APRIL 20-22, 2015
North Carolina Judicial College

The Magistrate's Role in Involuntary Commitment

"Nothing defines the quality of life in a community more clearly than people who regard themselves, or whom the consensus chooses to regard, as mentally unwell. "

Renata Adler

NORTH CAROLINA Judicial COLLEGE

MAGISTRATE'S ROLE IN INVOLUNTARY COMMITMENT
APRIL 20-22, 2015

UNC SCHOOL OF GOVERNMENT, ROOM 2401
CHAPEL HILL, NC

Monday, April 20

9:00 am	Welcome Dona Lewandowski, UNC School of Government
9:30	**Overview of the Commitment Process** Mark Botts, UNC School of Government
10:00	Break
10:15	**Involuntary Commitment: Law & Procedure** Mark Botts
11:45	Lunch at the School of Government *Dining Room, First Floor*
12:30 pm	**Law & Procedure, continued** Mark Botts
2:15	**Exercise: Writing a Petition** Mark Botts
2:45	Break
3:00	**Mental Health 101** Molly Richardson, LCSW, LCAS, CCS Behavioral Health Unit, Medwest - Haywood County
5:30	Heavy Hors d'oeuvres & Light Discussion
6:15	Recess

Tuesday, April 21

8:30 am	Revisiting Yesterday Dona Lewandowski	
8:45	**Getting the Information You Need** Crystal Farrow, NC Department of Health and Human Services	
10:15	Break	
10:30	**Getting the Information You Need**, continued Crystal Farrow	
12:00 pm	Lunch at the School of Government *Dining Room, First Floor*	
12:45	**Dealing with Physician Petitions** Mark Botts REVIEW Activity Stations	
1:15	**Station Activities**	
	Station A: Interviewing Video Exercise Crystal Farrow Molly Richardson, Therapist, Haywood County	Rooms 2502, 2503, 2504, 2505
	Station B: Feedback on Petitions Session Mark Botts	Room 2506
	Station C: Hearing Voices Bob Kurtz, NC Div. of MH/DD/SAS	Room 2402 (2321 & 2600)
	Station D: Taking It Back Home: Small Group Discussion Tammy Barrow, Magistrate, Guilford County Don Paschall, Chief Magistrate, Durham County	Room 2401
4:15	Break	
4:30	**Talking About the Afternoon** Dona Lewandowski	Room 2401
5:00	Recess	

Wednesday, April 22

8:30 am	Revisiting Yesterday Dona Lewandowski
8:45	**Movie: *A Revolving Door***
9:25	**Listening to Family Members**
9:55	Break
10:10	**Getting to Know Your LME** Mark Botts Crystal Farrow Molly Richardson
10:40	**Emerging Issues Panel Discussion** Tammy Barrow Mark Botts Crystal Farrow Don Paschall Molly Richardson
11:40	Evaluations, Award of Certificates
12:00 pm	Adjourn

COURSE OBJECTIVES

As a result of participating in this seminar, you will be able to:

1. Obtain the information you need to make a correct decision;

2. Correctly apply the law to the facts in determining whether to issue a custody order;

3. Assist petitioners with completing a petition containing detailed relevant facts and issue an appropriate custody order;

4. Supply petitioners with useful information about what happens next; and

5. Identify and implement one specific action to improve the IVC process in your county.

FACULTY BIOGRAPHIES

Tammy Barrow **336.822.6791** **Tammy.L.Barrow@nccourts.org**

Tammy earned her degree in Psychology at NC State with a minor in Criminal Justice. She has served as a magistrate for 22 years in the 18th Judicial District in Guilford County, fourteen of those years as Chief Magistrate. Tammy currently serves on the Client Rights Committee of Mental Health Association of the Triad in High Point. She also works with the Guilford County Sheriff's Department on Crisis Intervention Training (CIT).

Mark Botts **919.962.8204** **botts@sog.unc.edu**

Mark Botts joined the School of Government in 1992. Prior to that, he served judicial clerkships with the US Court of Appeals for the Sixth Circuit and the US District Court for the Western District of Michigan. Botts' publications include "Mental Health Services," in *County and Municipal Government in North Carolina, Second Edition*, and *A Legal Manual for Area Mental Health, Developmental Disabilities, and Substance Abuse Boards in North Carolina*. He specializes in mental health law and provides training, consulting, and publications for mental health professionals, consumers of services and their family members, employees and administrators of public mental health agencies, judicial officials, law enforcement officers, county commissioners, mental health authority board members, and other public and private officials and employees responsible for the management and delivery of mental health, developmental disabilities, and substance abuse services in North Carolina. Mark holds a B.A. from Albion College and a J.D. from the University of Michigan, School of Law.

Areas of Interest: Mental health law, including involuntary commitment; confidentiality; client rights; psychotherapist liability; legal responsibilities of area boards; and the governance, finance, and administration of public mental health services.

Crystal Farrow **919.715.1294** **Crystal.Farrow@dhhs.nc.gov**

Crystal Farrow is a human services professional with a career of more than 25 years in the leadership and management of mental health and social service crisis programs. Crystal retired from her position as the Crisis Services Administrator for Wake County Human Services in 2013. She is employed now by the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services in the Community Policy Management Section and is the project manager for the NC DHHS Crisis Solutions Initiative.

Robert Kurtz **919.715.2771** **bob.kurtz@dhhs.nc.gov**

Dr. Kurtz received a B.A. in social work and a M.A. in rehabilitation counseling from the University of Iowa, and an M.A. and Ph.D. in clinical psychology from the University of Louisville. He's worked in public mental health systems in five states before coming to

North Carolina. He's served many roles in his ten years with the NC Division of Mental Health, including that of clinical director of the Crisis Services Section, and acting chief of the Advocacy, Client Rights, and Quality Improvement section of the Division. For more than a decade he has initiated and administered various projects for adults with mental illness and criminal justice involvement, including assisting with the development of CIT programs throughout North Carolina. Dr. Kurtz just recently finished working with others on re-writing the basic law enforcement training (BLET) curriculum on mental health and developmental disabilities, which is the eight hours of instruction that all beginning law enforcement officers in NC will receive.

Dona Lewandowski 919.766.7288 lewandowski@sog.unc.edu

Dona Lewandowski joined the faculty of the Institute of Government in 1985 and spent the next five year writing, teaching, and consulting with district court judges in the area of family law. In 1990, following the birth of her son, she left the Institute to devote full time to her family. She rejoined the School of Government in 2006. Lewandowski holds a B.S. and an M.A. from Middle Tennessee State University and a J.D. with honors, Order of the Coif, from the University of North Carolina at Chapel Hill. After law school, she worked as a research assistant to Chief Judge R.A. Hedrick of the NC Court of Appeals.

Areas of Interest: Magistrates' issues (non-criminal law), including summary ejectment, small claims procedure, performing marriages, and appointment and removal matters

Don Paschall 919.560.6878 Donald.D.Paschall@nccourts.org

Don is a life-long resident of Durham County, North Carolina. He earned an AAS Degree in Criminal Justice at Durham Technical Community College and a BS in Criminal Justice Shaw University. Don retired from the Durham County Sheriff's Office as a Lieutenant over Criminal Investigations after 30 years in Law Enforcement. He was sworn in as a Magistrate for the 14th Judicial District in Durham County on August 1, 2007. Don was appointed Chief Magistrate by the Honorable Marcia Morey, Chief District Court Judge for the 14th Judicial District in 2011.

Molly Richardson 828.227.3842 Molly.richardson@haymed.org

Molly currently works as the clinical supervisor at Haywood Regional Hospital, Behavioral Health Unit in Haywood County. She has been involved in crisis work for more than 15 years. Her experience with crisis work has included direct crisis work with children and adults experiencing mental health, substance abuse or intellectual disabilities.

She has also worked as Director of Crisis Services with Smoky Mountain Center where she supervised three mobile crisis teams who provided crisis services to a seven county area in the western region. Molly has experience working in both inpatient, residential and outpatient mental health programs. Her passion is in working with individuals who are experiencing issues related to substance use.

Tab 1:

Day 1

THE MAGISTRATE'S ROLE IN INVOLUNTARY COMMITMENT

WELCOME

Welcome to the Magistrate's Role in Involuntary Commitment seminar. This seminar has been designed specifically for magistrates dedicated to improving their ability to perform a critically important task: to safeguard the freedom of citizens and provide protection to those citizens, while also assisting individuals who are mentally ill and dangerous to receive treatment. Your presence here is a testament to your commitment as a public servant. We hope that this course will be one of many steps you take toward making a difference in the lives of the citizens you serve.

AGENDA

These are the topics on today's agenda.

1. What to Expect While You're Here
2. Involuntary Commitment Law and Procedure
3. Lunch
4. Exercise: Writing a Petition
5. What a Magistrate Needs to Know About Mental Illness

MATERIALS

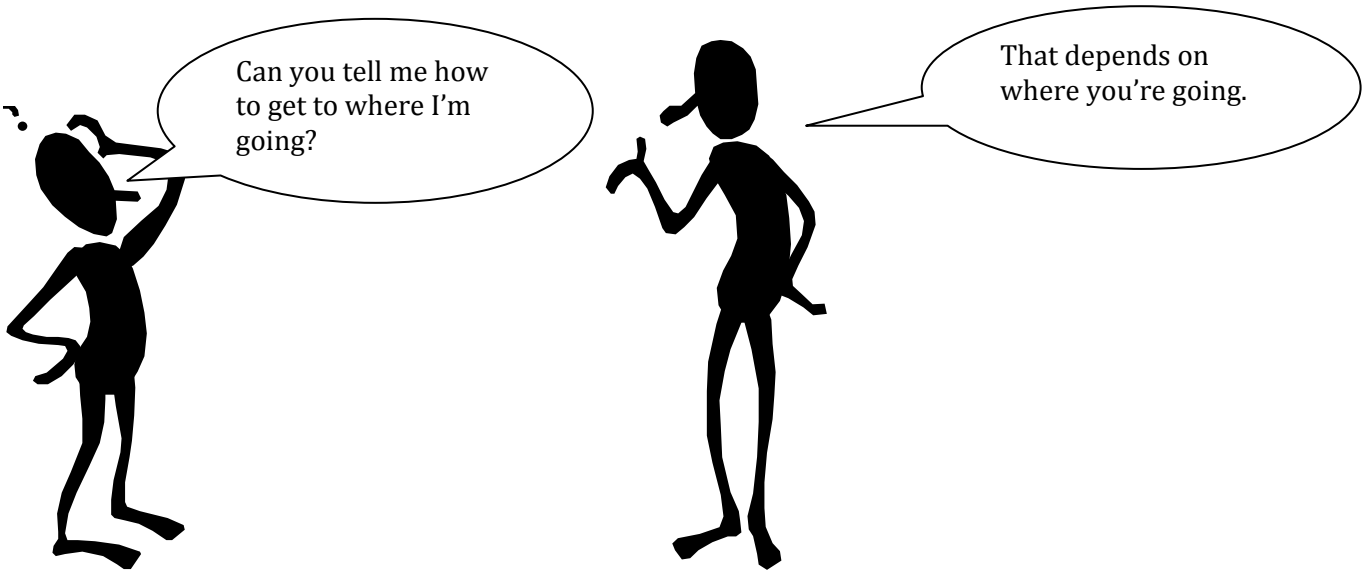
You will be using this participant manual throughout the next three days. It is yours to write in and use for future reference. A copy of these materials will also be available through the SOG website for magistrates (www.ncmagistrates.unc.edu). You will receive additional materials from instructors as we progress through the course.

WHAT TO EXPECT

In addition to the content-based goals set out at the front of this notebook, other objectives were also identified as important by the planners of this educational experience. One of the most valuable opportunities arising out of coming together for a period of shared focus on a single topic is the chance to exchange ideas and experiences with your colleagues. This opportunity can be the source not only of intellectual growth, but also of recognition and support for what is sometimes a lonely, difficult job. We believe that the time you spend together away from the classroom can be as valuable as classroom time. We will have lunch at the SOG on Monday and Tuesday, and on Monday we'll gather for refreshments and conversation when class ends for the day. Throughout the seminar, instructors will be present in the classroom and during breaks as well as at meals, and we hope you will not hesitate to spend informal time with them as well as with your fellow-students. As you'll hear more about later, we conceptualize this course as having begun before you arrived, and as continuing for a period of months after your departure from the classroom.

WHAT DOES SUCCESS LOOK LIKE?

As you know, a system for determining whether an individual should be compelled to submit to treatment for mental illness involves people playing many different roles, each with their own unique challenges and responsibilities. An essential component of doing your job effectively is a clear grasp of what you're trying to accomplish.



Take a moment to ask yourself this question: if I were evaluating a new magistrate's performance in handling a petition for involuntary commitment, what would I be looking for? What would I need to see in order to conclude that I had witnessed an exemplary performance?

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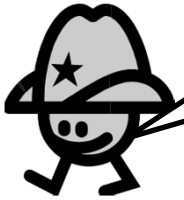

You say yes to way too many petitions! We don't have the manpower!

How can you say "no"? I'm telling you, he's sick! He's going to hurt somebody or himself, if you don't do something!!!

What does it mean to be the magistrate?

Look, I told you he's mentally ill and dangerous to himself. I'm a doctor, that's my diagnosis, and I'm too busy to spend any more time on this. I've got sick people to see to!

Every time I turn around, somebody's in here complaining about YOU!

It means that an impartial person listens to the evidence presented, considers that evidence in light of the law, carefully follows appropriate procedure, and determines what happens to another person—whether that person will be taken into custody for evaluation.

ASSESSING CREDIBILITY

The credibility of a witness or party . . . relates to the accuracy of his or her testimony as well as to its logic, truthfulness, and sincerity.

West's Encyclopedia of American Law, edition 2. Copyright 2008 The Gale Group, Inc. All rights reserved.

In determining the credibility of information supplied by a petitioner, consider the following factors:

- Does this person have a motive to lie?
- Is there independent corroborating evidence of critical facts?
- Is the demeanor of the person noteworthy? {Careful here!}
- Is the information provided by the person detailed? Is the person able to supply additional
- details when questioned?
- How well situated is this person to make observations of the respondent?

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WHAT DOES IT MEAN TO FOLLOW THROUGH?

If you deny the petition:

- ✓ Provide information about available resources, including the Crisis Line telephone number.
- ✓

If you grant the petition:

- ✓ Provide a clear explanation of what happens next.
- ✓ Give information about how to best negotiate the next 24 hours.
- ✓ Tell the petitioner how to contact the professional conducting the first evaluation.
- ✓ Provide directions to the location of the first assessment.Inform the petitioner how to be available and helpful at the next stages of the commitment process.

Lighting a Fire

You probably didn't decide to attend this course because you were interested in learning more about involuntary commitment in the abstract. Instead, you probably wanted to come in order to

Do Something Differently. . .

What that "something" is may be quite different from one person to the next. It may be as simple as making a change in how you ask questions, or as complex as arranging to meet and talk with key personnel at the local hospital emergency room. We'll be asking each of you to decide on a goal on Wednesday, before you return home. As you participate in the seminar over the next 2 ½ days, you might keep that in mind.

Use this space to make notes on your ideas about possible goals:

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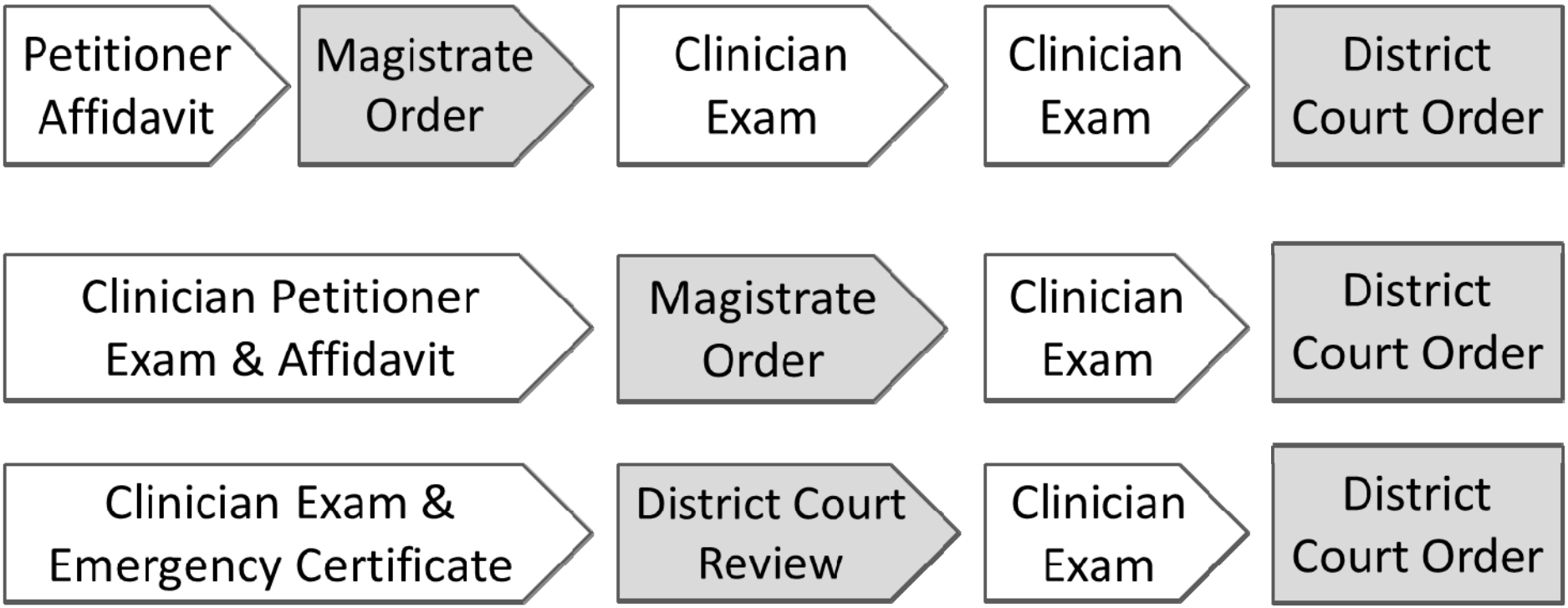
Overview of Commitment Procedure - 3 Potential Paths



Criteria for Involuntary Commitment in North Carolina

Mental Illness (Adults)
an illness that so lessens the capacity of the individual to use self-control, judgment, and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance, or control.

Mental Illness (Minors)
a mental condition, other than mental retardation alone, that so impairs the youth's capacity to exercise age-adequate self-control or judgment in the conduct of his activities and social relationships that he is in need of treatment.

Substance abuse
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. Substance abuse may include a pattern of tolerance and withdrawal.

