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At What Age May Minors Leave Home?

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Feature Articles

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On the cover Most murder victims know their assailants. Our article explores several myths about murder in North Carolina and examines contributing factors and what can be done to reduce their effects. Photo by Bob Donnan.

Photo by Bob Donnan.

Murder in North Carolina

Stevens H. Clarke

ON A WEDNESDAY AFTERNOON at about 3 P.M., Rebecca, a forty-six-year-old woman, drives to a supermarket. The large parking lot is nearly full, and she must park some distance from the store. As she is getting out of her car, two men in their twenties, whom she has never seen before, attack and rob her, grabbing her purse. As they turn to flee, one of them draws a handgun and shoots her, causing injuries from which she dies several hours later.

Stevens H. Clarke is an Institute of Government faculty member who specializes in criminal justice and corrections.

The kind of murder people seem to fear most is what happened to Rebecca—being killed by a stranger, perhaps in connection with a robbery or other crime. But in several respects, her killing is not a typical murder. Most murder victims are male, and most are younger than Rebecca. Most are killed by someone they know or are related to, not by strangers. The majority are not reported to have been killed in the course of another crime, like the robbery in Rebecca's case. Most are killed in a residence (either their own or someone else's home), not in a public place. Most are killed in the evening or nighttime. In only two respects is this murder typical: the perpetrators are young men, and the murder weapon is a firearm.

Murder is the intentional, unjustified killing of another human being. In its legal definition, to be murder a killing must be done with malice. This article uses a broader definition, that of the FBI's Uniform Crime Reports (UCR), whose "murder" category includes not only murder as legally defined, but also non-negligent manslaughter, which is roughly equivalent to voluntary manslaughter under North Carolina law. Voluntary manslaughter includes intentional killing that does not qualify as murder—for example, killing in the heat of passion caused by adequate provocation and killing involving the excessive use of force in self-defense. Murder, as the term is used in this article, does not include either killings by negligence or legally justifiable killings such as legal executions or killings by police in the course of duty.[1]

This article examines murder in North Carolina since 1970. It looks at the characteristics of murder victims, murderers, and their relationships. It describes the weapons used to kill and the immediate circumstances of the killings. It identifies persons who are at high risk of being involved in murder, as well as high-risk situations and relationships. It compares North Carolina counties' murder rates and examines factors that may explain the differences, and it concludes with some possible approaches for preventing murder.

Because of murder's unique severity, and because almost all deaths are reported, murder data probably are more complete, accurate, and consistent over time than are data available for any other crime. Most of the article relies on the sources of data listed below. The graphs and tables were based on the author's analysis of data from these sources.

- SHR (police Supplementary Homicide Report) data: The Federal Bureau of Investigation maintains a file of information from SHRs filed by police concerning victims, suspected offenders,[2] relationships, weapons, and circumstances. These data, referred to as "SHR data" in this article, are available for 1976 through 1992.[3]
- SBI data: The annual reports of the North Carolina State Bureau of Investigation (SBI), which also are based on information supplied by police. These data are used primarily for the year 1993, to supplement SHR data.
- Medical examiner data on murder victims, places, and times from the North Carolina Medical Examiner's Office, available from 1972 to 1993.
- Census data from the United States Census Bureau on North Carolina population by year, sex, race, and age, as well as social and economic characteristics of North Carolina counties in 1990. Most of these data were obtained from the State Data Center through its LINC system. (Note that except for 1970, 1980, and 1990 all census data are either interpolated or projected estimates.)

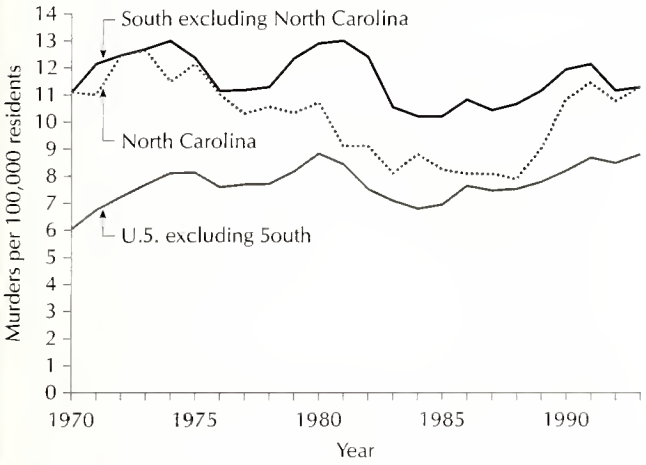
Victims

Overall Murder Victimization Rate

North Carolina's annual number of murders, according to SHR and SBI data, was 565 in 1970, increased to 677 in 1975, dropped to a low of 490 in 1983, and thereafter rose, reaching 774 in 1993. Much of the increase in crime is due to increases in population: the more people, the more crime. To look at murder in relation to population, we use the *murder victimization rate*: the number of murder victims per 100,000 state residents. This rate measures North Carolinians' overall risk of being murdered. SHR data indicate that the murder rate for the entire state population in the 1970s was between 10 and 12 per 100,000, reaching a peak of 12.7 in 1973. In the 1980s, it dropped considerably to 8 to 9 per 100,000 (see Figure 1). Thereafter it increased, reaching 11.3 in 1993, the year for which the latest published SBI data are available. Thus, although the rate has recently climbed, it still is lower than the highest point it reached in the mid-1970s.

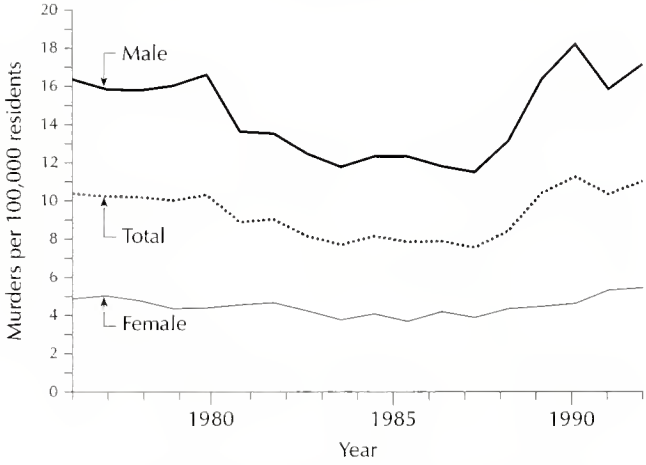
This article concentrates on North Carolina, but it is helpful to place its murder rate in the context of the region and the nation. North Carolina's murder rate has followed much the same pattern as that of the rest of the South,[4] and the South's rate has long been substantially above the rate for the rest of the country (see Figure 1). Both North Carolina's and the South's rates dipped in the 1980s, but North Carolina's did so to a greater extent. Both rates rose in the early 1990s; in 1993 they were equal

Figure 1
Murder Rates for North Carolina, Rest of South, and U.S. excluding South, 1970–93



Sources: Supplementary Homicide Reports, State Bureau of Investigation, U.S. Bureau of the Census.

Figure 2
North Carolina Murder Rates, by Victim's Sex, 1976–93



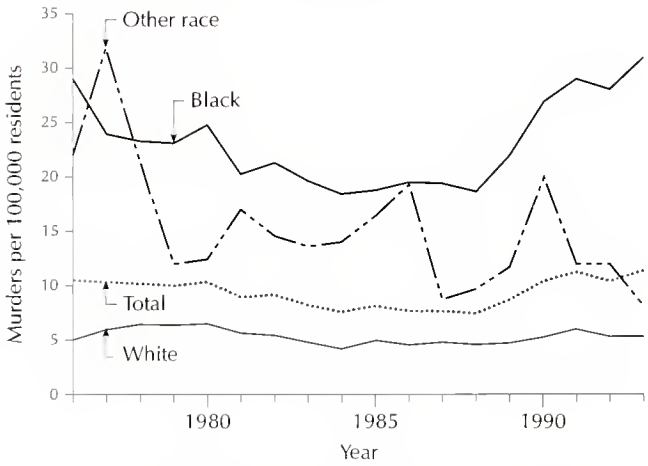
Sources: Supplementary Homicide Reports, State Bureau of Investigation, U.S. Bureau of the Census.

at 11.3 per 100,000. The linear trends for both rates have been essentially flat over the period, neither increasing nor decreasing.

The murder rate for the nation outside the South has been substantially lower than the South's rate throughout the period, not exceeding 9 per 100,000. Its linear trend has risen, but only slightly.

We have been discussing the overall murder rate as measured by the police. This rate takes into account all kinds of people and all kinds of murders. To better understand the risks of murder, one must take into account differences in sex, race, and age of victims and offenders, as well as victim-offender relationships, weapons, and immediate circumstances.

Figure 3
North Carolina Murder Rates, by Victim's Race, 1976–93



Sources: Supplementary Homicide Reports, State Bureau of Investigation, U.S. Bureau of the Census.

Victims' Sex, Race, and Age

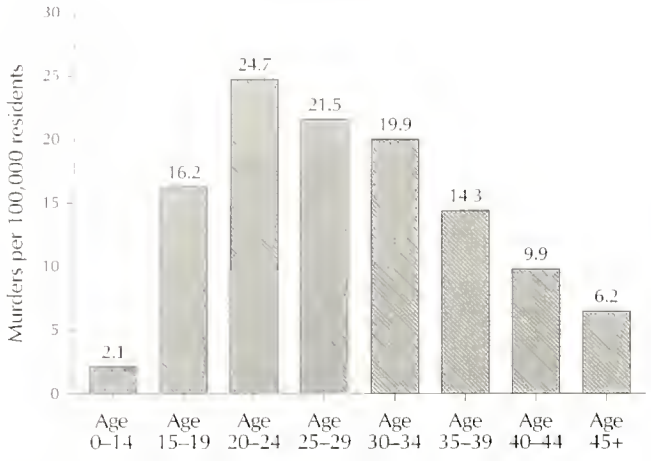
Men and boys are far more likely to be murdered than are women and girls. The murder victimization rate for males in North Carolina from 1976 to 1993 has been three to four times higher than the rate for females (see Figure 2). For example, in 1993 the rates were 17.2 per 100,000 males and 5.4 per 100,000 females.

Since 1976, females' murder victimization rate has barely changed (remaining in the range of 4 to 5 per 100,000). Males' rate has varied: after the 1970s it dropped, then increased rapidly in the late 1980s and early 1990s. The pattern in the overall murder victimization rate—dropping after the 1970s, then increasing in the late 1980s—clearly is due to changes in males' victimization risks, not females'.

Race is also associated with murder victimization (see Figure 3).[5] The victimization rate for black North Carolinians since 1976 consistently has been four or five times as high as the rate for whites. In 1993, blacks' rate was 30.7 per 100,000, compared with 5.5 for whites. Whites' rate showed little change after 1976, while blacks' rate dropped until the mid-1980s, then rose sharply.

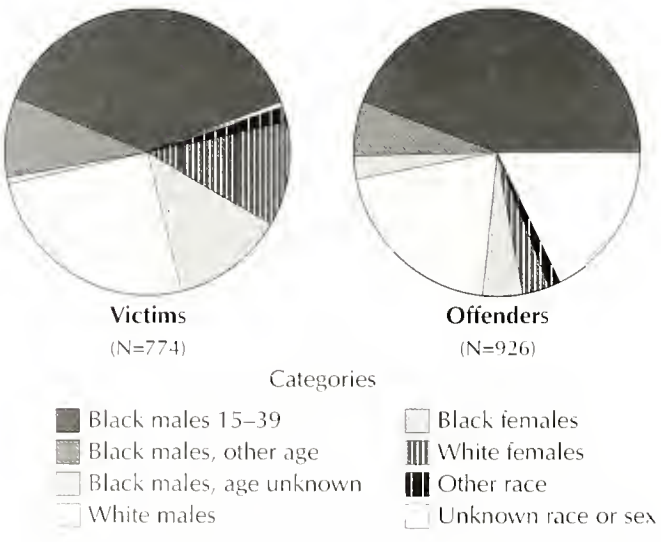
What about other racial groups? The victimization

Figure 4
North Carolina Murder Victimization Rates, by Age Group, 1993



Sources: State Bureau of Investigation, U.S. Bureau of the Census.

Figure 5
North Carolina: Victims and Suspected Offenders, by Race, Sex, and Age, 1993



Note: Victims and offenders were omitted if their age was unknown. (Of a total of 774 victims, the ages of 16 were unknown and 758 were included in the graph; of 926 suspected offenders, the ages of 200 were unknown and 726 were included on the graph.)

Source: North Carolina Department of Justice, State Bureau of Investigation, *Crime in North Carolina: Uniform Crime Report 1993* (Raleigh, N.C.: 1994), 27.

rate among persons not classified as white or black—in North Carolina most of these are Native Americans—also was much higher than that for whites. This rate has varied much more over the period than whites' or blacks' rates, probably because the number of those in other race groups has been too small for stable statistics and also perhaps because racial classifications may have changed over time.

Age is a third characteristic linked with murder (see Figure 4). Young adults from 20 to 34 years of age clearly had higher murder victimization risks than did either older persons or youth under 20. For example, those age 20 to 24 had two and a half times the murder rate (24.7 per 100,000) as did those age 40 to 44 (9.9 per 100,000). Due to recent rapid increases in their victimization (explained below), those in their late teens (age 15 to 19) had a higher murder rate than did all persons age 35 and over.

Putting sex, race, and age together (see Figure 5), black males accounted for almost half (48.4 percent) of murder victims: those age 15 to 39 for 38.6 percent and those of other ages (under 15 or over 39) for 9.0 percent; another 0.8 percent were black males of unknown age. White males constituted 25.2 percent of victims. The other victims were black females (12.8 percent), white females (11.8 percent), and all other racial groups regardless of sex (1.7 percent). One victim's race and sex were unknown to police.

Recent Increases in Victimization among Young Black Males

For North Carolina's young black men and teenage boys, murder victimization has increased with astonishing speed in recent years (see Figure 6). For black men age 20 to 24, the rate of murder victimization as shown by SHR data rose to 139.3 per 100,000 in 1993—a level two to four times higher than what it had been before 1990, when it generally was in the 30 to 60 range. Black males age 15 to 19 also experienced an extremely rapid increase in murder victimization. Their rate dropped in the early 1980s, reaching 9.9 in 1984, and thereafter increased to 82.3 in 1993, at least four times higher than its pre-1989 levels. For young white males in the same age groups, the victimization rates were much lower than the blacks' rates and generally did not increase.

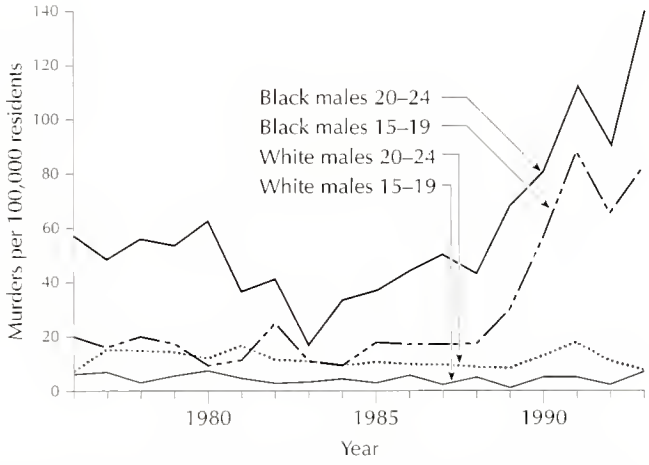
Murder has become the leading cause of death in North Carolina for young black males. In 1991, using the latest data available from the Centers for Disease Control, 135 of 283 deaths of black males age 15 to 24—47.7 percent—were due to homicide (see Figure 7). The next

most common causes of death for these young black males were motor vehicle traffic crashes (15.5 percent), other unintentional injuries (12.7 percent), suicide (7.8 percent), and heart and other circulatory system diseases (2.5 percent); all other causes amounted to 13.8 percent. Of the 453 deaths of white males age 15 to 24, only 11.7 percent were homicides. Unintentional injuries accounted for a majority of deaths (motor vehicle crashes for 42.6 percent and other unintentional injuries for 9.3 percent), suicides for 18.3 percent, circulatory disease for 3.5 percent, and other causes for 14.6 percent. Most of the homicides (44 of 53 for whites, 118 of 135 for blacks) were committed with firearms.

The rapid increase in murder victimization for young black males in the late 1980s and early 1990s is not unique to North Carolina; rather, it is part of a national trend. Data from the United States Centers for Disease Control, drawn from state medical examiners' reports, indicate that across the country, the murder victimization rate for black males age 15 to 19 more than tripled, rising from 38.8 per 100,000 in 1984 to 133.5 in 1991; for black males age 20 to 24 it more than doubled, going from 82.7 in 1984 to 182.4 in 1991.[6]

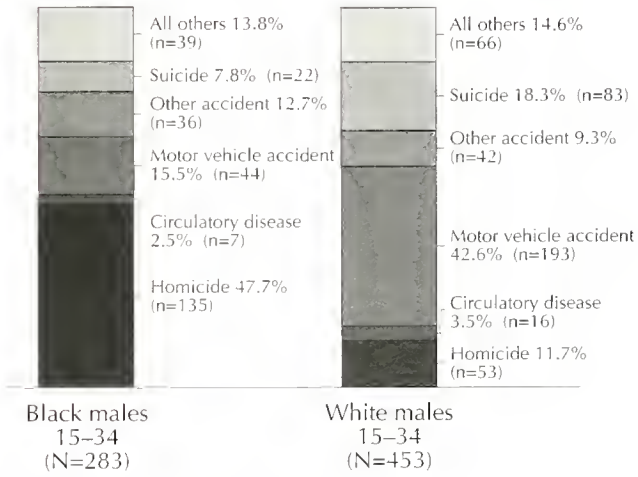
[By presenting these alarming data concerning young black men and boys, I do not mean to suggest that murder is exclusively a problem of African Americans. All ethnic groups share in the possibility of becoming victims or perpetrators of crime, including murder, and all groups share a fear of crime and a desire to reduce it. However, in efforts to prevent violent crime, it is important to keep in mind that young black males are especially vulnerable to being victims of murder.]

Figure 6
North Carolina Murder Rates for Young Males, 1976–93



Sources: Supplementary Homicide Reports, State Bureau of Investigation, U.S. Bureau of the Census.

Figure 7
Causes of Death for Males, Age 15–24, in North Carolina, Comparing Blacks and Whites, 1991



Source: U.S. Centers for Disease Control.

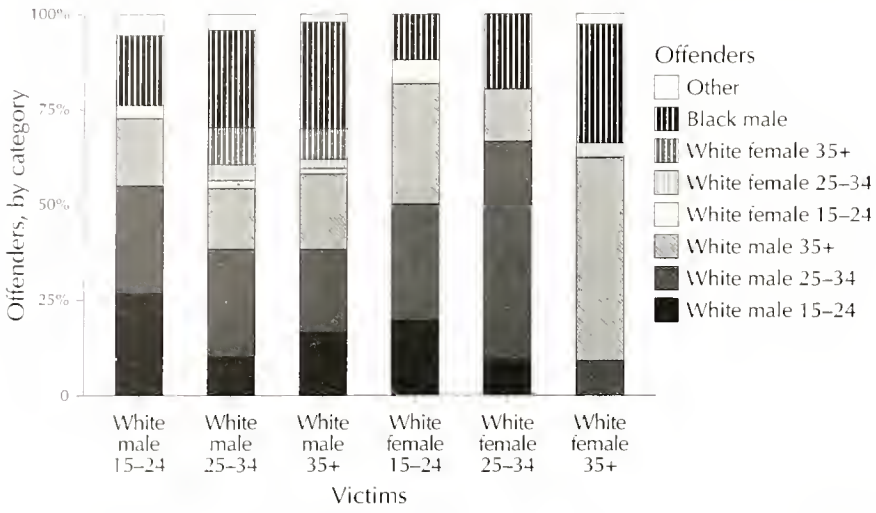
Offenders

This article's data on offenders—suspected killers—come from police reports. In a murder case, police submit information gathered in their investigation to the SBI and FBI. Based on that infomation, they describe the suspect as best they can—and sometimes there is no suspect. Police information about offenders is not as reliable as their information about victims. However, because murder is such a serious crime, and because the perpetrator often is known to the victim and his or her friends or relatives, police information about the suspect tends to be better in murder cases than in other types of crime.

Offenders' Sex, Race, and Age

The race or sex (or both) of about 18 percent of 926 suspected murderers in North Carolina in 1993, as reported by the SBI was unknown to police (see Figure 5, "Offenders"). Over half of the suspects (53.0 percent) were black males: black males age 15 to 39 constituted 44.2 percent and those older or younger 6.2 percent; another 2.6 percent were black males of unknown age. White males accounted for 20.3 percent, black females 4.5 percent, and white females 3.0 percent.

Figure 8
Combinations of White Murder Victims and Offenders, in North Carolina (1992)



Source: Supplementary Homicide Reports.

Murders Involving Very Young Killers: On the Increase?

Occasionally one hears of murders committed by very young offenders; understandably, the news media gives these prominent coverage. From 1976 to 1991, such murders were quite rare, the annual total averaging 3.6 and never exceeding 7. But such murders may be increasing. In 1992 the total jumped to 10 (1.4 percent of the 703 murders in which the suspected killer's age was reported in SBI data) and in 1993 to 14 (1.4 percent of 726 such murders). Two years are hardly enough to establish a trend, but the change is alarming.

Relationship of Offenders to Victims

Most Victims Are Killed by Relatives or Acquaintances

In murders in North Carolina in 1992, SHR data indicate that victims and killers usually knew each other. Of 707 victims that year, 68.4 percent had some kind of a relationship to their killers: 13.5 percent were spouses or former spouses, or present or former lovers; 7.6 percent were family members; and 47.3 percent had some other kind of relationship or acquaintanceship. For 13.5 percent, the police reported that the killer was a stranger. But the "stranger" category actually may be larger: the police could not determine the relationship for another 18.1 percent of the victims, and many or most of their killers may have been strangers (police would be much more likely to report the fact if victims and suspects had been acquainted).

Male and female victims differed in their relationship to their assailants. Females were much more likely to be killed by spouses or lovers (35.7 percent versus 5.7 percent for males), but less likely to be killed by other nonfamily acquaintances (26.1 percent versus 54.8 percent for males). Also, they were less likely to be killed by a stranger (7.4 percent versus 15.6 percent).

