoined the state from implementing the discrepant eligibility requirements.

North Carolina continues to violate Medicaid's comparability provision by failing to provide eighteen to twenty-one year olds with appropriate services in-state. The crux of this issue is a conflict between state regulations, state policy, and EPSDT provisions. The state's EPSDT policy documentation and service definitions regularly refer to those who are EPSDT eligible (i.e. Medicaid eligible individuals under twenty-one) as "child[ren]" and "adolescent[s]."[129] However, the section of the North Carolina Administrative Code that deals with inpatient-level services defines the terms "children and adolescents" as "minors from birth through [seventeen] years of age," not as anyone under age twenty-one.[130] According to the state's regulations, "a person [eighteen] years of age or older" is an "[a]dult."[131]

(c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.

(d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

42 C.F.R. § 440.230.

126. *Pashby*, 279 F.R.D. at 354 (quoting V.L. v. Wagner, 669 F.Supp.2d 1106, 1114–15 (N.D.Cal.2009)) (internal quotations omitted).

127. *Id.*

128. *Id.* at 355.

129. *See, e.g.*, N.C. EPSDT POLICY INSTRUCTIONS, *supra* note 16, at 2 ("A *child* under [twenty-one] years of age financially eligible for Medicaid is entitled to receive EPSDT services without any monetary cap provided the service meets all EPSDT criteria . . . ." (emphasis added)); Clinical Coverage Policy No.: 8A, *supra* note 57, at 34 ("Intensive In-Home (IIH) service [is designed for] *children and adolescents* . . . through age 20." (emphasis added)); N.C. Div. of Med. Assistance Enhanced Mental Health & Substance Abuse Serv., Clinical Coverage Policy No.: 8D-2, *supra* note 57, at 1 ("[EPSDT] requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiaries under [twenty-one]years of age . . . . [t]his means EPSDT covers most of the medical or remedial care a *child* needs . . . ." (emphasis added)).

130. 10A N.C. ADMIN. CODE 27G.0103(10) (2012); *see also* 10A N.C. ADMIN. CODE 27G.0103(9) (2012) ("'Child' means a minor from birth through 12 years of age."); 10A N.C. ADMIN. CODE 27G.0103(3) (2012) ("'Adolescent' means a minor from 13 through 17 years of age.").

131. 10A N.C. ADMIN. CODE 27G.0103(4) (2012) (internal quotations omitted); *cf.* 10A N.C. ADMIN. CODE 27G .0103(50) (2012) ("'School aged youth' means individuals from six through twenty-one years of age," which appears to be more in line with EPSDT's child-to-adult

As discussed earlier, Level II–IV facilities and PRTFs operate under North Carolina's regulatory definition of "children and adolescents," not Medicaid's, so these facilities are allowed to serve only "children and adolescents" until they turn eighteen. As a result, this incongruity between state and federal regulations creates an EPSDT "doughnut-hole" for eighteen to twenty-one year olds who need intensive mental health services.[132] Although EPSDT entitles these youth to receive any and all medically necessary services, there are no inpatient facilities or comparable services in the entire state that can treat them. More specifically, North Carolina has chosen to prohibit providers from offering these services to eighteen to twenty-one year olds.

As a result, Medicaid-eligible eighteen to twenty-one year olds who might have comparable needs to sixteen or seventeen year olds cannot obtain the same EPSDT services as sixteen and seventeen year olds. This places eighteen to twenty-one year olds at a distinct disadvantage from a treatment perspective. It ensures that all eighteen to twenty-one year olds will be forced to (a) go without essential services; (b) go without essential services until they are sick enough to warrant psychiatric hospitalization; or (c) seek treatment in another state.[133] As such, Medicaid eligible eighteen to twenty-one year olds who have comparable needs to other EPSDT qualified recipients should be able to receive a comparable "level and quality of . . . care" as their peers.[134] However, the state prohibits them from doing so.

3. Medicaid's Out-of-State Placement Requirements

Finally, North Carolina violates Medicaid's out-of-state placement requirements with regard to complex/hard-to-serve children and eighteen to twenty-one year olds. In fact, it operates under a paradox. Medicaid requires the state to "pay for services furnished [to a North Carolina resident] in another state to the same extent that it would pay for services furnished [to that resident] within its boundaries."[135]

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delineation age, although 10 N.C. ADMIN. CODE 27G only uses this term in a developmental delay education context).

132. *See supra* notes 64–69.

133. And Out-of-state placements generally are not in states with better Medicaid programs. *See* ANNETTE B. RAMÍREZ DE ARELLANO & SIDNEY M. WOLFE, UNSETTLING SCORES A RANKING OF STATE MEDICAID PROGRAMS (Apr. 2007), *available at* http://www.citizen.org/documents/2007UnsettlingScores.pdf. In this study, North Carolina's Medicaid program ranked 24th. *Id.* at 19. States like Virginia, South Carolina, Georgia, Florida, and Texas, where many North Carolina youth are currently placed ranked 42nd, 40th, 22nd, 27th, and 45th, respectively. *Id.*

134. Antrican v. Odom, 290 F.3d 178, 191 (4th Cir. 2002), *cert. denied Odom v. Antrican* 537 U.S. 973 (2002) (regarding a lack of Medicaid funded dental services.).