Dangerous to self
Within the relevant past, the individual has:

1. acted in such a way as to show that
    a. he would be unable, without care, supervision, and the continued assistance of others not otherwise available, to exercise self-control, judgment, and discretion in the conduct of his daily responsibilities and social relations, or to satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety; and
    b. there is a reasonable probability of his suffering serious physical debilitation within the near future unless adequate treatment is given. Behavior that is grossly irrational, actions that the individual is unable to control, behavior that is grossly inappropriate to the situation, or other evidence of severely impaired insight and judgment creates an inference that the individual is unable to care for himself; or
2. attempted suicide or threatened suicide and there is a reasonable probability of suicide unless adequate treatment is given; or
3. mutilated himself or attempted to mutilate himself and there is a reasonable probability of serious self-mutilation unless adequate treatment is given.

Previous episodes of dangerousness to self, when applicable, may be considered when determining the reasonable probability of serious physical debilitation, suicide, or serious self-mutilation.

Dangerous to others
Within the relevant past the individual has:

1. inflicted, attempted to inflict, or threatened to inflict serious bodily harm on another and there is a reasonable probability that this conduct will be repeated, or
2. acted in a way that created a substantial risk of serious bodily harm to another and there is a reasonable probability that this conduct will be repeated, or
3. engaged in extreme destruction of property and there is a reasonable probability that this conduct will be repeated.

Previous episodes of dangerousness to others, when applicable, may be considered when determining the reasonable probability of future dangerous conduct. Clear, cogent, and convincing evidence that an individual has committed a homicide in the relevant past is evidence of dangerousness to others.

Source: NC General Statutes 122C-3

Mark Botts, Associate Professor (2009)

North Carolina Involuntary Commitment Process

Respondent shows signs & symptoms

Layperson petition
Layperson completes petition in front of magistrate

Magistrate reviews petition & issues custody order

Officer transports respondent

Hospital ER or LME facility *(1st exam)*

Officer transports respondent

Clinician petition
Clinician completes petition & exam form *(1st exam),* then faxes to magistrate

Magistrate reviews petition & issues custody order

Officer transports respondent

Emergency petition*
Clinician completes exam form & emergency certificate *(1st exam),* submits to clerk of court for 24-hr. facility & local officer

Officer transports respondent pursuant to emergency certificate

District court judge reviews examination form

24-hour facility *(2nd exam)*

Hearing: Court orders release, outpatient, inpatient, or substance abuse commitment

**Use when respondent requires immediate hospitalization; procedure by-passes magistrate.*

Mark Botts, Associate Professor (2009)

What Happens After a Magistrate Issues a Custody and Transportation Order

Source: Administration of Justice Bulletin, September 2007

Upon request, the magistrate or clerk of court has issued an order for custody and transportation of a person alleged to be in need of examination and treatment. This order is not an order of commitment but only authorizes the person to be evaluated and treated until a court hearing. The individual making the request has filed a petition with the court for this purpose and is, therefore, called the "petitioner." The individual to be taken into custody for examination will have an opportunity to respond to the petition and is, therefore, called the "respondent." If you are taken into custody, the word "respondent," below, refers to you.

1. A law enforcement officer or other person designated in the custody order must take the respondent into custody within 24 hours. If the respondent cannot be found within 24 hours, a new custody order will be required to take the respondent into custody. Custody is not for the purpose of arrest, but for the respondent's own safety and the safety of others, and to determine if the respondent needs treatment.

2. Without unnecessary delay after assuming custody, the law enforcement officer or other individual designated to provide transportation must take the respondent to a physician or eligible psychologist for examination.

3. The respondent must be examined as soon as possible, and in any event within 24 hours, after being presented for examination. The examining physician or psychologist will recommend either outpatient commitment, inpatient commitment, substance abuse commitment, or termination of these proceedings.

    - *Inpatient commitment*: If the examiner finds the respondent meets the criteria for inpatient commitment, the examiner will recommend inpatient commitment. The law enforcement officer or other designated person must take the respondent to a 24-hour facility.

    - *Outpatient commitment*: If the examiner finds the respondent meets the criteria for outpatient commitment, the examiner will recommend outpatient commitment and identify the proposed outpatient treatment physician or center in the examination report. The person designated in the order to provide transportation must return the respondent to the respondent's regular residence or, with the respondent's consent, to the home of a consenting individual located in the originating county. The respondent must be released from custody.

    - *Substance abuse commitment*: If the examiner finds the respondent meets the criteria for substance abuse commitment, the examiner must recommend commitment and whether the respondent should be released or held at a 24-hour facility pending a district court hearing. Depending upon the physician's recommendation, the law enforcement officer or other designated individual will either release the respondent or take him or her to a 24-hour facility.

    - *Termination*: If the examiner finds the respondent meets neither of the criteria for commitment, the respondent must be released from custody and the proceedings terminated. If the custody order was based on the finding that the respondent was probably mentally ill, then the person designated in the order to provide transportation must return the respondent to the respondent's regular residence or, with the respondent's consent, to the home of a consenting individual located in the originating county.

4. If the law enforcement officer transports the respondent to a 24 hour facility, another evaluation must be performed within 24 hours of arrival. This evaluator has the same options as indicated in step 3 above. If the respondent is not released, the respondent will be given a hearing before a district court judge within 10 days of the date the respondent was taken into custody.

What Happens After a Clinician Petitions for Involuntary Commitment

A physician, psychologist, or other authorized clinician has requested a magistrate or clerk of court to start the legal process that may lead to court-ordered treatment for mental illness or substance abuse. The clinician making the request has filed a notarized petition with the court for this purpose. The clinician is called the "petitioner." The individual for whom treatment is being requested will have an opportunity to respond to the petition. This individual is called the "respondent." If you are the subject of the petition (the person for whom treatment is being sought), the word "respondent," below, refers to you.

1. The clinician has examined the respondent and recommended either outpatient commitment, inpatient commitment, or substance abuse commitment.

   - Inpatient commitment: If the clinician recommends inpatient commitment for mental illness, and the magistrate or clerk of court finds that the respondent meets the criteria for inpatient commitment, then the magistrate or clerk will issue an order to have a law enforcement officer or other designated person transport the respondent to a 24-hour facility for examination and treatment pending a district court hearing.
   - Outpatient commitment: If the clinician recommends outpatient commitment for mental illness, then the clinician must provide the respondent with written notice of any scheduled appointment and the name, address, and telephone number of the proposed outpatient treatment physician or center. If the magistrate or clerk of court finds that the respondent meets the criteria for outpatient commitment, then he or she will order that a hearing be held before a district court judge to determine whether the respondent will be involuntarily committed to outpatient treatment for mental illness.
   - Substance abuse commitment: If the clinician recommends substance abuse commitment, and the magistrate or clerk of court finds that the respondent meets the criteria for substance abuse commitment, then the magistrate or clerk will order that (a) a district court hearing be held to determine whether the respondent should be involuntarily committed to substance abuse treatment, or (b) a law enforcement officer or other person transport the respondent to a 24-hour facility for examination and treatment pending a district court hearing.

2. If the magistrate or clerk of court issues an order to have the respondent transported to a 24-hour facility, a law enforcement officer or other person designated in the order must take the respondent into custody within 24 hours after the order is signed. Custody is not for the purpose of arrest, but for the respondent's own safety and the safety of others, and to determine if the respondent is in need of court-ordered treatment.

3. Without unnecessary delay after assuming custody of the respondent, the law enforcement officer or other person designated to provide transportation must take the respondent to a 24-hour facility where a second examination will be performed within 24 hours of arrival at the facility. This second examiner will recommend either (a) that the respondent be released and the proceedings terminated, or (b) that the respondent be held at the 24-hour facility pending a district court hearing.

4. If the respondent is not released, he or she will appear at a hearing before a district court judge within 10 days of the date that he or she was taken into custody. The judge will order outpatient commitment, inpatient commitment, substance abuse commitment, or no commitment. If outpatient commitment or no commitment is ordered, the respondent will be released. If inpatient commitment is ordered, the respondent will be held for treatment at the 24-hour facility. If substance abuse treatment is ordered, the respondent will be either (a) released and treated on an outpatient basis, or (b) held and treated at the 24-hour facility.

Mark Botts, Associate Professor (2009)

Involuntary Commitment

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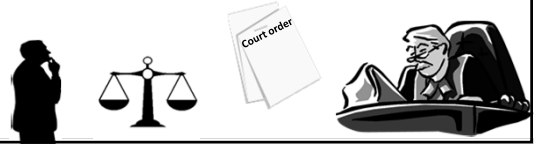
http://www.sog.unc.edu/node/858

Due Process

- Criteria—The grounds for court-ordered treatment.
- Procedure—The process for obtaining court-ordered treatment.

  Because the commitment statutes provide for a drastic remedy, those that use them must do so with "care and exactness." In re Ingram, 74 N.C. App. 579 (1985), quoting Samons, 9 NC App. 490 (1970).



Objectives

- Know the legal criteria for commitment
  - -For each of the three kinds of commitment
  - -For assessing the facts presented to you
- Know the procedure for initiating commitment
  - -The three kinds of procedure

Overview of Commitment Procedure—3 Potential Paths

Petitioner Affidavit	Magistrate Order	Clinician Exam	Clinician Exam	District Court Order
Clinician Petitioner Exam & Affidavit	Magistrate Order	Clinician Exam		District Court Order
Clinician Exam & Emergency Certificate	District Court Review	Clinician Exam		District Court Order

Three Kinds of Commitment Orders

1. Outpatient commitment → mental illness

2. Inpatient commitment → mental illness
3. Substance abuse commitment → alcohol/drug abuse

The District Court Role

Clear, cogent, and convincing evidence that the respondent meets the criteria for commitment

Clinician

The Magistrate's Role

Reasonable grounds to believe the respondent probably meets the criteria for commitment

Clinician

Criteria for Outpatient Commitment

- Mentally ill
- Based on psychiatric history, in need of treatment to prevent further disability or deterioration that would predictably result in dangerousness
- Capable of surviving safely in the community
- Mental status negates ability to seek or comply with recommended treatment

"preventive" commitment

Clinician

Criteria for Commitment

Inpatient commitment
mental illness + dangerous to self or dangerous to others

Substance abuse commitment
substance abuse + dangerous to self or dangerous to others

1. mental illness
2. substance abuse
3. dangerous to self
4. dangerous to others

Clinician

Dangerous to Self

Within the relevant past, the individual has:

- Acted in a way to show unable to care for self
- Attempted or threatened suicide
- Attempted or engaged in self-mutilation

Clinician

Relevant Past

Acts are within the relevant past if they occur close enough to the present time to have probative value on the question whether the conduct will continue

Clinician

Dangerous to Self

- Unable to care for self + reasonable probability of serious physical debilitation
- Attempted or threatened suicide + reasonable probability of suicide
- Attempted or engaged in self-mutilation + reasonable probability of serious mutilation

Clinician

Dangerous to self

- A two prong test that requires a finding of:
  - a lack of self-care ability regarding one's daily affairs, and
  - a probability of serious physical debilitation resulting from the more general finding of lack of self-caring ability. In re Monroe, 49 N.C.App. 23 (1980).

Clinician

Dorothy stopped taking her medication for mental illness. She has begun to experience visual and audio hallucinations and has ceased eating and bathing. You believe that she is unable to exercise judgment and discretion in the conduct of her daily responsibilities related to nourishment and medicine.

As you consider whether there is a reasonable probability that she will suffer serious physical debilitation in the near future, may you take into account that, two years ago, after exhibiting these same behaviors, she suffered serious dehydration and malnourishment requiring hospitalization?

A) Yes
B) No

Clinician

The respondent gets up 3 to 6 times a night and has unusual eating habits (sometimes fasts, sometimes eats a whole loaf of bread or whole chicken in one sitting, eats about 5 lbs. of sugar every 2 days).

Is the respondent dangerous to self?

A) Yes
B) No

Clinician

Dangerous to Others

Within the relevant past, the individual has:

1. Inflicted, attempted, or threatened serious bodily harm + reasonable probability of conduct repeating
2. Created a substantial risk of serious bodily harm + reasonable probability of conduct repeating
3. Engaged in extreme destruction of property + reasonable probability of conduct repeating

[more info]
Previous episodes of dangerousness to others, when applicable, may be considered when determining whether there is a reasonable probability of the respondent's conduct repeating.

Clinician

Summary

1. **Outpatient commitment**—mentally ill, capable of surviving in the community, in need of treatment to prevent dangerousness, and unable to seek treatment voluntarily
2. **Inpatient commitment**—mentally ill + dangerous to self or others
3. **Substance abuse commitment**—substance abuser + dangerous to self or others

Clinician

Procedure

- Layperson petition
- Clinician petition
- Emergency

Clinician

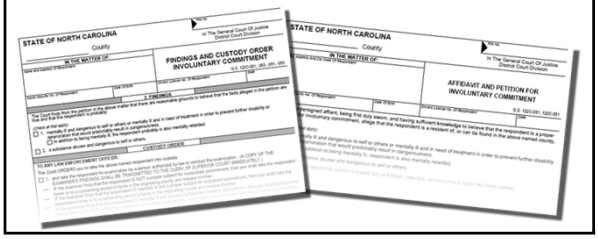
Petition Procedure for the Layperson

Layperson

Clinician

Involuntary Commitment Forms

1. Petition for Involuntary Commitment
2. Magistrate's Custody Order



Clinician

The Petition

- Anyone with knowledge may petition
- Petitioner must appear personally
- Jurisdiction is in the county where respondent resides or is found

Magistrate Custody Order

If the magistrate finds that the commitment criteria are met for either

- outpatient commitment,
- inpatient commitment, or
- substance abuse commitment

the magistrate must issue a custody and transportation order

Magistrate Must Explain Next Steps to Petitioner

- Next steps in the commitment process
- Other useful information:
  - Law enforcement protocol on restraint
  - Likely wait time at community hospital
- Useful contact information
  - Other resources/options for petitioner if the commitment process terminates at the first examination

Custody-GS 122C-261

The magistrate shall issue an order to a law enforcement officer or any other person authorized under G.S. 122C-251

- to take the respondent into custody for examination by a physician or psychologist

Clinician

Transportation

Not under arrest

Treatment

Safety

[more info]

If the respondent is not taken into custody within 24 hours after the magistrate signs the custody order, the order expires. This may happen in situations where the officer cannot find the respondent within 24 hours. If the order expires, a new commitment proceeding may be initiated to request another custody order.

Clinician

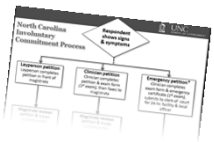
Examination Findings and Results

Findings		Result
No commitment criteria	→	Release
Outpatient commitment	→	Release pending hearing
Inpatient commitment	→	Inpatient facility
Substance abuse commitment	→	Release or inpatient facility

Clinician

Summary: Procedure for the Layperson

1. Petition
2. Custody Order
3. Custody and Transportation
4. Examination



Clinician

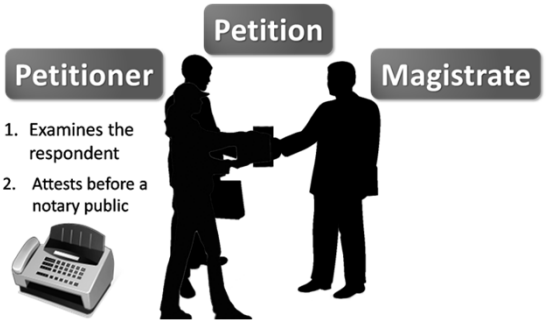
Petition Procedure for the Clinician

Authorized Clinicians

- Physicians
- Health services provider psychologists
- Licensed clinical social workers, psychiatric nurses, and clinical addictions specialists that are individually certified

Clinician

Requesting Involuntary Commitment



Clinician

Which of the following are true about the procedure for qualified clinicians?

A) To avoid appearing before a magistrate, a clinician petitioner must personally examine the respondent.

B) To avoid appearing before a magistrate, a clinician petition must be notarized.

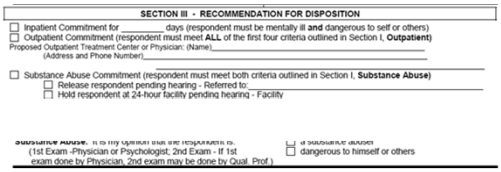
C) A qualified clinician who cannot examine the respondent can use the procedure for laypersons.

D) All of the above.

Clinician

Completing the Examination Form

Section III: Recommendation



SECTION III - RECOMMENDATION FOR DISPOSITION

☐ Inpatient Commitment for _____ days (respondent must be mentally ill **and** dangerous to self or others)
☐ Outpatient Commitment (respondent must meet **ALL** of the first four criteria outlined in Section I, **Outpatient**)
Proposed Outpatient Treatment Center or Physician: (Name)_____
(Address and Phone Number)_____

☐ Substance Abuse Commitment (respondent must meet both criteria outlined in Section I, **Substance Abuse**)
☐ Release respondent pending hearing - Referred to: _____
☐ Hold respondent at 24-hour facility pending hearing - Facility

Substance Abuse: It is my opinion that the respondent is: ☐ a substance abuser
(1st Exam -Physician or Psychologist; 2nd Exam - If 1st exam done by Physician, 2nd exam may be done by Qual. Prof.) ☐ dangerous to himself or others

- Inpatient commitment
- Outpatient commitment
- Substance abuse commitment

Clinician

Magistrate Orders

Hearing Custody

Outpatient commitment → Hearing

Inpatient commitment → Custody

Substance abuse commitment → Hearing **or** Custody

Clinician

Custody-GS 122C-261, -263

The magistrate shall issue an order for transportation to or custody at a 24-hour facility.

- Upon receipt of the custody order a law enforcement officer shall take the respondent into custody within 24 hours after the order is signed and take her to a 24 hour facility designated by the Secretary of NC DHHS for the custody and treatment of involuntary clients.

Clinician

Summary:
Procedure for the Authorized Clinician

1. Examination
2. Petition
3. Findings and Custody Order, or Hearing Order
4. Law Enforcement Custody

Clinician

Review Test

Clinician

Submitting a Legally Sufficient Petition

- Magistrate role
- Petitioner role

The Magistrate's Role

In re Ingram Petition

"Respondent has strange behavior and is irrational in her thinking. Leaves home and no one knows or her whereabouts, and at times spends the night away from home. Accuses husband of improprieties."

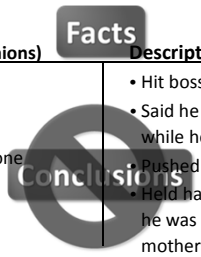
"Just the facts, Ma'am"

Statute requires the affidavit to contain the facts on which the affiant's opinion is based. **Mere conclusions do not suffice** to establish reasonable grounds for issuance of custody order. In re Ingram, 74 N.C. App. 579 (1985).