Victims' Characteristics Compared to Their Killers'

With the important exception that females almost always are killed by males, murder victims and perpetrators tend to have similar characteristics. This is not surprising in view of the fact that in most cases they are known to each other.

In 1992, according to SHR data, for white male victims of all ages, the majority of suspected killers (58.8 percent) were white males, while 22.2 percent were black males (see Figure 8). The suspects tended to be fairly close in age to the victims. For white male victims age 15 to 24, for example, 26.7 percent of the suspects were white males in the same age range, while 29.3 percent were 25 to 34 and 16.0 percent were 35 or older. For older white male victims, the white male offenders tended to be older.

Regarding black male victims of all ages (see Figure 9), most suspected killers (87.4 percent) were black males, and 8.9 percent were black females. For black males in the 15 to 24 age group—which, as explained earlier, has recently experienced an extremely rapid growth in murder victimization—67.3 percent of the suspected offenders in 1992 were black males in the same age group. The suspected killers of older black males were older (over 24) black males.

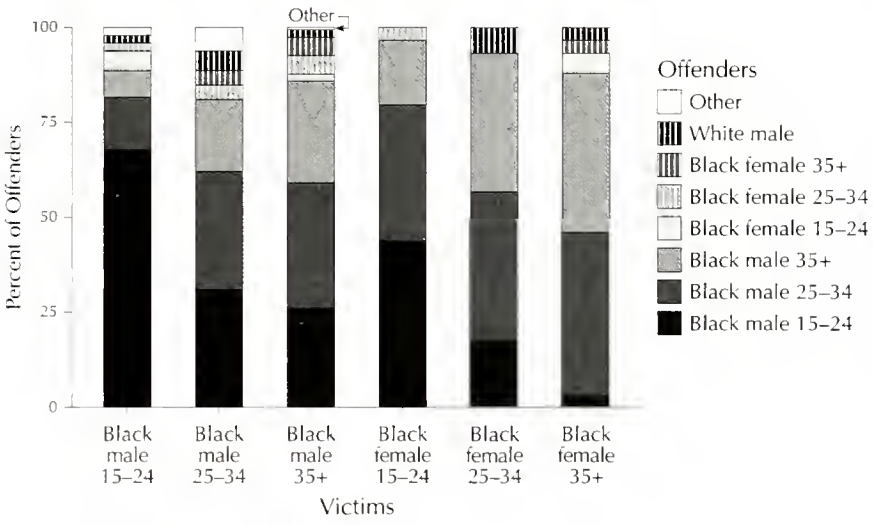
In murders of white females of all ages, almost all the suspects (94.0 percent) were males; the majority (69.8 percent) were white males, while 24.1 percent were black males. In murders of black females, most suspects (92.2 percent) were male; 87.9 percent were black males, and 4.3 percent were white males. Killers and female victims also tended to be in the same age groups—that is, younger women were more likely to be murdered by younger men and older women by older men.

Immediate Circumstances, Weapons, Places, Times, and Drug Use

Circumstances

In 1992, of 707 North Carolina murder cases reported in the SHR data, 40.7 percent occurred during "arguments" or "brawls" between the victim and offender, as well as a few conflicts stemming from what the SHR refers to as "romantic triangles." Another 27.0 percent occurred during the commission of another crime, for example, robbery, burglary, or a violation of drug laws.[7] In 32.2 percent of the cases, the police either did not know or did not report the specific circumstances.

Figure 9
Combinations of Black Murder Victims and Offenders, in North Carolina (1992)



Source: Supplementary Homicide Reports.

The proportion of murders occurring in the course of another crime has increased substantially in the last few years. From 1976 to 1990, it remained in the 9 to 15 percent range; in 1991 it increased to 19.9 and in 1992 to 27.0. In particular, the proportion that occurred during drug crimes was usually less than 1 percent through 1990, but in 1991 rose to 5.4 percent and in 1992 to 8.6 percent.

Murder in the course of another crime has recently become a more important contributor to murders of young black males age 15 to 24, although arguments and brawls also remain important precipitating factors. With regard to the circumstances reported by police about young black male victims, arguments or brawls have declined in relative frequency, while murders in the course of another crime have increased. For these young men, before 1990 the majority of murder circumstances were reported as arguments or brawls; in 1991, these circumstances dropped to 41.8 percent of young black male murders, while killing in the course of another crime rose to 24.2 percent that year and 24.4 percent in 1992. (Prior to 1991, this circumstance had usually accounted for only 4 to 10 percent.) Much of this growth appears to be connected to drug offenses. Of the 68 murders of young black males in 1991 and 1992 that according to police reports occurred during another crime, 40 (58.8 percent) occurred during violations of narcotics laws.

Despite the recent increase in murders committed during some other crime, the circumstances of murders most commonly reported by police in the SHR data have continued to be arguments or fights. It is also important to note that while the murder may be committed in the course of another crime, the victim and offender still are often acquainted or related. In 1991 and 1992, when 23.3 percent of murders were reported as being committed in the course of another crime, 44.1 percent of *those* murders were said to have involved acquaintances or relatives.[8]

Weapons and Other Means of Killing

In 1992, according to SHR data, 63.5 percent of North Carolina murders were committed with guns—48.0 percent with handguns and 15.5 percent with other firearms. Knives accounted for another 16.1 percent, and other means for 12.0 percent (these included blunt objects, hands or feet, strangulation, fire, and other methods of killing known to the police).[9] Before 1991, the percentage of all murders committed with handguns rarely exceeded 42, but in 1991 it went up to 46.6 and in 1992 to 48.0.

Where either the victim or the suspected killer was a young black male, the role of firearms was especially important. The increase in murders in the late 1980s and early 1990s where a young black male was the victim has consisted almost entirely of gun murders (see Figure 10, page 12).[10] In other words, without the increase in gun murders, there would have been virtually no increase. The graph also shows that the *decline* in murders involving young black males in the 1970s, lasting until the early

What Can Be Done to Reduce Murder?

Nonviolent Resolution of Interpersonal Conflict

Murder usually involves young people, and most victims have some kind of acquaintance or relationship with their killers. Murder usually takes place in someone's residence. A substantial number of murders appear to be the result of interpersonal conflict poorly resolved, rather than part of a predatory scheme (as in robbery or burglary) with economic motivation. These facts suggest that teaching ways of resolving conflict without violence—especially to young males—could be helpful in reducing murder and other violence. Scott Bradley and Frances Henderson, professional mediators writing in a recent issue of this magazine, describe the "peer mediation" programs for resolving conflict among students currently operating in a number of North Carolina public schools, as well as research showing that such programs are effective.[1] Daniel Webster, an instructor at the Johns Hopkins School of Hygiene and Public Health, is less optimistic. In a recent review of the literature, he concludes: "There is no evidence that such programs produce long-term changes in violent behavior or risk of victimization." He recommends long-term evaluations of the programs "to detect possible changes in perpetration and victimization involving serious injuries."[2] Certainly no such program has yet been shown to reduce murder.

Gun Control

Firearms, especially handguns, were involved in the enormous increase of murders among young black males in recent years. This fact suggests that controlling and reducing the spread of firearms might be an effective way of reducing violence. Gun control is a complex subject and a full discussion of it is beyond the scope of this article. Recent research suggests that it may be difficult to reduce the number of guns in private hands through commonly used legal measures.[3] A recent National Research Council review of the issue recommends careful testing of the following intervention strategies to determine their effectiveness:

- disrupting illegal gun markets using the centralized and street-level tactics currently in use for disrupting illegal drug markets
- enforcing existing bans on juvenile possession of handguns
- community-oriented or neighborhood-oriented police work involving close coordination with residents and community-based organizations[4]

Alfred Blumstein, the criminologist who sees the recent rise in murders of young black men as the result of the proliferation of handguns in the crack trade (see the main section of this article, under "The Illegal Drug Trade"), recommends that along with enforcing drug laws, police concentrate on the illegal gun market.[5]

Focusing on Children and Youth

This article's analysis of county-level data indicates that the murder rate is highest where families are weakest or most under stress, due to children living with a single parent, without a father, or in poverty, and due to high teenage pregnancy rates. The implication is that to reduce murder, efforts should focus on children and youth, for example, through assistance to high-risk families and through curbing teen pregnancy.

If the view is correct that much of the recent increase in murder among young black males is due to involvement in the illicit drug business, it still may be traceable to children's development. Recent longitudinal studies indicate that while drug abuse may to some extent be a cause of delinquency (including violent behavior), the same developmental pathways that lead from childhood to later delinquency also lead to drug abuse.[6]

Hirokazu Yoshikawa in a recent publication suggests that the best approach to prevention of chronic delinquency is to combine family support with early edu-

1980s, was due to a drop in gun murders. The data for the United States as a whole (not shown in these graphs) describe patterns similar to those in North Carolina.

What about the involvement of handguns compared to other firearms? In murders of young black male victims, the decline in the 1970s and early 1980s was mainly in murders with firearms other than handguns, such as rifles and shotguns (see Figure 10). However, the later *increase* in such murders (starting in the late 1980s) involved mainly handguns.

cation.[7] Reviewing research results on twenty-two programs, Yoshikawa found four that were shown to be successful in long-term prevention of chronic delinquency (repeated, serious delinquency). These four programs[8] had four elements in common:

1. They dealt with children under five years of age (and their families).
2. They lasted two to five years.
3. They focused on high-risk children in urban, low-income areas.
4. They involved family support *plus* early education. Family support took the form of home visitors who gave emotional support and helped parents with parenting skills and their own educational and vocational goals. Educational services included educational day care, preschool, or both.

Conclusion

These brief discussions of early childhood intervention programs, control of firearms, and nonviolent conflict resolution provide some examples of ways in which murder and other violence might be prevented. There is every reason to try these approaches, especially because the currently popular emphasis on imprisonment does not seem to have been very effective in curbing violent crime.[9] But there is also every reason to test and evaluate prevention programs. In this troublesome area of public policy, there are no guarantees of success.

Notes

1. Scott Bradley and Frances Henderson, "A Calm Approach to Violence in the Schools," *Popular Government* 59, no. 4 (Spring 1994): 34–40.

2. Daniel W. Webster, "The Unconvincing Case for School-Based Conflict Resolution Programs for Adolescents," *Health Affairs* 12, no. 4 (Winter 1993): 126–141. Webster also recommends more research on the situations that spark violent encounters involving youth. He believes that teaching negotiation skills may not be what it takes to reduce such encounters: "Currently, there is more convincing evidence that status attacks and macho posturing are more common precursors to violence than situations that would usually call for negotiation skills" (137–138).

3. Gary Kleck and Britt Patterson, in a recent careful analysis involving 170 U.S. cities of at least 100,000 population, found that none of the cities' various gun control measures appeared to have any impact on gun prevalence. The measures their study considered included requiring registration of firearms, requiring a license to possess a gun, requiring a permit to buy or acquire one, establishing a waiting period, prohibiting possession by criminals or mentally ill persons, prohibiting purchase by minors, and imposing an additional mandatory penalty if a crime is committed with a gun. *See* Gary Kleck and E. Britt Patterson, "The Impact of Gun Control and Gun Ownership Levels on Violence Rates," *Journal of Quantitative Criminology* 9, no. 3 (1993): 249–287.

4. Albert J. Reiss Jr. and Jeffrey A. Roth, eds., *Understanding and Preventing Violence* (Washington, D.C.: National Academy Press, 1993), 281.

5. *See* interview with Alfred Blumstein in *Law Enforcement News* 21, no. 422 (April 30, 1995): 10–13.

6. David Huizinga, Rolf Loeber, and Terence P. Thornberry, *Urban Delinquency and Substance Abuse: Initial Findings* (Washington, D.C.: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention, 1994).

7. Hirokazu Yoshikawa, "Prevention as Cumulative Protection: Effects of Early Family Support and Education on Chronic Delinquency and Its Risks," *Psychological Bulletin* 115, no. 1 (1994): 28–54. Yoshikawa believes that no single risk factor (such as genetic defects, perinatal risk, poor cognitive ability, hostile or rejecting parenting, poor attachment to parents, abuse by parents, or marital conflict) makes a child become a chronic delinquent. Rather, it is the *cumulative impact of two or more risk factors* that makes chronic delinquency likely. Therefore, prevention programs, he believes, should focus on more than one risk area—for example, the family as well as the child's cognitive development. He calls this concept "prevention as cumulative protection."

8. These four programs were the Perry Preschool Project (Ypsilanti, Mich.); the Houston (Tex.) Parent Child Development Center, the Syracuse (N.Y.) Family Development Project; and the Yale Child Welfare Project (New Haven, Conn.).

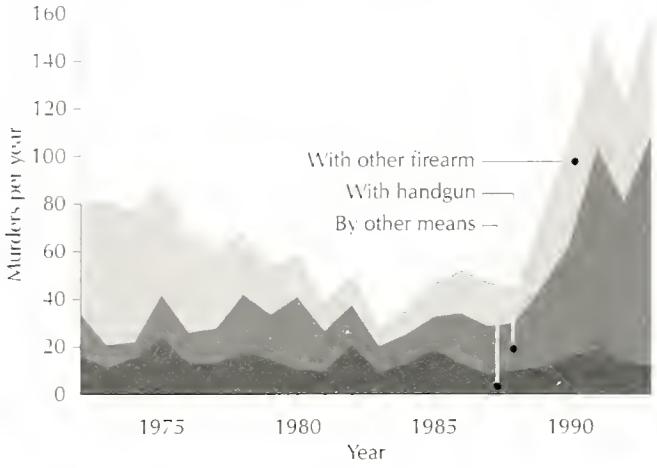
9. *See* Stevens H. Clarke, "Increasing Imprisonment to Prevent Violent Crime: Is It Working?" *Popular Government* 60, no. 1 (Summer 1994): 16–24.

These data suggest that the supply of firearms may contribute substantially to increases, as well as decreases, of murder involving young black males (see the later section dealing with the influence of the illegal drug trade).

Location and Time of Day

The North Carolina medical examiner reports for 1993 indicate that 54.4 percent of murders occurred in a residence, either the victim's or someone else's—a house,

Figure 10
North Carolina Murders where Victim Was Black Male Age 15–24: Firearms vs. Other Means, 1972–93



Note: "Other means" includes unknown.

Source: N.C. Medical Examiner.

apartment, mobile home, or other dwelling place.[11] Another 20.3 percent occurred on a street, parking lot, sidewalk, or other area used for transportation;[12] 9.1 percent occurred in bars, restaurants, stores, and other commercial establishments; the remainder occurred in a variety of locations, including rural land and recreational and sports facilities (7.7 percent of the locations were unknown to the medical examiner). Since 1972, there has been little change in the distribution of murders among types of premises.

In 1993, according to the medical examiner data, most murders occurred at night: 40.0 percent after 6 p.m. and before midnight, and 30.5 percent from midnight to 6 a.m. Only 29.6 percent occurred in the daytime (from 6 a.m. to 6 p.m.). This time pattern has been about the same since 1972.

Alcohol and Drug Use by Victims and Killers

Alcohol is involved in a large proportion of murders. In 1993, according to the medical examiner data,[13] 41.0 percent of *victims* had measurable amounts of ethanol in their blood: 29.1 percent had at least 0.08 grams per deciliter, North Carolina's legal standard for alcohol impairment,[14] while another 11.9 percent had some amount less than 0.05. Among those who met the legal standard for impairment at the time of death, the blood alcohol content often was quite high; in 1993, the median content for these victims was 0.16 grams per deciliter, and 25 percent had amounts ranging from 0.24 up to 0.51.

What about offenders' drug use? The medical examiner, of course, does not routinely test their blood alcohol content, and the police usually do not know about murder suspects' alcohol use. But because alcohol is such a social drug and because victims usually know their killers, it is reasonable to suppose that offenders often were intoxicated, or at least using alcohol, along with their victims. According to the Bureau of Justice Statistics of the United States Justice Department, in a 1986 study of violent offenders in state prisons, more than half said they committed their violent offense under the influence of alcohol or other drugs. The bureau cites another study of persons arrested for murder that indicates that 52 percent of male suspects and 49 percent of female suspects tested positive for cocaine, opiates, or other drugs excluding alcohol.[15]

The role of alcohol and other drugs in murder can take a variety of forms. For example, using alcohol could make victims less cautious about being in a dangerous situation or perhaps behave in a more provocative manner. Also, it could make them more vulnerable by reducing their ability to defend themselves. On the offender's side, drug use could make potential killers less inhibited or more aggressive. And then, of course, there is the possible contribution of the illegal drug trade, discussed in a later section.

Multiple Offenders and Multiple Victims

When looking at the numbers of victims and offenders involved in a murder event, the unit of analysis is the *murder incident*. A single murder incident may involve one or more victims, as well as one or more offenders.

According to SHR data for 1992, most murder incidents in North Carolina involved one victim and one killer. Another 11.7 percent involved a single victim and multiple killers, 2.8 percent involved multiple victims and a single killer, and 1.6 percent involved both multiple victims and multiple killers.

Recently, the percentage of incidents involving multiple killers and a single victim has gone up somewhat. Before 1990, it rarely exceeded 8 percent, then increased to 8.4 in 1990, 9.8 in 1991, and 11.7 in 1991.

This increase is more noticeable in killings of young black males age 15 to 24. In such killings, from 1976 to 1989 the percentage involving a single victim and multiple killers never exceeded 7.5 percent and usually was lower. It increased to 12.5 in 1990, 13.7 in 1991, and 13.9 in 1992.

The Illegal Drug Trade

The distinguished criminologist Alfred Blumstein, in a recent monograph, speculates on the reasons for the

recent national increase in gun homicides among nonwhite youth under age 18, as well as the rapid increase of arrests on drug charges for these youth:

> One explanation . . . involves a process that derives from the nature of illegal drug markets. They recruit juveniles, they arm these recruits with the guns that are standard tools of the trade in drug markets, and then guns and mores on their use diffuse into the larger community. . . . [The illegal drug] industry understandably recruits juveniles to work in it, partly because they will work more cheaply than adults, partly because they may be less vulnerable to the punishments imposed by the adult criminal justice system, partly because they tend to be daring and willing to take risks that more mature adults would eschew. The economic plight of many young urban black juveniles, many of whom see no other comparably satisfactory route to economic sustenance, makes them particularly amenable to the lure.[16]

Professor Blumstein notes that juveniles recruited into the drug industry are likely to carry guns for self-protection, "largely because that industry uses guns as an important instrument for dispute resolution." Also, they need protection when they are carrying money or valuable drugs, and are unlikely to call on the police. Blumstein speculates further that in response to the teenage drug dealers' being armed, other teenagers who are not involved in the drug trade also may arm themselves, either for their own protection or for enhanced social status. Thus, an escalation begins: "as more guns appear in the community, that increases the incentive for any single individual to arm himself."

Blumstein's theory about how gun prevalence increases among black youth is plausible, but there are some things it does not account for. As explained earlier, gun murders have increased rapidly since the late 1980s not only among black teenage boys but among older black males, those age 15 to 24. In particular, they have increased among those over 15 years of age who are not juveniles in North Carolina law. Blumstein's idea that young men are recruited into the drug industry because punishments are less severe for juveniles does not apply to these older males, who are adults for purposes of criminal sanctions. Nevertheless, these older males may, as he theorizes, be drawn into the drug trade because it seems to them better than other opportunities.

Blumstein's hypothesis also does not explain the *decrease* in gun murders involving young black males in the 1970s and early 1980s, which, as explained earlier, involved murders committed not with handguns but with rifles, shotguns, or other firearms.

Summary

For all North Carolinians taken together, the risk of being murdered is no higher than it was in the early 1970s, but for some groups—notably young black males—the risk has increased enormously in recent years. The state's overall murder rate varied from 1970 to 1993, following the pattern for the rest of the South, but without an increasing or decreasing trend (the South's rate has been consistently above the rate for the rest of the nation).

The risk of being a murder victim varies with individual characteristics: the murder victimization rate is much higher for males than for females, higher for blacks and other minorities than for whites (black males accounted for nearly half of all murders in 1993), and higher for young adults than for either older or younger persons.

For black male teenagers and those in their early twenties, the rate of murder decreased from the 1970s to the early 1980s, but then shot up, quadrupling by 1993. Murder now is by far the leading cause of death of young black males. Young black males' involvement as suspected offenders in murder cases also increased rapidly during this period. Some experts believe that involvement of these young men in the illegal drug trade and a concomitant proliferation of handguns were responsible for the recent surge in their murder victimization, most of which involved firearms—especially handguns.

Victims and killers usually are related or acquainted with each other and tend to have similar ethnicities and ages (for example, killers of young white men tend to be other young white men). Murders whose circumstances are reported by police are more likely to take place during an argument or fight than during the commission of another crime such as robbery. Most murders occur in someone's home, and most happen at night. Most are committed with firearms. Alcohol and drugs play an important role: 29 percent of North Carolina murder victims were legally drunk when killed, and another 12 percent had at least some alcohol in their blood. National studies indicate that roughly half of persons arrested for murder test positive for illegal drugs (excluding alcohol).

Conclusion

Murder and other violent crime is a formidable problem in North Carolina as in the rest of the nation. There is no instant solution to the problem. To solve it will require improved understanding of its dimensions—of who

is most at risk and why—as well as the patience to plan for the long term (see sidebar, "What Can Be Done to Reduce Murder?"). The information discussed in this article brings out the high and growing risks of youth in becoming involved in murder, either as victims or killers, and the strong connection between murder rates and indicators of conditions for child development. The best long-term strategy to reduce murder and other violence may be to try to improve the conditions under which children and youth grow up. Careful evaluation should be part of the strategy to document what is accomplished.

Notes

1. The author is grateful to the following persons who generously provided datasets, documentation, and analysis for this article: Patricia T. Barnes, information systems coordinator, Office of the Chief (North Carolina) Medical Examiner; Beth Moracco and Janet Heath of The University of North Carolina Injury Prevention Research Center; Professor James Alan Fox of Northeastern University; and Bill Tillman of the (North Carolina) Office of State Planning. The author also acknowledges the helpful criticism of Beth Moracco on a preliminary draft.

A few of the murders included in these statistics may have proven to be justifiable in other ways—for example, in exercise of the legal right of self-defense. Police and medical examiners usually report homicides before legal issues like self-defense can be decided by the courts.