135. 42 C.F.R. § 431.52(b) (2013). However, this language is missing from North Carolina's Medicaid billing guide. *See* BASIC MEDICAID AND NC HEALTH CHOICE BILLING GUIDE §7-2 (Apr. 2012) [hereinafter N.C. MEDICAID GUIDE] ("42 CFR §431.52(b)(1-4) (2013) only allows

However, by shipping eighteen to twenty-one year olds and complex/hard-to-serve children out of state for treatment, North Carolina is paying for out-of-state services that it does not pay for in-state at all. Furthermore, in order for the state to pay for out-of-state services, a recipient's need for those services must arise from one of the following:

> (1) a medical emergency;
> (2) a health-related inability for the resident to return to his state of residence;
> (3) "on the basis of medical advice" a needed treatment is "more readily available" in another state; or
> (4) it is "general practice for recipients in a particular locality to use medical resources in another State."[136]

Generally, the out-of-state placements for complex/hard-to-serve children and eighteen to twenty-one year olds requiring intensive mental health services are not based on out-of-state medical emergencies, nor do they result from out-of-state illnesses that prohibits them from returning to North Carolina. To the contrary, the out-of-state placements usually are imposed upon in-state youth who desperately want to remain in-state, near their families and communities. To that end, the first two predicate conditions for Medicaid's out-of-state placement requirements are not relevant for the purposes of this Article. However, the latter two at least warrant some analysis.

Under the third predicate condition, regarding out-of-state services being "more readily available," there is a profound difference between the availability of services in one location and the complete dearth of services in another.[137] Here, North Carolina's legal ban on eighteen to twenty-one year olds from receiving certain essential in-state services does not mean that treatment is more readily available in other states "on the basis of medical advice." Rather, it is the result of a direct failure by the state to provide *any* meaningful services for this class of individuals. To the extent that "medical advice" indicates that inpatient treatment is more "readily available" in other states, such out-of-state treatment is not the result of better treatment options elsewhere, but rather a complete lack of any treatment options in North Carolina.[138] Similarly, for complex/hard-to-serve children, by creating a system that is ill designed to accommodate the predictable

states to pay for out-of-state services when furnished to a recipient who resides in North Carolina and when any of the [four] conditions stated below are met.")

136. 42 C.F.R. § 431.52(b) (2013); *see* N.C. MEDICAID GUIDE, *supra* note 135, at §§ 7-2–7-3.

137. *See* 42 C.F.R. § 431.52(b)(3) ("[Payment for out-of-state treatment is permissible when] on the basis of medical advice [a needed treatment is] more readily available in [another] State.")

138. *See id.*

spectrum of complex/hard-to-serve children's needs, North Carolina is ensuring that there will be a void of providers to address their needs.

Under the fourth predicate condition, a basic analysis of "particular locality" underscores the fact that "particular locality" is not synonymous with "the entire state."[139] Rather, "particular locality" usually applies to localized communities that receive Medicaid eligible treatment in nearby, bordering states out of convenience.[140] North Carolina's own Medicaid documentation recognizes this.[141] Just because the state forces all eighteen to twenty-one year olds, and many complex/hard-to-serve children, out of the state in order to receive non-acute, intensive mental health services does not mean that youth from a "particular locality" are voluntarily seeking out treatment in other states. They are forced to do so from *every* locality in North Carolina.

Therefore, none of Medicaid's out-of-state placement requirements are met. North Carolina either is violating Medicaid's out-of-state payment requirements by funding services out-of-state that it refuses to provide itself, or it is tacitly acknowledging that these services should be available in-state. One possible counter to this analysis is that states are only *required* to pay for out-of-state treatment to the extent that certain services are furnished in-state and that *voluntarily* paying for services beyond this does not violate 42 C.F.R. § 431.52(b). However, accepting this line of reasoning would mean ignoring North Carolina's proclamation that out-of-state placement is always a measure of last resort.[142] The fact that EPSDT services are an entitlement, further underscores the point.[143]

B. *North Carolina's Violation of the Americans with Disabilities Act*

Olmstead, discussed earlier, explicitly established the "community integration" and "least restrictive treatment" mandates.[144] Specifically, the United States Supreme Court noted that "[u]njustified isolation . . . is properly regarded as discrimination based on disability."[145]

139. *See* 42 C.F.R. § 431.52(b)(4) ("[Payment for out-of-state treatment is permissible when it is] general practice for recipients in a particular locality to use medical resources in another State.").

140. *See, e.g.*, W. Virginia Univ. Hospitals, Inc. v. Casey, 885 F.2d 11, 23 (3d Cir. 1989) aff'd, 499 U.S. 83 (1991).

141. *See* N.C. MEDICAID GUIDE, *supra* note 135, at §7-3 ("[R]ecipients who reside in North Carolina but receive medically necessary care and services within 40 miles of the North Carolina border in the contiguous states of Georgia, South Carolina, Tennessee, and Virginia [fall under the "particular locality" rule].").

142. N.C. COMPLIANCE VERIFICATION PROTOCOL *supra* note 14, at 3.

143. NAMI, *supra* note 100.

144. *See* Olmstead v. L. C. by Zimring, 527 U.S. 581, 592, 599–600 (1999).

145. Letter from Thomas E. Perez, Assistant Attorney General, U.S. Dept. of Justice, Civil Rights Div. to The Honorable Haley R. Barbour, Governor State of Miss., Re: United States'

The *Olmstead* Court also indicated that, although the ADA does not impose a "standard of care" on states for mental health services, neither can states discriminate "with regard to the services they in fact provide."[146] Arguably, North Carolina has violated (1) *Olmstead*'s "community integration" and "least restrictive treatment" mandates with regard to both complex/hard-to-serve children and eighteen to twenty-one year olds and (2) *Olmstead*'s non-discrimination requirement primarily with regard to complex/hard-to-serve children.