The Petition

- hearing voices, not eating
- said he doesn't deserve to live
- has not bathed in two weeks
- not taking medication, waved kitchen knife at mother

Information Must Be Factual



Conclusions (Opinions)

- Violent
- Threatening
- Aggressive
- Assaulted someone

Descriptive Facts

- Hit boss with a wrench
- Said he would cut brother while he slept
- Pushed Mom off the porch
- Held hammer in air saying he was going to bust mother's head

Indicate whether the phrase below is an appropriate or inappropriate statement for the fact section of the petition:

"Stands on street corner all night talking to him/herself"

A) Appropriate

B) Inappropriate

Clinician

Indicate whether the phrase below is an appropriate or inappropriate statement for the fact section of the petition:

"Says she is going to fly to the moon with the President"

A) Appropriate

B) Inappropriate

Clinician

Indicate whether the phrase below is an appropriate or inappropriate statement for the fact section of the petition:

"Exhibits bizarre behavior"

A) Appropriate

B) Inappropriate

Clinician

Indicate whether the phrase below is an appropriate or inappropriate statement for the fact section of the petition:

"Irrational thinking"

A) Appropriate

B) Inappropriate

Clinician

Indicate whether the phrase below is an appropriate or inappropriate statement for the fact section of the petition:

"Doesn't know what day or month it is"

A) Appropriate

B) Inappropriate

Clinician

The statement, *"this individual is suicidal,"* is appropriate for the "facts" section of the petition.

A) True

B) False

Clinician

Case Studies

Clinician

Options During Wait Time Following The First Examination

After 1st exam and recommendation of inpatient commitment:

1. If 24-hour facility not
   - Immediately available or
   - Medically appropriate
2. Respondent may be temporarily detained

Clinician

Change in Respondent's Status

1. If at any time a physician or psychologist determines respondent no longer meets the inpatient criteria:
   - Respondent must be released (proceedings terminated), or
   - Physician may recommend outpatient commitment
2. Decision to release or recommend outpatient commitment must
   - Be made in writing (conduct exam and use exam form)
   - Reported to the clerk of superior court by most reliable and expeditious means

Clinician

Seven Day Limit

1. Seven days after issuance of custody order, commitment must be terminated if 24-hour facility still not available or medically appropriate
   - Physician must report to clerk of court
   - Proceedings must be terminated
2. New commitment proceedings may be initiated
   - Requires new petition
   - Requires new examination if petitioner is clinician
   - Requires new custody order

Clinician

The Emergency Procedure

1. Procedure for mental illness
2. Procedure for substance abuse

Clinician

Criteria for Emergency Commitment—Mental Illness

1. Mentally ill + Dangerous
2. Requires immediate hospitalization

Clinician

Procedure for Emergency Commitment—Mental Illness

- Examination and Recommendation Form
- Supplemental Emergency Certificate

STATE OF NORTH CAROLINA Department of Health and Human Services
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

County _____ File # _____

Client Record # _____

EXAMINATION AND RECOMMENDATION TO DETERMINE NECESSITY FOR INVOLUNTARY COMMITMENT

Film # _____

NAME OF RESPONDENT:	AGE	BIRTHDATE	SEX	RACE	M.S.

The Respondent, _____
requires immediate hospitalization to prevent harm to self or others because:

Clinician

Procedure for Emergency Commitment—Mental Illness

STATE OF NORTH CAROLINA
Department of Health and Human Services
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

SUPPLEMENT TO EXAMINATION AND RECOMMENDATION FOR INVOLUNTARY COMMITMENT

SUPPLEMENT TO SUPPORT IMMEDIATE HOSPITALIZATION
(To be used in addition to "Examination and Recommendation for Involuntary Commitment, Form 572-01)

CERTIFICATE

The Respondent, _____
requires immediate hospitalization to prevent harm to self or others because:

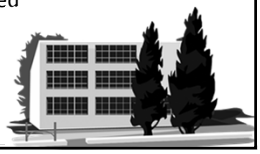
I certify that based upon my examination of the Respondent, which is attached hereto, the Respondent is (check all that apply):

- ☐ Mentally ill and dangerous to self
- ☐ Mentally ill and dangerous to others

Clinician

Transportation and Communication

- ☐ Magistrate is not involved
- ☐ No other custody order needed



Clinician

Emergency Procedure - Substance Abuse

- Criteria
  - substance abuser + danger to self or others
  - violent and requires restraint
  - delay would likely endanger life or property
- Procedure
  - officer may take into custody and petition magistrate—form AOC-SP-909M
  - magistrate order authorizes transport directly to 24-hour facility
  - local exam bypassed

Clinician

Additional Orders

1. Transfer Order—AOC-SP-222
2. Committed Substance Abuser Fails to Comply with Treatment—AOC-SP-223

Clinician

Transfer between 24-Hour Facilities

1. Form AOC-SP-222--request and order to transport respondent from one 24-hr. facility to another
   - Applies to respondents held pending hearing and those held after hearing under a commitment order
2. Facility
   - Obtains authorization from receiving facility
   - Notifies client or legally responsible person
   - Submits request to clerk of court or magistrate
3. Clerk or magistrate issues order to law enforcement

Clinician

Managing SA Commitments

1. Substance abuse commitment (SAC)--The area authority or physician responsible for the respondent's commitment may prescribe or administer reasonable and appropriate treatment
   - either on an outpatient basis or in a 24-hour facility.
2. If respondent fails to comply with all or part of the prescribed treatment,
   - The "area authority or physician" shall make all reasonable effort to solicit compliance

Managing SA Commitments

- If Respondent "fails to comply" after reasonable efforts to solicit compliance, the "area authority or physician" may request the clerk or magistrate to order the respondent taken into custody for the purpose of examination.
  - Form AOC-SP-223
- Law enforcement shall take respondent into custody and take him/her immediately to the provider designated on the form for an examination

Mental Retardation

Procedure for Mental Retardation

- If magistrate finds respondent, in addition to being mentally ill, is also probably MR
  - Must contact area authority before issuing custody order
- Area authority determines the facility where R is to be taken

Determining Mental Retardation

- Historical information needed
- Not possible to determine MR from behavior during a mental health crisis
  - Did problems related to intelligence and functioning begin before age 22?
  - Has a doc. or psych. said respondent has MR?
  - Attended special education classes for MR students?
  - Received special services for persons with MR e.g., sheltered wkshop or group home for MR persons?

Questions

?

State of North Carolina
Department of Justice
P. O. Box 629
RALEIGH
27602-0629

ROY COOPER
ATTORNEY GENERAL

MAILING ADDRESS
BROUGHTON HOSPITAL
P. O. BOX 121
MORGANTON, NC 28655
828-433-2006

November 12, 2004

Dear:

My office represents the Petitioner, Broughton Hospital and the State in the involuntary commitment hearings held weekly at Broughton Hospital.

At you know, before a person can be involuntarily committed for treatment, and "Affidavit and Petition for Involuntary Commitment form, (AOC-SP-300, Rev. 5/98), must be completed and reviewed by a Magistrate or Clerk of Court. This is required before one of these officials issues a "Custody Order" to the law enforcement personnel to take the patient into custody for examination or treatment. The Petition is required to contain sufficient facts to show that the person is both mentally ill and dangerous to self or others to provide legal justification for taking the person into custody against his will.

We recently received a "Petition" and "Custody Order" for involuntary commitment which you completed for which was insufficient to meet the legal requirements.

If the Judge is asked by the patient's attorney through a Motion to Dismiss to review a Petition, the Judge can be required by the law to dismiss the case before the Judge hears any of the evidence about the patient if the Judge finds it to be weak.

A weak Petition is one which does not contain sufficient facts to support the conclusion that the respondent is both mentally ill and dangerous to self or other. Sometimes the line between facts and conclusions seems a bit murky.

Conclusions are a matter of individual opinion. For example, whether the observable fact that a person was holding a gun justifies the conclusion that he or she was "dangerous to self or others", depends upon other observable facts such as whether the person holding the gun was a police officer making an arrest or a person with a history of

mental illness who has recently been acting in a bizarre manner; whether the gun was loaded or not; whether the person was engaged in a hunting game in a wilderness area or standing in the street in the middle of a city; whether the gun was pointed at anyone or aimed at the ground; what the person said while holding the gun, etc. The law requires that enough observable facts be written on the Petition itself to enable the Judge to draw the conclusion that the person appeared to be mentally ill and dangerous to self or others at the time the Petition was taken out for involuntary commitment without referring to any information outside the Petition.

To review a Petition, the Judge looks at the contents of the Petition to see if the contents appear to be legally sufficient. What the Judge is saying by dismissing a case due to a weak Petition is that "considering only the facts stated in the Petition (and no other information), the Magistrate (or the Petitioner) did not write down enough evidence to justify the Magistrate's issuance of the Custody Order" (the legal document which gives law enforcement personnel permission to pick up the person against his will).

When a case is dismissed, the patient must be discharged from the hospital without consideration of the patient's treatment needs. It is sometimes possible for the psychiatrist at Broughton Hospital to take out a new Petition for the patient's involuntary commitment, but not always. It depends on the particular situation. So obviously, it is very important for the patient's care and the community's protection to do as much as possible to provide the needed information in the original petition.

These are some of the most common faults in Petitions:

a. Stating that a person is "VIOLENT" or THREATENING" or even "AGRESSIVE." All of these words are mere conclusions and will not hold up in court. The facts underlying those conclusions must be included in the Petition.

For example, instead of saying "violent", the Petition should state exactly what the patient was doing (i.e. lunged at Petitioner, held Petitioner at knifepoint, slapped Petitioner in face, kicked at Petitioner). You must be very, very specific in stating what exactly took place. If the patient has verbally threatened someone, the Petition should state the exact words that the patient used (not just "threatened bodily harm" or anything of that nature).

b. Stating that the patient has "ASSAULTED" someone. This is definitely not enough since the law provides an extremely broad definition of assault.
You must state specifically what the respondent did - i.e. slapped, punched,
pushed, kicked, and also include where on the body the victim was struck and note any injuries sustained (brusing, cuts, etc. Sometimes the age or condition of the victim makes an action dangerous, i.e., an elderly or ill person or a child may be more vulnerable and likely to be injured by some

actions.)

c. Stating that the patient is "SUICIDAL." This will not stand up in court. You must state on what facts this conclusion is based. For example, quote what the patient has said or done that lead the Petitioner to the conclusion that the person is suicidal.

Frequently Petitions will contain many facts to show that the patient is mentally ill, but no facts to show that the patient is dangerous to self or others. It is essential to remember that the Petition must contain facts to support the conclusions that both mental illness and dangerousness are present in the patient. Just acting very bizarre or really "crazy" is not sufficient under the law to have someone committed.

It is very distressing and frustrating for the families and friends of patients to go through the whole commitment process only to be presented with the unpleasant situation that the court had to throw the case out because the petition did not contain enough factual information. Another problem is that if a person must then be re-committed soon after the court dismissal, the time and efforts of the law enforcement personnel, physicians and hospital personnel have to be duplicated to deal with the original situation.

I hope this information will help to avoid future dismissals by the court and that we can all work together to address this serious problem with the commitment process. I am available by telephone to answer any questions that arise concerning involuntary commitments. Please feel free to call with your questions or concerns.

Very truly yours,

M. Elizabeth Guzman
Assistant Attorney General

MEG/bd

FORMS

"Affidavit and Petition for involuntary Commitment," AOC-SP-300, revised July, 2011.

"Findings and Custody Order Involuntary Commitment (Petitioner Appears Before Magistrate or Clerk)," AOC-SP-302A, New 11/12.

"Findings and Custody Order involuntary Commitment (Petitioner Is Clinician Who Has, Examined Respondent)," AOC-SP-302B, new 11/12.

"Findings and order Involuntary Commitment Physician-Petitioner Recommends Outpatient Commitment," AOC-SP-305, revised Jan., 1998.

"Examination and Recommendation to Determine Necessity for Involuntary Commitment," DMH 5-72-01, revised Dec., 2009.

"Supplement to Support Immediate Hospitalization/Certificate," DMH 5-72-01-A, revised Sept., 2001.

"Petition and Custody Order for Special Emergency Substance Abuse Involuntary Commitment," AOC-SP-909M, revised Sept., 2003.

"Notice of Need for Transportation Order and Order (From One 24-Hour Facility to Another)," AOC-SP-222, revised July, 2011.

"Request for Transportation Order and Order (Committed Substance Abuser Fails to Comply)," AOC-SP-223, revised July, 2004.

STATE OF NORTH CAROLINA

_____ County

File No.

In The General Court Of Justice
District Court Division

IN THE MATTER OF:

Name And Address Of Respondent

AFFIDAVIT AND PETITION FOR INVOLUNTARY COMMITMENT

G.S. 122C-261, 122C-281

Date Of Birth	*Drivers License No. Of Respondent*	*State*

I, the undersigned affiant, being first duly sworn, and having sufficient knowledge to believe that the respondent is a proper subject for involuntary commitment, allege that the respondent is a resident of, or can be found in the above named county, and is:

(Check all that apply)

☐ 1. mentally ill and dangerous to self or others or mentally ill and in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness.

☐ in addition to being mentally ill, respondent is also mentally retarded.

☐ 2. a substance abuser and dangerous to self or others.

The facts upon which this opinion is based are as follows: *(State facts, not conclusions, to support ALL blocks checked.)*

Name And Address Of Nearest Relative Or Guardian		*Name And Address Of Person Other Than Petitioner Who May Testify*	
Home Telephone No.	*Business Telephone No.*	*Home Telephone No.*	*Business Telephone No.*

Petitioner requests the court to issue an order to a law enforcement officer to take the respondent into custody for examination by a person authorized by law to conduct the examination for the purpose of determining if the respondent should be involuntarily committed.

SWORN/AFFIRM AND SUBSCRIBED TO BEFORE ME

Signature Of Petitioner

Date	*Signature*	*Name And Address Of Petitioner (Type Or Print)*
☐ *Deputy CSC* ☐ *Assistant CSC* ☐ *Clerk Of Superior Court* ☐ *Magistrate*		
☐ *Notary (use only with physician or psychologist petitioner)*	*Date Notary Commission Expires*	
SEAL	*County Where Notarized*	*Relationship To Respondent*
		Home Telephone No. / *Business Telephone No.*

Original-File Copy-Hospital Copy-Special Counsel Copy-Attorney General

(Over)

PETITIONER'S WAIVER OF NOTICE OF HEARING

I voluntarily waive my right to notice of all hearings and rehearings in which the Court may commit the respondent or extend the respondent's commitment period, or discharge the respondent from the treatment facility.

Signature Of Witness	*Date*
	Signature Of Petitioner

NOTE: *"Upon the request of the legally responsible person or the minor admitted or committed, and after that minor has both been released and reached adulthood, the court records of that minor made in proceedings pursuant to Article 5 of [Chapter 122C] may be expunged from the files of the court." G.S. 122C-54(e)*

STATE OF NORTH CAROLINA

File No.

_____ County

In The General Court Of Justice
District Court Division

IN THE MATTER OF:

Name And Address Of Respondent

FINDINGS AND CUSTODY ORDER INVOLUNTARY COMMITMENT

(PETITIONER APPEARS BEFORE MAGISTRATE OR CLERK)

G.S. 122C-252, -261, -263, -281, -283

Social Security No. Of Respondent	*Date Of Birth*	*Drivers License No. Of Respondent*	*State*

I. FINDINGS

The Court finds from the petition in the above matter that there are reasonable grounds to believe that the facts alleged in the petition are true and that the respondent is probably:

(Check all that apply)

☐ 1. mentally ill and dangerous to self or others or mentally ill and in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness.

☐ In addition to being mentally ill, the respondent probably is also mentally retarded. (If this finding is made, see G.S. 122C-261(b) and (d) for special instructions.)

☐ 2. a substance abuser and dangerous to self or others.

II. CUSTODY ORDER

TO ANY LAW ENFORCEMENT OFFICER:

The Court ORDERS you to take the above named respondent into custody **WITHIN 24 HOURS AFTER THIS ORDER IS SIGNED** and take the respondent for examination by a person authorized by law to conduct the examination. (A COPY OF THE EXAMINER'S FINDINGS SHALL BE TRANSMITTED TO THE CLERK OF SUPERIOR COURT IMMEDIATELY.)

- IF the examiner finds that the respondent IS NOT a proper subject for involuntary commitment, then you shall take the respondent home or to a consenting person's home in the originating county and release him/her.
- IF the examiner finds that the respondent IS mentally ill and a proper subject for outpatient commitment, then you shall take the respondent home or to a consenting person's home in the originating county and release him/her.
- IF the examiner finds that the respondent IS mentally ill and a proper subject for inpatient commitment, then you shall transport the respondent to a 24-hour facility designated by the State for the custody and treatment of involuntary clients and present the respondent for custody, examination and treatment pending a district court hearing.
- IF the examiner finds that the respondent IS a substance abuser and subject to involuntary commitment, the examiner must recommend whether the respondent be taken to a 24-hour facility or released, and then you shall either release him/her or transport the respondent to a 24-hour facility designated by the State for the custody and treatment of involuntary clients and present the respondent for custody, examination and treatment pending a district court hearing.

Date	*Time* ☐ AM ☐ PM	*Signature*	☐ *Deputy CSC* ☐ *CSC* ☐ *Assistant CSC* ☐ *Magistrate*

This Order is valid throughout the State. If the respondent is taken into custody, this Order is valid for seven (7) days from the date and time of issuance.

III RETURN OF SERVICE
A. CUSTODY CERTIFICATION

☐ Respondent WAS NOT taken into custody for the following reason:

☐ I certify that this Order was received and respondent served and taken into custody as follows:

Date Respondent Taken Into Custody	*Time* ☐ AM ☐ PM
Name Of Law Enforcement Officer (Type Or Print)	*Signature Of Law Enforcement Officer*
Name Of Law Enforcement Agency	*Badge No. Of Officer*

NOTE TO LAW ENFORCEMENT OFFICER: *If respondent is not taken into custody within 24 hours after this Order is signed, check the appropriate box above and return to the Clerk of Superior Court immediately. If respondent is served and taken into custody, complete return of service on the reverse. When taking respondent into custody you must inform him or her that he or she is not under arrest and has not committed a crime, but is being transported to receive treatment and for his or her own safety and that of others.*

Original-File Copy-24-Hour Facility Copy-Special Counsel Copy-Attorney General

(Over)

B. PATIENT DELIVERY TO FIRST EXAMINATION SITE

The respondent was presented to an authorized examiner as shown below:

Date Presented	*Time* ☐ AM ☐ PM	*Name Of Examiner (Type Or Print)*
Name Of Examining Facility		*County Of Examining Facility*
Name Of Law Enforcement Officer (Type Or Print)		*Signature Of Law Enforcement Officer*
Name Of Law Enforcement Agency		*Badge No. Of Officer*

C. FOR USE WHEN TRANSPORTING AFTER FIRST EXAMINATION: PATIENT RELEASED OR DELIVERED TO 24-HOUR FACILITY

☐ 1. The examiner found that the respondent does not meet the commitment criteria, or meets the criteria for outpatient commitment, or meets the criteria for substance abuse commitment and should be released pending a hearing. I returned respondent to his/her regular residence or the home of a consenting person and released respondent from custody.