2. The data on offenders, relationships, and circumstances, while the best available, probably are not as reliable as the data concerning victims. In the UCR system, the police report the characteristics of persons they treat as murder suspects, presumably to the best of their ability in their investigation. They do not take into account—and the data do not reflect—the outcome of prosecution or whether a person is charged with a murder.

3. Data from the UCR Supplementary Homicide Report (SHR), prepared by police and maintained by the FBI, were supplied by Professor James Alan Fox of Northeastern University in a form convenient for statistical analysis.

4. The South, as defined in UCR and census data, comprises sixteen southern and border states (Delaware, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia, Alabama, Kentucky, Mississippi, Tennessee, Arkansas, Louisiana, Oklahoma, and Texas) plus the District of Columbia.

5. Note that the classification of race in these data was done by different people. With respect to murder victims and offenders, investigating police officers determined racial groups. With respect to census data on North Carolina's population, those enumerated in decennial censuses classified themselves.

6. Data after 1991 were not available from this source.

Continued on page 17.

Social and Economic Factors in

How do North Carolina counties differ in their murder rates, and what sorts of social and economic factors affect them? These questions can be addressed by comparing counties' characteristics with their murder rates.

Because murder rates can vary quite a lot from year to year in counties with small populations, I used the average number of murders for 1991, 1992, and 1993 for each county, and then divided it by the county's 1992 population to estimate the county's current murder rate. This helped to reduce the contribution of variability, particularly in small counties' rates, and made the rates more comparable among counties. I used murder data from the North Carolina medical examiner.[1]

The 1991–93 average murder rates of the hundred counties varied from 0 for Clay and Tyrrell counties to a high of 34.1 murders per 100,000 residents for Hoke County (see Table 1, page 16).[2] The overall state average was 13.0 per 100,000.

To try to understand the differences in murder rates among counties, I looked at 1990 census data for the following county characteristics. The numbers in square brackets are the correlations[3] of each characteristic with the murder rate.

- density (population per square mile) [.13]
- percentage of county considered urban area [.19]
- percentage of population in 15 to 24 age group [.06]
- percentage black [.52]
- male unemployed as percentage of total population [.12]
- female unemployed as percentage of total population [.20]
- median family income [–.13]
- percentage of residents living in poverty [.33]
- percentage of children under 18 living in poverty [.41]
- teenage pregnancies (of girls age 15 to 19) per 100,000 residents [.65]
- AFDC (Aid to Families with Dependent Children) recipients per 100,000 residents [.50]

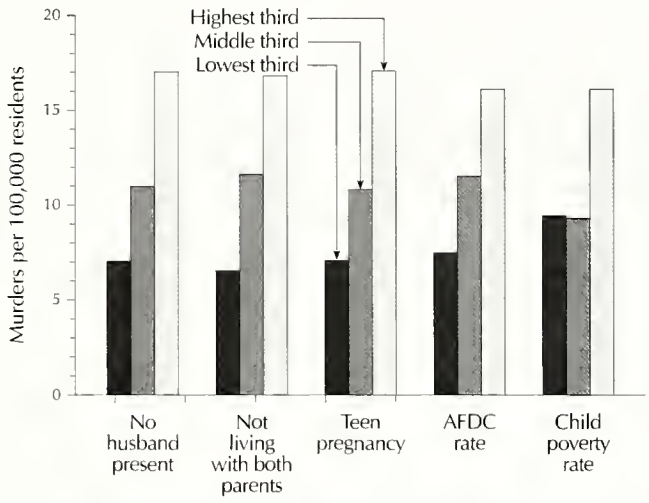
- reports of child abuse and neglect per 100,000 residents [.06]
- percentage of families with children under 18, a female householder, and no husband present [.68]
- children under 18 not living with both parents, per 100,000 residents [.67]

These variables were selected because among the available census data, they seemed to be the most likely to represent conditions or status that could cause crime, including violent crime. The age 15 to 24 variable was included because of the data (explained earlier in this article) showing that persons of that age were more likely than others to be involved in murder, either as victims or offenders. The percentage of black residents was included because blacks' murder victimization (as explained earlier) is higher than whites'.

The family-related variables were chosen as indicating conditions that might impede children's development, making it less likely that they would get proper care or more likely that they would be abused or neglected. The possible causal effects of these variables might be direct, or they could indirectly lead to violent crime by influencing children's physical, psychological, or moral development. Some of these variables did, in fact, prove to be correlated to murder rates. This does not prove that the murder-correlated variables were causes—correlation does not necessarily mean causation—but suggests that they played an important role.

Of the variables that were significantly correlated with counties' murder rate, the following had by far the highest correlations: (1) percentage of female-headed families with children under 18 and no husband present (correlation 0.68); (2) children under 18 not living with both parents, per 100,000 residents (correlation 0.67); and (3) teenage pregnancies per 100,000 residents (correlation 0.65). Any one of these three variables explained, statistically, about 45 percent of the total variance among counties in the murder rate. Two other variables that were important were the AFDC recipient rate (correlation 0.50) and the child poverty rate (correlation 0.41). The remaining variables had considerably lower correlations, some of which were not statistically significant.[4]

Figure 11
North Carolina Counties' Murder Rates, by Family Variables



Sources: N.C. Medical Examiner, U.S. Bureau of the Census.

Note: The murder rate is shown for counties that fall into the lowest third, middle third, or highest third of the distributions of each of the five family-related variables.

The five variables with the highest correlations to the murder rate—families with no husband present, children not living with both parents, teenage pregnancy, AFDC rate, and child poverty rate—together explained about 54 percent of the total variance among counties.[5] (The relationship of these five variables with counties' murder rates is illustrated in Figure 11.) This analysis suggests that of the various social and economic factors that can be measured with available Census data, those related to family structure and conditions have the most to do with the murder rate. Family factors do not account for all the variation in murder, but they apparently play an important role in a county's murder rate regardless of its population density, urbanization, or racial composition.

The percentage of county residents who were black, although it had a rather high first-order correlation with the murder rate (.52), ceased to matter statistically when the family variables were taken into account. In other

Continued on page 17.

Table 1
North Carolina Murder Rates by County:
Average for 1991–93

	County Name	Murders per 100,000 Population	Average Murders per Year, 1991, 1992, 1993	Est. 1992 Population
1.	Hoke	34.1	8.0	23,439
2.	Anson	31.2	7.3	23,468
3.	Hyde	24.7	1.3	5,400
4.	Robeson	23.0	24.7	107,238
5.	Mecklenburg	22.7	122.0	536,870
6.	Wilson	22.5	15.0	66,786
7.	Richmond	22.2	10.0	45,080
8.	Cleveland	22.0	19.0	86,332
9.	Bladen	21.9	6.3	28,907
10.	Jones	21.2	2.0	9,430
11.	Vance	21.2	8.3	39,352
12.	Duplin	21.1	8.7	40,978
13.	Swain	20.6	2.3	11,306
14.	Edgecombe	19.4	11.0	56,666
15.	Columbus	19.3	9.7	50,168
16.	Cumberland	19.1	53.7	281,478
17.	Durham	18.6	35.0	188,260
18.	Lee	18.6	8.0	43,086
19.	Lenoir	17.8	10.3	58,174
20.	Pitt	16.8	19.0	112,838
21.	Harnett	15.7	11.0	70,051
22.	Montgomery	15.6	3.7	23,525
23.	Nash	15.5	12.3	79,712
24.	Sampson	15.1	7.3	48,428
25.	Wayne	14.9	16.0	107,438
26.	Hertford	14.9	3.3	22,418
27.	Gaston	14.6	26.0	177,678
28.	Scotland	14.6	5.0	34,281
29.	Iredell	14.4	14.0	97,132
30.	Caswell	14.4	3.0	20,824
31.	Granville	14.3	5.7	39,596
32.	Washington	14.3	2.0	14,004
33.	Alexander	14.1	4.0	28,282
34.	Beaufort	14.0	6.0	42,796
35.	Chatham	14.0	5.7	40,463
36.	Graham	13.9	1.0	7,220
37.	Johnston	13.5	11.7	86,368
38.	Warren	13.4	2.3	17,444
39.	Bertie	13.1	2.7	20,330
40.	Martin	13.1	3.3	25,461
41.	Franklin	13.0	5.0	38,435
42.	Halifax	13.0	7.3	56,489
43.	Guilford	12.9	46.0	355,330
44.	Perquimans	12.8	1.3	10,433
45.	Yancey	12.8	2.0	15,675
46.	Forsyth	12.7	34.3	270,116
47.	Pasquotank	12.5	4.0	32,038
48.	Catawba	11.8	14.3	121,550
49.	Rowan	11.5	13.0	113,120
50.	Brunswick	11.0	6.0	54,550
51.	Greene	10.5	1.7	15,810
52.	Rockingham	10.4	9.0	86,404
53.	Davidson	10.4	13.7	131,352
54.	Alamance	10.2	11.3	110,830
55.	Alleghany	10.2	1.0	9,786
56.	Wilkes	9.9	6.0	60,353
57.	Pender	9.7	3.0	31,022
58.	Northampton	9.7	2.0	20,717
59.	Randolph	9.4	10.3	109,659
60.	Rutherford	9.2	5.3	57,772
61.	New Hanover	8.9	11.3	127,568
62.	Stanly	8.8	4.7	52,907
63.	Moore	8.7	5.3	61,257
64.	Pamlico	8.7	1.0	11,558
65.	Onslow	8.4	12.3	146,576
66.	Caldwell	8.4	6.0	71,726
67.	Orange	8.4	8.3	99,790
68.	Union	8.3	7.3	88,632
69.	Buncombe	8.2	14.7	179,921
70.	Ashe	7.4	1.7	22,436
71.	Cabarrus	7.4	7.7	103,657
72.	Henderson	7.4	5.3	72,128
73.	Burke	7.3	5.7	77,276
74.	Dare	7.1	1.7	23,524
75.	Lincoln	7.0	3.7	52,208
76.	Stokes	6.9	2.7	38,435
77.	Wake	6.8	31.3	459,982
78.	Craven	6.8	5.7	83,892
79.	Avery	6.7	1.0	14,928
80.	Cherokee	6.5	1.3	20,628
81.	Surry	5.8	3.7	62,831
82.	Camden	5.5	0.3	6,046
83.	Yadkin	5.3	1.7	31,502
84.	Carteret	4.8	2.7	55,086
85.	Davie	4.6	1.3	28,696
86.	Currituck	4.6	0.7	14,558
87.	Person	4.3	1.3	30,722
88.	Haywood	4.1	2.0	48,224
89.	Macon	4.1	1.0	24,512
90.	Madison	3.9	0.7	17,202
91.	Mcdowell	3.7	1.3	36,000
92.	Jackson	3.6	1.0	27,573
93.	Watauga	3.5	1.3	37,832
94.	Gates	3.5	0.3	9,521
95.	Transylvania	2.5	0.7	26,225
96.	Chowan	2.4	0.3	13,917
97.	Mitchell	2.3	0.3	14,470
98.	Polk	2.2	0.3	15,030
99.	Tyrrell	0.0	0.0	3,846
100.	Clay	0.0	0.0	7,241

Note: Rates per 100,000 1992 population estimated by State Data Center.

Sources: N.C. Medical Examiner, U.S. Bureau of the Census.

Continued from page 15.

words, given the rates of families with no husband present, teenage pregnancy, child poverty, etc., it made no difference what proportion of residents were black. This result suggests not only that family factors were of major importance, but also that blacks' higher murder victimization rate may be due to family characteristics.

Notes

1. Note that these rates are slightly higher than would be computed from police data because of differences in reporting. For example, the statewide rate of 13.0 was higher than the rate based on police data (10.6) for 1992. As explained in note 11 in the main section of this article, state medical examiners routinely report more murders than do the police; this is true throughout the United States.

2. Some of these rates, especially in low-population counties, are based on very small numbers of murders and therefore could be unstable over time.

3. The correlation coefficient ranges from 0 (meaning no relationship at all) to either 1 (meaning perfect positive correlation) or –1 (meaning perfect negative correlation). Positive correlation means that the murder rate increases as the variable's value increases, and negative correlation means that the murder rate increases as the variable's value *decreases*. If the correlation coefficient was significant (or "statistically significant"), this means that the value of the correlation was very unlikely (with a probability less than 5 percent) to have occurred through random variation in drawing the data samplethat is, without there having been a true relationship between the variable and the murder rate. If the correlation coefficient was *not* significant, this means that we cannot exclude the possibility that the correlation occurred just by random variation in sampling.

4. The following variables from the above list were not significantly correlated with the murder rate: the percentage age 15 to 24; density of population; median family income; male unemployed persons per 100,000; and the rate of reported child abuse/neglect. The rate of *female* unemployed was significantly correlated with the murder rate, but the correlation was fairly weak (0.20).

5. These variables were highly intercorrelated, so that it is difficult to consider the independent contribution of any single one to the murder rate. For example, the teenage pregnancy rate and the percentage of children living in poverty had a correlation of .32. The contribution to the murder rate of all of the county characteristics listed above in the text was analyzed by a statistical technique known as multiple regression.

Continued from page 14.

7. In this category I also include cases where another felony was merely suspected (17 total), cases where children were killed by babysitters (5 total), and cases reported as "gangland killings" (a total of 2).

8. Conversely, in those two years, 37.3 percent of the murders in the course of another crime reportedly involved acquainted or related victims and killers.

9. The police did not report the means of killing in 8.4 percent of the cases.

10. The same pattern is seen if one looks at murders in which young black males are the suspected killers.

11. Location, as used here, refers to the place of the fatal assault on the victim, not the place where the victim died (often the victim was moved to another place, such as a hospital, before death). The medical examiner reported 931 murders in North Carolina in 1993. In this state and in the rest of the country, the medical vital statistics system reports more murders than do the police in the UCR system. Apparently this is due to underreporting by police. See William M. Rokaw, James A. Mercy, and Jack C. Smith, "Comparing Death Certificate Data with FBI Crime Reporting Statistics on U.S. Homicides," *Public Health Reports* 105:5 (Sept.–Oct. 1990), 447–455.

12. Numbers in this category (killings on the street) have recently increased; before 1992, they were in the 10 to 16 percent range.

13. The medical examiner routinely tests the bodies of murder victims for the presence of ethanol (the consumable form of alcohol) in the blood. The examiner does not test routinely for other drugs; such tests are only done occasionally, for example, where poisoning or a drug overdose is suspected.

14. With regard to driving while impaired, see N.C. Gen. Stat. 20-4.01(0.2) and -138.1(a).

15. United States Department of Justice, Bureau of Justice Statistics, Drugs, Crime, and the Justice System (Washington, D.C.: GPO, 1992), 5, 7. The arrestee study was based on voluntary urinalysis while in custody, about 28,000 arrestees in twenty-one cities.

16. Alfred Blumstein, Youth Violence, Guns, and the Illicit-Drug Industry (Pittsburgh, Pa.: Heinz School of Public Policy and Management, Carnegie Mellon University, 1994), 18–19 (draft monograph cited with author's permission; to appear as article in forthcoming issue of *Journal of Criminal Law and Criminology*).

Community Mental Health Services in North Carolina:

Yesterday, Today, and Tomorrow

Mark F. Botts

IN THE EARLIEST DAYS, local mental health services consisted entirely of locking up people with mental disabilities on the basis that they were dangerous. As our understanding of mental disabilities grew in the late nineteenth and twentieth centuries, the state took the lead in attempting to care for citizens with mental disabilities. At the close of this century, North Carolina is looking increasingly at the local government level for solutions to problems in mental health services. In the three articles that follow, Institute of Government faculty member Mark F. Botts, who specializes in mental health law, looks at today's system of public mental health, developmental disabilities, and substance abuse services, at how we got here, and where we may be going. The author wishes to thank Ingrid M. Johansen, research associate at the Institute, whose research assistance made this article possible.

—Editors

Yesterday
A Brief History

Only in recent history has local government in North Carolina adopted a significant treatment role in mental health care. In fact, there existed no public or private institutions designed specifically for the care and treatment of persons with mental disabilities until the mid-nineteenth century. Before then, however, it was common for people with mental disabilities to live in confinement due to the threat, perceived or real, that they posed to property and public safety. Confinement was the responsibility of families or guardians, with county governments assuming custody only when the family could not fulfill the responsibility. Thus, while local government's current service role is relatively new, the earliest government response to persons with mental disabilities, albeit de facto and limited to detention, was exclusively local.

"I come not to urge personal claims nor to seek individual benefits. I appear as the adovocate of those who cannot plead their own cause. In the Providence of God, I am the voice of the maniac whose piercing cries come from the dreary dungeons of your jails—penetrate not to your halls of legislature. I am the hope of the poor crazed beings who pine in cells and stalls and cages of your poorhouses."

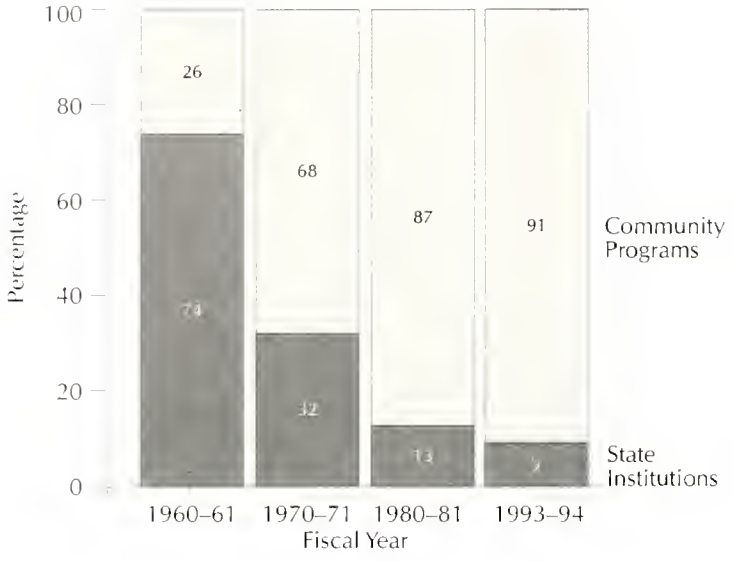
Dorothea Dix, 1848

Local jails and county poorhouses provided local government with the means for confinement. A 1785 law authorizing the construction of county poorhouses provided that persons "distracted or otherwise deprived of their senses" and judged "incapable of self preservation" shall be under the care of county wardens and confined in the poorhouses for as long as the warden deemed necessary.[1] People with violent or agitated behavior were commonly jailed for the duration of their disturbance, as judged by their jailer.[2] These kinds of responses to persons with mental disabilities were not unique to North Carolina and could be found throughout early America.

Early State Facilities

Eventually, concern about the wretched conditions endured by people confined in local facilities, together with a growing belief that environment contributed to mental disability, fueled a national movement to state asylums capable of offering curative care in a more humane environment.[3] South Carolina established the first state mental hospital in the South during this period, but it was a Massachusetts schoolteacher who brought the reform movement to North Carolina.[4] Dorothea Dix, a prominent activist for the humane treatment of the mentally disabled, toured North Carolina's local facilities and documented her observations in a report made to the General Assembly in 1848. She described a Lincoln County man whose family had locked him in a log cabin without windows or heat. "[F]erocious, filthy, unshorn, half-clad . . . wallowing in foul, noisome straw, and craving for liberty," he apparently had been "insane" and kept in the cabin for more than thirteen years. She reported finding an aged,

Figure A-1
Percentage of People Served by Community Mental Health Programs and State Institutions in North Carolina
Fiscal Years 1960–61 to 1993–94



Sources for Figures A-1 and A-2: Data for fiscal years 1960–61, 1970–71, and 1980–81 derived from N.C. Division of Mental Health, Mental Retardation, and Substance Abuse Services, Quality Assurance Section, *Strategic Plan 1983–1989*, vol. 1 (Raleigh, N.C.: 1981). Fiscal year 1993–94 figures from Deborah Merrill, Data Support Branch, N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, memorandum to author, Dec. 8, 1994.

Note: The figures for state-operated institutions include psychiatric hospitals, mental retardation centers, alcoholic rehabilitation centers, and other special care institutions.

mentally disabled man held in a Rockingham County jail for more than thirty years, although he had committed no crime. In a Granville County poorhouse, she found a man who had been chained to the floor for years, "miserable and neglected . . . flesh and bones crushed out of shape by the unyielding irons."[5]

In response to Dix's report, the 1848 General Assembly established North Carolina's first State Hospital for the Insane.[6] Inspired by the thinking of the reform era, the legislature required the state hospital site, named Dix Hill in honor of Dorothea Dix, to have a "never-failing supply of wholesome water" and to "command cheerful views." By 1914 North Carolina had opened three more institutions, including a facility in Kinston for "feeble minded" children and a hospital for the "colored insane" in Goldsboro. Due to the limited capacity of state institutions, however, many people with mental disabilities remained in confinement in local poorhouses and jails, "some chained in the dungeons, without anything around them or about them but cold, bleak, dreary darkness, wallowing in squalid filth and in chains, and . . . stinted for food . . . even . . . deprived of sufficient cold water to quench their thirst."[7]

Limited Early Efforts by Local Government

In the first half of the twentieth century, education promoting the role of prevention in mental health care[8] led to a growing interest in the development of local mental health care systems capable of intervening in potential or existing mental disabilities before costly remedial care at state institutions became necessary.[9] The State Bureau of Mental Health and Hygiene, established in 1921, sponsored local "demonstration" clinics—clinics of limited duration intended to initiate community interest in establishing permanent clinics. Charlotte, Raleigh, and Winston-Salem responded with permanent clinics, but other communities could not afford to do so. Consequently, county jails, poorhouses, and state hospitals remained the primary institutions for mental health care until the 1950s.

It was not until World War II, when both the induction process and the return of servicemen revealed a surprising prevalence of mental disabilities, that the federal government got involved in mental health policy.[10] Immediately after the war, Congress passed the National Mental Health Act (NMHA) to provide grants for community mental health care clinics.[11] As an initial response, the North Carolina General Assembly authorized the State Board of Health to administer NMHA grants. The board's role, however, was generally limited to providing consultation services, sponsoring experiments, and offering publicity through local boards of health and other local social service agencies. Many North Carolina communities did not have the financial resources or substantive expertise sufficient to develop mental health clinics, and the state was slow to appropriate state money to match the NMHA grants.[12] By 1959 the state had successfully utilized the NMHA to establish psychiatric services in eight county departments of health and eleven full-scale community mental health clinics.