1. Olmstead's Community Integration and Least Restrictive Mandates

North Carolina's current mental health treatment scheme for complex/hard-to-serve children and eighteen to twenty-one year olds violates *Olmstead*'s "community integration" and "least restrictive treatment' mandates.[147] The state has continually failed to implement meaningful community-based services for both children and those over the age of eighteen.[148] Furthermore, the state has created a legal bar to eighteen to twenty-one year olds, and a de facto bar to complex/hard-to-serve children, from seeking appropriate services in-state.[149] This ensures that many complex/hard-to-serve children and all eighteen to twenty-one year olds who require intensive mental health services will be forced to (a) go without essential services; (b) go without essential services until they are sick enough to warrant psychiatric hospitalization; or (c) seek treatment in another state.

Forcing complex/hard-to-serve children and eighteen to twenty-one year olds to go without essential services is certain to isolate them from their communities and stigmatize them. It deprives complex/hard-to-serve children and eighteen to twenty-one year olds of the care they need to function as contributing members of society. Forcing these youths to go without essential services until they are sick enough to warrant psychiatric hospitalization further isolates them and carries more risk of stigmatization.[150] It also fosters a legal preference for overly-restrictive institutionalization.[151] Finally, forcing complex/hard-to-serve children and eighteen to twenty-one year olds to seek treatment in other states wholly excludes them from their communities,

Investigation of the State of Mississippi's Service System for Persons with Mental Illness and Developmental Disabilities (Dec. 22, 2011) (quoting *Olmstead*, 527 U.S. at 597.)

146. *Olmstead*, 527 U.S. at 603 n.14.

147. *See Olmstead*, 527 U.S. at 592, 599–600 (1999)

148. N.C. COMPLIANCE VERIFICATION PROTOCOL, *supra* note 14, at 2–3.

149. *See supra* Part I.D.1

150. *See generally* Pashby v. Cansler, 279 F.R.D. 347, 355 (E.D.N.C. 2011) (admonishing against schemes that create a legal preference for institutionalization).

151. *Id.*

largely isolates them from their families,[152] and carries with it an even bigger risk of stigmatization.[153] Not only does this hinder these youths' ability to reintegrate back into their communities, but when they are forced to seek treatment in other states—hundreds of miles away from their homes—it is de facto more restrictive.

2. Olmstead's *Non-Discrimination Requirement*

In treating complex/hard-to-serve children, North Carolina violates the *Olmstead* requirement that states cannot discriminate "with regard to the services they in fact provide." [154] Unsurprisingly, complex/hard-to-serve children can be, on average, more expensive to treat. They are, by definition, complex and hard-to-serve. However, when coupled with the state's bifurcation of children's intensive mental health services [155]—and the increasing number of lower-need children being placed in more restrictive settings—providers are either unable to, or otherwise plied with incentives not to, treat complex/hard-to-serve children.[156] Instead, many complex/hard-to-serve children find themselves completely "excluded from participation in . . . services" in-state solely "by reason of [their] disability[ies]."[157]

Some courts have held expressly that "the severity of [a person's] handicaps is itself a handicap."[158] Under this interpretation, where a state's service system discriminates against a particular class due to the severity of their respective disabilities, it is discriminating against them on the basis of a disability. By constructing a mental health system that funnels the sickest children out of that system, North Caro-

152. As a general rule, families cannot afford to fly across the county on a regular basis. By definition, many Medicaid eligible children come from low-income households. Moreover, even high-functioning, mentally healthy ©eighteen year olds can have difficulty transitioning when they leave their home state for the first time—for instance, when going to college. Expecting an eighteen year old—let alone a child—who is in crisis and has significant psychological and emotional issues to get shipped off as far away as Texas for treatment and to then seamlessly reintegrate into his or her community upon discharge is nonsensical.

Family dynamics also can be an aggravating factor that contributes to an individual needing intensive mental health services in the first place. Providing families and youths with adequate training to resolve those issues can be challenging on its own. It becomes almost impossible with a geographic divide between parties. Out-of-state placement also limits the availability of certain evidence-based practices, such as "parent-child interaction therapy," which require parents and children to be in the same room. *See* U.S. SCIENCE TO SERVICE REPORT, *supra* note 49, at 41.

153. The fact that this isolation occurs during crucial developmental years also has the potential of dire long-term consequences.

154. Olmstead v. L. C. by Zimring, 527 U.S. 581, 603 n.14 (1999).

155. *See supra* notes 73–75 and corresponding text.

156. *See supra* note 76.

157. *Contra* 42 U.S.C. § 12132 (2006).

158. Plumber v. Brandstad, 731 F.2D 574, 578 (8th Cir. 1984).

lina is discriminating against complex/hard-to-serve children.[159] This practice violates *Olmstead*'s non-discrimination requirement.