☐ 2. The examiner found that the respondent is mentally ill and meets the criteria for inpatient commitment, or meets the criteria for substance abuse commitment and should be held pending a district court hearing. I transported and placed the respondent in the custody of the 24-hour facilty named below for observation and treatment.

Name Of 24-Hour Facility	*County Of 24-Hour Facility*

☐ 3. Respondent was temporarily detained under appropriate supervision at the site of first examination because the first examiner recommended inpatient commitment and a 24-hour facility was not immediately available or medically appropriate. Upon further examination, an examiner determined that the respondent no longer meets inpatient commitment criteria or meets the criteria for outpatient commitment. I returned the respondent to his/her regular residence or the home of a consenting person and released respondent from custody.

Date Delivered	*Time Delivered* ☐ AM ☐ PM	*Name Of Examiner (Type Or Print)*
Name Of Examining Facility		*County Of Examining Facility*
Name Of Law Enforcement Officer (Type Or Print)		*Signature Of Law Enforcement Officer*
Name Of Law Enforcement Agency		*Badge No. Of Officer*

NOTE TO LAW ENFORCEMENT OFFICER: *Upon completing this section, immediately return this form and a copy of the examiner's written report (Form No. DMH 5-72-01) to the Clerk of Superior Court of the county where the petition was filed and the custody order issued (See top of reverse side).*

STATE OF NORTH CAROLINA

File No.

County

In The General Court Of Justice
District Court Division

IN THE MATTER OF:

Name And Address Of Respondent

FINDINGS AND CUSTODY ORDER INVOLUNTARY COMMITMENT

(PETITIONER IS CLINICIAN WHO HAS EXAMINED RESPONDENT)

G.S. 122C-252, -261, -263, -281, -283

Social Security No. Of Respondent	*Date Of Birth*	*Drivers License No. Of Respondent*	*State*

I. FINDINGS

The Court finds from the petition in the above matter that there are reasonable grounds to believe that the facts alleged in the petition are true and that the respondent is probably:

(Check all that apply)

☐ 1. mentally ill and dangerous to self or others.

☐ In addition to being mentally ill, the respondent probably is also mentally retarded. (If this finding is made, see G.S. 122C-261(b) and (d) for special instructions.)

☐ 2. a substance abuser and dangerous to self or others.

II. CUSTODY ORDER

TO ANY LAW ENFORCEMENT OFFICER:

The Court ORDERS you to take the above named respondent into custody **WITHIN 24 HOURS AFTER THIS ORDER IS SIGNED** and transport the respondent directly to a 24-hour facility designated by the State for the custody and treatment of involuntary clients and present the respondent for custody, examination and treatment pending a district court hearing.

Date	*Time*	*Signature*	
	☐ AM ☐ PM		☐ *Deputy CSC* ☐ *CSC* ☐ *Assistant CSC* ☐ *Magistrate*

This Order is valid throughout the State. If the respondent is taken into custody, this Order is valid for seven (7) days from the date and time of issuance.

III. RETURN OF SERVICE
A. CUSTODY CERTIFICATION

☐ Respondent WAS NOT taken into custody for the following reason:

☐ I certify that this Order was received and the respondent served and taken into custody as follows:

Date Respondent Taken Into Custody	*Time* ☐ AM ☐ PM
Name Of Law Enforcement Officer (Type Or Print)	*Signature Of Law Enforcement Officer*
Name Of Law Enforcement Agency	*Badge No. Of Officer*

NOTE TO LAW ENFORCEMENT OFFICER: *If respondent is not taken into custody within 24 hours after this Order is signed, check the appropriate box above and return to the Clerk of Superior Court immediately. If respondent is served and taken into custody, complete return of service on the reverse. When taking respondent into custody you must inform him or her that he or she is not under arrest and has not committed a crime, but is being transported to receive treatment and for his or her own safety and that of others.*

Original-File Copy-24-Hour Facility Copy-Special Counsel Copy-Attorney General

(Over)

B. FOR USE WHEN 24-HOUR FACILITY NOT IMMEDIATELY AVAILABLE OR MEDICALLY APPROPRIATE

A 24-hour facility is not immediately available or medically appropriate. The respondent is being temporarily detained under appropriate supervision at the facility named below.

Date	*Time* ☐ AM ☐ PM	*Name Of Examiner (Type Or Print)*
Name Of Examining Facility		*County Of Examining Facility*
Name Of Law Enforcement Officer (Type Or Print)		*Signature Of Law Enforcement Officer*
Name Of Law Enforcement Agency		*Badge No. Of Officer*

C. FOR USE WHEN RESPONDENT RELEASED BEFORE TRANSPORT TO 24-HOUR FACILITY

Respondent was temporarily detained under appropriate supervision at the site of first examination because the first examiner (petitioning clinician) recommended inpatient commitment and a 24-hour facility was not immediately available or medically appropriate. Upon further examination, an examiner determined that the respondent no longer meets the inpatient commitment criteria or meets the criteria for outpatient commitment. I returned the respondent to his/her regular residence or the home of a consenting person and released respondent from custody.

Date Delivered	*Time Delivered* ☐ AM ☐ PM	*Name Of Examiner (Type Or Print)*
Name Of Examining Facility		*County Of Examining Facility*
Name Of Law Enforcement Officer (Type Or Print)		*Signature Of Law Enforcement Officer*
Name Of Law Enforcement Agency		*Badge No. Of Officer*

NOTE TO LAW ENFORCEMENT OFFICER: *Upon completing this section, immediately return this form and the examiner's written report (Form No. DMH 5-72-01) to the Clerk of Superior Court of the county where the petition was filed and the custody order issued (See top of reverse side).*

D. PATIENT DELIVERY TO 24-HOUR FACILITY

I transported the respondent and placed him/her in the custody of the 24-hour facility named below.

Date Delivered	*Time Delivered* ☐ AM ☐ PM
Name Of 24-Hour Facility	*County Of 24-Hour Facility*
Name Of Law Enforcement Officer (Type Or Print)	*Signature Of Law Enforcement Officer*
Name Of Law Enforcement Agency	*Badge No. Of Officer*

NOTE TO LAW ENFORCEMENT OFFICER: *Upon completing this section, immediately return this form to the Clerk of Superior Court of the county where the petition was filed and the custody order issued (See top of reverse side).*

STATE OF NORTH CAROLINA

File No.

_____ County

In The General Court Of Justice
Superior Court Division

IN THE MATTER OF:

Name And Address Of Respondent

FINDINGS AND ORDER INVOLUNTARY COMMITMENT PHYSICIAN-PETITIONER RECOMMENDS OUTPATIENT COMMITMENT

G.S. 122C-261

NOTICE: *This form is to be used instead of the Findings And Custody Order (AOC-SP-302) only when the petitioner is a physician or psychologist who recommends outpatient commitment or release pending hearing for a substance abuser.*

FINDINGS

The petitioner in this case is a physician/eligible psychologist who has recommended outpatient commitment/substance abuse commitment with the respondent being released pending hearing.

The Court finds from the petition in the above matter that there are reasonable grounds to believe that the facts alleged in the petition are true and that the respondent is probably:

☐ mentally ill and in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness.

☐ a substance abuser and dangerous to himself/herself or others.

ORDER

It is ORDERED that a hearing before the district court judge be held to determine whether the respondent will be involuntarily committed.

Date

Signature

☐ *Deputy CSC* ☐ *Assistant CSC*
☐ *Clerk Of Superior Court* ☐ *Magistrate*

NOTE TO CLERK: *Schedule an initial hearing for the respondent pursuant to G.S. 122C-264 or G.S. 122C-284 and give notice of the hearing as required by those statutes.*

AOC-SP-305, Rev. 1/98

STATE OF NORTH CAROLINA Department of Health and Human Services
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

County_____ File #_____

Client Record #_____

EXAMINATION AND RECOMMENDATION TO DETERMINE NECESSITY FOR INVOLUNTARY COMMITMENT

Film # _____

Name of Respondent:	Age	DOB	Sex	Race	M.S.

Address (Street, Box Number, City, State, Zip (use facility address after 1 year in facility):	County:
	Phone:
Legally Responsible Person □Next of Kin (Name and Address)	Relationship:
	Phone:
Petitioner (Name and address)	Relationship:
	Phone

The above-named respondent was examined on _____, 20___ at _____ o'clock ____.M. at _____ _____. OR, I examined the respondent via telemedicine technology on _____ 20__ at _____o'clock ___M. Included in the examination was an assessment of the respondent's: ❑ (1) current and previous mental illness or mental retardation including, if available, previous treatment history; (2) dangerousness to self or others as defined in G.S. 122C-3 (11*); (3) ability to survive safely without inpatient commitment, including the availability of supervision from family, friends, or others; and (4) capacity to make an informed decision concerning treatment. ❑ (1) current and previous substance abuse including, if available, previous treatment history; and (2) dangerousness to himself or others as defined in G.S. 122C-3 (11*). The following findings and recommendations are made based on this examination. For telemedicine evaluations only: ❑ I certify to a reasonable degree of medical certainty that the results of the examination via telemedicine were the same as if I had been personally present with the respondent OR ❑The respondent needs to be taken to a facility for a face to face evaluation. (*Statutory Definitions are on reverse side)

SECTION I - CRITERIA FOR COMMITMENT

Inpatient. It is my opinion that the respondent is:
(1st Exam – Physician or Psychologist)
(2nd Exam – Physician only)

- ❑ mentally ill; ❑ dangerous to self; ❑ dangerous to others
- ❑ in addition to being mentally ill is also mentally retarded
- ❑ none of the above

Outpatient. It is my opinion that:
(Physician or Psychologist)

- ❑ the respondent is mentally ill
- ❑ the respondent is capable of surviving safely in the community with available supervision
- ❑ based upon the respondent's treatment history, the respondent is in need of treatment in order to prevent further disability or deterioration which would predictably result in dangerousness as defined by G.S. 122C-3 (11*)
- ❑ the respondent's current mental status or the nature of his illness limits or negates his/her ability to make an informed decision to seek treatment voluntarily or comply with recommended treatment
- ❑ none of above

Substance Abuse. It is my opinion that the respondent is:
(1st Exam – Physician or Psychologist; 2nd Exam – If 1st exam done by Physician, 2nd exam may be done by Qual. Prof.)

- ❑ a substance abuser
- ❑ dangerous to himself or others
- ❑ none of the above

SECTION II – DESCRIPTION OF FINDINGS

Clear description of findings (findings for each criterion checked above in Section I must be described):

over

Notable Physical Conditions: Current Medications (medical and psychiatric)

Impression/Diagnosis:

SECTION III - RECOMMENDATION FOR DISPOSITION

❑ Inpatient Commitment for _____ days (respondent must be mentally ill **and** dangerous to self or others)
❑ Outpatient Commitment (respondent must meet **ALL** of the first four criteria outlined in Section I, **Outpatient)**
Proposed Outpatient Treatment Center or Physician: (Name)_____
(Address and Phone Number)_____
_____
LME notified of appointment: (Name of LME and date)_____
❑ Substance Abuse Commitment (respondent must meet both criteria outlined in Section I, **Substance Abuse)**
❑ Release respondent pending hearing - Referred to:_____
❑ Hold respondent at 24-hour facility pending hearing – Facility: _____
❑ Respondent does not meet the criteria for commitment but custody order states that the respondent was charged with a violent crime, including a crime involving assault with a deadly weapon, and that he was found not guilty by reason of insanity or incapable of proceeding: therefore, the respondent will not be released until so ordered following the court hearing.
❑ Respondent or Legally Responsible Person Consented to Voluntary Treatment
❑ Release Respondent and Terminate Proceedings (insufficient findings to indicate that respondent meets commitment criteria)
❑ Respondent was held 7 days from issuance of custody order but continues to meet commitment criteria. A new petition will be filed.

❑ Other (*Specify*) _____

_____M.D. Physician Signature _____ Signature/Title – Eligible Psychologist/Qualified Professional _____ Print Name of Examiner _____ Address or Facility _____ City and State _____ Telephone Number	This is to certify that this is a true and exact copy of the Examination and Recommendation for Involuntary Commitment _____ Original Signature – Record Custodian _____ Title _____ Address or Facility _____ Date **NOTE:** Only copies to be introduced as evidence need to be certified

CC: Clerk of Superior Court where petition was initiated (initial hearing only)
Clerk of Superior Court where 24-hour facility is located or where outpatient treatment is supervised
Respondent or Respondent's Attorney and State's Attorneys, when applicable
Proposed Outpatient Treatment Center or Physician (Outpatient Commitment); Area Program / Physician (Substance Abuse Commitment)
NOTE: If it cannot be reasonably anticipated that the clerk will receive the copies within 48 hours of the time that it was signed, the physician or eligible psychologist/qualified professional shall communicate his findings to the clerk by telephone.

***STATUTORY DEFINITIONS**

"Dangerous to self". Within the relevant past: (a) the individual has acted in such a way as to show: (1) that he would be unable without care, supervision, and the continued assistance of others not otherwise available, to exercise self-control, judgment, and discretion in the conduct of his daily responsibilities and social relations or to satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety; and (2) that there is a reasonable probability of his suffering serious physical debilitation within the near future unless adequate treatment is given. A showing of behavior that is grossly irrational, of actions that the individual is unable to control, of behavior that is grossly inappropriate to the situation, or of other evidence of severely impaired insight and judgment shall create a **prima facie** inference that the individual is unable to care for himself; or (b) the individual has attempted suicide or threatened suicide and that there is a reasonable probability of suicide unless adequate treatment is given; or (c) the individual has mutilated himself or attempted to mutilate himself and that there is a reasonable probability of serious self-mutilation unless adequate treatment is given. NOTE: Previous episodes of dangerousness to self, when applicable, may be considered when determining reasonable probability of physical debilitation, suicide, or self-mutilation.

"Dangerous to others". Within the relevant past, the individual has inflicted or attempted to inflict or threatened to inflict serious bodily harm on another, or has acted in such a way as to create a substantial risk of serious bodily harm to another, or has engaged in extreme destruction of property; and that there is a reasonable probability that this conduct will be repeated. Previous episodes of dangerousness to others, when applicable, may be considered when determining reasonable probability of future dangerous conduct.

"Mental illness:. (a) when applied to an adult, an illness which so lessens the capacity of the individual to use self-control, judgment, and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance or control; and (b) when applied to a minor, a mental condition, other than mental retardation alone, that so lessens or impairs the youth's capacity to exercise age adequate self-control and judgment in
the conduct of his activities and social relationships so that he is in need of treatment.

"Substance abuser". An individual who engages in 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. Substance abuse may include a pattern of tolerance and withdrawal.

SUPPLEMENT TO SUPPORT IMMEDIATE HOSPITALIZATION
(To be used in addition to "Examination and Recommendation for Involuntary Commitment, Form 572-01)

CERTIFICATE

The Respondent, _____
requires immediate hospitalization to prevent harm to self or others because:

I certify that based upon my examination of the Respondent, which is attached hereto, the Respondent is (check all that apply):

- ☐ Mentally ill and dangerous to self
- ☐ Mentally ill and dangerous to others
- ☐ In addition to being mentally ill, is also mentally retarded

_____
Signature of Physician or Eligible Psychologist

Address: _____
City State Zip: _____
Telephone: _____
Date/Time: _____

Name of 24-hour facility: _____
Address of 24-hour facility: _____

CC: 24-hour facility
Clerk of Court in county of 24-hour facility

Note: If it cannot be reasonably anticipated that the clerk will receive the copy within 24 hours (excluding Saturday, Sunday and holidays) of the time that it was signed, the physician or eligible psychologist shall also communicate the findings to the clerk by telephone.

NORTH CAROLINA
_____ County
Sworn to and subscribed before me this
_____ day of _____, 20__

(seal)

_____
Notary Public

My commission expires:_____

Pursuant to G.S. 122C-262 (d), this certificate *shall serve as the Custody Order* and the law enforcement officer or other person *shall* provide transportation to a 24-hr. facility in accordance with G.S. 122C-251.

TO LAW ENFORCEMENT: See back side for Return of Service

RETURN OF SERVICE

☐ **Respondent WAS NOT taken into custody for the following reason:**

☐ **I certify that this Order was received and served as follows:**

Date Respondent Taken into Custody	*Time* ☐ AM ☐ PM		
Name of 24-Hour Facility	*Date Delivered*	*Time Delivered* AM ☐ PM ☐	*Date of Return*
Name of Transporting Agency	*Signature of Law Enforcement Official*		

STATE OF NORTH CAROLINA

File No.

_____ County

In The General Court Of Justice
District Court Division

IN THE MATTER OF:

Name And Address Of Respondent

Drivers License No., If Known | *State*

Date Of Birth Of Respondent

PETITION AND CUSTODY ORDER FOR SPECIAL EMERGENCY SUBSTANCE ABUSE INVOLUNTARY COMMITMENT

G.S. 122C-282

I, the undersigned affiant, being first duly sworn, and having sufficient knowledge to believe that the respondent is a proper subject for involuntary commitment, allege that the respondent is a resident of, or can be found in the above named county, and is a substance abuser who is dangerous to himself or others. I have taken the respondent into custody and brought the respondent immediately before the Court because he/she is violent and requires restraint and the delay which would result from obtaining a medical examination would endanger life or property.

Name And Address Of Nearest Relative Or Guardian (Including Zip Code)		*Name And Address Of Other Person Who May Testify To Facts (Including Zip Code)*	
Home Telephone No.	*Business Telephone No.*	*Home Telephone No.*	*Business Telephone No.*

I request the Court to authorize the transportation of the respondent to a 24-hour facility for temporary custody, observation and treatment pending a district court hearing.

SWORN AND SUBSCRIBED TO BEFORE ME

Date

Signature

☐ *Deputy CSC* ☐ *Assistant CSC* ☐ *Clerk Of Superior Court*
☐ *Magistrate*

Signature Of Petitioner-Officer

Name And Address Of Petitioner-Officer (Including Zip Code) (Type Or Print)

Original-File Copy-hospital Copy-Special Counsel Copy- ttorney General

(Over)

FINDINGS

The Court finds that there ☐ are ☐ are not reasonable grounds to believe that the facts alleged in the petition are true and that the respondent is probably a substance abuser and dangerous to himself or others.