During the postwar era, North Carolina focused primarily on the state-operated institutional system. It spent money to improve existing state facilities, adding a fourth mental hospital and three more facilities for mentally retarded children, including the state's first institution for mentally retarded African American children, the O'Berry School in Goldsboro.[13] Ironically, this expansion occurred concurrently with a growing nationwide dissatisfaction with the large institutional model of mental

health care. Stories about overcrowding and inhumane treatment at some state institutions, advocacy for community services by parents of mentally retarded children, and new drug therapies for mental illness were setting the stage for the next phase of reform: deinstitutionalization.[14]

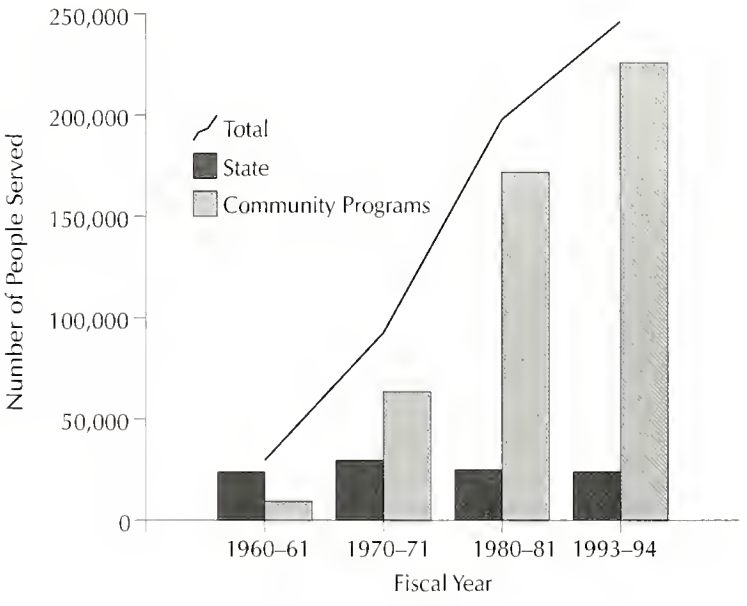
Federal Role in Spurring Local Efforts

In a message submitted to Congress in 1963, President Kennedy proclaimed that mental disabilities occur more frequently, affect more people, cause more suffering, waste more human resources, and constitute more financial drain on both the public treasury and personal family finances than any other health problem.[15] Although the president believed that public understanding, treatment, and prevention of mental disabilities had seriously lagged in comparison to the progress made in attacking other major diseases, he nevertheless felt that mental disabilities were susceptible to public action and deserved the attention of the federal government.

Relying on recent advances in drug therapies and decrying the traditional methods of treatment—prolonged or permanent confinement in huge, crowded mental hospitals—the president proposed legislation that would allow the use of federal resources to stimulate state, local, and private development of community-based services to the mentally ill and the mentally retarded.[16] Conceptually, "community-based care" would be a sort of psychiatric hospital without walls, capable of fulfilling the institutional functions of mental health treatment, medical care, nutrition, recreation, social contact, and social control, but without excessive restrictions on personal liberty.

Congress quickly responded to Kennedy's proposal by passing the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963.[17] Perhaps most important were the provisions in Title II, the Community Mental Health Centers Act (CMHCA),[18] which authorized the use of federal funding for the construction of community mental health clinics. With the enactment of the CMHCA, the prevention of mental illness and mental retardation and the promotion of mental health—matters previously left to the states—became national priorities. In pursuit of these goals in the two decades that followed, Congress expanded federal support to include funding for clinic operations and staffing. Federal appropriations significantly influenced the development of mental health care in North Carolina and other states by providing states an incentive to implement federal mental health policy, a policy that emphasized the responsibility of communities and local governments.

Figure A-2
Number of People Served by Community Mental Health Programs and State Institutions in North Carolina (in thousands)
Fiscal Years 1960–61 to 1993–94



Note: The figures for state-operated institutions include psychiatric hospitals, mental retardation centers, alcoholic rehabilitation centers, and other special care institutions. State institutions served approximately 23,300 persons in 1961, while in fiscal year 1993–94 all state institutions combined served 21,825 persons. The number of persons served by community programs increased from 31,523 in 1961 to 225,167 in 1994.

Evolution of North Carolina's Current Mental Health Care System

North Carolina responded to the CMHCA in 1963 by creating the Department of Mental Health to develop, promote, and administer a plan for establishing community mental health outpatient clinics.[19] The General Assembly also authorized local communities to establish and operate local mental health clinics as a joint undertaking with the state, which would administer federal grants, set standards for clinic operations, and appropriate state funds for community services. In North Carolina, as in other states, deinstitutionalization reduced the proportion of mental disability clients receiving services in state hospitals as it spurred the development and provision of community-based services to thousands of new clients. (See Figures A1 and A2.) Although the federal government repealed the CMHCA in 1981,[20] North Carolina's current mental health care system—local governmental entities created specifically for the purpose of coordinating and delivering mental health services with state supervision and financial support—is founded

squarely upon a vision of the community as the locus of care, the goal of the CMHCA and its legislative progeny.

Simply changing the locus of care, however, does not automatically improve the mental health of all persons with mental disabilities. When states first began to shed responsibility for care to decentralized community sites, a host of problems arose, including a lack of coordination among multiple providers and a lack of continuity in treatment planning over time, which led to difficulty in accessing services and a lack of follow-up for individual clients. Consequently, the promise of a community-based system able to fully accommodate clients with appropriate and effective care remained unrealized, thwarted by an "unmanaged" system of local services. Local providers under this system found it difficult to accommodate individuals with *serious* and *chronic* mental disabilities who lacked financial resources, had relied on psychiatric hospitals for care prior to deinstitutionalization, and continued to create a demand for such services in the absence of alternative community-based services that could prevent or ameliorate the acute phases of illness precipitating the need for inpatient care.[21]

Courtesy N.C. Council of Community Programs

Opened in 1883, Broughton Hospital in Morganton is one of four state-run psychiatric hospitals in North Carolina. The Avery Building, shown here, is still in use.

Since its initial response to the CMHCA, North Carolina has implemented and continues to implement strategies to improve the public-sector service system by identifying and resolving fragmentation of authority and responsibility. Prior to 1977, funds appropriated by the General Assembly for community-based services were diffusely allocated. Some funds were allocated directly to specific provider agencies, while other funds for additional services were allocated to the *area mental health programs*—the local governmental entities providing mental disability services at that time.[22] By revising the statutes in 1977 and establishing *area authorities* as the local agencies responsible for managing the delivery of all community-based mental health services, the General Assembly consolidated allocations and centralized administrative and fiscal responsibility for community services in one local agency accountable to a locally appointed governing board.[23] Today's community mental health care system retains these features.[24]

The general consensus of policymakers in this and other states is to continue the trend of maintaining a community locus of care and reducing the need for institutional care. The challenge that continues to confront this policy, however, is how local communities can develop the resources and organizational structures sufficient to meet the service demand and, at least, provide the care and treatment necessary for preventing repeated admissions to hospitals—state psychiatric hospitals, general hospital psychiatric units, and emergency rooms—and continued reliance on a separately funded and administered state system of institutional care that competes with the community system for financial resources.[25] Strategies to meet this challenge are discussed in "Tomorrow: The Movement to Greater Local Responsibility," beginning on page 34.

The endnotes for this article begin on page 37.

Today
Focus on Area Authorities

In North Carolina, local governments bear primary responsibility for the treatment of mental illness, developmental disabilities, and substance abuse. Some people receive services directly from state-operated facilities such as Dorothea Dix Hospital in Raleigh or Broughton Hospital in Morganton, but most public mental health services are planned, coordinated, and delivered on the local level by agencies known as *area authorities*—short for area mental health, developmental disabilities, and substance abuse authorities. They operate under state supervision, are bound by state policy, and spend state funds, but the main tasks in community mental health rest with these local government agencies.[1]

This article discusses the governing structure of the area authority and the relationship between area authority and county government. In addition, the article outlines the primary sources of revenue for community services, analyzes recent funding trends, and describes some of the client groups served and services provided by area authorities.

What "Area" Does an Area Authority Serve?

Each area authority serves a "catchment area," a designated geographic portion of the state. Of the forty-one area authorities, twenty-five serve multicounty catchment areas ranging from two to seven counties in size. The remaining sixteen area authorities each serve a single county. (See Figure B-1, page 24.)

Catchment areas vary greatly in size and population. Cleveland Area Authority serves one county with a population of 86,000, for example, while Wake Area Authority's one county has a population of 460,000. Some catchment areas serve large geographic areas. Tideland Area Authority serves five eastern counties with a population of 92,000, while Smoky Mountain Area Authority serves seven western counties with a population of 147,000.

Who Receives Area Authority Services?

Anyone in need of care or treatment for a mental disability[2]—meaning mental illness, developmental disabilities, or substance abuse—may come to an area facility for evaluation and make a written application for services.[3]

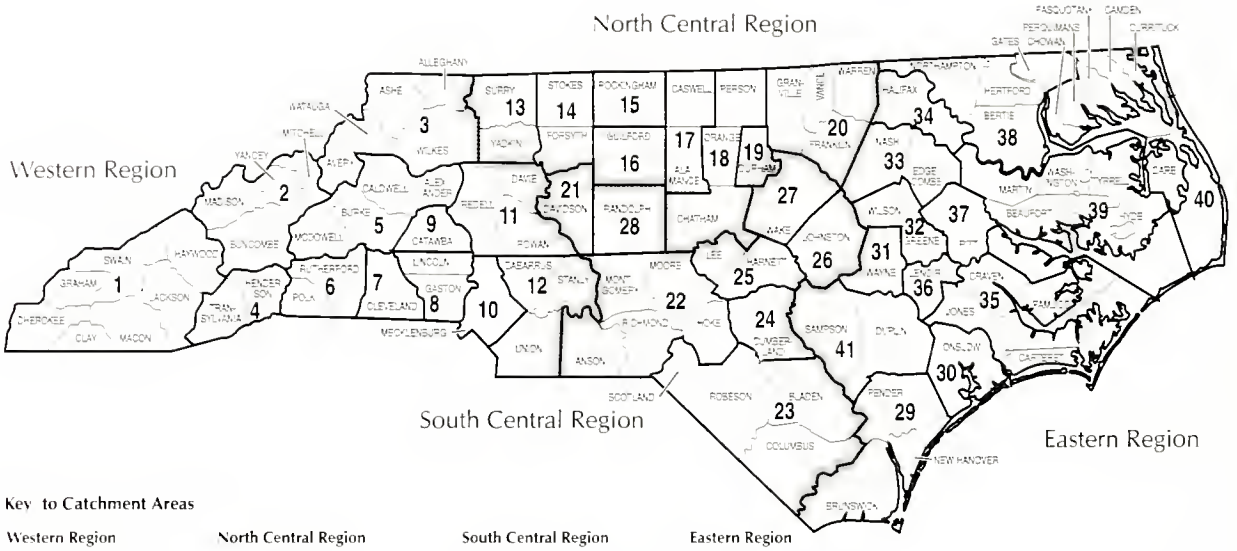
Mental illness covers a group of illnesses, including both mental and cognitive disorders, that may be evidenced by disordered thinking, perceptual difficulties, delusions, visual and auditory hallucinations, mood disturbances, and impairments in personal, social, and occupational functioning.[4] For children, the common term is "emotional disturbance." Schizophrenia, affecting a small percentage of the population, is the most expensive and devastating of all the mental illnesses.[5] Depression, on the other hand, is quite common and a major cause of suicide, but it frequently goes unrecognized and untreated, particularly in elderly populations.[6]

Developmental disabilities include severe physical, cognitive, and mental impairments that show themselves before age twenty-two, are likely to continue indefinitely, and produce substantial functional limitations in three or more of the following major areas of life activities: self-care, learning, mobility, language, independent living, self-direction, and economic self-sufficiency. Depending on severity, developmental disabilities may include mental retardation, epilepsy, autism, and cerebral palsy. The term also includes delayed cognitive, physical, or communication and social-emotional development in children.[7]

Substance abuse is the pathological use or abuse of alcohol or other drugs in a way or to a degree that produces an impairment in personal, social, or occupational functioning.[8]

Whether an area authority will serve a particular individual depends on the individual's needs, the purpose of the services applied for, the resources available to the area authority, and the geographic area served.[9] Inability to pay is not a factor, but the area authority will collect appropriate fees from people who can pay.[10] The area authority may also contract to provide services to

Figure B-1
Area Mental Health, Developmental Disabilities, and Substance Abuse Programs



Key to Catchment Areas

Western Region
1 Smoky Mountain
2 Blue Ridge
3 New River
4 Trend
5 Foothills
6 Rutherford-Polk
7 Cleveland
8 Gaston-Lincoln
9 Catawba
10 Mecklenburg
11 Tri-County
12 Piedmont

North Central Region
13 Surry-Yadkin
14 Forsyth-Stokes
15 Rockingham
16 Guilford
17 Alamance-Caswell
18 Orange-Person-Chatham
19 Durham
20 Vance-Warren-Granville-Franklin

South Central Region
21 Davidson
22 Sandhills
23 Southeastern Regional
24 Cumberland
25 Lee-Harnett
26 Johnston
27 Wake
28 Randolph
29 Southeastern

Eastern Region
30 Onslow
31 Wayne
32 Wilson-Greene
33 Edgecombe-Nash
34 Halifax
35 Neuse
36 Lenoir
37 Pitt
38 Roanoke-Chowan
39 Tideland
40 Albemarle
41 Duplin-Sampson

governmental or private entities and to enrollees of a health care plan provided by a health maintenance organization.[11]

How Many People Need Community Mental Health Services?

Mental health professionals acknowledge a gap between the needs of people with mental disabilities and the service capacity of the public mental health system. Area authorities served 225,167 persons in fiscal year 1993–94,[12] but state studies estimate that 900,000 North Carolinians are disabled by substance abuse, mental illness, or developmental disabilities.[13] The following list indicates, according to broad age and disability categories, the number of persons served by area authorities in fiscal year 1991–92 and the estimated need for such services:[14]

- *Children with mental illness:* Approximately 250,000 children need services for emotional disturbance, including 40,000 children and adolescents who are considered *seriously* emotionally disturbed. The latter category includes children who are suicidal, severely depressed, schizophrenic, or traumatized by physical or sexual abuse, and children with serious emotional disturbance who abuse drugs or commit sexual offenses. Area authorities served 25,222 emotionally disturbed children and adolescents in 1991–92.
- *Youthful substance abusers:* Using national percentages, it is estimated that 62,000 North Carolina youth experience substance abuse problems. During 1991–92, area authorities provided substance abuse services to 7,289 children who were, or were at risk of becoming, substance abusers.[15]
- *Adult substance abusers:* Based on national percentages, the state estimates that 637,000 adults experience substance abuse problems. About 54,000 adults received area authority services in 1991–92.[16]
- *Adults with mental illness:* In North Carolina, it is estimated that 514,000 adults need treatment for mental illness. Of these, about 84,000 suffer *serious* or *chronic* mental illness, a major impairment of emotional or behavioral functioning for an extended period of time, not usually remediable by short-term treatment alone.

This disability is often characterized by periods of health interspersed with acute episodes of illness that interfere substantially with the individual's capacity to meet basic survival needs.[17] This 84,000 figure represents only 1.76 percent of all adults in North Carolina, but it means that 18 of every 1,000 adults lack the capacity to remain in the community without long-term treatment or support services. Approximately 30 percent of those with serious mental illness received area authority services in 1991–92.

- *Developmentally disabled:* Approximately 117,000 persons have developmental disabilities,[18] and 14,080 of these persons received area services in 1991–92.

What Services Do Area Authorities Provide?

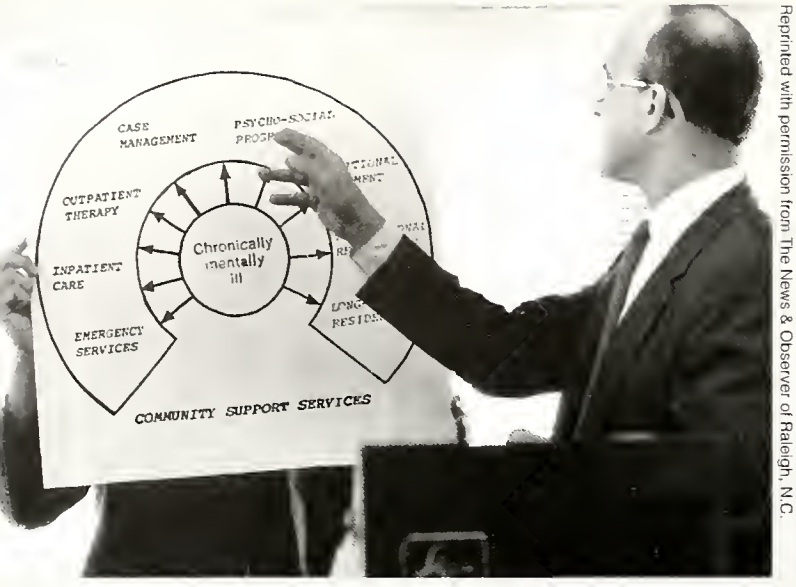
The area authority may provide services directly or it may contract with other public or private entities to provide them.[19] Either way, the area authority must monitor the services to assure they meet state standards and any federal requirements attached to federal aid. Certain services are required by state law, while others are optional.[20] Services required by law include

- *outpatient services* for individuals of all disability groups, including at least one clinic that holds no fewer than forty office hours per week;
- *emergency services* for individuals of all disability groups, twenty-four hours per day, seven days per week, on a nonscheduled basis for immediate screening or assessment of problems;
- *consultation and education services* provided to other human service agencies, community organizations, individual practitioners, clients, families, schools, businesses, and churches to help them understand mental disabilities, know the community resources, and carry out their service responsibilities;
- *case management* for individuals of all disability groups: a support service designed to coordinate services from other agencies with services provided by the area authority to assist clients in meeting their total needs (including treatment, educational, vocational, residential, health, financial, social, and other needs);
- *inpatient psychiatric services* for children, adolescents, adults, and elderly individuals who are acutely mentally ill (intensive treatment and supervision in a controlled environment on a twenty-four-hour basis);
- *a psychosocial rehabilitation program* to help chronically mentally ill persons achieve and maintain independent living (day program with peer support group) *or a partial hospitalization service* intended to prevent psychiatric hospitalization (day program providing intensive treatment);
- *developmental day services for preschool children* with—or at risk for—developmental disabilities or delays, including mental retardation, in a specialized child care center (year-round habilitative programming in self-help, physical, language, cognitive, and psychosocial skills);
- *adult developmental activity programs* for adults who are substantially mentally retarded or severely physically disabled, to prepare the individual to live and work as independently as possible;
- *alcohol and drug education traffic schools* for first offenders convicted of driving while impaired;
- *drug education schools* for drug offenders;
- *inpatient hospital detoxification services* for alcohol or drug abusers in need of detoxification who cannot be withdrawn safely from the substance in any other setting, due to life-threatening physical problems or accompanying psychiatric or behavioral problems;
- *nonhospital or outpatient detoxification services* for alcoholics;
- *forensic screening and evaluation* for all disability groups to assess a criminal offender's capacity to proceed to trial;
- *early childhood intervention services* for children who are mentally retarded, are otherwise developmentally disabled or delayed, have atypical development, or are at risk for the preceding conditions (support and information to families on child-rearing skills and available services, and assessment and programming in cognitive, language, physical, self-help, and psychosocial development).

In addition to the required services, many area authorities offer employee assistance programs for individuals with personal problems affecting job performance, specialized foster care services provided in conjunction with the local department of social services, supervised community-based alternatives to incarceration for substance abusers involved in crimes of a nonviolent nature, and group homes or supervised apartment living programs for persons with mental retardation or other developmental disabilities.[21]

Who Governs the Area Authority?

Each area authority is governed by an area board, exercising the powers and duties conferred by the General Assembly. Membership must include a county commis-



Reprinted with permission from The News & Observer of Raleigh, N.C.

State task force and commission studies indicate that individuals who are chronically mentally ill require multiple community-based services to prevent the hospitalization, incarceration, and homelessness that often attends their illness. North Carolina has recently taken steps to expand such services using Medicaid and other federal money, but Congress is now considering federal spending cuts for mental health care.

sioner; two licensed physicians; another health care professional; clients of mental health, developmental disabilities, alcoholism, and drug abuse services; family representatives of clients; and an attorney. Members of citizens' organizations representing the interests of clients with mental illness or developmental disabilities may substitute for client board members with those disabilities, and a professional clergy may serve in the place of a health care professional. In a single-county area the county commissioners may appoint any resident of the county instead of a county commissioner.

Area boards must have between fifteen and twenty-five members, with the size determined by the boards of county commissioners. In a single-county area, the board of county commissioners appoints the members of the area board.[22] In a multicounty area authority, each board of county commissioners within the catchment area is authorized to appoint one commissioner as a member of the area board; these commissioner members then appoint the remaining members. The terms of commissioner members on the area board are concurrent with their terms as county commissioners. Other area board members serve four-year terms, except that area board members may be removed for any or no reason by the group authorized to make the initial appointment. Area board members elect the area board chair, who may be a commissioner member of the area board.[23]

In the special case of a single-county area authority in a county with at least 425,000 people, the board of county commissioners, by a resolution adopted after a public hearing, may become the governing body for the area authority.[24] In this event, all the powers and duties of the area board become the responsibility of the board of county commissioners. Initially, only Mecklenburg County qualified for and exercised this option. Although Wake County now meets the population requirement and has on occasion considered the "Mecklenburg option," Mecklenburg County remains the only area authority not governed by an area board. The North Carolina Association of County Commissioners favors legislation that would delete the population requirement, allowing any county in a single-county catchment area to substitute the board of county commissioners for the area board. Any county that opts for the substitution would effectively nullify the requirement, applicable only to area boards, that the area authority's governing body include individuals representing the interests of clients, family members, and health professionals.

The governing body for the area authority is ultimately responsible for the execution of all legal responsibilities of the area authority, which include determining the needs of catchment area residents, reviewing and evaluating area programs, developing an annual budget, and establishing policies for the implementation of area authority services.[25] The board appoints an area director who serves at the pleasure of the area board. The area director in turn appoints and supervises the employees of the area authority, implements area board programs and policies, administers programs in compliance with state rules and board policies, and generally supervises all service programs.[26] The area board has the legal authority to select, hire, and fire the area director; approval by the county commissioners is not required. Implicit in the area board's legal authority to hire and dismiss the area director is the authority and responsibility for evaluating the director's performance.