C. *North Carolina's Violation of Its Own Mental Health Policies*

Although not "evidence-based," North Carolina's "best practice" service model has praiseworthy policy behind it. North Carolina recognizes the following:

> [T]he practice of discrimination based upon a disabling condition is contrary to the public interest and to the principles of freedom and equality of opportunity; the practice of discrimination on the basis of a disabling condition threatens the rights and proper privileges of the inhabitants of this state; and such discrimination results in a failure to realize the productive capacity of individuals to their fullest extent.[160]

The state also recognizes that "[f]or [mental health] system reform to be comprehensive and enduring, it must be based on values and principles that reflect the consensus of stakeholders in the system, as well as national perspectives and scientific findings" that are based on six principals that treatment be (1) "[p]articipant-driven;" (2) "[c]ommunity based;" (3) "[p]revention focused;" (4) "[r]ecovery outcome oriented;" (5) "[r]eflect best treatment/support practices;" and (6) "[c]ost effective."[161]

The state publicly endorses "person centered planning" which "focuses on the identification of the individual's/family's needs and desired life outcomes."[162] The state also requires that "[f]amily members or other legally responsible persons *shall* be involved in the develop-

159. This paper largely argues that the treatment needs of eighteen to twenty-one year olds are generally not so distinct from their slightly younger peers as to render them "untreatable" within the state. *See supra* Part II.A.1. However, to the extent that certain eighteen to twenty-one year olds could be more difficult to treat, they may not be covered by Medicaid Comparability Provision in this regard).

160. Persons with Disabilities Protection Act, N.C. GEN. STAT. §168A-2(b) (2011).

161. NC DEP'T HEALTH AND HUMAN SERV., TRANSFORMATION OF NORTH CAROLINA'S SYSTEM OF SERVICES FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE, THE STATE STRATEGIC PLAN: 2007-2010 5–6 (2007) [hereinafter N.C. STATE STRATEGIC PLAN], *available at* http://www.ncdhhs.gov/mhddsas/statspublications/annualrptsstrategicplans/Strategicplan07-10/strategicplan07-10finalweb-06-29-07.pdf.

162. DIV. MENTAL HEALTH, DEV. DISABILITIES AND SUBSTANCE ABUSE SERV.,PERSON-CENTERED PLANNING MANUAL 5 (2010) [hereinafter N.C. PERSON-CENTERED PLANNING MANUAL], available at http://www.ncdhhs.gov/mhddsas/statspublications/Manuals/pcp-instruction manual2-3-10.pdf ("The Person-Centered Plan (PCP) is the umbrella under which all planning for treatment, services and supports occurs. . . . It focuses on the identification of the individual's/family's needs and desired life outcomes. It is not just a request for a specific service(s) . . . . Natural and community supports should always be considered within all person-centered plans.")

ment and implementation of treatment plans in order to assure a smooth transition to . . . less restrictive setting[s]."[163]

In the application process, prospective PRTFs must agree to "participate in the North Carolina Medicaid Program" and each provider "certifies and agrees" to make "PRTF services . . . available to recipients under [twenty-one] years of age."[164] State policy explicitly recognizes that PRTF level treatment is supposed to be utilized by youth through the age of twenty-one,[165] as do federal regulations.[166] With regard to treatment, generally, "[u]nder EPSDT, North Carolina Medicaid must make available a variety of individual and group providers qualified and willing to provide EPSDT services," and "[r]ecipients under [twenty-one] must be afforded access to the *full panoply* of EPSDT services . . . ."[167]

The North Carolina Compact on Mental Health, which allows for out-of-state placement for North Carolinians requiring mental health treatment, provides that the purpose of such an interstate compact is to "benefit . . . patients, their families, and society as a whole," citing "humanitarian[ ]" reasons.[168] The compact strongly emphasizes that out-of-state treatment is appropriate only when "the care and treatment of [a] patient would be facilitated or *improved*" by seeking treatment out-of-state, and only when it would be "in the *best interest* of

163. 10A N.C.A.C. 27G §§ .1303(b), .1706(b), .1805(b), .1903(e) (2012) (applying to Level II, Level III & IV, Psychiatric Hospital, and PRTF treatment facilities, respectively) (emphasis added).

164. NC DEP'T HEALTH AND HUMAN SERV.,NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE MEDICAID PARTICIPATION AGREEMENT, NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES PRTF ENROLLMENT PACKET 11, 13 (2009) *available at* http://qa.dhhs.state.nc.us/dma/provenroll/residentialprtfenroll.pdf.

165. In fact, the state's own clinical coverage policy that specifically covers PRTF treatment is titled "Psychiatric Residential Treatment Facilities for Children Under the Age of [twenty-one]." *See* Clinical Coverage Policy No.: 8D-1, *supra* note 3. The comingling of PRTF treatment and a twenty-one year old age cap is endemic to other PRTF related documentation. *See, e.g.*, NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE CLINICAL POLICY AND PROGRAMS, DMA CERTIFICATION OF NEED FOR MEDICAID INPATIENT PSYCHIATRIC SERVICES IN A PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF) FOR A RECIPIENT UNDER THE AGE OF 21, *available at* http://www.docstoc.com/docs/123910472/PRTF-CON (in title of form); *July 2012 Medicaid Bulletin*, NC DHHS, http://www.ncdhhs.gov/dma/bulletin/0712bulletin.htm ("Federal regulations require a [certain] form to be completed for admissions of Medicaid recipients under the age of 21 to a psychiatric hospital or PRTF.").

166. *See* Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs, 42 C.F.R. § 441.151(a) (2013); *see also* Medicaid Program, Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Psychiatric Services to Individuals Under Age 21, 66 Fed. Reg. 28110 (May 22, 2001); Letter from Center for Medicaid and State Operations/Survey and Certification Group to State Survey Agency Directors, Psychiatric Residential Treatment Facilities (PRTF) Clarification (Feb. 16, 2007).