The Court further finds by clear, cogent, and convincing evidence that the respondent ☐ is ☐ is not in fact violent and requires restraint, and delay in taking the respondent to a person authorized by law to conduct an examination, for examination would endanger life or property.

CUSTODY ORDER

TO ANY LAW ENFORCEMENT OFFICER

The Court orders you to take the named respondent into custody and transport the respondent directly to the 24-hour facility named below, for temporary custody, examination and treatment pending a district court hearing.

Name And Address of 24-Hour Facility For Substance Abuser	*Date*	*Time* ☐ AM ☐ PM
	Signature	
	☐ *Deputy CSC* ☐ *Assistant CSC* ☐ *Clerk Of Superior Court* ☐ *Magistrate*	

RETURN OF SERVICE

☐ The respondent WAS NOT taken into custody for the following reason:

☐ I certify that this Order was received and served as follows:

Date Respondent Taken Into Custody	*Time* ☐ AM ☐ PM

☐ I transported the respondent directly to and placed him in the temporary custody of the facility named below.

Name Of 24-Hour Facility For Substance Abuser	*Date Order Received*	*Date Of Return*
Date Delivered	*Signature Of Law Enforcement Officer*	
Time ☐ AM ☐ PM	*Name Of Transporting Agency*	

PETITIONER'S WAIVER OF NOTICE OF HEARING

I voluntarily waive my right to notice of all hearings and rehearings in which the Court may commit the respondent or extend the respondent's commitment period, or discharge the respondent from the treatment facility.

Signature Of Witness	*Date*
	Signature Of Petitioner-Officer

STATE OF NORTH CAROLINA

_____ County

File No.

In The General Court Of Justice
District Court Division

IN THE MATTER OF:	NOTICE OF NEED FOR TRANSPORTATION ORDER AND ORDER (FROM ONE 24-HOUR FACILITY TO ANOTHER)
Name And Address Of Respondent	G.S. 122C-206
Transport From (Name And Address Of Current 24-Hour Facility)	*Transport To (Name And Address Of Receiving 24-Hour Facility)*

NOTE: *Use this form **ONLY** to request transport of the Respondent from one 24-hour facility to another when the Respondent is in the current 24-hour facility either (1) pending district court hearing or upon commitment in an involuntary commitment proceeding or (2) under a voluntary admission effected by a minor or by a responsible person for a minor or incompetent adult. Other transportation orders are: Request For Transportation Order And Order (Outpatient Fails But Does Not Clearly Refuse To Comply With Treatment)," AOC-SP-220; "Request For Transportation Order And Order (Committed Substance Abuser Fails To Comply With Treatment Or Is Discharged From 24-Hour Facility)," AOC-SP-223; "Request For Transportation Order And Order (Outpatient Fails To Appear For Prehearing Examination)," AOC-SP-224.*

NOTICE OF PROPOSED TRANSFER

The responsible professional named below gives notice pursuant to G.S. 122C-206(c1) that the Respondent named above is to be transferred from the current 24-hour facility named above to the receiving 24-hour facility named above, and that transportation is needed for this purpose. The undersigned requests that the Clerk of Superior Court or Magistrate issue an order to take the Respondent into custody for that purpose, and in support of this request states:

☐ **Respondent In Involuntary Commitment Proceeding**

1. ☐ a. The Respondent is being held at the current 24-hour facility for a district court hearing.
   ☐ b. An Inpatient Commitment Order has been entered in this proceeding and the Respondent is being held at the current 24-hour facility pursuant to that Order.

2. I have obtained authorization from the receiving facility that the facility will admit the Respondent, have provided reasonable notification to the Respondent, or legally responsible person, of the reason for the transfer, and have documented the notice in the client's record.

☐ **Respondent Minor Or Incompetent Adult Who Was Voluntarily Admitted**

1. The Respondent is a minor or incompetent adult who was admitted to the 24-hour facility pursuant to Part 3 or Part 4 of Article 5 of Chapter 122C of the General Statutes.

2. I have obtained authorization from the receiving facility that the facility will admit the Respondent, have provided reasonable notification to the Respondent, or legally responsible person, of the reason for the transfer, have documented the notice in the client's record, and have consulted with the legally responsible person.

Date	*Signature Of Responsible Professional*
	Name Of Responsible Professional (Type Or Print)

ORDER

TO ANY LAW ENFORCEMENT OFFICER:

You are ORDERED to take the Respondent into custody at the current 24-hour facility specified above and to transport the Respondent to the receiving 24-hour facility specified above.

Date	*Signature*	☐ *Clerk Of Superior Court* ☐ *Magistrate* ☐ *Assistant CSC*

NOTE: *See Side Two for Officer's Return.*

(Over)

OFFICER'S RETURN

Respondent Taken Into Custody At Current 24-Hour Facility		*Respondent Turned Over To 24-Hour Facility*	
Date	*Time* ☐ AM ☐ PM	*Date*	*Time* ☐ AM ☐ PM

☐ On the date and time shown above, I took the Respondent into custody at the specified current 24-hour facility. I took the Respondent immediately to the specified receiving 24-hour facility and turned the Respondent over to the custody of that facility.

☐ I DID NOT take the Respondent named above into custody because:

Date Of Return	*Signature Of Deputy Sheriff Or Law Enforcement Officer Making Return*
	Name Of Deputy Sheriff Or Law Enforcement Officer Making Return (Type Or Print)
	County Of Sheriff Or City Of Law Enforcement Officer

STATE OF NORTH CAROLINA

_____ County

File No.

In The General Court Of Justice
District Court Division

IN THE MATTER OF:

Name And Current Address Of Respondent

REQUEST FOR TRANSPORTATION ORDER AND ORDER
(COMMITTED SUBSTANCE ABUSER FAILS TO COMPLY WITH TREATMENT OR IS DISCHARGED FROM 24-HOUR FACILITY)

G.S. 122C-290(b), -205.1(b)

Date Of Substance Abuse Commitment Order	*Transport To (Name And Address Of Area Facility Or Physician)*
Date Period Of Commitment Expires	

NOTE: *Use this form only when (1) the respondent has been committed as a substance abuser after a hearing in district court; (2) the respondent has either (a) failed to comply with all or part of prescribed outpatient treatment or (b) has been discharged from a 24-hour facility after escaping or breaching a condition of his/her release from the 24-hour facility, and 3) the respondent is to be taken to an area facility or physician for examination.* ***DO NOT*** *use this form in mental health cases. Mental health transportation orders are: Request For Transportation Order And Order (Outpatient Fails But Does Not Clearly Refuse To Comply With Treatment)," AOC-SP-220; "Notice Of Need For Transportation Order And Order (From One 24-Hour Facility To Another)," AOC-SP-222; "Request For Transportation Order And Order (Outpatient Fails To Appear For Prehearing Examination)," AOC-SP-224.*

REQUEST

The area facility or physician named below requests that the Clerk of Superior Court or Magistrate enter an order, pursuant to G.S. 122C-290(b), to take the Respondent named above into custody and to take the Respondent to the area facility or physician designated above for examination. In support of this request, the undersigned states:

☐ 1. A Substance Abuse Commitment Order was entered in this proceeding on the date shown above. The period of substance abuse commitment has not expired.

2. ☐ a. The area facility or physician responsible for management and supervision of the Respondent's commitment prescribed treatment on an outpatient basis; the Respondent failed to comply with all or part of the prescribed treatment after reasonable efforts to solicit the Respondent's compliance, in that *(Summarize facts showing failure to comply and reasonable efforts to solicit compliance):*

☐ b. The Respondent was discharged from a 24-hour facility in accordance with G.S. 122C-205.1(b).

Date	*Signature Of Physician Or Representative Of Area Facility*	☐ *Physician*
	Name Of Physician Or Representative Of Area Facility	☐ *Representative Of Area Facility (Title)*

ORDER

TO ANY LAW ENFORCEMENT OFFICER:

You are ORDERED to take the Respondent named above into custody, take the Respondent immediately to the area facility or physician designated above for examination, and to turn the Respondent over to the custody of that area facility or physician.

Date	*Signature*	☐ *Clerk Of Superior Court* ☐ *Assistant Clerk Of Superior Court*	☐ *Magistrate*

NOTE: *See Side Two for Officer's Return(s).*

NOTE: *The officer who first takes the Respondent into custody shall turn the Respondent over to the custody of the specified area facility or physician. The area facility of physician may release the Respondent or "have the Respondent taken" to a 24-hour facility. If the officer who took the Respondent into custody is also officer by whom the Respondent is taken to the 24 hour facility, that officer should complete the "Officer's Return" below by checking both Option #1 and Option #3. If a different officer takes the Respondent to the 24-hour facility, the first officer should complete the "Officer's Return" below by checking only Option #1. The second officer should complete the portion headed "For Use When A Different Officer Takes Respondent To 24-Hour Facility."*

OFFICER'S RETURN

Respondent Taken Into Custody		*Respondent Turned Over To Custody Of Area Facility Or Physician*	
Date	*Time* ☐ AM ☐ PM	*Date*	*Time* ☐ AM ☐ PM

☐ 1. On the date and time shown above, I took the Respondent into custody. I took the Respondent to the specified area facility or physician and, on the date and time shown above, turned the Respondent over to the custody of that area facility or physician.

☐ 2. I DID NOT take the Respondent named above into custody because:

☐ 3. In addition to turning the Respondent over to the custody of the specified area facility or physician, I then, at the examiner's request, took the Respondent to the 24-hour facility named below and turned the Respondent over to the custody of that 24-hour facility.

Respondent Taken From Area Facility Or Physician		*Respondent Turned Over To 24-Hour Facility*	
Date	*Time* ☐ AM ☐ PM	*Date*	*Time* ☐ AM ☐ PM

Date Of Return	*Signature Of Deputy Sheriff Or Law Enforcement Officer Making Return*
Name And Address Of 24-Hour Facility	*Name Of Deputy Sheriff Or Law Enforcement Officer Making Return (Type Or Print)*
	County Of Sheriff Or City Of Law Enforcement Officer

FOR USE WHEN A DIFFERENT OFFICER TAKES RESPONDENT TO 24-HOUR FACILITY

At the examiner's request, I took the Respondent into custody at the specified area facility or physician and took the Respondent to the 24-hour facility named below and turned the Respondent over to the custody of that 24-hour facility.

Respondent Taken From Area Facility Or Physician		*Respondent Turned Over To 24-Hour Facility*	
Date	*Time* ☐ AM ☐ PM	*Date*	*Time* ☐ AM ☐ PM

Date Of Return	*Signature Of Deputy Sheriff Or Law Enforcement Officer Making Return*
Name And Address Of 24-Hour Facility	*Name Of Deputy Sheriff Or Law Enforcement Officer Making Return (Type Or Print)*
	County Of Sheriff Or City Of Law Enforcement Officer

Judicial College for Magistrates

Case Studies

1. You receive a petition from an emergency room physician. The physician has checked box number 1 on the petition, which states that the respondent, Martin, is "mentally ill and dangerous to self of others or mentally ill and in need of treatment in order to prevent further disability and deterioration that would predictably result in dangerousness." The facts upon which the physician's opinion is based, according to the petition, are: "Patient behaving in a bizarre manner. Confused. Poor judgment. Unclear if suicidal."

   What do you do? Describe what you do and explain why.

2. Molly lives with her husband and daughter. Her husband reports that Molly has forgotten to turn off the stove two times in the last week, resulting in the burning of some pots and pans and a Formica countertop. Molly is extremely forgetful, frequently talks to the wall, and appears to be out of touch with her real surroundings. She has been diagnosed with bipolar disorder (manic-depressive disorder).

   Is Molly dangerous to herself or others? Why or why not?

3. John goes downtown, hangs out on the main street sidewalk, blocks people from walking by, preaches loud words, and refuses to leave after being directed by the city police. John's brother says that John is religiously preoccupied, has ideas of persecution, and delusions of grandeur. John cannot understand why City Hall will not give him a license. John's brother is afraid that if John persists in trying to convert someone on the street who is resisting John's idea, then this person might become physically aggressive toward John. John's brother does not get any indication that John is aggressively motivated in the sense of being physically violent. John's brother has prepared a petition/affidavit for commitment for the magistrate. John's brother has written down in the petition the facts stated above and added that he believes John is in a mentally ill state of mind, is dangerous to himself or others, and needs medical treatment.

   Is John dangerous to himself or others? Why or why not?

4. Same facts as in number 3, except the petitioner adds that John "assaulted two people yesterday." Is John dangerous to himself or others? Why or why not?

5. Jane has been unemployed for almost one year, having left her job because she felt she was being harassed by married men at work. She has not attempted to seek other employment and has been living in her car for the past two weeks, despite the cold weather (December). Jane believes that people are harassing her. Jane's daughter, Mary, was able to get her mother assessed by a physician who diagnosed Jane as suffering from psychotic depression, and possibly paranoid schizophrenia. The doctor also noted to Mary that Jane was not eating well. Since this initial evaluation two weeks ago, Jane has refused treatment and begun living in her car. Mary reports that her mother seems to have imaginary friends visiting her car, has a flat affect, and believes that others are "harming her." Mary believes that her mother is incapable of providing for herself in her present state and is not getting sufficient nourishment. Mary says that Jane does not appear to have eaten much in the last two weeks and is losing weight. Jane apparently runs the car engine periodically to keep warm. Mary fears that Jane might die of carbon monoxide poisoning if Jane continues to live in her car the rest of the winter.

   Is Jane dangerous to herself? Why or why not?

6. Mary has a hammer in the house, breaks everything she can find, and told her husband that if he went to sleep she would bash his brains out. She has threatened to kill her daughter, granddaughter and sister. The daughter says, "Upon coming home, I found the TV busted, the telephone had been cut away from the wall, and glass was all over the living room. When I asked what happened, mother became excited and said that she had broken the TV, cut the phone, and broke some of the glass. On the phone the night before, mother had threatened to kill father and aunt."

   Is Mary dangerous to herself? Why or why not?

7. David was found sitting on the edge of a busy airport runway. He had been observed in the woods with a rope around his neck and cutting his arm with a knife. He kept an iron pipe and hatchet under his bed and threatened his mother three days age by forcing her to sit in one chair and not move for two hours while he was screaming, shouting, and cursing. He threatened to "bust" his mother's head if she called anybody. He complained of demons and of feeling that his bones were being pulled out.

   Is David dangerous? Why or why not?

State of North Carolina
Department of Justice
P. O. Box 629
RALEIGH
27602-0629

ROY COOPER
ATTORNEY GENERAL

MAILING ADDRESS
BROUGHTON HOSPITAL
P. O. BOX 121
MORGANTON, NC 28655
828-433-2006

November 12, 2004

Dear:

My office represents the Petitioner, Broughton Hospital and the State in the involuntary commitment hearings held weekly at Broughton Hospital.

At you know, before a person can be involuntarily committed for treatment, and "Affidavit and Petition for Involuntary Commitment form, (AOC-SP-300, Rev. 5/98), must be completed and reviewed by a Magistrate or Clerk of Court. This is required before one of these officials issues a "Custody Order" to the law enforcement personnel to take the patient into custody for examination or treatment. The Petition is required to contain sufficient facts to show that the person is both mentally ill and dangerous to self or others to provide legal justification for taking the person into custody against his will.

We recently received a "Petition" and "Custody Order" for involuntary commitment which you completed for which was insufficient to meet the legal requirements.

If the Judge is asked by the patient's attorney through a Motion to Dismiss to review a Petition, the Judge can be required by the law to dismiss the case before the Judge hears any of the evidence about the patient if the Judge finds it to be weak.

A weak Petition is one which does not contain sufficient facts to support the conclusion that the respondent is both mentally ill and dangerous to self or other. Sometimes the line between facts and conclusions seems a bit murky.

Conclusions are a matter of individual opinion. For example, whether the observable fact that a person was holding a gun justifies the conclusion that he or she was "dangerous to self or others", depends upon other observable facts such as whether the person holding the gun was a police officer making an arrest or a person with a history of

mental illness who has recently been acting in a bizarre manner; whether the gun was loaded or not; whether the person was engaged in a hunting game in a wilderness area or standing in the street in the middle of a city; whether the gun was pointed at anyone or aimed at the ground; what the person said while holding the gun, etc. The law requires that enough observable facts be written on the Petition itself to enable the Judge to draw the conclusion that the person appeared to be mentally ill and dangerous to self or others at the time the Petition was taken out for involuntary commitment without referring to any information outside the Petition.

To review a Petition, the Judge looks at the contents of the Petition to see if the contents appear to be legally sufficient. What the Judge is saying by dismissing a case due to a weak Petition is that "considering only the facts stated in the Petition (and no other information), the Magistrate (or the Petitioner) did not write down enough evidence to justify the Magistrate's issuance of the Custody Order" (the legal document which gives law enforcement personnel permission to pick up the person against his will).

When a case is dismissed, the patient must be discharged from the hospital without consideration of the patient's treatment needs. It is sometimes possible for the psychiatrist at Broughton Hospital to take out a new Petition for the patient's involuntary commitment, but not always. It depends on the particular situation. So obviously, it is very important for the patient's care and the community's protection to do as much as possible to provide the needed information in the original petition.

These are some of the most common faults in Petitions:

a. Stating that a person is "VIOLENT" or THREATENING" or even "AGRESSIVE." All of these words are mere conclusions and will not hold up in court. The facts underlying those conclusions must be included in the Petition.

For example, instead of saying "violent", the Petition should state exactly what the patient was doing (i.e. lunged at Petitioner, held Petitioner at knifepoint, slapped Petitioner in face, kicked at Petitioner). You must be very, very specific in stating what exactly took place. If the patient has verbally threatened someone, the Petition should state the exact words that the patient used (not just "threatened bodily harm" or anything of that nature).

b. Stating that the patient has "ASSAULTED" someone. This is definitely not enough since the law provides an extremely broad definition of assault.
You must state specifically what the respondent did - i.e. slapped, punched,
pushed, kicked, and also include where on the body the victim was struck and note any injuries sustained (brusing, cuts, etc. Sometimes the age or condition of the victim makes an action dangerous, i.e., an elderly or ill person or a child may be more vulnerable and likely to be injured by some

actions.)

c. Stating that the patient is "SUICIDAL." This will not stand up in court. You must state on what facts this conclusion is based. For example, quote what the patient has said or done that lead the Petitioner to the conclusion that the person is suicidal.

Frequently Petitions will contain many facts to show that the patient is mentally ill, but no facts to show that the patient is dangerous to self or others. It is essential to remember that the Petition must contain facts to support the conclusions that both mental illness and dangerousness are present in the patient. Just acting very bizarre or really "crazy" is not sufficient under the law to have someone committed.