What Is the Relationship between the Area Authority and County Government?

The area authority is a local political subdivision of the state, except that a single-county area authority is considered a department of the county in which it is located for purposes of budget and fiscal control.[27] Thus for most purposes the area authority is a separate, local unit of government, not a mere agency or department of a particular county or city.[28] The area board has the author-

ity and responsibility to act independently of the board of county commissioners on many matters.

County government is directly involved in some ways, however. The board or boards of county commissioners within a catchment area appoint, and may remove, area board members. County commissioners must serve on the multicounty area board and may serve on the single-county area board. The authority to purchase and hold title to real property used by an area authority is vested in the county where the property is located, unless the county commissioners expressly delegate this authority to the area authority.[29] Counties may appropriate funds for the support of programs that serve their catchment area, even if the county does not own or operate the facilities housing the programs or the programs are not physically located within a single county.[30] Employees of the area authority are not county employees,[31] but the county may pursue statutory options to bring the personnel administration of a single-county authority within the county personnel system.

How Are Single-County Areas Different from Multicounty Areas?

The primary difference rests in budget and fiscal control. Because a single-county area authority is considered a *department of the county* for purposes of the Local Government Budget and Fiscal Control Act, its administration is linked to county administration in ways not characteristic of the more independent multicounty authorities. The single-county area authority must present its budget for approval of the county commissioners in the manner requested by the county budget officer, and the area authority's financial operations must follow the budget set by the county commissioners in the county's budget ordinance. Further, the county has responsibility for fiscal management and may require all disbursements, receipts, and financial management of the area authority to be handled by the county's finance officer. However, the county may designate for the area authority a deputy finance officer who may disburse money (sign checks) and preaudit obligations, such as contracts and purchase orders, to ensure that the budget ordinance for the county contains an appropriation authorizing the obligation and that a sufficient amount remains in the appropriation to meet the obligation. This officer could be an employee of the area authority.

In contrast, multicounty area authorities—considered "public authorities" for purposes of the Local Government Budget and Fiscal Control Act—are not a part of

Photos courtesy N.C. Council of Community Programs

Demonstrators listen to speakers at the Coalition 2001 Legislative Rally in Raleigh in April 1993. In late 1990 advocates representing the diverse needs of persons disabled by mental illness, developmental disabilities, or substance abuse met in Raleigh to form Coalition 1991 to unify their efforts to obtain more state funding for services. Seeing the need to be heard on an ongoing basis, the group later changed its name to Coalition 2001 and now comprises nearly fifty statewide organizations.

Group homes like this one in Burlington serve developmentally disabled adults who are in need of a supervised living environment within a community setting.

the budgeting and accounting system of any county. They are responsible for their own budgeting, disbursing, accounting, and financial management, and they must appoint a budget officer and a finance officer to assume the duties of those offices as set forth in the budget and fiscal control law.

What Is the State's Role in Providing Mental Health Services?

The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services is the state body authorized to adopt, amend, and repeal rules governing the delivery of mental health, developmental disabilities, and substance abuse services.[32] Appointed by the governor and the General Assembly, the twenty-six-member commission includes consumers and professionals experienced in these areas. Commission rules set standards for the management and operation of area authorities and their contract agencies, the use of federal funds according to federal requirements, and the licensing of public and private facilities that provide mental health, developmental disabilities, and substance abuse services. The rules that pertain specifically to area authorities, typically called "area program standards," are intended to ensure that area authorities and their contract agencies provide adequate and appropriate services.

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services in the Department of Human Resources (DHR) is the state agency responsible for enforcing state regulations and statutes governing the operation of area authorities.[33] The division also administers federal and state funds designated by the General Assembly for area authority services, enforces requirements for federal and state aid, and adopts rules governing the evaluation of area authority programs and the expenditure of all area authority funds.[34] The division is directly responsible for operating sixteen state facilities for persons in need of twenty-four-hour treatment or residential services: four psychiatric hospitals, five mental retardation centers, three alcohol and drug abuse treatment centers, three specialized facilities for children and adolescents, and a special care center for adults in need of mental health and nursing care services.[35]

In 1973 the General Assembly established the Mental Health Study Commission (MHSC) to study mental health, developmental disabilities, and substance abuse services and make recommendations to the legislature for changes in the law. Since then, most of the improvements made to the public-sector mental health service system, and most of the legislation adopted by the General Assembly related to mental disabilities, have evolved from the work of the MHSC.

For example, the state's funding priorities are guided by long-range plans developed by the MHSC and adopted by the General Assembly. Since 1987 the MHSC has recommended the child mental health plan, the child and adolescent substance abuse plan, the plan for adults with severe and persistent mental illness, the adult substance abuse treatment plan, and the plan for persons with developmental disabilities. Each plan identifies unmet service needs, sets service goals and strategies, outlines specific service improvements, and targets services to particular clients within an age and disability group. The area authority's local service planning must be consistent with the state's long-range plans.

How Are Local and State Services Coordinated?

The state is divided into four regions—the western, north central, south central, and eastern regions. (See Figure B-1, page 24.) Each region is served by a state psychiatric hospital and a state mental retardation center, and three are served by a state alcohol and drug abuse treatment center. The specialized state facilities (special care center and schools for adolescents and children) provide services to persons from throughout the state. The area authorities in each region use the regional facilities to provide services that are unavailable in the community or cannot practically be carried out in each individual community.

Area authorities may implement a "single portal of entry and exit policy" that gives the area authority the responsibility and authority for coordinating and integrating services among otherwise independent facilities.[36] A single-portal policy channels users of state and other inpatient facilities to the area authority, which acts as a gatekeeper to facilities covered by the policy to assure that the client receives services from the facility most capable of meeting the client's needs. The area authority encourages diversions to less intensive and less costly kinds of treatment where appropriate, and monitors the treatment needs of clients discharged from inpatient facilities to assure that the client receives services that might reduce the need for subsequent institutional care, enhance the efficiency and quality of care, and improve the quality of life for the client.[37] The statute authorizing single-portal plans, however, does not require their use for all services, and, consequently, not all area au-

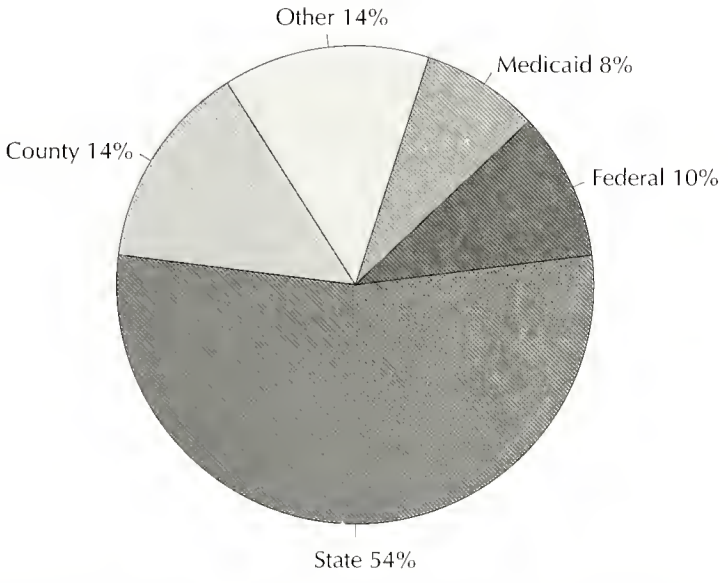
thorities use the single-portal concept for mental health and substance abuse services.[38]

What Sources of Revenue Fund Area Authority Services?

Funding for area authorities comes from state appropriations, federal and private grants,[39] county appropriations, Medicaid receipts, and other patient and third-party receipts.

Area authority revenues totaled $434.2 million for fiscal year 1993–94.[40] State funds appropriated directly to area authorities accounted for more than $235.6 million, or 54 percent.[41] (See Figure B-2.) Federal grants administered by the division provided approximately $41 million, and county appropriations funded through property tax proceeds or other local revenues contributed $61.6 million.[42] Medicaid receipts accounted for $33 million.[43] Because area authorities do not have the power to levy taxes, their ability to generate revenue is restricted. Client receipts other than Medicaid provide some revenue, but this, too, is limited, as no person may be refused services because of an inability to pay.[44] In Figure B-2, fees collected from clients and private insurance make up a portion of the revenue category designated "Other."[45]

Figure B-2
Sources of Revenue as a Percentage of
Total Area Authority Revenues in North Carolina
Fiscal Year 1993–94



Source for Figures B-2 and B-3: Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, *Financing Initiatives, An Update on DMHDDSAS Activities Related to MHSC Financing Initiatives Report* (Raleigh, N.C.: N.C. Department of Human Resources, Dec. 1994).

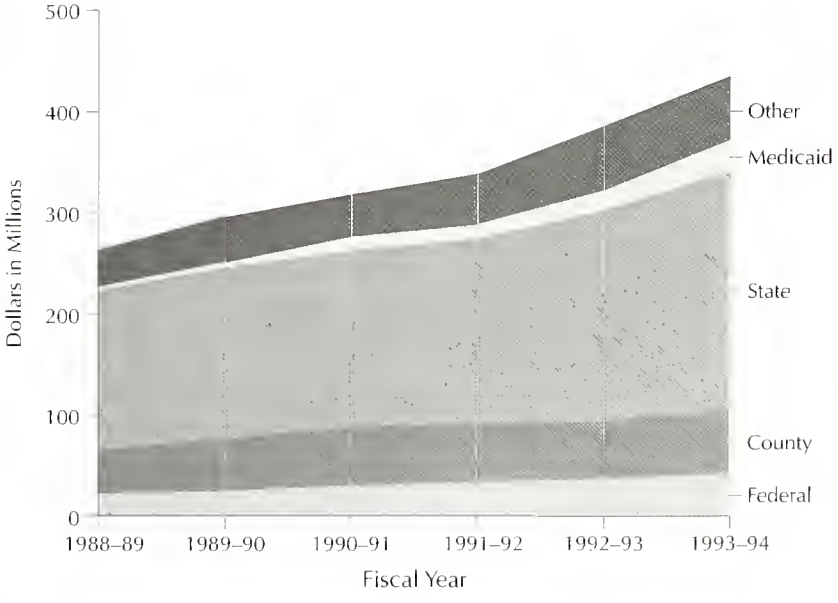
Has Funding for Community Services Grown in Recent Years?

In the last six years, combined revenues for all area authorities have grown by $171 million, from $263 million in fiscal year 1988–89 to $434 million in 1993–94, with the largest increases occurring in the 1992–93 and 1993–94 fiscal years. (See Figure B-3.)

Federal Medicaid dollars grew at a faster rate than any other source of revenue during the six-year period—from about $5 million to $33 million. Relatively recent efforts by the state and area authorities to maximize Medicaid as a funding source, including billing Medicaid for services previously supported by state or local funds, appear to account for some of the increase.[46] In fact, Medicaid is viewed by some as presenting the only real opportunity for expanding revenues for mental health care in the face of limited state and local resources and an increasing demand for services.

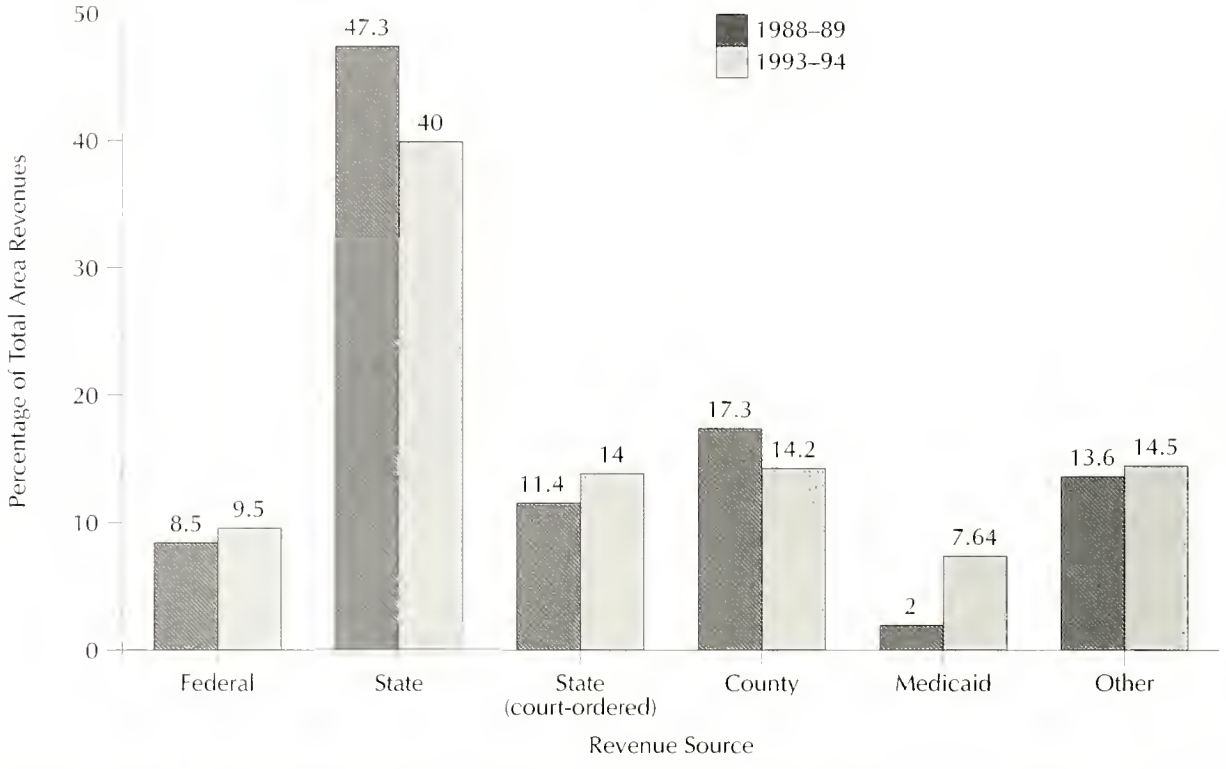
County funding, which dipped from $58 million to $56.8 million between fiscal years 1990–91 and 1991–92, showed the slowest rate of growth, rising from $45.5 million to $61.6 million (a 35 percent increase) between 1988 and 1994. Federal funding increased by 85 percent, from

Figure B-3
Total Area Authority Revenues by Source in North Carolina
Fiscal Years 1988–89 to 1993–94



Note: Figure represents absolute growth and is not adjusted for inflation.

Figure B-4
Change in Funding as a Percentage of Total Area Authority Revenues in North Carolina
Fiscal Years 1988–89 to 1993–94



Source: Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, *Financing Initiatives, An Update on DMHDDSAS Activities Related to MHSC Financing Initiatives Report* (Raleigh, N.C.: N.C. Department of Human Resources, Dec. 1994).

$22.2 million to $41.1 million. The state, which continues to serve as the largest single source of revenue, raised funding from $154.5 million in fiscal year 1988–89 to $235.6 million in 1993–94, an increase of 52 percent over the six-year period.

The figures cited above represent absolute dollars. When adjusted for inflation, total combined revenues for area authorities increased by 19 percent between 1989–90 and 1993–94; county funding *decreased* by 5 percent, the federal portion of Medicaid rose by 288 percent, and state funding grew by 14 percent.

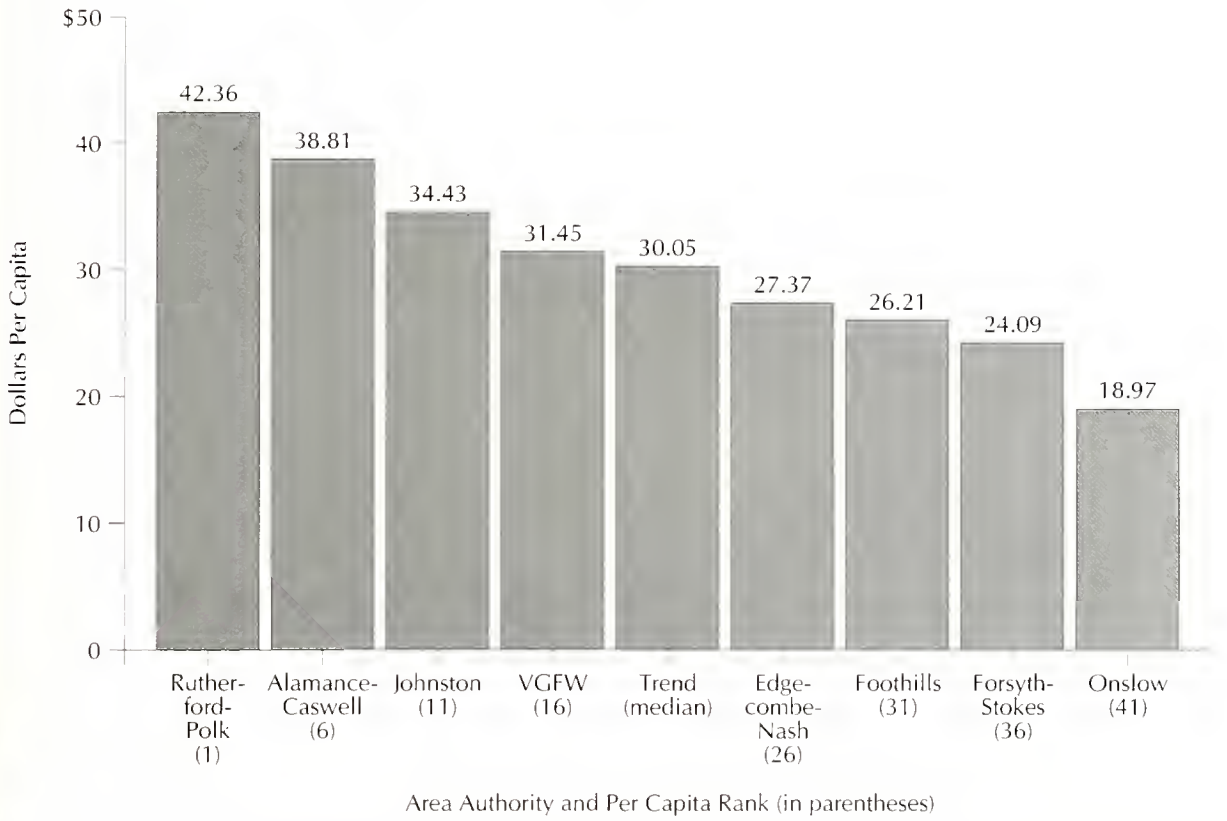
What Is the Significance of the Different Rates of Growth among Revenue Sources?

The varying rates of growth among revenue sources have resulted in modest, but notable, shifts in the proportionate financial responsibility of the federal, state, and local governments for community mental health services. (See Figure B-4.)

First, combined county and state dollars are slipping as a proportion of total area authority revenues, from 76 percent in 1988 to 68 percent in 1994, while combined federal funding through Medicaid and federal grants has grown from 10 to 17 percent of area revenues during the same period. This recent reliance on greater federal funding, as well as continuing efforts to further maximize the use of federal funds, comes at a time when Congress is considering proposals to reduce the federal dollars available for state and local human services programs. Congressional measures to cut back or cap the federal funds available to the states for mental health services, particularly in Medicaid, would reverse North Carolina's growing reliance on federal money and increase the financial responsibility of the state and local governments should they choose to maintain current levels of service.

Second, a growing portion of the state funding for community-based services is going to specific court-ordered programs such as the Thomas S. and Willie M. programs (services to two client groups that the state is obligated to provide without regard to budgetary restraints),[47] leaving

Figure B-5
State-Administered Funding to Selected Area Authorities in North Carolina
Fiscal Year 1993–94 Per Capita Funding



Source: Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "1993–94 Area Program Per Capita—Division Funds Only," budget office tables (Raleigh, N.C.: N.C. Department of Human Resources, June 1994).

Note: Excludes Willie M., Thomas S., Fort Bragg, Robert Wood Johnson, one-time, carryover, cross area service, local, and Carolina Alternatives (federal portion) funds.

a lesser portion of state dollars for other community services.[45] (See Figure B-4.) Although the percentage of area authority revenues coming from state funding has declined only slightly when viewed in the aggregate, from 58.7 to 54 percent of total area revenues, state funding not dedicated to such court-ordered programs makes up only 40 percent of area revenues today versus over 47 percent in 1988–89. In the view of some in the local service system, this has the effect of reducing the area authority's flexibility to utilize funds for other, potentially more responsive and effective services.[49]

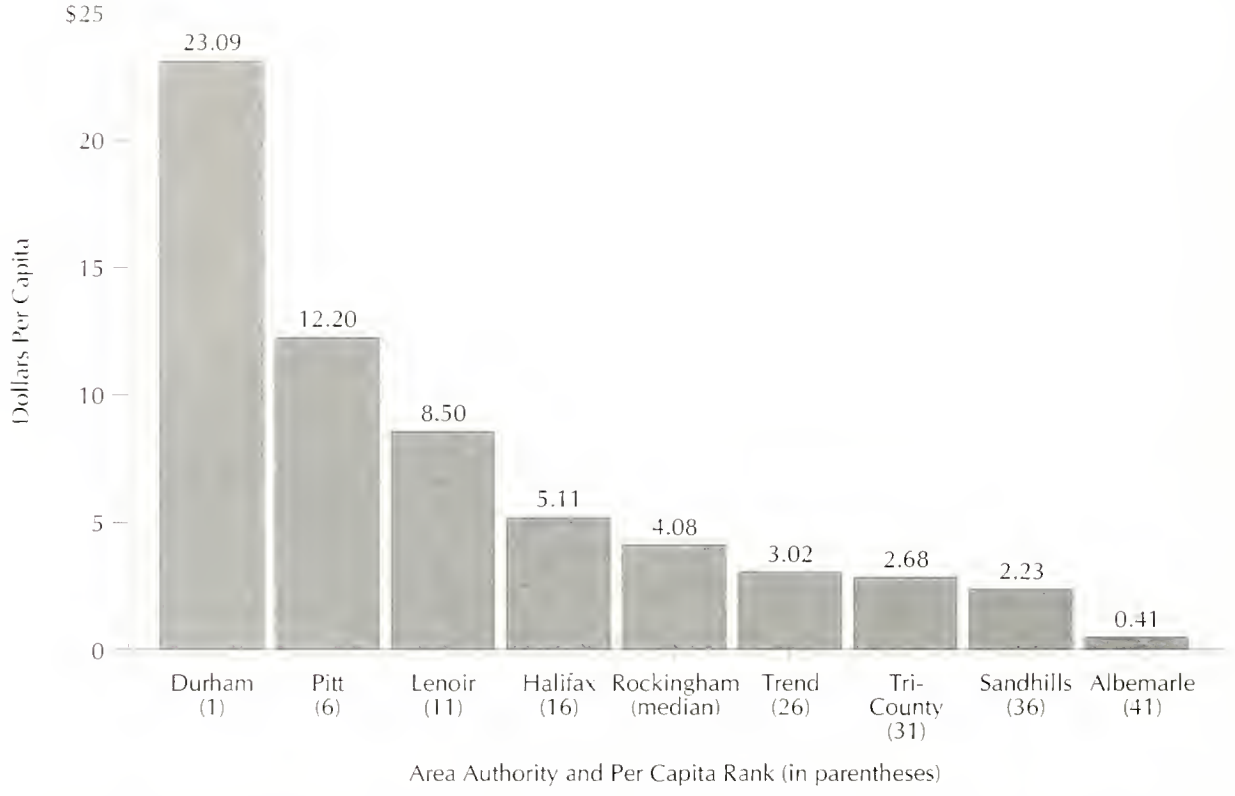
Do Revenues for Area Authority Services Vary among the Area Authorities?