167. N.C. EPSDT POLICY INSTRUCTIONS, *supra* note 16, at 4 (emphasis added).

168. Interstate Compact on Mental Health, N.C. GEN. STAT. § 122C-361, Art. I. (2011).

the patient."[169] It also requires that North Carolina keep tabs on the youth it sends to other states for treatment.[170]

Even more boldly, North Carolina's out-of-state placement policy for youth proclaims that "[i]n-state placement for the support and continuity of family involvement is the first priority, with [out-of-state] placements as the last option."[171] Specifically, "[out-of-state] placement will only be considered for youth who have: Co-occurring disabilities, which may include but are not limited to medical problems, that are *so* complex that *only* an [out-of-state] facility, with *specialty programming* meets their needs. . . ."[172] "No exceptions are allowed."[173]

North Carolina has failed to live up to its own stated policies. Forcing North Carolina's youth to forego services or seek treatment in other states as a first line of treatment "is contrary to the public interest and to the principles of freedom and equality of opportunity."[174] The current system does not "reflect the consensus of stakeholders in the system . . . and scientific findings."[175] It is not "[p]articipant-driven;" "[c]ommunity based;" "[p]revention focused;" "[r]ecovery outcome oriented;" or "[c]ost effective."[176] It does not respect "the individual's/family's needs and desired life outcomes."[177] It does not ensure that Medicaid "[r]ecipients under [twenty-one are] afforded access to the full panoply of EPSDT services," nor does it ensure these youths' "right to a free choice of providers."[178]

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169. § 122C-361, Art. III §§ (b), (e) (2011) (emphasis added).

170. § 122C-361, Art. X (2011) ("Each party state shall appoint a 'Compact Administrator' who, on behalf of his state, shall act as general coordinator of activities under the Compact in his state and who shall receive copies of all reports, correspondence, and other documents relating to any patient processed under the Compact . . . ."); N.C. GEN. STAT. §7B-3806 (2011) (The Governor is hereby authorized to appoint [the] Compact Administrator . . . ."); *see generally* Interstate Compact on the Placement of Children N.C. GEN. STAT.§§ 7B-3800–3806 (2011). North Carolina has divided the Compact Administrator duties between multiple individuals who are in charge of multiple counties. *See* NC DEP'T HEALTH AND HUMAN SERV., Interstate Serv. ICPC Cnty. Assignment 2011, *available at* http://icpc.aphsa.org/home/doc/NC_DHHS.pdf.

171. N.C.COMPLIANCE VERIFICATION PROTOCOL, *supra* note 14, at 3.

172. *Id.* (emphasis added).

173. *Id.* at 4.

174. Persons With Disabilities Protection, Act, N.C. GEN. STAT. § 168A-2(b) (2011).

175. *Contra* N.C. STATE STRATEGIC PLAN, *supra* note161, at 5.

176. *Contra id.*

177. *Contra* N.C. PERSON-CENTERED PLANNING MANUAL *supra* note 162, at 5 (explaining "The Person-Centered Plan (PCP) is the umbrella under which all planning for treatment, services and supports occurs. . . . It focuses on the identification of the individual's/family's needs and desired life outcomes. It is not just a request for a specific service(s). . . . Natural and community supports should always be considered within all person-centered plans.").

178. *Contra* N.C. EPSDT POLICY INSTRUCTIONS *supra* note 16, at 4; Clinical Coverage Policy No.: 8D-2, *supra* note 57, at 1 ("Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician . . . and the determination does not limit the beneficiary's right to a free choice of providers.")

With regard to forced out-of-state placements, specifically, North Carolina's mental health system fails to "benefit . . . patients, their families, and society as a whole."[179] It certainly is not based on "humanitarian[ ]" principles.[180] Very often, out-of-state placements are not made because "the care and treatment of [a] patient would be facilitated and improved" by out-of-state treatment, and thus would be "in the best interest of the patient."[181] Instead, these placements often happen because families have no other option. Furthermore, once youth are placed out-of-state, the geographical divide between youth and their families can block family members from involvement "in the development and implementation of treatment plans," which is a right which they are guaranteed under the law.[182] This does not ensure the "continuity of family involvement [as] the first priority."[183] More to the point, it does not treat out-of-state placements "as the last option."[184]

III. SUGGESTIONS FOR MEANINGFUL REFORM

A. *North Carolina Should Implement the Reforms that it Promised Over a Decade Ago*

The failure of North Carolina's mental health reform effort is most vividly defined by its lost promises and missed opportunities. As more youths slip through the cracks of North Carolina's fractured mental health system, the contrast between where we are today and where we could be is thrown into starker and starker relief. For years, North Carolina's Science to Service Blueprint and SAMHSA's evidence-based practice implementation toolkits have been readily available for lawmakers to use when crafting their so-called reforms.[185] And yet, these vital resources remain unutilized.

Were North Carolina to actually implement the meaningful reforms that it promised over a decade ago by adopting an evidence-based

179. *Contra* Interstate Compact on Mental Health, N.C. GEN. STAT.§ 122C-361, Art. I (2011).

180. *Contra Id.*

181. *Contra* N.C. GEN. STAT. §§ 122C-361 (b), (e).

182. 10A N.C. ADMIN. CODE 27G §§ .1303(b), .1706(b), .1805(b), .1903(e) (2012) (applying to Level II, Level III & IV, Psychiatric Hospital, and PRTF treatment facilities, respectively) ("Family members or other legally responsible persons *shall* be involved in the development and implementation of treatment plans in order to assure a smooth transition to . . . less restrictive setting[s]." (emphasis added)).