It is very distressing and frustrating for the families and friends of patients to go through the whole commitment process only to be presented with the unpleasant situation that the court had to throw the case out because the petition did not contain enough factual information. Another problem is that if a person must then be re-committed soon after the court dismissal, the time and efforts of the law enforcement personnel, physicians and hospital personnel have to be duplicated to deal with the original situation.

I hope this information will help to avoid future dismissals by the court and that we can all work together to address this serious problem with the commitment process. I am available by telephone to answer any questions that arise concerning involuntary commitments. Please feel free to call with your questions or concerns.

Very truly yours,

M. Elizabeth Guzman
Assistant Attorney General

MEG/bd

Mental Health 101

Molly Richardson LCSW, LCAS, CCS
Clinical Supervisor
Behavioral Health Unit
Haywood Regional Medical Center
(828)337-8202
Molly.richardson@haymed.org

BHU at Haywood Regional Medical Center

- 16 bed inpatient psychiatric unit for adults
- Primarily identified as a mental health facility, but actively treat co-occurring disorders
- Average length of stay is 7 days
- On average 2/3 of individuals are voluntary and 80% convert to voluntary status prior to court
- I spend about 30% of my day talking to collateral (family and friends) contacts
- We very rarely have an empty bed…and we turn away more people than we serve each year

Why are we here today?

The involuntary commitment process is about saving lives.

It is a unique partnership between the legal system, the mental health system, the health care system and law enforcement.

Its complicated, its frustrating, but it does work. It works by saving lives

General Statistics

SAVE-Suicide Facts

- Suicide is the 10th leading cause of death in the US for all ages. (CDC)
- The suicide rates decreased from 1990-2000 from 12.5 suicides per 100,000 to 10.4 per 100,000. Over the past decade, however, the rate has again increased to 12.1 per 100,000. Every day, approximately 105 Americans die by suicide. (CDC)
- There is one death by suicide in the US every 13 minutes. (CDC)
- Depression affects 20-25% of Americans ages 18+ in a given year. (CDC)
- Suicide takes the lives of over 38,000 Americans every year. (CDC)
- Only half of all Americans experiencing an episode of major depression receive treatment. (NAMI)
- 80% -90% of people that seek treatment for depression are treated successfully using therapy and/or medication. (TAPS study)
- An estimated quarter million people each year become suicide survivors (AAS).
- There is one suicide for every estimated 25 suicide attempts. (CDC)
- There is one suicide for every estimated 4 suicide attempts in the elderly. (CDC)

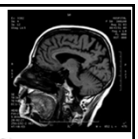
The Involuntary Commitment process can save lives

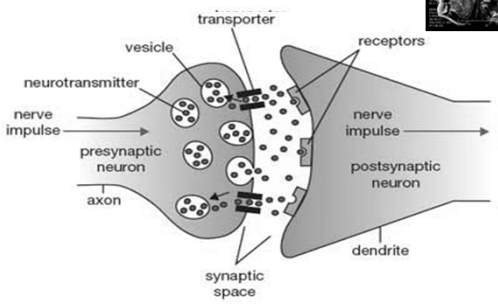
Goals for this session

- Understand why the brain is important
- Understand the different categories of mental illness
- Understand symptoms that are typically present in mental illness
- Understands the basics of addiction
- Understand the symptoms that are typically present in substance abuse

Goal is not to make you a mini me…..

The Brain





Mental Disorders

When we think about Mental Illness in the mental health field we are typically referring to three different groups of disorders.

Mentally ill
(Mood disorders, Psychotic Disorders, Personality Disorders, etc)

Substance Abuse
(Drug and Alcohol Disorders)

Developmental Disorders
(Cognitive Disorders)

It's a problem, only if it's a problem

- A maladaptive pattern that leads to clinically significant impairment or distress
- Social/occupational dysfunction- one or more major areas of functioning such as work, interpersonal relationships, or self-care are markedly below the level achieved prior to the onset

Risk or Protective Factor

Biological	Psychological
Social	Spiritual

- **Mood Disorders**
- **Anxiety Disorders**
- **Psychotic Disorders**
- **Substance Related Disorders**
- **Personality Disorders**

Mood Disorders

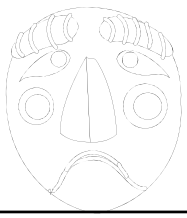
- Major Depressive Disorder
- Dysthymia
- Bipolar Disorder

Depressive Episodes

- Symptoms have been present for at least 2 weeks
- Feels sad/empty
- Tearful
- Irritable
- Life is not pleasurable
- Weight loss or gain
- Can't sleep or sleeps too much
- Fatigue or loss of energy
- Worthlessness
- Can't think or concentrate
- Recurrent thoughts of death

Dysthymia

- A chronic disorder characterized by a presence of a depressed mood that lasts most of the day and is present almost continuously
- Symptoms have been present for at least 2 years



Bipolar Disorder

- Highs and the lows
- Depressive Episodes
- Manic Episodes
  - A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week

Manic Episodes

- Inflated self-esteem or grandiosity
- Decreased need for sleep
- More talkative
- Flight of ideas
- Distractibility
- Increase in goal-directed activity
- Excessive involvement in pleasurable activities

Anxiety Disorders

- Panic Disorder and Agoraphobia
- Specific Phobia and Social Phobia
- Obsessive-Compulsive Disorders
- Posttraumatic Stress Disorder
- Generalized Anxiety Disorder

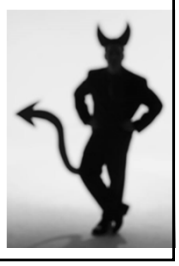
Trauma

Post-Traumatic Stress Disorder

- A syndrome that develops after a person sees, is involved in, or hears of an extreme traumatic stressor
- The person's response involved intense fear, helplessness or horror
- Recurrent and intrusive distressing recollections of the event

Psychotic Disorders

- Schizophrenia
- Schizoaffective Disorder
- Delusional Disorder



Characteristic symptoms of Schizophrenia

DSM-IV-TR

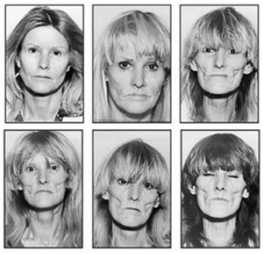
- Delusions- false belief, based on incorrect inference about external reality, not consistent with patient's intelligence and cultural background which cannot be corrected by reasoning
- Hallucinations-false sensory perception not associated with real external stimuli; there may or may not be a delusional interpretation of the hallucinatory experience
  - Command Hallucinations- false perception of orders that a person may feel obliged to obey or unable to resist
- Disorganized speech
- Disorganized or catatonic behavior
- Negative symptoms

Schizophrenia

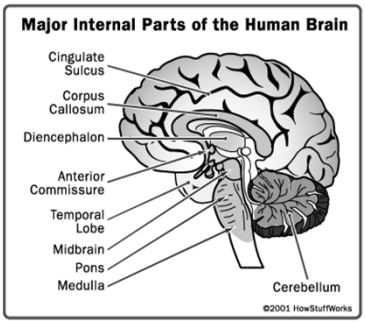
- Patients with schizophrenia more frequently attempt suicide, not in relation to active psychotic processes but in relation to devastating demoralization and depression, resulting from years of pain and frustration
- Many medication issues

Substance-Related Disorders

- Alcohol-Related Disorders
- Amphetamine Related Disorders
- Caffeine-Related Disorders
- Cannabis-Related Disorders
- Cocaine-Related Disorders
- Hallucinogen-Related Disorders
- Inhalant-Related Disorders
- Nicotine-Related Disorders
- Opioid- Related Disorders
- Phencyclidine Related Disorders
- Sedative-,Hypnotic-, or Anxiolytic D/O
- Anabolic Steroid Abuse
- Other Substance-Related Disorders



ADDICTION IS A BRAIN DISORDER



Substance-Related Disorders

- 40% individuals report using one or more illicit substances in their lifetimes
- 15 % have used illicit substance in the past year
- Substance abuse is a major precipitating factor for suicide
- Persons who abuse substance are about 20 times more likely to die by suicide than the general population

Alcohol Withdrawal

- Cessation of (or reduction in) alcohol use that has been heavy and prolonged
- Two or more of the following developing within several hours to a few days after cessation of use
  - Autonomic hyperactivity (eg sweating or pulse rate greater than 100)
  - Increased hand tremor
  - Insomnia
  - Nausea or vomiting
  - Transient visual, tactile, or auditory hallucinations or illusions
  - Psychomotor agitation
  - Anxiety
  - Grand mal seizures

Other bits of information

- Try to get as much information regarding the substance use from the petitioner as possible
  - What are they using
  - How often are they using
  - How much are they using
  - When was the last time they used
- Alcohol and Benzodiazepines can be life threatening in withdrawal
- Opiates feel life threatening
- Drug screens will not show if an individual has use a hallucinogen or other designer or OTC drug (ecstasy, Computer duster, Triple C, etc)
- Psychosis can be common in methamphetamine use
- No programs for adults for long term involuntary substance abuse treatment, this level of treatment must be voluntary
- Encourage family members to call your local LME

For every **1 overdose death** from prescription painkillers there are…

- 10 treatment admissions for abuse
- 32 emergency department visits for misuse or abuse
- 130 people who abuse or are dependent
- 825 people who take prescription painkillers for nonmedical use

- http://www.cdc.gov/injury/about/focus-rx.html

Treatment Works

- Studies show that substance use disorder treatment cuts drug use in half, reduces criminal activity up to 80 percent, and reduces arrests up to 64 percent.
- For every $1 invested in treatment, there is a return of between $4 and $7 in reduced drug-related crime and criminal justice costs. When savings related to health care are included, total savings can exceed costs by a ratio of 12 to 1

Other Disorders

- Personality Disorders
- Eating Disorder
- Postpartum Depression/Psychosis
- Dissociative Disorders

Personality Disorders

- An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas
  - Cognition (i.e., ways of perceiving and interpreting self, other people, and events)
  - Affectivity (i.e., the range, intensity, lability and appropriateness of emotional response)
  - Interpersonal functioning

Eating Disorders

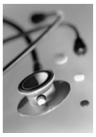
- The decision to hospitalize a patient is based on the patient's medical condition and the amount of structure needed to ensure patient cooperation. In general, anorexia nervosa patients who are 20 % below the expected weight for their height are recommended for inpatient programs, and patients who are 30 % below their expected weight require psychiatric hospitalization for 2 to 6 months

Postpartum Depression & Psychosis

- A specific disorder that occurs in women who have recently delivered a baby.
- Characterized by the mother's depression, delusions, and thoughts of harming either her infant or herself
- Symptoms often begin within days of the delivery but can be within 8 weeks post delivery
- Early symptoms include fatigue, insomnia, restlessness and emotional lability
- Later symptoms include suspiciousness, confusion, incoherence, irrational statements and obsessive concerns about the baby's health and welfare
- Delusions are present in 50 % of patients and hallucinations in about 25%

Disorders related to a General Medical Condition

- Delirium
- Dementia
- Amnestic Disorder
- Mental Disorders Due to a General Medical Condition



Delirium

- A syndrome, not a disease
- A disturbance of consciousness and a change in cognition that develop over a short period of time
- Classically delirium has a sudden onset (hours or days), a brief and fluctuating course, and rapid improvement when the causative factor is identified and eliminated

Intellectual and Developmental Disabilities

- Significantly sub average general intellectual functioning resulting in, or associated with, concurrent impairment in adaptive behavior and manifested during the developmental period, before the age of 18.
- Degree of impairment can be from Mild, Moderate, Severe to Profound

Dementia

- The development of multiple cognitive deficits
  - Memory impairment and (one or more of the following)
  - Aphasia (language disturbance
  - Apraxia (impaired ability to carry out motor activities)
  - Agnosia (failure to recognize or identify objects)
  - Disturbance in executive functioning

Questions ?

I'm Alive

http://vimeo.com/2885074

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- Kaplan & Sadock's. 2003.Synopsis Of Psychiatry.
- DSM-5

Understanding Suicide

Fact Sheet *2012*

Suicide is when people direct violence at themselves with the intent to end their lives, and they die as a result of their actions. Suicide is a leading cause of death in the United States.

A suicide attempt is when people harm themselves with the intent to end their lives, but they do not die as a result of their actions. Many more people survive suicide attempts than die, but they often have serious injuries. However, a suicide attempt does not always result in a physical injury.

To learn more about suicide and other self-directed violence, please visit: http://www.cdc.gov/ViolencePrevention/pub/selfdirected_violence.html

Why is suicide a public health problem?

Suicide is a significant problem in the United States:

- 38,364 people killed themselves in 2010--an average of 105 each day.[1]
- Over 487,700 people with self-inflicted injuries were treated in U.S. emergency departments in 2011.[1]
- Suicide and self-inflicted injuries result in an estimated $41.2 billion in combined medical and work loss costs.[1]

These numbers underestimate this problem. Many people who have suicidal thoughts or make suicide attempts never seek services.[2]

How does suicide affect health?

Suicide, by definition, is fatal and is a problem throughout the life span. Suicide is the third leading cause of death among persons aged 15-24 years, the second among persons aged 25-34 years, the fourth among person aged 35-54 years, and the eighth among person 55-64 years.[1]

People who attempt suicide and survive may experience serious injuries, such as broken bones, brain damage, or organ failure. These injuries may have long-term effects on their health. People who survive suicide attempts may also have depression and other mental health problems.

Suicide also affects the health of others and the community. When people die by suicide, their family and friends often experience shock, anger, guilt, and depression. The medical costs and lost wages associated with suicide also take their toll on the community.

Who is at risk for suicide?

There is no single cause of suicide. Several factors can increase a person's risk for attempting or dying by suicide. However, having these risk factors does not always mean that suicide will occur.

Risk factors for suicide include:

- Previous suicide attempt(s)
- History of depression or other mental illness
- Alcohol or drug abuse
- Family history of suicide or violence
- Physical illness
- Feeling alone

Suicide affects everyone, but some groups are at higher risk than others. Men are about four times more likely than women to die from suicide.[1] However, women are more likely to have suicidal thought than men.[3] The prevalence of suicidal thoughts, suicide planning, and suicide attempts is significantly higher among young adults aged 18-29 years than it is among adults aged ≥30 years.[3] Other groups with higher rates of suicidal behavior include American Indian and Alaska Natives, rural populations, and active or retired military personnel.[4]

Note: This is only some information about risk. To learn more, go to www.cdc.gov/injury/violenceprevention.

Understanding Suicide

How can we prevent suicide?

Suicide is a significant public health problem, and there is a lot to learn about how to prevent it. One strategy is to learn about the warning signs of suicide, which can include individuals talking about wanting to hurt themselves, increasing substance use, and having changes in their mood, diet, or sleeping patterns. When these warning signs appear, quickly connecting the person to supportive services is critical. Promoting opportunities and settings that strengthen connections among people, families, and communities is another suicide prevention goal.

For more information about suicide prevention and connectedness, see Preventing Suicide: Program Activities Guide *(www.cdc.gov/violenceprevention/suicide/index.html) and* Promoting Individual, Family, and Community Connectedness to Prevent Suicide Behavior *(www.cdc.gov/ViolencePrevention/pdf/Suicide_Strategic_Direction_Full_Version-a.pdf).*

How does CDC approach prevention?

CDC uses a four-step approach to address public health problems like suicide.

Step 1: Define the problem

Before we can prevent suicide, we need to know how big the problem is, where it occurs, and who it affects. CDC learns about a problem by gathering and studying data. These data are critical because they help us know where prevention is most needed.

Step 2: Identify risk and protective factors

It is not enough to know that suicide affects certain people in certain areas. We also need to know why. CDC conducts and supports research to answer this question. We can then develop programs to reduce or get rid of risk factors and to increase protective factors.

Step 3: Develop and test prevention strategies

Using information gathered in research, CDC develops and evaluates strategies to prevent suicide.

Step 4: Ensure widespread adoption

In this final step, CDC shares the best prevention strategies. CDC may also provide funding or technical help so communities can adopt these strategies.

For a list of CDC activities, see Preventing Suicide: Program Activities Guide *(www.cdc.gov/violenceprevention/suicide/index.html).*

Where can I learn more?

If you or someone you know is thinking about suicide, contact the National Suicide Prevention Lifeline at 1-800-273-TALK (1-800-273-8255).

Centers for Disease Control and Prevention
www.cdc.gov/violenceprevention

CDC Facebook Page on Violence Prevention
www.facebook.com/vetoviolence

National Institute for Mental Health
www.nimh.nih.gov

Substance Abuse and Mental Health Services Administration
www.samhsa.gov

Suicide Prevention Resource Center
www.sprc.org

Surgeon General's Call to Action to Prevent Suicide
www.surgeongeneral.gov/library/calltoaction

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3. Crosby AE, Han B, Ortega LAG, Parks SE, Gfoerer J. Suicidal thoughts and behaviors among adults aged ≥18 years-United States, 2008-2009. MMWR Surveillance Summaries 2011;60(no. SS-13). Available from www.cdc.gov/mmwr/preview/mmwrhtml/ss6013a1.htm?s_cid=ss6013a1_e.
4. Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, editors. World report on violence and health [serial online]. (2004). [cited 2012 July 23]. Available from www.who.int/violence_injury_prevention/violence/world_report/wrvh1/en.

Tab 2:

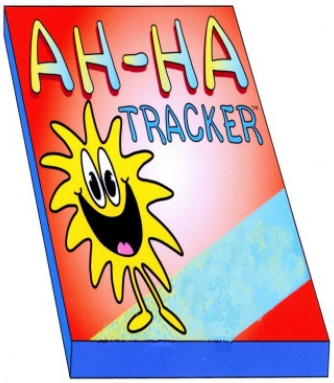
Day 2

DAY TWO - AGENDA

These are the topics on today's agenda:

1. *Getting the Information You Need*
2. *Lunch*
3. *Dealing with Physician Petitions*
4. *Station Activities:*
    a. *Interviewing Exercise*
    b. *Feedback on Petition Session*
    c. *Hearing Voices*
    d. *Taking it Back Home: Small Group Discussions*
5. *Talking About This Afternoon*

Checking In



Discuss with your tablemates what struck you most about our time together yesterday. For example, did you find anything surprising or thought-provoking? Do you disagree with anything you heard? Do you have questions about any of the material?

_____

_____

_____

_____

_____

JUST THE FACTS

Getting the Information You Need

The Magistrate's Role in Involuntary Commitment

School of Government
University of North Carolina at Chapel Hill
April 20-22, 2015

Crystal Farrow
NC Division of MH/DD/SAS
Crisis Solutions Initiative Project Manager

Agenda

- Risk factors to consider in the petition process
- What's happening with the petitioner
- Interviewing and crisis intervention skills
  - Using interpersonal skills that help you get the information you need
- Knowing other resources

Mental health and addictive disorders are the leading cause of combined death and disability for women & the second leading cause for men.