State-administered funds for mental health services are unevenly distributed among the area authorities. As shown in Figure B-5, the 1993–94 per capita allocation of state and federal dollars ranged from $18.97 for Onslow Area Authority to $42.36 for Rutherford-Polk Area Authority, with Trend Area Authority representing the median allocation at $30.05 per capita.

Similarly, the level of county support for community mental health services varies. As depicted in Figure B-6, page 32, per capita county funding for mental health services in fiscal year 1991–92 ranged from $0.41 for the six-county Albemarle Area Authority to $23.09 for Durham Area Authority. It is difficult to know to what degree the differences in county funding are due to differences in local service needs or how the level of local appropriations correlates to unmet mental health needs. It is clear, however, that the level of per capita county funding is not necessarily related to the size of the area authority budget or how much money is spent on mental health services in a county's catchment area. Even as a percentage of total revenues for the area authority, county funding varies widely from area to area.

For example, in fiscal year 1993–94, county funds made

Figure B-6
County Funding to Selected Area Authorities in North Carolina
Fiscal Year 1991–92 Per Capita Funding



Source: Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "Comparison of County Funds in Area MHDDSAS Programs—Actual for SFY 1991–92," budget office tables (Raleigh, N.C.: N.C. Department of Human Resources, May 1993).

Note: Figures represent actual revenue received.

up 38 and 25 percent of the total revenues for the Mecklenburg and Forsyth-Stokes programs, respectively. In contrast, county dollars provided only 3.6 percent of the total revenue for Sandhills Area Authority, and Onslow Area Authority received no revenue at all from the county.[50] Although there is no statutory requirement that counties appropriate funds to support area authority services,[51] only the Onslow and Wayne programs received no revenue from their respective counties in fiscal year 1993–94.

How Are State-Administered Funds Allocated to Area Authorities?

Because the state is the largest single source of revenue for area authorities and also administers most federal funding, the way the legislature appropriates money and the manner in which the division allocates those funds can determine the kinds of services available on the local level.

Initially, state funding included both *categorical funding* and *area match funding*.[52] A portion of the area matching funds did not require a match but was distributed on a per capita basis, called a base grant. The remainder was awarded as a match for local investment, with poorer areas receiving a more favorable ratio of state-to-local dollars. Thus the area match funding was not designed to provide each area authority with equal per capita funding but to distribute state dollars in a manner that attempted to equalize, at least somewhat, the fiscal capacities of area authorities.[53]

Categorical funds—appropriated by the General Assembly for specific services to specific clients (for example, funds for group homes for persons with mental retardation)—started small relative to the area matching funds but soon grew to be the primary method of funding community services, involving the largest percentage of state-appropriated funds.[54] By limiting the use of state funds to particular purposes, categorization limited the capacity of area authorities to respond to local service priorities not

aligned with state budget priorities. Categorization also created funding inequities between area authorities, channeling funds to those area authorities that happened to be ready to develop a categorical program when funds were appropriated. Because categorical funds varied from year to year, these area authorities might garner a disproportionate share of state resources for commencing new programs, only to have difficulty maintaining these programs when legislative funding priorities shifted.

By 1986 few categories of services were consistently in effect statewide. Inequities in the distribution of state funds and local variations in resources, priorities, and program development caused wide variations in service availability.[55] Yet the lack of a uniform reporting and data system for area authorities made it difficult for the state to compare the services provided and needed in each area authority. To address these problems and to approach the allocation of state and federal funds to community services in a less piecemeal and more systematic fashion, the General Assembly directed the MHSC to develop a set of policies for funding community services. Approved as a pilot project in 1987 and codified in 1993,[56] this system of funding, called the Pioneer Funding System, attempts both to move away from categorical funding and to develop an information system to meet the state's need for accurate and comparable data.

How Does the Pioneer Funding System Work?

Pursuant to the system, the General Assembly *may* appropriate money according to six categories: adult mental health, child mental health, adult developmental disabilities, child developmental disabilities, adult substance abuse, and child substance abuse. The division then allocates these appropriations to area programs on a purchase-of-services basis of funding, a system of earning state funds based on the provision of *eligible* services rather than simply on the expenditures incurred by area authority service providers.[57] Services are eligible for reimbursement if they fall within the "circle of services" designated by DHR payment policies, which target a range of services to the more severely impaired in each appropriations category. To receive funds allocated by the division, the area authority must prepare an "annual memorandum of agreement" that delineates the area services and activities to be supported by state-administered funds.[58] The memorandum of agreement provides a means of accounting for fund allocations according to set payment rates and actual units of service delivered.[59] The agreement also

Courtesy N.C. Council of Community Programs

A staff member of Roanoke-Chowan Human Services Center administers a screening test designed to identify children with developmental disabilities. Once problems are identified, home-based services can be provided.

ensures that area authorities use state resources for the categories of persons and kinds of services given priority in the MHSC's long-range plans.[60] The Pioneer Funding System does not limit the kinds of clients the area authority may serve, as area authority receipts from fees, county appropriations, and other nonstate funding sources may be used to support services for the less impaired.

The decategorization of appropriations from specific categories to broad disability groups and the area authority's capacity to choose within parameters the kinds of clients and services to offer using state allocations appear intended to balance the state's desire to retain control over the use of state-administered dollars with the area authority's need for flexibility in responding to local variations in service needs. In actual practice, however, the General Assembly continues to appropriate funds for mental disability services according to categories narrower than the broad age and disability categories. Consequently, the level of decategorization initially anticipated under Pioneer has not occurred.

Nevertheless, the division allocates nearly all appropriations through Pioneer's purchase-of-services and annual-memorandum-of-agreement components, which require area authorities to use standardized accounting and reporting procedures to report the costs of services provided, the units of services delivered, and the kinds of clients served. Consequently, the Pioneer Funding System performs the intended functions of a uniform reporting and data system that may provide useful information for future policy and appropriation decisions. ▣

The endnotes for this article begin on page 39.

Tomorrow
The Movement to Greater Local Responsibility

Like other states, North Carolina is exploring ways to provide mental health services to its citizens efficiently and inexpensively. The strategies increasingly point to local governments.

A starting point is control of institutional care. Treatment in a mental hospital is the most costly of all treatment options. If people are to get the services they need without institutionalization, however, there must be an increase in the availability of community resources devoted to mental health care, and there must be closer coordination between state and local service systems. These mutually dependent objectives are designed to control costs at a time of shrinking resources and to improve the quality of client care by providing comprehensive services and *continuity of care*, the coordination of services "that assures the orderly, uninterrupted movement of patients among diverse elements of the service delivery system."[1]

This article discusses three strategies for change in the mental health care system, all of which significantly affect local government.

Integrated Funding System

The first strategy for change would put the state money now allocated for state mental health and substance abuse facilities into the hands of area mental health, developmental disabilities, and substance abuse authorities, the local government entities responsible for community-based care. The resulting change is an "integrated funding system." Traditionally, the state funds state institutions and area authorities through two separate funding streams. That provides an incentive, some suggest, for area authorities to send difficult-to-treat clients to state institutions where the state will pay the bill, instead of developing local services to fully meet clients' needs. In 1993 the General Assembly directed the Department of Human Resources (DHR) to develop a plan for pilot-testing an integrated funding system in one of the four administrative regions of the state. By redirecting state allocations normally received by the region's psychiatric hospital and alcohol and drug abuse treatment center to the area authorities in the region—thus *integrating* community and state-institution mental health and substance abuse funding—the strategy seeks to establish a single point of accountability for managing all allocations to meet the hospital and nonhospital needs of adult clients of substance abuse and mental health services.

In theory this approach would lead to a better coordination of institutional and community-based services, resulting in improved capacity and appropriateness of local services.[2] Because area authorities would pay for inpatient care out of their own budgets, they would have an incentive to prevent and shorten hospitalizations through the provision of community-based alternative and preventive services. Consolidating the funding streams into one pool for each area authority would give the area authority the fiscal flexibility and necessary resources to expand local outpatient, residential, and aftercare services necessary to prevent or reduce hospital admissions—through the savings accrued by limiting inpatient care.

A task force of state and area authority personnel developed a plan called the Unified System of Services (USS) that would integrate not only funding but also the procedural practices and systems designs for managing the availability, quality, and continuity of client care.[3] However, due to the systems changes required for effective implementation[4] and the start-up funding to develop and expand the community services necessary for commencing the plan,[5] DHR recommended to the 1995 General Assembly that the state not implement a pilot of USS at this time. Nevertheless, the USS planning effort improved the level of consensus among state and local officials over the appropriate roles of the state and local governments, the objectives and goals of the public mental health system, and the problems that need to be overcome. Further, USS focused attention on certain strategies for system

change that, though considered prerequisites to or elements of USS, have also been deemed sufficiently important to pursue independently of USS. One of those strategies is the Crisis Services System (CSS).

Crisis Services System

The second strategy for change would shift to the local level increased responsibility for management of people in crises, including those committed for treatment under a court-ordered involuntary commitment.

Although a system akin to USS would purportedly achieve a closer coordination of institutional and community care, no system can coordinate resources that do not exist. A study conducted during the USS planning revealed that approximately 25 percent of the short-term (fewer than ninety days) residents of one regional psychiatric hospital could have avoided hospitalization and been served in a less restrictive environment, such as an unlocked crisis unit, had such services been available in the community.[6] Among the services cited as being needed in the communities in order to implement a unified system of services are (1) "mobile response teams" capable of quick and safe intervention in mental illness or substance abuse crises and (2) "assertive community treatment teams" designed to stabilize clients in the community and avert hospital admissions through intensive monitoring of clinical status and medication administration.[7]

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services established the Crisis Services Committee in November 1993 to address inadequacies in the current delivery of crisis services. This committee developed a plan for a Crisis Services System that includes an array of crisis prevention, crisis response, and crisis stabilization services designed to meet client needs in the least restrictive and most therapeutically appropriate environment whenever possible, in the client's home or community.[8] Citing numerous gaps in the current system of services, including inadequate resources and an incapacity for crisis response at the local level, the committee recommended, among other things, that each area authority establish local crisis response strategies with law enforcement and other crisis response agencies.[9]

By emphasizing the community as the locus of activity, the Crisis Services Committee continues to pursue the traditional ideal, commenced by President Kennedy's Community Mental Health Centers Act of 1963, that the need for services should not force clients to leave their community and social support network. On the other hand, the committee draws upon strategies recently associated with managed care, such as assertive community treatment teams, in order to improve the continuity of care at the local level and reduce the incidence of recurring crises, institutionalization, and incarceration.[10] Moreover, consistent with USS, the committee seeks to shift responsibility for the administration of crisis services from the state to the local level. This would occur not only as the area authority develops or expands crisis services to divert hospital admissions, but also under the recommendation that persons committed for treatment under the involuntary commitment laws be committed to the area authority rather than to state institutions.[11] Thus, both in philosophy and in design, the CSS plan not only embraces concepts similar to USS and the initiative discussed below, but also can be viewed as a necessary complement to any strategy that attempts to further centralize the locus of mental health care in the community.

Managed Care

A third strategy involves the local mental health authority in the increasingly popular concept of managed care.

Since 1986 there has been a dramatic increase in the use of Medicaid funds for the psychiatric hospitalization of children and adolescents under the age of twenty-one.[12]

The division attributes this growth to a lack of available, less intensive, less restrictive, and less costly services designed to address the treatment needs of children and adolescents and to a lack of coordination and management of the use of hospital services. In response, and with the goal of controlling costs by diverting hospital admissions to alternative services, the state has developed Carolina Alternatives, a set of managed care strategies for coordinating and financing mental health and substance abuse services for Medicaid-eligible children and adolescents under the age of eighteen.[13] Like the USS and CSS plans, this plan seeks to improve the continuity of client care and to maximize the efficient use of resources. And, like the other initiatives, the strategies employed under this system place greater administrative, clinical, and fiscal responsibility at the local level.

In early 1994 ten area authorities covering thirty counties began participating in Carolina Alternatives. Statewide implementation is planned for July 1996. (However, that date could be affected by anticipated changes in the federal Medicaid laws).[14] Area authorities, the designated managed care providers under Carolina Alternatives,

serve as the entry point for all mental health and substance abuse services for Medicaid-eligible children and adolescents in their catchment areas. In its *gatekeeper* role, the area authority implements procedures designed to limit access to costly inpatient services and encourage diversion to less intensive treatment.

As the *case manager*, the area authority arranges and coordinates all medically necessary mental health and substance abuse services and monitors the client's condition and other health needs to provide continuity of treatment planning over time. This means that the area authority also functions as a referral and linkage to services, assuring access to necessary services through a network of public and private service providers by subcontracting with other direct service providers for services that the area authority does not provide directly.

Through the financing strategy called *capitated funding*, the state prospectively awards a Medicaid allocation to the area authority based on the estimated number of Medicaid-eligible clients to be served and the anticipated service needs of those clients over a specified time. Using this fixed amount of money, the area authority assumes clinical and fiscal responsibility for providing services to the entire capitated population absorbing the loss if the prepaid funds are not sufficient to cover the services offered for the identified period of time. Thus, like the USS plan, Carolina Alternatives uses a centralizing finance strategy to bring administrative, service, and fiscal responsibilities together within one organizational framework, the area authority, and attempts to create financial incentives for preventing and shortening hospital care.[15]

This contrasts with the traditional fee-for-service arrangement that reimburses providers of Medicaid services on the basis of the cost of each service provided to a particular patient. Compared to the fee-for-service arrangement, where the provider makes more money the more care it provides, the provider paid on a capitated basis will lose money if it provides too many services or too many expensive services, or does not allocate its resources efficiently.

While the case management component of managed care ideally leads to a better assessment and coordination of care, improved access to a comprehensive range of services, and continuity of treatment over time, these objectives undeniably compete with the objective to maximize economic efficiency in light of the constraint on resources inherent in capitated funding.[16] Because of the financial risks and incentives associated with risk-based managed care, clients potentially face underservice if managed care providers are undercapitalized, inadequately staffed, or ineffectively monitored.[17] On the other hand, public-sector managed care may allow difficult decisions concerning resource allocation to be made in a more deliberate and rational manner rather than evolving de facto from diffuse, unorganized, and conflicting administrative forces.[18]

Early evaluations of the ten pilot programs indicate that a greater number of Medicaid-eligible children are being served at a lower cost per child and that inpatient costs are being reduced.[19] Thus the theory that Carolina Alternatives will contain the cost of care is supported by the early data, and the question remains whether it has led or will lead to the development and implementation of the full range of services necessary for meeting each individual's needs.

Public-sector managed care appears to offer enough promise to have prompted the state to plan widening Carolina Alternatives to include Medicaid-eligible *adult* clients of mental health and substance abuse services. These plans may need to be altered, however, after the consequences of present reform measures on the federal level become clearer.

Governance Issues Related to System Change

The early success of the ten pilot programs should be tempered with the acknowledgment that area authorities, like other units of local government in North Carolina, vary in political climate, geographic characteristics, economic conditions, and patient population. The anticipated outcomes of managed care and related strategies rest not only on the premise that centralizing fiscal and clinical *responsibility* in area authorities creates the necessary incentives to accomplish intended goals, but also on the premise that these local governments will have the necessary *authority* and resource *capacity* to efficiently coordinate services for the purpose of eliminating inappropriate hospital treatment and expanding community-based services.

Capacity

Area authorities with small catchment areas and a smaller pool of Medicaid-eligible children may not have the resource capacity to develop the requisite local services, to perform the required technical and administrative functions, or to absorb the financial risk of clients who require higher, or more intensive, levels of care. To improve the economies of scale, these area authorities could pool their resources and share service and administrative

functions through contracts or joint agency agreements authorized by statute.[20] Some area authorities are currently studying private, nonprofit corporate models as a means for several area authorities to jointly save administrative costs, share risks, and establish resources. In addition, state rules currently provide for the merger of two or more area authorities with the consent of the affected boards of county commissioners and area boards.[21]

Authority

An oft-cited prerequisite to operating as a managed care provider and competing in a managed care marketplace is flexibility: the flexibility to react quickly to changing market conditions and opportunities and the flexibility to administer funds to meet the changing needs of patients.[22] Yet, a single-county area authority operates under the budget and fiscal control of county government and has less flexibility than the multicounty authority to manage its own fiscal and administrative processes. Where the county does not allow the single-county area authority to disburse money, maintain a reserve balance, preaudit obligations, or otherwise implement service provider contracts without county approval, the area authority's personnel transactions, contracting, and purchasing become time-consuming and cumbersome, undermining its ability to operate with the level of responsiveness and efficiency required of a managed care system.

In addition, county fiscal practices that create barriers to the enhancement, retention, and investment of revenues by the area authority may deny the area authority the necessary fiscal and administrative authority to take advantage of the financial incentives for expanding community services and performing cost-effectively. For example, pursuant to fiscal practice in some single-county areas, the county considers the authority's noncounty revenues—state appropriations, Medicaid, and client fees—expended before county dollars budgeted for the area authority are spent. At the end of the fiscal year, most unspent revenues to the area authority, regardless of the original source, revert to the county general fund to be spent for purposes other than mental health care. Sometimes this occurs not only at the end of the fiscal year, but throughout the year—an unexpected increase in Medicaid receipts for a given month or set of months may result in a concomitant reduction in county appropriations or a county decision on how and where that revenue will be spent.

Thus single-county administrators are quick to point out that area authority revenue enhancement—through the improved collection of client receipts or the generation of other revenues—often functions to enhance county, not area authority, revenues. Rather than providing the area authority with the capacity to invest in improved, more cost-effective services or administrative systems, these practices create a disincentive to enhance noncounty revenues or to rigorously pursue the collection of client receipts.[23] Single-county administrators argue for the area authority's need to control unexpended receipts in order to develop a fund balance that allows the area authority to respond more quickly to changing service needs and to manage the financial risks associated with unforeseen variations in service demands and costs.

Given the fiscal relationship between single-county area authorities and their respective county governments, the outcomes of managed care and related strategies for changing the mental health care system depend, in part, on the political relationship between the two local governments at a particular area. County governments accustomed to maintaining tight control over single-county fiscal practices may be reluctant to give the single-county area authority the flexibility to operate successfully in a managed care environment. Whether the political challenges of system transformation can be met in order to sustain sufficient cooperation on the part of the participating local governments may determine not only the ability to meet program goals under managed care but also where the public-sector system goes from here.

The endnotes for this article begin on page 41.

Notes

Yesterday: A Brief History

1. "An Act to Empower the County Wardens of the Poor for the Counties therein Mentioned, to Build Houses in their Respective Counties for the Reception of the Poor and Other Purposes," State Records of N.C., vol. XXIV, "Laws, 1777–1788" (Goldsboro, N.C.: Nash Brothers, 1905), ch. 18 (1785).

2. Guion Griffis Johnson, *Antebellum North Carolina: A Social History* (Chapel Hill, N.C.: The University of North Carolina Press, 1937), 709.

3. David A. Rochefort, *From Poorhouses to Homelessness: Policy Analysis and Mental Health Care* (Westport, Conn.: Auburn House, 1993), 21 (hereinafter Rochefort, *From Poorhouses*).

4. The South Carolina Lunatic Asylum was established in 1828. North Carolina and Delaware were the last of the original thirteen states to establish such institutions. By 1861 the United States had forty-eight mental institutions, twenty-seven of them under state auspices. Lloyd J. Thompson, *A Study of Mental Health Care in North Carolina: Report to the Governor's*

Commission to Study the Care of the Insane and Mental Defectives (Ann Arbor, Mich.: Edward Bros., 1937), 113 (hereinafter Thompson, *Mental Health in North Carolina*).

5. "Memorial Soliciting a State Hospital for the Protection and Cure of the Insane," N.C. *Legislative Documents*, 1848–49, House of Commons Doc. No. 2 (Raleigh, N.C., Nov. 1848), 2728.

6. 1848 N.C. Pub. Laws ch. 1. Although this enabling legislation called the institution the State Hospital for the Insane, the 1854–55 General Assembly incorporated the institution under the name The Lunatic Asylum for the State of North Carolina. 1854–55 N.C. Pub. Laws ch. 2. Thereafter, in 1872, the General Assembly voted to make the institution a "curative hospital," causing the institution's name to be changed back to the State Hospital. Thompson, *Mental Health in North Carolina*, 113.

7. "Fourth Annual Report of the Board of Public Charities of North Carolina," N.C. *Legislative Documents*, 1872–73, Doc. No. 22 (Raleigh, N.C., 1873), 12.

8. North Carolina's State Mental Hygiene Society, an organization of interested laypersons formed in 1914 and reformed in 1936, disseminated great quantities of information about mental health care through meetings, speakers sent to communities, quarterly bulletins, and Mental Health Week, which started in 1949. The State Board of Charities and Public Welfare, established as the State Board of Charities in 1869 to pay attention to the causes and incidents of mental disability, emphasized prevention as the greatest opportunity for promoting mental health. State Board of Charities and Public Welfare, *Biennial Report to the General Assembly, 1922–24* (Raleigh, N.C.: SBC PW, 1924), 9.