183. *Contra* N.C. COMPLIANCE VERIFICATION PROTOCOL, *supra* note 14, at 3 (proclaiming that "all appropriate in-state [treatment] options [must be] exhausted prior to requesting out-of-state placement[ ]," for any of North Carolina's children with mental illness and that "[i]n-state placement for the support and continuity of family involvement is the first priority, with [out-of-state] placements as the last option").

184. *Id.*

185. *See supra* notes 51–55 and corresponding text.

practice model for all of its mental health services, North Carolina would ensure that every tax-payer dollar that went to providing mental health services for its citizens would go to treatments that were actually proven to work.[186] This would provide an obvious benefit for the North Carolinians who are receiving mental health services and their families. It also would benefit the state by (1) reducing wasteful spending on ineffectual services, (2) streamlining the processes for creating new and even more effective services in the future,[187] and (3) alleviating the burden on police departments, social service departments, and other service entities that invariably are strained when the state's mental health system fails.[188] The status-quo is no longer tenable. North Carolina keeping its promise of meaningful mental health reform is no longer just the right thing to do—it is the prudent thing to do.

B. *North Carolina Should Build on the Success of Other States*

Fortunately, North Carolina would not be alone in implementing an evidence-based system of care. Numerous states have already begun utilizing evidence-based practices in their mental health service sys-

186. Or at least that showed the promise of being supported by empirical research. Currently, the state essentially bans the creation of emerging practices, by instituting a blanket prohibition on "experimental/investigational" services under EPSDT, even though emerging practices are distinct from other "experimental/investigational" services that might be based on pseudo-science or that just don't work. *See supra* note 100; *see generally supra* note 62; *infra* note 206 and corresponding text.

187. *Id.*

188. *See* Corey Friedman, Mentally *Ill Pose Challenge to Police*, WILSON TIMES (Apr. 17, 2013, 11:46 PM), http://www.wilsontimes.com/News/Feature/Story/20003678—-MENTAL-HEALTH—-THE-LAW ("State and federal funding cuts have hobbled mental health services, [said Janelle Clevinger, executive director of the Mental Health Association in Wilson County], and patients left untreated are more prone to aggressive and violent behavior. 'Several years ago, the state of North Carolina decided to put the burden of mental health care back on communities,' she said. 'Psychiatric hospitals were closed, leaving these people with nowhere to go.' The result is more work for police and sheriff's deputies who have to drive patients hundreds of miles to be committed to a long-term care facility and who may have to confront an armed mentally ill person in the community. 'The legal system has been bearing the brunt of this, I think, for the last several years,' Clevinger said. 'Right now, the taxpayers are paying for highly trained officers to work as taxis and babysitters.' When a magistrate judge signs an involuntary commitment order, the law enforcement officers tasked with serving it have to escort the committed person to the hospital emergency room for psychological evaluations.); E. Fuller Torry, *How to Bring Sanity to Our Mental Health System*, HERITAGE FOUNDATION (Dec. 19, 2011), http://www.heritage.org/research/reports/2011/12/how-to-bring-sanity-to-our-mental-health-system#_ftn17 ("Just as jails and prisons have become America's new psychiatric inpatient system, so too have the police, sheriffs, and courts become the nation's psychiatric outpatient system. Police and sheriffs are now the first responders for most mental illness crisis calls in the community. Many such calls are to transport mentally ill persons to hospitals. . . . In North Carolina in 2010, sheriffs' departments 'reported more than 32,000 trips last year to transport psychiatric patients for involuntary commitments.' " (citing Ruth Sheehan, *Shuttling Patients Burdens Deputies*, News & Observer, Jan. 15, 2010, *available at* http://www.newsobserver.com/2010/01/15/285369/shuttling-patients-burdens-deputies.html).

tems.[189] Beginning in 2002, eight states implemented the National Evidence-Based Practices Project, which aimed to put in place evidence-based mental health practices across the country.[190] Underpinning this effort was a recognition that leaving "the details and content of clinical practice to providers" alone would not facilitate effective change.[191] Instead, implementing evidence-based practices requires mental health authorities at the state-level to "explicitly and extensively focus on both the organization and financing of care and the content and quality of direct clinical care simultaneously."[192] Not only did the services need to change, but the systemic infrastructure that supported those services had to change as well.

Of the states that participated in the National Evidence-Based Practices Project, Kansas, in particular, has had great success in implementing evidence-based practices using this approach. First, Kansas made sure that the state's mental health authorities were invested in the implementation of evidence-based practices.[193] Lip-service to the notion of reform was not enough. This alone had a profound effect on the success of the reform effort.[194] Then, as the implementation and data collection/dissemination process was underway, state grants allowed the University of Kansas to "hire consultant trainers and monitors to support [evidence-based practice] implementation" as part of its ongoing "responsib[ility] for monitoring [treatment] fidelity and outcomes."[195] Not only did implementing evidence-based practices require the collection of treatment data, it required active monitoring of that data to ensure compliance with service guidelines. The state and University of Kansas performed regular and frequent "Fi-

189. *See* MOLLY FINNERTY ET AL., STATE HEALTH AUTHORITY YARDSTICK (SHAY): IMPACT OF STATE LEVEL ACTION ON THE QUALITY AND PENETRATION OF EBPS IN THE COMMUNITY 7 (2005) (discussing the implementation of evidence-based practices in Indiana, Kansas, Ohio, New Hampshire, New York, Vermont, Washington, and Maryland); National Association of State Mental Health Program Directors Research Institute, Implementing Evidence Based Practices Project National Review of Effective Implementation Strategies and Challenges (Apr. 7 & 8, 2003) (meeting notes), *available at* http://www.nriinc.org/reports_pubs/2003/EBPNatIReviewImplementationMtg2003.pdf (also discussing the implementation of evidence-based practices in Oregon and in the United States Department of Veterans Affairs).