TOP 10 QUESTIONS A MAGISTRATE SHOULD ASK A PETITIONER IN THE IVC PROCESS

Danger to Self

More than 30,000 Americans die by suicide each year and more than 90% of those have a mental illness or addictive disorder.

Relationship between suicide and mental illness

The presence of a severe psychiatric disorder is the single strongest statistical correlate with suicide risk

1. Major depression
2. Alcoholism
3. Schizophrenia
4. Borderline personality disorder

Facts About Suicide

- Suicide is the 9th leading cause of death.
- The highest rate of suicide is for persons over the age of 65.
- Suicide by firearm is the most common method for both men and women, accounting for 61% of all suicides.
- The number of attempted suicides is estimated to be 650,000.
- 80% of the individuals who attempt or commit suicide DO give some indication of their impending action.

Suicide Risk Factors

- Family history of mental illness or substance abuse disorder
- Family history of suicide
- Family violence including physical, emotional, and sexual abuse
- Recent or perceived loss (not just death) of a friend, family member, pet, or a breakup of a relationship.

Suicide Risk Factors

- Firearms in the home
- Incarceration
- Exposure to the suicide of others, including family, peers and/or media news or fiction (The closer the relative, the greater the risk)
- Acute intoxication

?

Does he want to die?

Or does he think he can fly?

Psychosis as a Risk Factor

- Psychosis should be considered as a suicide risk factor, because rational thought often acts as the final obstacle to self-destruction
- Any evidence of psychosis warrants a thorough evaluation of lethality
  - Command hallucinations
  - Feelings of alien control
  - Religious preoccupation

?

Michael _____, a charismatic and loving soul died Thursday, March 11th 2010 at the age of 21.

Michael was born August 15th 1988 in Raleigh, North Carolina. He was an Eagle Scout with Troop 213. He graduated from the North Carolina School of Science and Math in 2007. He was in the environmental engineering program at North Carolina State University. Mike was a lifeguard and instructor at the YMCA and previously worked at the Eaton Corporation in Middlesex, North Carolina. An avid backpacker and outdoor enthusiast, Michael never got to hike the Appalachian Trail like he had hoped. With his intellectual capabilities and his passionate nature, Michael was driven to make a difference in the world.

Michael is survived by his parents, Vince and Theresa as well as his siblings, Kelley, Colleen, and Nolan.

There will be a mass at Saint Michael the Archangel Catholic Church in Cary celebrating his life to be held Tuesday March 16th at 4 pm.

Michael was grateful to the Wake County Crisis and Assessment Services Center for the great work they do in maintaining the mental health of the public and of the Occoneechee Council Boy Scouts of America for the experience and education they provide for growing young men. In Memory of Michael please contribute or volunteer with one of the above causes in some way and remember to enjoy the natural beauty around you and within you.

The address for Wake County Crisis and Assessment Services Center is 3000 Falstaff Rd, Raleigh 27610 and the Occoneechee Council Boy Scouts of America can be reached at (919) 872-4884.

Arrangements made by the Cremation Society of the Carolinas

There is an increased suicide risk among individuals who abuse substances.

(About 20 times the rate for the general population.)

Substance Abuse and Suicidality

- Among completed suicides in persons under age 30, the majority had a principal diagnosis of substance abuse
- Substance use can “mask” serious symptoms of other mental illness and may be used to self-medicate
- Withdrawal from alcohol and benzodiazepenes may be deadly
- More than 90% of suicidal, intoxicated individuals are no longer suicidal upon reaching sobriety

Suicide Warning Signs

- A change in habits (sleeping, eating, studying, activity level, sexual activity, job)
- Giving away prized possessions
- Increase in drug or alcohol abuse
- Depression
- Talking about suicide or threats to commit suicide (implied or explicit)
- Cutting off friendships- isolation

More warning signs

- Reckless/thrill-seeking behavior
- Expressing helplessness or an “I don’t care” attitude
- Feeling life is less meaningful, hopeless
- Preoccupation with death
- Making arrangements, setting one's affairs in order
- Command hallucinations

As many as one in eight teens and one in 33 children have clinical depression.

Suicide is the second leading cause of death among adolescents.

Risk Factors for Adolescents

- Include all factors present for adults
- Additional factors include:
  - Puberty: heightened emotional intensity
  - Immature brain (develops until age 25)
    - Inability to see beyond the moment = decreased control of impulsive behaviors
    - "I'm going to live forever" thinking increases risk-taking behavior.
  - Public humiliation or denigration by peers.

?

Depression in elders accounts for a majority of suicidal ideation, inpatient admissions, medical outpatient visits, emergency room use, and medical co-morbidity.

Risk factors for Seniors

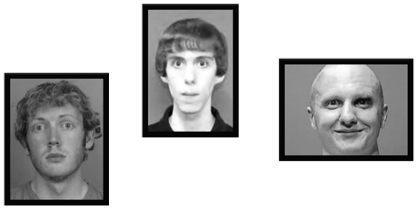
- Elderly persons have a higher risk for suicide than any other population
- 1/3 of elderly persons report loneliness as the principal reason for considering suicide
- 10% of elderly with suicidal ideation report financial problems, poor medical health, or depression as reasons for suicidal thoughts
- Most elderly persons who commit suicide communicate their suicidal thoughts to family or friends prior to the act of suicide

?

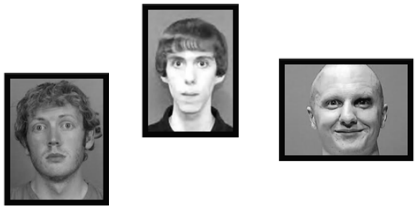
Risk Reduction Factors

- Pregnancy
- Responsible for children under 18 years old
- Sense of responsibility to family
- Catholicism or Judaism is religion of choice
- Employed
- Full-time student
- Living with another person, especially a

DANGER TO OTHERS



DANGER TO OTHERS



Risk factors and Violence

- Degree of desperation and/or despair
- Recent losses: perceived or real
- Active psychosis, especially paranoid delusions
- Degree of organization of the plan
- Young age (< 30)
- Anger
- Impulsivity
- Traumatic Brain Injury
- Active intoxication
- Concern by significant others (petitioner) that the person will follow through on the threat

Danger and Mental Illness

- Dangerousness is typically a temporary state along a continuum from low to high risk
- The best predictor of future behavior is past behavior:

A history of violence is the #1 risk factor

Violence and Mental Illness

- "Research has shown that the vast majority of people who are violent do not suffer from mental illnesses (American Psychiatric Association, 1994)."
- ". . . the absolute risk of violence among the mentally ill as a group is still very small and . . . only a small proportion of the violence in our society can be attributed to persons who are mentally ill (Mulvey, 1994)."
- People with psychiatric disabilities are far more likely to be victims than perpetrators of violent crime (Appleby, et al., 2001). Researchers at North Carolina State University and Duke University found that people with severe mental illnesses, schizophrenia, bipolar disorder or psychosis, are 2 ½ times more likely to be attacked, raped or mugged than the general population (Hiday, et al., 1999).

Danger to others

What are the Good Questions

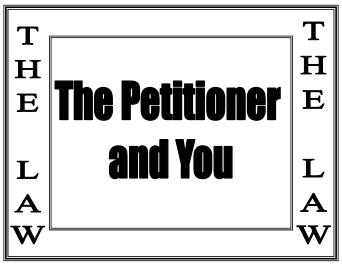
BREAK

TOP 10 QUESTIONS A MAGISTRATE SHOULD ASK A PETITIONER IN THE IVC PROCESS

1. Is he on medications and taking them?
2. Has she been in mental health treatment in the past?
3. What kind of recent stressors has he had? (job loss, relationship changes, bereavement, etc.)
4. What changes in behavior have you noticed? (sleep, appetite, schedule changes, etc.)
5. Has he ever attempted to hurt himself in the past?
6. Has she ever attempted to hurt anyone else in the past?
7. Does he have the means to harm himself or others?
8. Is she hearing voices or seeing things that no one else hears or sees?
9. How much is he drinking or using other drugs?
10. What's different today?

Table reports

A Framework for Successful Interviewing



Understanding the petitioner

Crisis responses and the role of stigma

Crisis Provokes a Set of Responses

- Heightened emotions
  - Overwhelmed, helpless, abandoned, anxious
- Physiological arousal
  - Increased heart rate and blood pressure
  - Classic “fight or flight” response
- Cognitive
  - Impaired problem solving ability, diminished ability to use normal coping mechanisms

Crisis as Opportunity

危險 + 機會 =

(dangerous) *(opportunity)*

危機

(crisis)

cri·sis (krss)

1. A crucial or decisive point or situation; a turning point.
2. A sudden change in the course of a disease or fever, toward either improvement or deterioration.
3. An emotionally stressful event or traumatic change in a person's life.
4. An unstable condition, as in political, social, or economic affairs, involving an impending abrupt or decisive change.
5. A point in a story or drama when a conflict reaches its highest tension and must be resolved.

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4. An unstable condition, as in political, social, or economic affairs, involving an impending abrupt or decisive change.
5. A point in a story or drama when a conflict reaches its highest tension and must be resolved.

crisis intervention

Brief therapeutic approach which is ameliorative rather than curative of acute psychiatric emergencies.

Used in contexts such as emergency rooms of psychiatric or general hospitals, or in the home or place of crisis occurrence, this treatment approach focuses on interpersonal and intra-psychic factors and environmental modification.

Source: On-line Medical Dictionary, © 1997-98 Academic Medical Publishing & CancerWEB

Crisis as Opportunity
- from crisis to growth -

- Motivation for change/resolution is high
- Defenses are down, emotions are more accessible, and poor coping mechanisms are notable
- Individuals are pushed toward learning how to ask for and receive help
- Receptivity to learning and trying new positive coping mechanisms is high
- Individuals are empowered to try new skills in the next crisis

The Role of Stigma

Stigma:

- Labeling someone with a condition
- Stereotyping people with that condition
- Creating a division — a superior "us" group and a devalued "them" group, resulting in loss of status in the community
- Discriminating against someone on the basis of their label

Depression job interview

Blackboard exercise

The Role of Stigma in the Petition Process

Mental Illnesses and Addictive Disorders are Family Illnesses

- Guilt, Embarrassment, and Shame
- Losses and Sacrifices
- Denial and Enabling

"He's here every other week!"

Bogus petitions, frequent flyers, and kids who should have their you-know-whats tanned

Every visit is a NEW event

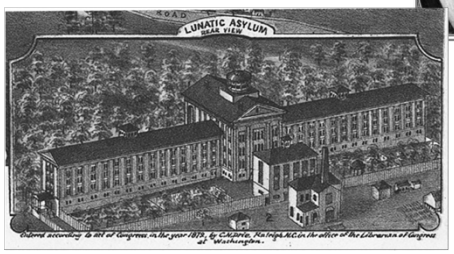
- Never say "Never", never say "Always"
- Use history to inform the current decision, not to make the current decision
- Look for what's different this time
- Listen for the facts

"Even if she gets committed the hospital won't keep her long enough to do any good."

Assisting people in crisis

through a system in crisis

The Original MH Reform



150+ years later……

The Los Angeles County Jail holds more psychiatric consumers at any given time than any other institution in the country.

Assisting people in crisis through a system in crisis

- The system's failures are not your failures.
  - There can be value in repeated petitions
    - The consumer is put in front of a clinician who can work to engage him—involuntarily or voluntarily
    - You and the clinician get another opportunity to educate the petitioner
- Provide a list of alternative resources to the petitioner.
  - Mobile Crisis Team
  - Walk-in Crisis Centers
  - Access Center number for your Local Management Entity/ Managed Care Organization (LME-MCO)

Benefits of effective crisis intervention work

- For the petitioner:
  - S/he leaves calmer than s/he arrived
  - Taken an effective step toward helping the family/friend/neighbor respondent
  - Probably willing to help more or again
- For the magistrate:
  - Gather the information you need to make good decisions
  - Satisfaction of knowing you've done what you can within the authority you have to positively impact a life

Effective crisis intervention

Answering machine

BREAK

□ or□i□□ □it□ □eo□le i□ □ri□i□

aka Th e □etitio□er□

HOW TO INTERVIEW A PETITIONER

Communication skills demo

Setting a tone, modeling behavior for the conversation

- Use the person's name and introduce yourself.
- Be polite in requests and statements.
- Be respectful and genuine in manner.
- Talk calmly in moderated voice.
- Reduce noise and distractions if possible.

Active listening

- Focus on the speaker
  - Maintain good eye contact
  - Use open, non-threatening posture
- Listen for key points
  - Do not jump to conclusions
  - Encourage continued speaking

Asking good questions

- Ask open-ended questions for clarification
  - Avoid yes/no answer questions
  - "Tell me more…." "Help me to understand."
- Avoid "Why?" questions
  - Feels like interrogation
  - Elicits "because" non-answers and/or defensiveness

Using empathy to engage & de-escalate

- Use "I" statements
  - "I'd like to help…"
  - "I want you to……"
- Validate feelings and concerns
  - "I understand you're nervous…."
  - "Sounds like it's been a hard day…"

Directing and re-directing until you have the required information

- Use simple & direct instructions
- Repeat and rephrase as needed
- Allow for delayed response time
- Clarify and summarize
- Restate the message, usually with fewer words
- Request verification of your understanding
- Put key ideas and feelings into broad statements
- DO NOT add new ideas

Monitoring your own response

Try not to:

- Take anything personally
- Make promises you can't keep
- Get into power struggles
- Act angry, frustrated, or impatient
- Laugh inappropriately

Wrapping up the process

- Explain next steps to the petitioner
- How long until the LEO arrives
- Use of cuffs
- Where to go next
- What to take to the evaluating clinician
- What happens if the petition is terminated

Working with "special populations"

Working with MD petitioners

- Check your assumptions
  - ED MD's ≠ Psychiatrists
  - The MD relies on other clinicians for the information.
- Try to speak their language
  - Ask for the "History of present illness (HPI)"
  - Facts = signs and symptoms
    - Or "as evidenced by…"
  - Conclusions = diagnoses

Working with MD petitioners

- Work the systems
  - Develop relationships with ED officials
  - Develop relationships with LME-MCO officials
- Be assertive and persistent
  - Know your authority

Demo Role Play

Role Play Observations

Active Listening Skills

- Used a calm tone of voice
- Maintained good eye contact
- Maintained a relaxed posture
- Introduced self to the petitioner
- Quieted the environment
- Restated/Clarified petitioner's concerns
- Used "I" statements
- Avoided "Why" questions
- Used simple instructions

Fact Finding Skills

- Assessed for Mental Illness
- Assessed for Substance Abuse
- Assessed for Dangerousness and Need for Treatment in the following areas…
  - Ability to care for self
  - Suicidality
  - Self mutilation
  - Attempted/threatened harm to others
  - Extreme destruction to property

Role Play Observations, II

Follow Through Skills

Provided:

- clear information about what happens next and the petitioner's role in the process
- helpful information about the next 24 hours
- contact information and directions to the site of the first examination
- information about other available resources for the respondent and the petitioner.

Video clips

- http://www.youtube.com/watch?v=_TUCjBWV7IA
- http://www.youtube.com/watch?v=ILa9ynqYfEs&feature=related
- http://www.youtube.com/watch?v=Dkhy6FUVV04
- http://www.youtube.com/watch?feature=endscreen&v=W1RY_72O_LQ&NR=1

Contact Info

Crystal.Farrow@dhhs.nc.gov

919-715-1294

Role-Play Observation Sheet

For your use during Interviewing Exercise

Active Listening / De-escalation Skills

	Good	Needs Improvement
Used a calm tone of voice	_____	_____
Maintained good eye contact	_____	_____
Introduced self to the petitioner	_____	_____
Quieted the environment	_____	_____
Restated / clarified petitioner's concerns	_____	_____
Used "I" statements	_____	_____
Avoided "Why?" questions	_____	_____
Used simple instructions	_____	_____

Fact-Finding Skills

	Good	Needs Improvement
Assess for Mental Illness	_____	_____
Assessed for Substance Abuse	_____	_____
Assessed for dangerousness and need for treatment in the following areas:		
o Ability to care of self	_____	_____
o Suicidality	_____	_____
o Self-mutilation	_____	_____
o Attempted / threatened harm to others	_____	_____
o Extreme destruction of property	_____	_____

Follow Through Skills

	Good	Needs Improvement
Provided a clear explanation about what happens next	_____	_____
Provided helpful information about how to best negotiate the next 24 hours	_____	_____
Gave the petitioner contact information for the professional conducting the first assessment	_____	_____
Gave the petitioner directions to the location where the assessment will be performed	_____	_____
Provided useful information to the petitioner about how to be available and helpful at the next stages of the commitment process	_____	_____
Provided information about available resources in the event the respondent is not committed.	_____	_____

About *Hearing Voices*

Hearing Voices That Are Distressing is a complete training/curriculum package in which participants use headphones for listening to a specially designed recording. During this simulated experience of hearing voices, participants undertake a series of tasks including social interaction in the community, a psychiatric interview, cognitive testing, and an activities group in a mock day treatment program. The simulation experience is followed by a debriefing and discussion period.

> "...The first graduate students who experienced *Hearing Voices* said it changed their lives. We now require it for all our graduate students in sites across the country."
> ~ *Paul J. Carling, Ph.D. Executive Director The Center for Community Change, Trinity College, Vermont*

> "The voices simulation gave me a good overview of what people who do hear voices go through on a day to day basis."
> "...Incredible experience which gave a great insight."
> "Every Officer should have this experience so they can understand what people who hear voices are going through."
> ~ *Law Enforcement Officers from Utah CIT Academies*

This curriculum [was] developed and piloted for a wide range of mental health professionals including: Inpatient/outpatient psychiatric nurses, psychiatrists, social workers; psychologists; direct care workers in residential, day treatment and psychosocial rehabilitation programs; mental health administrators, policy makers; and police officers, academic faculty and students.

> "...I recently participated in the *Hearing Voices* training. I must confess, I was disturbed by the sudden realization that I have been treating schizophrenia for four years, yet I have never known what it really was. I may have had the knowledge, but not the wisdom or true empathy - until now."
> ~ *Jim Willow, M.D. Psychiatric Resident, PsycHealth Centre, Winnipeg, Manitoba*

Patricia E. Deegan, Ph.D., holds a doctorate in clinical psychology and developed this curriculum as part of her work with the National Empowerment Center. She also publishes and lectures internationally on the topics of recovery and empowerment. Dr. Deegan was diagnosed with schizophrenia when she was 16, and so has herself experienced hearing voices that are distressing.
Taken from www.power2u.org

You can visit Dr. Deegan's website by going to www.patdeegan.com.