9. Ethel Speas, *History of the Voluntary Mental Health Movement in North Carolina* (Raleigh, N.C.: N.C. Mental Health Association, 1961), ivv, 17 (hereinafter Speas, *Voluntary Mental Health*).

10. Rochefort, *From Poorhouses*, 35. Approximately 12 percent of all men screened nationwide for induction into the armed services were rejected for psychiatric reasons (p. 35). North Carolina had the highest percentage of rejectees of any state in the nation and, though it is not known how many were based on psychiatric reasons, the state also ranked highest in percentage of "feeble-minded" citizens during this period. Speas, *Voluntary Mental Health*, 28.

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

12. The state appropriated no money for direct development of community clinics until 1954, when the General Assembly granted the State Health Department's request for $380,000. Speas, *Voluntary Mental Health*, 50.

13. In 1953 the General Assembly authorized, and voters approved, the issuance of $22 million in state bonds to improve the state mental hospitals. 1953 N.C. Sess. Laws ch. 1148.

14. Rochefort, *From Poorhouses*, 31–32. Cited by newspapers as an example of patient abuse in North Carolina was a 1955 accident involving seventy-two "colored" female patients from the Goldsboro hospital. The patients had been loaded onto the back of a truck to be taken to a nearby farm to pick cotton. One side of the truck fell off en route, and twenty-eight women were injured, seven seriously. Upon investigation of the incident, the Hospitals Board of Control reapproved the practice of hiring out Goldsboro patients and absolved all hospital personnel of responsibility, blaming the accident on a defective piece of wood that could not have been detected. Not satisfied with the board's report, the Raleigh *News and Observer* wrote on December 18, 1955, that humane people of the state would view the incident as gross negligence on the part of the state.

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

16. Kennedy, *President's Messages*, 1468.

17. Pub. L. No. 88-164 (1963).

18. While Title II funded the construction of "community mental health clinics," Title I of the act funded the construction of "mental retardation facilities" that were not necessarily community based.

19. 1963 N.C. Sess. Laws ch. 1166; formerly N.C. Gen. Stat. (hereinafter G.S.) 122-35.1 through -35.12.

20. The Omnibus Budget and Reconciliation Act of 1981, Pub. L. No. 97-35, Title IX, 901, 42 U.S.C. 300x. The repeal of the CMHCA was part of a larger reform of federal-state relations when President Reagan first came to office and included the consolidation of federal funds for mental health and drug abuse programs into one block grant funded at a level 25 percent below previous appropriations. The "new federalism" left states with greater discretion to determine service needs and allocate funds accordingly, diminished the federal role in mental health care, and, in many states, created an expansion of the policymaking and administrative roles of state governments.

21. The multiple needs of persons with severe mental disabilities require a comprehensive range of services. Assessment of need, allocation of resources, and overcoming impediments to access should occur at the client level in planning for the care of the individual and at the systems level in planning for the targeted population. Michael A. Hoge et al., "Defining Managed Care in Public-Sector Psychiatry," *Hospital and Community Psychiatry* 45 (Nov. 1994): 1087.

22. *Concept Paper, MHSC Committee on Funding Development Policy* (Raleigh, N.C.: Mental Health Study Commission, Sept. 8, 1986), 1.

23. 1977 N.C. Sess. Laws ch. 568; formerly G.S. 122-35.35 to -35.57.

24. The community system of services created in 1977 differs minimally from the current system authorized by the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985. G.S. 122C-1 through -433.

25. Without sufficient resources, community programs cannot provide the various levels of support necessary to prevent repeated hospitalizations of persons who suffer from severe or chronic mental illness or substance abuse. Further, even with good outpatient care and treatment—outreach, crisis prevention, and programs for care following institutional discharge—mental health systems still need nonhospital detoxification services or crisis stabilization facilities for acute phases of mental illness and substance abuse. Where the resources or will is insufficient to provide these services on the local level, communities will continue to rely on the state psychiatric hospitals and psychiatric units in general hospitals to provide twenty-four-hour care for persons in need of crisis services.

Today: Focus on Area Authorities

1. "An area authority is the locus of coordination among public services for clients of its catchment area." G.S. 122C-101. The area authority shall "[p]rovide services to clients in the catchment area . . . [and] coordinate with the Secretary [of DHR] the provision of services to clients through area and State facilities." G.S. 122C-117(a)(2), (3).

2. When using the term "mental disability," the author refers collectively to mental illness, developmental disabilities, and substance abuse. Alcoholism and chemical dependency are classified as "mental disorders" by the International Classification of Diseases, and some writers use the term "mental disability" to refer to both mental illness and developmental disabilities. *See* Deborah Zuckerman and Marc Charmatz, *Mental Disability Law, a Primer*, 4th ed. (Washington D.C.: Commission on Mental and Physical Disability Law, American Bar Association, Washington D.C. 1992), 2 (hereinafter Zuckerman and Charmatz, *Mental Disability Law*).

3. G.S. 122C-211(a); -221(a); -241(a)(3). The procedures vary when the person seeking services is a minor, an adult who has been adjudicated incompetent, or when admission is sought to a twenty-four-hour facility.

4. Zuckerman and Charmatz, *Mental Disability Law*, 3.

5. Rebecca T. Craig and Barbara Wright, *Mental Health Financing and Programming* (Washington, D.C.: National Conference of State Legislatures, May 1988), 23 (hereinafter Craig and Wright, *Mental Health Financing*).

6. Of the nation's 31 million people age sixty-five or older, 5 million have depressive symptoms severe enough to require treatment. About 8 to 10 percent of Americans experience a significant affective disorder at some point in their lives. Over 4 million Americans suffer from a major depressive illness at any given time, costing from $16 billion to $45 billion annually in treatment costs, loss of work productivity, permanent disability, and associated substance abuse. Suicide, a major complication of depression, is the tenth leading cause of death in the United States, and some 50 to 90 percent of suicides are due to depression. Simeon Margolis and Peter V. Rabins, *The Johns Hopkins White Papers, Depression and Anxiety* (Baltimore, Md.: The Johns Hopkins Medical Institutions, 1994), 5, 8. *See also* Kathy Cronkite, *On the Edge of Darkness* (New York: Doubleday, 1994), 317 (interview with Lewis Judd, M.D., Department of Psychiatry, University of California at San Diego).

7. *See* G.S. 122C-3(12a) and N.C. Admin. Code tit. 10, ch. 14K § .0103(24).

8. G.S. 122C-3(36).

9. For each program "component" (a service developed to meet a particular need), the governing body of the area authority must develop written policies that address procedures for screening, the purpose of the service, client eligibility requirements, waiting lists, and the geographical areas from which individuals will be admitted. N.C. Admin. Code tit. 10, ch. 18L § .0600.

10. G.S. 122C-146.

11. G.S. 122C-117(a1) and -141(c).

12. Memorandum to author from Deborah Merrill, Data Support Branch, N.C. Division of Mental Health, Mental Retardation, and Substance Abuse Services (Dec. 8, 1994).

13. This statistic is from information presented by the Mental Health Study Commission (MHSC) at a December 1992 conference on the mental health care system in North Carolina. The study commission handouts do not reflect the source of statistics cited. (Hereinafter, information presented by the study commission at the conference will be cited as MHSC conference materials.)

14. Unless otherwise indicated, figures listed are from N.C. Division of Mental Health, Developmental Disabilities and Substance Abuse Services, Department of Human Resources, *FY 1991–92 Community Services Report for Services Provided by Area Mental Health, Developmental Disabilities and Substance Abuse Programs and Their Contract Agencies* (Raleigh, N.C: NCDMHDDSAS, Apr. 1993) (hereinafter cited as *Community Services Report*). Number of persons served at the forty-one area authorities are projections based on data from seventeen area authorities. Clients are counted only once, and numbers do not include Willie M. and Thomas S. clients.

15. In a survey, over 44 percent of eleventh and twelfth grade students reported using alcohol and other drugs on a monthly basis, 21 percent reported that they regularly become intoxicated, and 13,000 students reported using a needle to inject drugs. MHSC conference materials.

16. Approximately 32 percent of all AIDS cases are reportedly related to intravenous drug use, and 70 percent of all pediatric AIDS cases are related to maternal exposure to HIV through drug use or sexual relations with a drug user. MHSC conference materials.

17. Craig and Wright, *Mental Health Financing*, 23.

18. MHSC conference materials.

19. G.S. 122C-141.

20. N.C. Admin. Code tit. 10, ch. 18I § .0119. Required services are set forth at N.C. Admin. Code tit. 10, ch. 18M §§ .0100 through .1400.

21. Optional services are set forth at N.C. Admin. Code tit. 10, chs. 18N through 18Q.

22. G.S. 122C-118.

23. G.S. 122C-119.

24. G.S. 153A-77.

25. N.C. Admin. Code tit. 10, ch. 18J § .0110. Other responsibilities are codified at G.S. 122C-117, -141 through -144.1, -146, -151.3, -156 through -157, and -191.

26. G.S. 122C-121.

27. G.S. 122C-116.

28. However, unlike most units of local government, neither multicounty nor single-county area authorities have the power to levy taxes.

29. G.S. 122C-147(c). Further, an area authority may not finance or acquire real or personal property by means of an installment contract under G.S. 160A-20 without the approval of the board or boards of county commissioners for the counties constituting the catchment area.

30. G.S. 122C-115(b).

31. G.S. 122C-154.

32. G.S. 143B-147 through -150.

33. G.S. Ch. 143B; G.S. 122C-111 and -112. Many of the statutory responsibilities attributed in this text to the division are based on statutory provisions that actually name the DHR as the responsible entity. The secretary of DHR, however, pursuant to his or her statutory authority, has delegated these

responsibilities to the director of the division. G.S. 143B-10; Department of Human Resources Directive No. 6 (July 1, 1980).

34. G.S. 122C-112(a)(6), (11); 143B-139.1.

35. G.S. 122C-112(a)(3) and -181. The four psychiatric hospitals are the John Umstead Hospital in Butner, Dorothea Dix Hospital in Raleigh, Broughton Hospital in Morganton, and Cherry Hospital in Goldsboro. The five mental retardation centers are the Caswell Center in Kinston, O'Berry Center in Goldsboro, Murdoch Center in Butner, Western Carolina Center in Morganton, and Black Mountain Center in Black Mountain. The three alcohol and drug abuse treatment centers (ADATC) are the Black Mountain ADATC, the Butner ADATC, and the Walter B. Jones ADATC in Greenville. The three facilities for special populations of children or adolescents include two residential schools for emotionally disturbed youth (the Wright School in Durham and the Whitaker School in Butner) and the Butner Adolescent Treatment Center serving multiply handicapped and chronically impaired adolescents. The facility for adults needing mental health and nursing care services, called the Special Care Center, is located in Wilson.

36. *See* G.S. 122C-3(34), -101, and -132 through -132.1.

37. Quality Assurance Section, Division of Mental Health, Mental Retardation, and Substance Abuse Services, *Strategic Plan 1983–1989*, vol. 1 (Raleigh, N.C.: N.C. Department of Human Resources, 1981), 196.

38. State law *requires* area authorities, in cooperation with private providers, to develop and secure division approval for a single portal of entry and exit policy for both public and private providers of day/night and twenty-four-hour services for individuals with *developmental disabilities*. State policy, however, only *encourages* area authorities to develop a single-portal policy for the public system of *mental health* and *substance abuse services*. In addition, emergency provisions in the civil commitment laws allow admissions to twenty-four-hour facilities that bypass the area authority. The division has indicated that it plans to seek legislation to close these gaps in the single-portal system.

39. North Carolina receives federal funding for mental disabilities services through the Mental Health Services Block Grant, the Social Services Block Grant, the Block Grant for the Prevention and Treatment of Substance Abuse, and the Child Care and Development Block Grant. In addition, states may apply for special purpose grants from the federal government and private foundations. In North Carolina, federal and private special purpose grants total $34 million for fiscal year 1994–95, funding housing programs for the homeless mentally ill (federal), mental health services to children of military families (federally funded Fort Bragg Demonstration Project), the development of a case management curriculum at The University of North Carolina at Chapel Hill (Annie E. Casey Foundation grant), and the development of interagency collaboration in two western area authorities (Robert Wood Johnson grant).

40. Unless otherwise indicated, the figures pertaining to area authority expenditures and revenues are based on information reported by the division to the MHSC in December 1994. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, *Financing Initiatives, An Update on DMHDDSAS Activities Related to MHSC Financing Initiatives Report* (Raleigh, N.C.: N.C. Department of Human Resources, Dec. 1994) (hereinafter *1994 Financing Initiatives Report*). Funds for the Fort Bragg Demonstration Project and Carolina Alternatives capitated Medicaid payments are not included in the analysis of area authority revenues.

41. This includes state funding for the court-ordered Thomas S. and Willie M. programs.

42. "County" includes not only county general funds supported by local tax revenues but also a portion of the state's revenue from the sale of alcoholic beverages, which is allocated to counties for the treatment of alcoholism or for research or education on alcohol abuse. *See* G.S. 18B-805.

43. "Medicaid" in this section refers only to the federal share of Medicaid payments under the state's mental health plan.

44. G.S. 122C-146. In addition, fees may not be charged for services that are required to be offered free to infants and toddlers pursuant to the amendments to the Education of the Handicapped Act, Pub. Law 99-457, unless the legally responsible person for the recipient of services grants permission for an insuror or other payor to be billed for the service.

45. "Other" includes receipts from clients, private insurance, and contracts; Medicaid receipts for services through Intermediate Care Facilities for the Mentally Retarded (ICF-MR) and the Community Alternatives Program for the Mentally Retarded (CAP-MR); state funds from other divisions; and any federal or private funds granted directly to area authorities.

46. *See* The Technical Assistance Collaborative, Inc., *North Carolina Council of Community Programs Preliminary Findings and Recommendations from the Area Authority Case Studies* (Raleigh, N.C.: The Technical Assistance Collaborative, Inc., Oct. 31, 1994), 56 (hereinafter *N.C. Council Preliminary Findings*). Making state money go farther by maximizing the use of federal funding has been a goal of the division at least since 1990, and efforts to increase Medicaid receipts continue to be one strategy for pursuing that goal. *1994 Financing Initiatives Report*, 1, 12, 21, and 24.

47. The services are required as a result of two separate class-action lawsuits in federal court against the state on behalf of plaintiffs inappropriately institutionalized or inadequately treated: mentally retarded adults who were inappropriately institutionalized in psychiatric hospitals and emotionally disturbed minors who were often denied needed services due to a history of violent behavior.

48. Although Willie M. funding made up the bulk of court-ordered funding in fiscal year 1989–90 ($32 million compared to $500,000 for the Thomas S. program), the Thomas S. program is responsible for the *growth* in court-ordered funding, rising 4967 percent to $25.3 million by 1993–94, compared to an 11 percent increase in Willie M. funding over the same five-year period (Willie M. received $36 million in 1993–94).

49. *See N.C. Council Preliminary Findings*, 11 and 20.

50. Figures are based on actual revenue by source as reported in a table entitled "Actual Summary of Expenditures and Revenue by Source (Fiscal Year 1993–1994)," prepared by the Fiscal Services Section of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (Raleigh, N.C: N.C. Department of Human Resources, 1994).

51. Although a county "*shall* provide [mental health] ser-

vices through an area authority, counties "*may* make appropriations" for these purposes. G.S. 122C-115.

52. Mental Health Study Commission, *Final Report* (Raleigh, N.C.: MHSC, 1979), 9–10.

53. Division of Mental Health, Mental Retardation, and Substance Abuse Services, *Historical Summary of Allocation of Funds to the Area Programs by Region* (Raleigh, N.C.: N.C. Department of Human Resources, Mar. 26, 1986), 1 (hereinafter *Historical Summary*).

54. *Historical Summary*, 3.

55. Mental Health Study Commission, *Final Report* (Raleigh, N.C.: MHSC, 1987), 8. Although local variations in financial resources had been identified at least as early as 1985, the relationship to service availability had not yet been established. Mental Health Study Commission, *Final Report* (Raleigh, N.C.: MHSC, 1985).

56. The General Assembly repealed G.S. 122C-143 through -144; -147(a); and -148 through -150. G.S. Ch. 122C was amended by adding new sections 122C-143.1; -144.1; -147.1; -147.2; -151.3; and 151.4 and by amending sections 122C-3; -151; and -112(a).

57. G.S. 122C-147.1.

58. G.S. 122C-143.2.

59. The Pioneer Funding System requires area authorities to engage in standardized cost-finding and rate-setting procedures to determine reimbursement rates for specific types of services. Through a unit-cost reimbursement system, the area authority is reimbursed at a prospective, negotiated reimbursement rate, specific to each type of service, for actual units of service delivered and reported to the division. G.S. 122C-143.2, -147.1, and -147.2.

60. The DHR payment policies designate the disability populations and the kinds of services to be supported by state resources. These payment policies, in turn, are based on the priorities expressed in the MHSC's long-range age and disability plans, which currently target the more severely impaired in all disability groups. The rationale for this policy is based on the MHSC's findings that not even the highest funded area authority was meeting the demand for services for any one client group and the fact that the broad definition of services that an area authority is authorized to provide creates a potentially infinite demand for state dollars.

Tomorrow: The Movement to Greater Local Responsibility

1. Michael A. Hoge et al., "Defining Managed Care in Public-Sector Psychiatry," *Hospital and Community Psychiatry* 45 (Nov. 1994) (hereinafter Hoge, "Defining Managed Care"): 1087, quoting L. L. Bachrach, "Continuity of Care for Chronic Mental Patients: A Conceptual Analysis," *American Journal of Psychiatry* 138 (1981): 1449–56. *Continuity of care* is a "multidimensional concept that includes coordination of all services offered at a given point in time, a longitudinal continuity in the way in which services are offered over time, and a consistency in the patient-provider relationship (p. 1087).

2. *See* Mental Health Study Commission, *North Carolina Comprehensive Long Range Plan for Persons with Severe and Persistent Mental Illness, Report of the MHSC to the 1989 General Assembly* (Raleigh, N.C.: MSHC, 1989), sec. 1, 1454; and Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, *Report of the Integrated Funding Task Force* (Raleigh, N.C.: N.C. Department of Human Resources, Sept. 1990).

3. Because the reallocation of institutional-care dollars to area authorities was viewed as simply one of several mechanisms necessary for achieving the presumed outcomes of more comprehensive and better continuity of care at the client level, the initiative, originally called the Integrated Funding System, was renamed the Unified System of Services to more accurately reflect the purpose of the effort. *See* Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, *Unified System of Services, An Interim Report on an "Integrated Funding System" for Mental Illness and Substance Abuse Services* (Raleigh, N.C.: N.C. Department of Human Resources, May 1, 1994), 1 (hereinafter *USS Interim Report*).

4. *See* Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, *Unified System of Services for Mental Illness and Substance Abuse Services, The Final Report*, draft (Raleigh, N.C.: N.C. Department of Human Resources, Jan. 12, 1995), 3537, 41 (hereinafter, *USS Final Report*, draft).

5. The committee and work groups that developed the plan identified three sets of community services needed under USS: (1) generic crisis response and stabilization services, (2) intensive outpatient services, and (3) case management. Expansion funding of $10 million was recommended for implementing these services in the pilot region. *USS Final Report*, draft, 2829.

6. *USS Interim Report*, 30.

7. *USS Interim Report*, 32; and *USS Final Report*, draft, 38.

8. *Crisis* is defined as "a sudden attack or sharp recurrence of pain, distress, or disordered function." Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, *Crisis Services, A Report on a Delivery System of Services for Mental Illness, Developmental Disabilities, and Substance Abuse Crises* (Raleigh, N.C.: N.C. Department of Human Resources, Oct. 1994), 1 (hereinafter *Crisis Services Report*).

9. *Crisis Services Report*, 3, 7. For fiscal year 1993–94 the General Assembly appropriated approximately $6 million in expansion funding for area authority crisis services. 1994 N.C. Sess. Laws ch. 769.

10. *See* Hoge, "Defining Managed Care," 1086.

11. *Crisis Services Report*, 35. Although the area authority would be responsible for managing the commitment, the area authority would have the flexibility to move committed individuals between more and less restrictive environments based on the individual's needs.

12. Between 1988 and 1991, Medicaid-financed mental health expenditures for children and adolescents more than doubled, with $34 million spent for the inpatient care of 2,000 children in 1991. About $6 million, in 1991, was spent on outpatient services for 9,000 children, meaning that 80 percent of the dollars went to highly restrictive care for a relatively small number of children. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "Review of Major Decision Points," in *Carolina Alternatives: North Carolina's Coordinated Mental Health and Substance Abuse Care Program for Medicaid Children* (Raleigh, N.C.: N.C. Department of Human Resources, June 1994), 3.

13. To pursue Carolina Alternatives, North Carolina had to seek and obtain from the Health Care Financing Adminis-

tration a "waiver" of requirements of the federal Medicaid law. Section 1915(b) of the Social Security Act [42 U.S.C. 1396n(b)] authorizes a waiver of requirements to establish a risk-based managed-care system like Carolina Alternatives.

14. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, *Carolina Alternatives, North Carolina's Coordinated Mental Health and Substance Abuse Care Program for Children Covered by Medicaid, A Progress Report* (Raleigh, N.C.: N.C. Department of Human Resources, Dec. 15, 1994) (hereinafter *Carolina Alternatives Progress Report*).

15. Because area authorities must pay for inpatient care out of their capitated payments, they presumably would have an incentive to expand less expensive outpatient and residential services to keep clients out of expensive inpatient programs.

16. Hoge, "Defining Managed Care," 1086–87. "For example, a well-managed system does not eliminate the tension between overwhelming patient need and limited economic resources" (p.1089).

17. *See* Jane Perkins and Michele Melden, "The Advocacy Challenge of a Lifetime: Shaping Medicaid Waivers to Serve the Poor," *Clearinghouse Review* (Dec. 1994): 864–85.

18. Hoge, "Defining Managed Care," 1086–87.

19. *Carolina Alternatives Progress Report.*

20. *See* G.S. 160A-460 through -464.

21. N.C. Admin. Code tit. 10, ch. 18W § .0004.

22. The Technical Assistance Collaborative, Inc., *North Carolina Council of Community Programs Preliminary Findings and Recommendations from the Area Authority Case Studies* (Raleigh, N.C.: The Technical Assistance Collaborative, Inc., Oct. 31, 1994), 21; and Hoge, "Defining Managed Care," 1087.