190. *See generally* Doug Marty et al., *Factors Influencing Consumer Outcome Monitoring in Implementation of Evidence-Based Practices: Results from the National EBP Implementation Project*, 35 Journal of Administration and Policy in Mental Health 204 (2008); Charles A. Rapp et al., *Evidence-Based Practice Implementation in Kansas*, 46 COMMUNITY MENT. HEALTH J. 461, 461 (2010).

191. Kimberley Roussin Isett et al., *The Role of State Mental Health Authorities in Managing Change for the Implementation of Evidence-Based Practices*, 44 COMMUNITY MENT HEALTH J. 195, 208 (2008).

192. *Id.*

193. Rapp et al., *supra* note 190, at 462.

194. Isett et al., *supra* note 191, at 209.

195. Rapp et al., *supra* note 190, at 462 ("Fidelity" is a measure of how in compliance a given provider is with the guidelines of a particular evidence-based service).

delity and Outcomes" reviews to ensure that treatment was, in fact, data-driven and that outcomes were successful.[196]

Beyond these global changes, Kansas also engaged with providers and encouraged them to embrace evidence-based methodologies.[197] The state utilized basic economic incentives, rewarding providers with higher reimbursement rates when they could demonstrate, through objective data, that they had achieved "high-fidelity" with evidence-based methodologies.[198] Kansas implemented local "Leadership Teams" that expeditiously addressed local barriers to treatment fidelity with evidence-based methodologies.[199] Staff at all levels received training on evidence-based practices, sometimes even in the field.[200] Kansas recognized that simply relying on "workshop training" would not suffice.[201]

In short, it was a group effort. But it had to be. "The movement to implement [evidence-based practices] is complex and often requires changes in the state['s] infrastructure of policy and financing, the organization level of provider agencies, and the practice methods used by practitioners."[202] The goal could not "only [be for] the implementation of . . . evidence based practice[s], but also to help sustain [them] over time."[203]

Today, Kansas continues to implement evidence-based practices in-state successfully.[204] It also utilizes evidence-based methodologies to design novel and innovative services.[205] These "emerging practices" show promise, and may even be supported by data, just not enough to earn the label of "evidence-based."[206] But because the state's data collection/dissemination infrastructure already exists, Kansas is able to

196. *Id.* at 463. .

197. *Id.* at 462.

198. "High-fidelity" means that a provider's actual practices strongly match a given evidence-based services' guidelines.

199. Rapp et al. *supra* note 190, at 462.

200. *Id.* at 463–4.

201. *Id.* at 465.

202. *Id.* at 464.

203. *Id.* at 465.

204. *Id.* at 461.

205. *Id.* One of those practices, Integrated Dual Diagnosis Treatment, is specifically geared towards treating individuals with dual-diagnoses and was recently approved as an evidence-based practice in Kansas. *See Integrated Dual Diagnosis Treatment (IDDT)*, U. KAN. SCH. SOC. WELFARE, http://mentalhealth.socwel.ku.edu/overview-iddt (last visited Nov. 28, 2013). Currently, Kansas is developing other evidence-based practices, such as, Supported Education, Supported Housing, Pathways to Recovery, Wellness Recovery Action Plan (WRAP), Consumers as Providers (CAP), and Common Ground/Decision Support Center. *Id.*

206. *Emerging Practices*, U. KAN. SCH. SOC. WELFARE, https://web.archive.org/web/20110216015820/http://www.socwel.ku.edu/mentalhealth/projects/Emerging/index.shtml (last visited Nov. 28, 2013) (accessed by searching http://www.socwel.ku.edu/mentalhealth/projects/Emerging/index.shtml in the Internet Archive index) ("[An emerging practice] differs from a true evidence-based practice in that it has less than five published scientifically rigorous studies using consis-

test these novel services in real time. This approach to developing new and effective services has the potential to compound and eventually allow the state to develop a full continuum of evidence-based services across the entire spectrum of its citizens' mental health needs.

C. *North Carolina Should Fix What it Has Broken*

Of course, were North Carolina to follow Kansas' lead and implement evidence-based services, this would not entirely fix the damage to the North Carolina's mental health system. As an example, for eighteen to twenty-one year olds and complex/hard-to-serve children, the promise of evidence-based services in North Carolina means very little if they still are summarily denied access in-state services. As such, North Carolina should amend its regulations and implement new reforms to ensure that intensive in-state mental health services are available to these youth. To be clear, this paper does not advocate for expanding the scope of already existing services, such as PRTFs, to fill the service gaps faced by these populations. Instead, the well-defined service gaps that eighteen to twenty-one year olds and complex/hard-to-serve children currently face are fertile ground for beginning to implement evidence-based practices in the state. Meaningful, systemic reform has to start somewhere, and these are two groups that particularly could use some positive change.