23. Single-county administrators argue that this is inconsistent with the law requiring that all funds collected from fees be used for the operation or capital improvement of area authority programs, not to reduce or replace local tax revenue budgeted for mental disability services. *See* G.S. 122C-146. ☒

Special Series: Local Government on the Internet

Part One: What You Can Find, How to Get On, and How to Get Around

Patricia A. Langelier

The Internet offers a world of resources to local governments—a world that is expanding faster than the imagination. Now, for the first time, North Carolina local governments have a convenient and affordable way to get onto the Internet: through an access service provider under state contract. For the first time, they now also have a convenient and effective way to get around once they are on: through NCINFO, a joint project of the Institute of Government, the Association of County Commissioners, and the League of Municipalities.

Over the course of the next several issues of *Popular Government*, "Local Government on the Internet" will introduce the Internet to potential local government users. In Part One we will look at what users can find on the Internet, how to get on, and how to get around.

What You Can Find on the Internet

The recent explosion in use of the Internet—by governments, by businesses, by individuals—has spurred increased development of Internet resources. Data files, reports, directories, catalogs, and other resources have sprung up on the Internet, and their numbers grow daily.

The author is the Institute of Government librarian and project manager for NCINFO.

NCINFO, the Institute of Government's "home page" and your starting point to access other state, local, and even national and international Internet resources.

E-mail

One of the most heavily used features of the Internet is electronic mail, or e-mail. You can compose e-mail at your computer and send it to anyone in the world who is connected to the Internet. You can attach a text file—such as a memorandum or a report or a chart—to the message and, with one keystroke, e-mail it to one person or to a group of people. The mail arrives at its destination in minutes rather than days. The quick delivery enables you to get a response to your inquiry more quickly, and it reduces or eliminates telephone tag. E-mail also decreases the need for repetitive data entry. The receiver can revise your draft and return it to you with comments and revisions.

Easy access to more complete information on a broad range of topics will enable you to make better-informed decisions. If you want to know how other municipalities deal with panhandling, for example, conducting a quick survey by e-mail will help you find out. Colleagues share their experiences with you to help you determine the best solution for your particular situation.

Current Information

The Internet speeds the delivery of timely information. For example, if you want new U.S. Supreme Court decisions, you can subscribe for free to the *LII Bulletin*, an electronic bulletin at Cornell University's Legal Information Institute, which sends e-mail announcements about the decisions as soon as they appear. Subscribers then can request a free copy of the full text of any decision, which will be delivered to their electronic mailbox automatically, usually within twenty-four hours. Known as "listservs," these mailing lists are fully automated and require little effort to set up or maintain. Some listservs, such as the *LII Bulletin*, are one-way distribution only: the provider sends the information to the people on the list. Other listservs are meant to be discussion groups with give-and-take among subscribers. All that's required for a successful listserv is a sufficient number of people connected to the Internet who are interested in sharing information with other subscribers on a particular topic.

How to Get on the Internet

Access to the Internet requires a computer, a modem, and an account with an Internet service provider.

Service providers. Internet service

Glossary

Note – Terms set in **this style of type** are defined elsewhere in the glossary.

Browser – A program installed on your computer that enables you to use the resources of the **Internet**. The browser reads documents and can retrieve them from other sources on the Internet.

Gopher – A text-based distributed information system for exploring the **Internet** developed at the University of Minnesota (and named after its mascot). A gopher presents information in a series of menus to automate access to information on the Internet.

Home Page – A top-level document of an organization that directs users to the information and services provided by that site.

HTML (Hypertext Markup Language) – The rules that govern the way we create documents so that they can be read by a World Wide Web **browser**. Most documents that are displayed by **Mosaic** or **Netscape** are HTML documents. These documents are characterized by the .html or .htm file extension. For example, homepage.html or homepage.htm

HTTP (Hypertext Transport Protocol) – The **protocol** used by the World Wide Web **servers (WWW)**.

Hypermedia – Documents that may combine sounds, images, animation, and text. Hypermedia documents can be found on multimedia compact discs and the **Internet**.

Hypertext – Hypertext is text with built-in links to other documents that appear as highlighted words or phrases. When you select one of the highlighted words, your **browser** software finds the appropriate **Internet** server and retrieves the document for you.

Internet – An international computer network of networks that are connected to one another, using **TCP/IP protocols**.

Mosaic – **Browser** software that allows users to retrieve information from the **Internet** and the World Wide Web.

Netscape – Another popular browser for retrieving information from the **Internet** and World Wide Web.

Protocol – A set of conventions for exchanging data over the **Internet**. Protocols enable different kinds of computers to communicate.

Server – A computer that runs software that provides information and software to the **Internet** community. **Browsers** access servers to retrieve information.

TCP/IP (Transport Control Protocol/Internet Protocol) – Communication **protocols** developed by the U.S. Department of Defense to exchange data over the **Internet**.

URL (Uniform Resource Locator) – The address of a source of information on the **Internet**, containing four distinct parts: the **protocol** type, the machine name, the directory path, and the file name. For example, http://ncinfo.iog.unc.edu/nclgisa/nclgisa.html

WWW (World Wide Web = WWW = W3 = The Web) – A system for providing **hypertext** access to documents wherever they are located on the **Internet**. It was conceived at the European Laboratory for Particle Physics (CERN). CERN's work with hypertext made the development of the World Wide Web possible.

providers have sprung up across the country, offering access to the Internet for fees ranging from $10 to $50 per month. There are several specialized providers in North Carolina, and the major, commercial online services such as America Online, CompuServe, Delphi, and Prodigy are beginning to provide gateways to the Internet. Some of these services charge by the hour, others charge a flat monthly fee.

New state contract. The simplest way for local governments to gain access, however, is through the new state contract. The State Telecommunications Service recently entered an access service contract with a provider called Interpath. Cities and counties can use this contract to get connected. Interpath—and other Internet providers—provide access to the Internet at varying fees and with a range of options, depending on just what the user wants and can afford.

The state contract has its advantages, according to Lee Mandell of the North Carolina League of Municipalities. "One advantage of using the state's contract with Interpath is that the company has guaranteed that an individual user will be able to connect 95 percent of the time," he says in a recent edition of the League's newsletter. "For some other services, Internet access on the first phone call is blocked much more often. Other advantages are an enhanced 'help desk' for users and the large percentage of the state that can access the network with a local call."

How to Get Around the 'Net

NCINFO

Once connected to the Internet, you'll need help finding the information that can be beneficial to you. That help exists in NCINFO. The three organizations that sponsor it—the Institute of Government, the Association of County Commissioners, and the League of Municipalities—provide on-screen information about these organizations but also provide links to other useful Internet resources. Since its international debut on January 25, 1995, NCINFO has been accessed many thousands of times. Through NCINFO you can read selected new articles from *Popular Government* and *School Law Bulletin*, search an online version of the Institute's catalog of publications, locate research surveys from the League and the Association, identify job listings in state and local government, get statistical data from the state planning office and the U.S. Bureau of the Census, find information about legislators, follow the status of bills before the General Assembly, read recent decisions of the North Carolina appellate courts, and much more.

Two ways to reach NCINFO. How you reach NCINFO depends on the type and speed of your Internet connection.

Selected Resources on NCINFO

Note: All Internet addresses should be typed on one line—without spaces or "returns"—even if they appear below on two lines.

To connect to the Internet:

Gopher address:
ncinfo.iog.unc.edu
World Wide Web address:
http://ncinfo.iog.unc.edu

Daily Summary
The Institute of Government's record of activity in the North Carolina General Assembly
URL: http://ncinfo.iog.unc.edu/daily_summary

1995 Directory of the State and County Officials of North Carolina
An online version of this annual publication
URL: http://www.secstate.state.nc.us/secstate/toc.html

Office of State Planning
Access to a directory of data sources and annual statistical data for the state and its counties
URL: http://www.ospl.state.nc.us/OSPL

Department of Commerce
Guides to state and local taxes, regional and county demographic/economic data, and lots more
URL: http://www.commerce.state.nc.us

Dept. of Public Instruction
Statistics, reports, and education events
URL: http://www.dpi.state.nc.us

Employment Security Commission
Labor Market Information, lists of North Carolina's largest employers, civilian labor force estimates, etc.
URL: http://www.esc.state.nc.us

North Carolina General Assembly
Bill status, calendars, and legislator information
URL: ftp://ftp.legislature.state.nc.us

Thomas
Current information about congressional legislative activity
URL: http://thomas.loc.gov

U.S. Bureau of the Census
Data, data, data
URL: http://www.census.gov

N.C. Division of Purchase and Contract
Microcomputer and peripherals contract information
URL: http://www.doa.state.nc.us/PandC

Hardware and Software Requirements to Use the Internet

	Minimum	Recommended
Computer	386sx25 or Macintosh	486sx25 or higher or Macintosh
Modem	9600 bps	14,400 bps or higher
Software	DOS-based World Wide Web Gopher, E-mail	Windows-based World Wide Web Gopher, E-mail

The quickest way is through the gopher ("go for") site (see "Selected Resources on NCINFO," above, for the gopher address). The NCINFO gopher provides a series of menus that lead you from one topic to another until you reach the information needed. That information is presented as text only—that is, words on your screen. The newer and more popular way is through NCINFO's World Wide Web (WWW) site (see above for the Web address). The WWW provides not only text but images, sound, and animation (if you have the right equipment). It also provides links embedded in the images and text that allow you, with the click of your computer mouse, to jump from one document to another. Searching for information can take longer on the Web, however, because images take longer to transmit than text.

The software needed. To access NCINFO on the Internet, you must have the right kind of software, but that is not a problem, because software to browse gophers and WWW sites is available free over the Internet and from your Internet service provider. You can use gopher software such as TurboGopher (for Macintosh computers) or WSGopher (for other computers), as well as World Wide Web client software such as Mosaic or Netscape.

In Future Parts of This Series

In future issues of *Popular Government*, this series will look at ways in which local governments can make full use of Internet resources. Topics will include the North Carolina Information Highway, developments on NCINFO, electronic journals, how to choose an Internet access provider, and closer looks at listservs, and new developments on the Internet.

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E-mail: rtroutman@sips.state.nc.us

State Information Processing Services
Phone: (919) 981-5555 (for Interpath contract information)
E-mail: info@sips.state.nc.us

Questions I Am Frequently Asked: At What Age May a Minor Leave Home?

Janet Mason

A recent newspaper article included the following statement: "In North Carolina, 16-year-olds can live on their own if they want." While that statement may reflect the practical experiences of many parents, it does not reflect the law in North Carolina. In fact, our law specifically subjects children under age eighteen to the control of their parents and provides legal procedures to enforce that control.

Section 44.1 of Chapter 110 of the North Carolina General Statutes (G.S.) reads as follows: "Notwithstanding any other provision of law, any child under 18 years of age, except as provided in G.S. 110-44.2 and 110-44.3, shall be subject to the supervision and control of his parents." The exceptions are for children under eighteen who are married, emancipated, or in the armed forces. A child under age eighteen can be emancipated only by marriage or by order of the district court in an emancipation proceeding initiated by the minor. In other words, a minor cannot declare his or her own emancipation or establish it by living independently or by other behavior; and a parent cannot initiate an emancipation proceeding.

G.S. 110-44.4 allows a parent to file a civil action in district court to enforce the parent's right (and obligation) to supervise and control a minor child. This remedy may be impractical or ineffective in some situations, but it reflects a legislative intent to assist parents whose children have left home without permission. (Someone who houses or harbors the minor may be named as a defendant, and the court may order that person not to allow the child to remain on the person's premises or in the person's home.)

The author is an Institute of Government faculty member who specializes in juvenile justice and social services law.

Juvenile Code Provisions

The North Carolina Juvenile Code deals differently with minors under age sixteen and those who are sixteen or seventeen. When a minor under sixteen runs away from home, he or she is engaged in what the Juvenile Code defines as *undisciplined* behavior—a category that includes being truant from school, being beyond the parents' disciplinary control, and being in places where it is unlawful for a minor to be. The code provides law enforcement officers, juvenile court counselors, and district court judges in juvenile court the authority to deal with such individuals. Minors age sixteen and seventeen are excluded from the definition of "undisciplined juveniles," however, and are not subject to the same law enforcement and court authority. (A special section of the code that deals with interstate procedures *does* authorize a judge to enter an order for the return to North Carolina of *any* minor who runs away and leaves the state.)

The difficulty and frustration that some parents experience in trying to supervise and control their sixteen- and seventeen-year-old children have received recent legislative attention. In 1993 the General Assembly authorized a pilot program in which the Juvenile Code's definition of "undisciplined juvenile" was expanded to include sixteen-

and seventeen-year-olds who are beyond the disciplinary control of their parents. This change applied only in Catawba, Bertie, and McDowell counties, however. In 1995 the General Assembly neither expanded the program to other counties nor reauthorized it for the three pilot counties.

Recent Amendments to the Code

In the same session, however, the legislature did amend the Juvenile Code to provide a limited response to parents' concerns about sixteen- and seventeen-year-olds who leave home without permission and refuse to return. Rather than expand the definition of "undisciplined juvenile," which would have resulted in the application of a wide range of Juvenile Code procedures to these young people, the legislature simply added the following language to the Code:

> A law-enforcement officer may take physical custody of a juvenile who is 16 or 17 years of age without a court order, at the request of the juvenile's parent, guardian, or custodian if there are reasonable grounds to believe the juvenile is beyond the disciplinary control of the juvenile's parent, guardian, or custodian and has been absent from the home without permission for 48 consecutive hours.

This change, in G.S. 7A-571(b), is effective October 1, 1995. Another new provision, in G.S. 7A-572(c), directs a law enforcement officer who takes a juvenile into custody under the above provision to return the juvenile to the custody of the parent or to notify the parent that the child has been taken into custody. (Different procedures apply if the officer has reasonable grounds to believe that the juvenile is abused, neglected, or dependent and would be injured if returned to the parents' custody.) Thus in the circumstances described in the new section, the sixteen- or seventeen-year-old can be taken into custody and returned home or held while the parents are notified to come get their child, but no juvenile proceeding or other court action is involved.

The unavailability of other Juvenile Code procedures for dealing with sixteen- and seventeen-year-olds does not mean that those young people have "legal permission" to leave home, to live on their own, or to defy their parents' supervision and control in other ways. It just means that parents have a harder time enforcing their right to supervise and control their children during the two years before those children reach majority at age eighteen.

Books Noted

A New Overview of North Carolina's Political Culture

North Carolina Government and Politics, by Jack D. Fleer. University of Nebraska Press, 1994. 343 pages. $18.95.

North Carolina Government and Politics is the latest in a series of books on states published by the Center for the Study of Federalism and the University of Nebraska Press. The author, Jack Fleer, is a professor of political science at Wake Forest University and a respected authority on North Carolina state government and politics. In 1968 he published a less comprehensive book, *North Carolina Politics: An Introduction.* His new book goes much farther, examining North Carolina political culture, its political traditions and practices, key interest groups, and the constitutional framework within which the state carries out its various functions.

Fleer begins with an overview of the history and culture of North Carolina, noting that its settlement by individuals of ordinary background led it to be labeled, in contrast to the more sophisticated societies of Virginia and South Carolina, "a vale of humility between two great mountains of conceit." But in recent times, Fleer notes, North Carolina has emerged as one of the major states in the country, noted for relatively progressive and scandal-free government, an outstanding university system, and a healthy economy.

The book's best feature is its in-depth profiles of the legislative and executive branches and their leaders. These chapters, along with the chapter on policy making at the state level, provide insight into how important issues are handled in the state. The author observes that the North Carolina General Assembly is, in one sense, the most powerful legislative institution in the nation by virtue of the fact that the governor has no veto power (that may change, of course, now that the legislature has authorized a constitutional referendum on the matter). He also describes the General Assembly as one in

transition from a citizens' body to a professional legislature. Fleer's observations on the office of the governor are likewise cogent, including his descriptions of the influences of recent incumbents from Luther Hodges through Jim Hunt.

The book also provides a good brief description of the judicial system and local government structure in North Carolina, as well as an analysis of the relationship of the state to the federal government.

North Carolina Government and Politics is useful for students of political science and the public at large. It is insightful without being slanted, descriptive without being dry, and a valuable resource to anyone seeking to understand our state.

—*Stephen Allred*

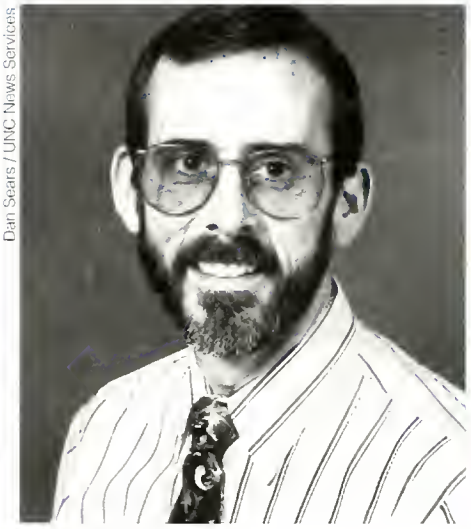
At the Institute

Phil Andrews Retires

Phillip M. Andrews, Jr., long-time office services manager at the Institute of Government, is retiring this summer after nearly twenty-five years of service. He lent to the Institute during those years a great enthusiasm for work—long hours, meticulous care—which was grounded in a solid respect for the public officials of the state. Colleagues have all known that they could count on Phil to react positively to their difficulties and work quickly to find a solution. A faculty member who waited to the last minute to ask for help with classroom materials or a secretary who could not locate a needed supply knew where to turn.

Phil is a native of Carrboro, N.C. He attended Chapel Hill High School and The University of North Carolina at Chapel Hill. He joined the Institute as a typist in 1971 and was quickly promoted, first to varitype operator in the publications section, and then to manager over various operations. By the early 1980s Phil was in charge of the Institute's printing and mailing, shipping and receiving, publications storage and distribution, motor pool, telecommunications, office supplies, and asset and supply inventory. He continued in those duties until his retirement.

"Phil has a passion for the quality of the appearance of his work," recalls Margaret Taylor, who formerly directed the Institute's publications operations. "The work we produced benefited greatly from his careful eye."



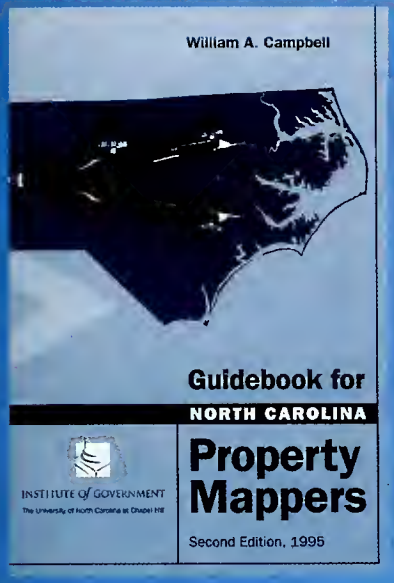
Dan Sears / UNC News Services

Phillip M. Andrews, Jr.

"We counted on Phil to solve daily problems and lift our spirits," adds Marilyn Penrod, Publications Division manager. "We'll all miss his attention to detail, his good nature, and easy laugh."

"North Carolina public officials are familiar with Institute faculty members," says Michael R. Smith, Institute director. "They see us in front of the classroom, they talk with us on the telephone. But few of them know the folks behind the scenes. It is the dedication of many talented staff people that makes the work of the Institute possible. Phil Andrews is an unalloyed example of that dedication. Thank you, Phil, and good luck." ⊠

Off the Press



Guidebook for North Carolina Property Mappers

Second edition, 1995
William A.Campbell
[95.04] ISBN 1-56011-232-8 (64 pages)
$11.00 plus 6% tax for N.C. residents

Contains sections on real property law, land records resources, issues and implications of ownership transfer, recording requirements for maps and plats. This second edition includes various changes in statutes and in the procedures of the Clerk of Superior Court's and Register of Deeds' offices.

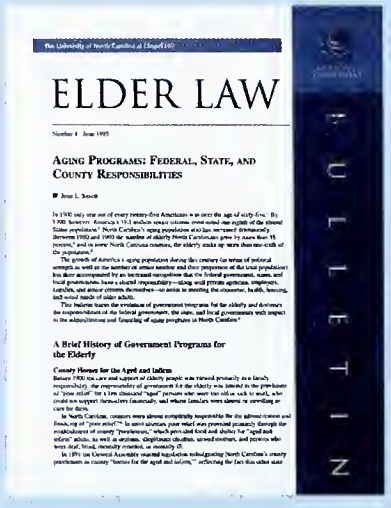
To order

Orders and inquiries should be sent to the Publications Office, Institute of Government, CB# 3330 Knapp Building, UNC–CH, Chapel Hill, NC 27599-3330. Please include a check or purchase order for the amount of the order plus 6 percent sales tax. A complete publications catalog is available from the Publications Office on request. For a copy, call (919) 966-4119.

ELDER LAW BULLETIN No. 1
"Aging Programs: Federal, State, and County Responsibilities"

John L. Saxon (15 pages)
$4.00 plus 6% tax for N.C. residents

Gives a brief history of government programs for the elderly and describes the allocation of responsibility among current federal, North Carolina state, and local aging programs. The price of future issues may vary. Please call (919) 966-4119 for additional information regarding this and other Institute bulletin series.



State and Local Government Relations in North Carolina
Their evolution and current status

Second edition, 1995
Edited by Charles D. Liner
[95.10] ISBN 1-56011-244-1 (251 pages)
$30.00 plus 6% tax for N.C. residents

Describes the state's system of government, the complex relationships that exist between the state government and units of local government, and current issues involving state and local government relations. Chapters new to this edition include chapters on the tax system; state supervision of local government finance; programs for the elderly; and mental health.

A Legal Manual for Area Mental Health, Developmental Disabilities, and Substance Abuse Boards in North Carolina

1995
Mark F. Botts
Produced in cooperation with the North Carolina Council of Community Programs.
[95.16] ISBN 1-56011-247-6 (102 pages)
$12.00 plus 6% tax for N.C. residents

Covers topics such as the role of county and state government in mental health services; area board responsibilities for client services, client rights, personnel, budget and finance, contracts, and board meetings; civil liability; and conflicts of interest. Includes numerous references to other published materials.

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. . . and at the same time
to preserve the form and spirit of
popular government . . .

—James Madison
The Federalist, No. 10