CONCLUSION

North Carolina's children are growing up; the system that oversees their care is broken. The state has constructed systemic barriers to youth and their families, preventing them from obtaining vital, life-affirming services in-state. Not only do these barriers violate federal law, they undermine North Carolina's fundamental values and harm its credibility. Where the realities of mental health services in North Carolina do not match the state's own lofty statements of policy, its youth and their families find themselves adrift at the disconnect.

North Carolina must stop wasting money on ad hoc and piecemeal reform efforts. As of 2008, "[t]he state [had already] wasted at least $400 million in . . . ill-conceived and poorly executed" reforms.[207] How much additional money has been wasted in the five years subsequent? North Carolina can *start* counting at $287 million.[208] Rather

tent dependent variables. Emerging practices, like evidence-based practices, are highly specified interventions that have been manualized.").

207. Pat Smith & David Raynor, *Reform Wastes Millions, Enriches Providers, Fails to Serve Mentally Ill*, NEWS & OBSERVER, Feb. 24, 2008, at 1A, *available at* http://www.media2.newsobserver.com/static/content/pdf.

208. *See supra* note 43 (regarding the ongoing adult care home settlement).

than spend more and more taxpayer money on shipping youth to other states, that money could be used right here in North Carolina to provide *better* services. Community-based treatment is at least cost-neutral, and in some cases may cost a fraction of PRTF, or comparable inpatient, treatment.[209] More importantly, these services are effective.[210] By combining a meaningful community-based treatment model with the proven efficacy of evidence-based practices, the state

209. *See* OSWALDO URDAPILLETA ET AL, NATIONAL EVALUATION OF THE MEDICAID DEMONSTRATION HOME- AND COMMUNITY-BASED ALTERNATIVES TO PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES xiv (Nov. 1, 2011) ("The fact that the Demonstration has easily met cost neutrality tests and on average has consistently maintained or improved functional status for all children and youth is a success story."); U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, PUBLIC FINANCING OF HOME AND COMMUNITY SERVICES FOR CHILDREN AND YOUTH WITH SERIOUS EMOTIONAL DISTURBANCES: SELECTED STATE STRATEGIES 9, Table II.1 (June 2006), *available at* http://www.mathematica-mpr.com/publications/PDFs/pubfinhome.pdf; *S 3289: Children's Mental Health Accessibility Act*, FAMILIES LIKE OURS (Sept. 19, 2012, 3:03 PM), https://www.familieslikeours.org/blog/201209/s-3289-children's-mental-health-accessibility-act ("[I]ntensive in-home and community-based services costs are on average less than a third of the cost of PRTF institutional costs."); *see also* Deficit Reduction Act of 2005 (Public Law 109-171); US DHHS, Public Financing of Home and Community Services for Children and Youth with Serious Emotional Disturbances: Selected State Strategies (June 2006) (noting that "the 2005 Deficit Reduction Act (Public Law 109-171) authorizesdemonstration projects for up to ten states to assess the effectiveness of home and community-based alternatives to psychiatric residential treatment facilities (PRTFs)") A study was conducted under the authority of the Debt Reduction Act of 2005. *See generally* KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND HUMAN SERVICES, REPORT TO THE PRESIDENT AND CONGRESS MEDICAID HOME AND COMMUNITY-BASED ALTERNATIVES TO PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES DEMONSTRATION (July 2013), *available at* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Downloads/PRTF-Demo-Report-.pdf. It specifically was designed to "to test whether children and youth who meet the requirements to be served in a psychiatric residential treatment facility (PRTF) could successfully and cost effectively be served in the community." *Id.* at 1. Nine states participated. *Id.* at 2 (Alaska, Georgia, Indiana, Kansas, Maryland, Mississippi, Montana, South Carolina, and Virginia). And the results were astounding:

> For all nine states over the first three Demonstration years for which cost data was available to be collected, there was an average savings of 68 percent. In other words, the waiver services cost only 32 percent of comparable services provided in PRTFs. The Demonstration proved cost effective and consistently maintained or improved functional status on average for all enrolled children and youth.

Id. at 3.

210. *See supra* note 209. And beyond general efficacy, the United States Department of Health and Human Services recognizes the inherent value of community-based services:

> These children and adolescents have claimed a great deal of attention because of the gap between their need for intensive treatment and the availability of appropriate home and community services, which include a range of nontraditional treatments from home-based family counseling, respite care, and family-to-family support to independent skills training, crisis intervention, and treatment foster care. More and more studies indicate that these services are effective not only in improving mental health outcomes for youth with SED, but also in reducing or preventing stays in residential care and other out-of-home settings.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, PUBLIC FINANCING OF HOME AND COMMUNITY SERVICES FOR CHILDREN AND YOUTH WITH SERIOUS EMOTIONAL DISTURBANCES: SELECTED STATE STRATEGIES vii (June 2006), *available at* http://www.mathematica-mpr.com/publications/PDFs/pubfinhome.pdf.

can ensure that North Carolina tax dollars will be spent only on the most efficient and efficacious services. The toolkits to implement evidence-based practices, in step-by-step fashion, already exist. Not only have they also been proven to work, they are free and readily available.[211]

While much change is needed for North Carolina's mental health system, simply complying with federal law and living up to its own policies will bring North Carolina exponentially closer to providing its youth with the services—and dignity—that they deserve. The mistakes of the past decade need not doom the state in the next. But hoping that meaningful reform will somehow magically appear is not an effective strategy. The time to act is now. North Carolina's youth and their families cannot wait any longer.

211. *See supra* notes 51–55 and corresponding text.