You can listen to a sample of the recording by going to **http://tinyurl.com/5rbfodb**

Tab 3:

Day 3

AGENDA FOR DAY 3

What's on for this morning:

1. Check-In
2. Movie: A Revolving Door
3. Listening to the Voices of Family Members
4. Getting to Know Your LME
5. Instructors Respond to Your Questions and Discuss Emerging Issues

CHECKING IN

One of the most important things students do in the course of a seminar is reflect upon new information and how it applies to their particular situation. Taking time to process new information is likely to generate both new ideas and new questions. Take a couple of minutes to jot down one or two ideas or questions concerning yesterday's material.

_____

_____

_____

_____

About *The Revolving Door*

Review by Catherine Sailant
Staff Writer, *Los Angeles Times*

Even if a short film about Tommy Lennon's life is nominated for an Academy Award on Tuesday, its 35-year-old subject won't be attending the awards show next month. Mentally ill and addicted to drugs, Lennon is in a Santa Barbara jail waiting to learn if his next stop is a courtroom or a prison psychiatric ward. Lennon has cycled in and out of jails for a decade, and his most recent arrest was on a petty theft charge. As detailed in "A Revolving Door," a short documentary about him, when he's not incarcerated, he is shuffled from low-rent motels to the streets to mental institutions and back again.

"It's a road to hell," Debbie Lennon said of watching helplessly as inner demons consumed her son's life starting at age 17. "It's not easy for the person afflicted with it, and it's not easy for the people who love him."

Filmmakers Marilyn and Chuck Braverman of Santa Monica spent three years chronicling Lennon's chaotic life to illustrate how society deals with the mentally ill. Marilyn Braverman knew the Lennons and has a son who is the same age as Tommy, Chuck Braverman said.

Lennon suffers from manic depression, a severe mental disorder marked by cycles of frantic activity and grinding depression. He uses drugs, usually amphetamines, because, he says, they make him "feel great." The Ventura man has been arrested numerous times, usually for being under the influence or violating probation, his mother said. While in prison, he often refuses to take his medication, resulting in ever more erratic behavior, she said.
Debbie Lennon said she has become a "squeaky wheel," badgering police, attorneys and jail officials in an effort to help her son get the medicines he needs. "I'm resourceful," she said. "But what about the thousands of others who are trying to do the same thing?"

Mental illness in California's jail population is widespread, according to Stephen Mayberg, director of the state Department of Mental Health. He estimates that up to 30% of those incarcerated are dealing with some type of mental health issue. California has attempted to address the problem by making community-based mental health services available to the poor in each county, Mayberg said. In the past, there has not been enough money to meet the need, he said. Now the state is distributing an additional $1.5 billion to expand mental health services, Mayberg said. . . .

One program, tested in Los Angeles County, attempts to keep mentally ill offenders out of jail by getting them counseling, medications and hospital care at the first sign that they are spiraling out of control, he said. The pilot program reduced jail days by 70%, he said. "What we know is treatment does work," Mayberg said. "But it's got to be coordinated and available around the clock, not just from 9 to 5."

The 39-minute documentary uses a low-key cinema verite style to depict Lennon's reality. In one showdown, his parents and a brother struggle to persuade Lennon to enter a Ventura psychiatric facility. He resists so violently that the family eventually calls police to help, and he is taken away in handcuffs. The film also shows good days, when Lennon has taken his medications faithfully and stayed away from amphetamines.

Chuck Braverman said he hopes the movie will help the public see how difficult it is to deal with chronic mental illness. . . . Making the film caused Braverman to question the wisdom of locking up mentally ill people for petty crimes instead of sending them for treatment. Lennon's arrests over the years have typically been for being under the influence or possessing drugs, he said. "I hope this film wakes some people up," he said. "If this was your son or daughter, would you want them to be treated like this? We can do better than this."

At a court hearing earlier this month, a Santa Barbara judge agreed to a psychiatric evaluation of Lennon to determine if he should stand trial or be sent to Patton State Hospital for treatment until he is competent. Santa Barbara prosecutor Josh Webb said Lennon is well known around the courts, having been arrested in the past. Although he is sympathetic with Lennon's family, he said he has little choice but to prosecute when a law has been violated. "Undoubtedly, you try to treat them with medication," he said. "It's a case of 'you're damned if you do and you're damned if you don't.' "

Taken from www.newday.com/**reviews**.lasso?filmid=FpSkMMH0f

For more information about the film, and to watch the trailer, visit www.arevolvingdoor.com.

Notes on your thoughts about *A Revolving Door:*

_____

_____

_____

_____

_____

_____

_____

_____

Son's surfing accident leads family into advocacy

Alicia Doyle
Nov 9, 2010

Debbie and Tom Lennon of Ventura, the parents of a man named Tommy who suffered a traumatic brain injury that went undiagnosed for 20 years after a surfing accident at age 16, will participate in a community forum in Newbury Park on Nov. 19.

Hosted by Conejo Valley Unitarian Universalist Fellowship in conjunction with the National Alliance on Mental Illness, the event will feature a screening of "A Revolving Door," an award-winning documentary directed by Marilyn and Chuck Braverman that highlights the Lennon family's struggles.

The documentary shows how Tommy Lennon grappled with the dual diagnosis of mental illness and addiction.

As he went through homelessness, drug abuse and stints in jail and mental institutions, his family remained strong and continued to support and advocate for him.

Debbie and Tom Lennon also opened The Lennon Closet in Ojai, a consignment store that donates 1 percent of sales to traumatic brain injury charities.

Debbie Lennon said her son filmed parts of "A Revolving Door" himself. The documentary was shortlisted for an Academy Award in 2007, and aired on HBO as part of the network's drug addiction series. "The Oprah Winfrey Show" featured clips of the film to advertise an episode of the program associated with HBO.

"Oprah's people asked our family to be on (her show) three different times," Debbie Lennon said, including episodes devoted to bipolar disorder, drug addiction and mental illness. "However, we declined," she said. "We asked about a traumatic brain injury show; they said they would invite us to do that kind of show when the timing was right."

After Tommy's accident, which led to a fractured skull when his surfboard rammed into his forehead, "his personality changed immediately," Debbie Lennon said. "He went from being a good student on the football team in a private school to where we couldn't keep him in school. His life just fell apart."

Some people believe that mental illnesses are just expressions of bad behavior or caused by poor parenting. The truth is that these brain disorders are real brain illnesses, just like heart disease or diabetes, said Ratan Bhavnani, executive director of the National Alliance on Mental Illness in Ventura County.

Bhavnani was invited to join the event at Conejo Valley Unitarian Universalist Fellowship after a congregation member saw the documentary during a general meeting of the National Alliance on Mental Illness. The nonprofit provides support for all serious mental illnesses, including schizophrenia, bipolar disorder, major depression, panic disorder, borderline personality disorder, severe anxiety disorder and obsessive compulsive disorder.

At the community forum, "we hope to erase the stigma that is sometimes associated with mental illness, to encourage more people to seek treatment, and to dispel the myths and fears surrounding mental illness," Bhavnani said. "The good news is that mental illnesses are treatable, recovery is possible and there is hope for those affected."

In Tommy's case, "he is on a perfect cocktail of medication that deals with the manic depressive symptoms and schizophrenia and delusion," his mother said.

Now 39, Tommy lives at an assisted living facility in Camarillo and can come and go as he pleases, with a curfew of midnight. Sometimes he stays overnight with family.

"He's doing great," his mom said. "And yes, he still surfs."

Local Contacts: Local Management Entities by County

Local Management Entities (LMEs) are where you go to find information on receiving mental health, developmental disability or substance abuse services in your county. LMEs will also help you with complaints about your services. They are available 24 hours a day. In order to find your LME, they are listed below by county.

Alamance

Cardinal Innovations Healthcare Solutions
Corporate Office
4855 Milestone Avenue
Kannapolis, NC 28081
Phone: 704-939-7700
Fax: 704-939-7907
24-hour Access / Crisis Number: 800-939-5911
Area Director: Pam Shipman

Alamance Caswell Community Operations Center
2451 South Church Street
Burlington, NC 27215
Phone: 336-513-4222
Fax: 336-513-4225
24-hour Access / Crisis Number: 888-543-1444

Five County Community Operations Center
134 South Garnett Street
Henderson, NC 27536
Phone: 252-430-1330
Fax: 252-431-3463
24-hour Access / Crisis Number: 877-619-3761

Mecklenburg County Community Operations Center
10150 Mallard Creek Rd. Suite 305
Charlotte, NC 28269
Phone: 980-938-4100
Fax: 980-938-4195
24-hour Access / Crisis Number: 800-939-5911

OPC Community Operations Center
201 Sage Rd. Suite 300
Chapel Hill, NC 27514
Phone: 919-913-4000
Fax: 919-913-4001
24-hour Access / Crisis Number: 800-939-5911

Piedmont Community Operations Center
245 LePhillip Court
Concord, NC 28025
Phone: 704-721-7000
Fax: 704-721-7010
24-hour Access / Crisis Number: 800-939-5911

Alexander

Smoky Mountain Center
44 Bonnie Lane
Sylva, NC 28779
Phone: 828-586-5501
Fax: 828-586-3965
24-hour Access / Crisis Number: 800-849-6127
Area Director: Brian Ingraham

Alleghany

Smoky Mountain Center
44 Bonnie Lane
Sylva, NC 28779
Phone: 828-586-5501
Fax: 828-586-3965
24-hour Access / Crisis Number: 800-849-6127
Area Director: Brian Ingraham

Anson

Sandhills Center for MH/DD/SAS
PO Box 9
West End, NC 27376-0009
Phone: 910-673-9111
Fax: 910-673-6202
24-hour Access / Crisis Number: 800-256-2452
Chief Executive Officer: Victoria Whitt

Ashe

Smoky Mountain Center
44 Bonnie Lane
Sylva, NC 28779
Phone: 828-586-5501
Fax: 828-586-3965
24-hour Access / Crisis Number: 800-849-6127
Area Director: Brian Ingraham

Avery

Smoky Mountain Center
44 Bonnie Lane
Sylva, NC 28779
Phone: 828-586-5501
Fax: 828-586-3965
24-hour Access / Crisis Number: 800-849-6127
Area Director: Brian Ingraham

Beaufort

East Carolina Behavioral Health
1708 E. Arlington Blvd.
Greenville, NC 27858
Phone: 252-695-6400
Fax: 252-215-6881
24-hour Access / Crisis Number: 877-685-2415
CEO: Leza Wainwright

Bertie

East Carolina Behavioral Health
1708 E. Arlington Blvd.
Greenville, NC 27858
Phone: 252-695-6400
Fax: 252-215-6881
24-hour Access / Crisis Number: 877-685-2415
CEO: Leza Wainwright

Bladen

Eastpointe Corporate Office
514 East Main Street
PO Box 369
Beulaville, NC 28518
Phone: 800-913-6109
Fax: 910-298-7180
Web: www.eastpointe.net
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112
Area Director: Ken Jones

Goldsboro Regional Office
100 S. James St.
Goldsboro, NC 27530
Phone: 800-913-6109
Fax: 910-298-7180
24-hour Access/ Crisis Number: 800-913-6109
TTY: 888-819-5112

Rocky Mount Regional Office
500 Nash Medical Arts Mall
Rocky Mount, NC 27804
Phone: 800-913-6109
Fax: 910-298-7180
24-hour Access/ Crisis Number: 888-893-8640
TTY: 888-819-5112

Lumberton Regional Office
450 Country Club Road
Lumberton, N. C. 28360
Phone: 800-913-6109
Fax: 910-298-7180
24-hour Access / Crisis Number: 800-670-6871
TTY: 888-819-5112

Brunswick

CoastalCare Corporate Office:
Website
3809 Shipyard Blvd
Wilmington, NC 28403
or
PO Box 4147
Wilmington, NC 28406
Phone: 910-550-2600
Fax: 910-796-3133
24-hour Access / Crisis Number: 866-875-1757
Customer Services: 855-250-1539
LME Area Director: Foster Norman

Buncombe

Smoky Mountain Center
44 Bonnie Lane
Sylva, NC 28779
Phone: 828-586-5501
Fax: 828-586-3965
24-hour Access / Crisis Number: 800-849-6127
Area Director: Brian Ingraham

Burke

Partners Behavioral Health Management Corporate Office
901 South New Hope Road
Gastonia, NC 28054
Phone: 704-884-2501
Fax: 704-854-4809
24-hour Access / Crisis Number: 1-888-235-4673
Administrative Number: 1-877-864-1454
Web
Area Director: W. Rhett Melton

Hickory Regional Office Site:
1985 Tate Blvd. SE Suite 529
Hickory, NC 28602
Phone: 828-327-2595
Fax: 828-325-9826
24-hour Access / Crisis Number: 1-888-235-4673

Elkin Regional Office Site
200 Elkin Business Park Drive
Elkin, NC 28621
Phone: 336-835-1000
Fax: 336-835-1002
24-hour Access / Crisis Number 888-235-4673

Cabarrus

Cardinal Innovations Healthcare Solutions
Corporate Office
4855 Milestone Avenue
Kannapolis, NC 28081
Phone: 704-939-7700
Fax: 704-939-7907
24-hour Access / Crisis Number: 800-939-5911
Area Director: Pam Shipman

Alamance Caswell Community Operations Center
2451 South Church Street
Burlington, NC 27215
Phone: 336-513-4222
Fax: 336-513-4225
24-hour Access / Crisis Number: 888-543-1444

Five County Community Operations Center
134 South Garnett Street
Henderson, NC 27536
Phone: 252-430-1330
Fax: 252-431-3463
24-hour Access / Crisis Number: 877-619-3761

Mecklenburg County Community Operations Center
10150 Mallard Creek Rd. Suite 305
Charlotte, NC 28269
Phone: 980-938-4100
Fax: 980-938-4195
24-hour Access / Crisis Number: 800-939-5911

OPC Community Operations Center
201 Sage Rd. Suite 300
Chapel Hill, NC 27514
Phone: 919-913-4000
Fax: 919-913-4001
24-hour Access / Crisis Number: 800-233-6834

Piedmont Community Operations Center
245 LePhillip Court
Concord, NC 28025
Phone: 704-721-7000
Fax: 704-721-7010
24-hour Access / Crisis Number: 800-939-5911

Caldwell

Smoky Mountain Center
44 Bonnie Lane
Sylva, NC 28779
Phone: 828-586-5501
Fax: 828-586-3965
24-hour Access / Crisis Number: 800-849-6127
Area Director: Brian Ingraham

Camden

East Carolina Behavioral Health
1708 E. Arlington Blvd.
Greenville, NC 27858
Phone: 252-695-6400
Fax: 252-215-6881
24-hour Access / Crisis Number: 877-685-2415
CEO: Leza Wainwright

Carteret

CoastalCare Corporate Office:
Website
3809 Shipyard Blvd
Wilmington, NC 28403
or
PO Box 4147
Wilmington, NC 28406
Phone: 910-550-2600

Fax: 910-796-3133
24-hour Access / Crisis Number: 866-875-1757
Customer Services: 855-250-1539
LME Area Director: Foster Norman

Caswell

Cardinal Innovations Healthcare Solutions

Corporate Office
4855 Milestone Avenue
Kannapolis, NC 28081
Phone: 704-939-7700
Fax: 704-939-7907
24-hour Access / Crisis Number: 800-939-5911
Area Director: Pam Shipman

Alamance Caswell Community Operations Center
2451 South Church Street
Burlington, NC 27215
Phone: 336-513-4222
Fax: 336-513-4225
24-hour Access / Crisis Number: 888-543-1444

Five County Community Operations Center
134 South Garnett Street
Henderson, NC 27536
Phone: 252-430-1330
Fax: 252-431-3463
24-hour Access / Crisis Number: 877-619-3761

Mecklenburg County Community Operations Center
10150 Mallard Creek Rd. Suite 305
Charlotte, NC 28269
Phone: 980-938-4100
Fax: 980-938-4195
24-hour Access / Crisis Number: 800-939-5911

OPC Community Operations Center
201 Sage Rd. Suite 300
Chapel Hill, NC 27514
Phone: 919-913-4000
Fax: 919-913-4001
24-hour Access / Crisis Number: 800-233-6834

Piedmont Community Operations Center
245 LePhillip Court
Concord, NC 28025
Phone: 704-721-7000
Fax: 704-721-7010
24-hour Access / Crisis Number: 800-939-5911

Catawba

Partners Behavioral Health Management Corporate Office
901 South New Hope Road
Gastonia, NC 28054
Phone: 704-884-2501
Fax: 704-854-4809
24-hour Access / Crisis Number: 1-888-235-4673
Administrative Number: 1-877-864-1454
Web
Area Director: W. Rhett Melton

Hickory Regional Office Site:
1985 Tate Blvd. SE Suite 529
Hickory, NC 28602
Phone: 828-327-2595
Fax: 828-325-9826
24-hour Access / Crisis Number: 1-888-235-4673

Elkin Regional Office Site
200 Elkin Business Park Drive
Elkin, NC 28621
Phone: 336-835-1000
Fax: 336-835-1002
24-hour Access / Crisis Number 888-235-4673

Chatham

Cardinal Innovations Healthcare Solutions
Corporate Office
4855 Milestone Avenue
Kannapolis, NC 28081
Phone: 704-939-7700
Fax: 704-939-7907
24-hour Access / Crisis Number: 800-939-5911
Area Director: Pam Shipman

Alamance Caswell Community Operations Center
2451 South Church Street
Burlington, NC 27215
Phone: 336-513-4222
Fax: 336-513-4225
24-hour Access / Crisis Number: 888-543-1444

Five County Community Operations Center
134 South Garnett Street
Henderson, NC 27536
Phone: 252-430-1330
Fax: 252-431-3463
24-hour Access / Crisis Number: 877-619-3761

Mecklenburg County Community Operations Center
10150 Mallard Creek Rd. Suite 305
Charlotte, NC 28269
Phone: 980-938-4100
Fax: 980-938-4195
24-hour Access / Crisis Number: 800-939-5911

OPC Community Operations Center
201 Sage Rd. Suite 300
Chapel Hill, NC 27514
Phone: 919-913-4000
Fax: 919-913-4001
24-hour Access / Crisis Number: 800-939-5911

Piedmont Community Operations Center
245 LePhillip Court
Concord, NC 28025
Phone: 704-721-7000
Fax: 704-721-7010
24-hour Access / Crisis Number: 800-939-5911

Cherokee

Smoky Mountain Center
44 Bonnie Lane
Sylva, NC 28779
Phone: 828-586-5501
Fax: 828-586-3965
24-hour Access / Crisis Number: 800-849-6127
Area Director: Brian Ingraham

Chowan

East Carolina Behavioral Health
1708 E. Arlington Blvd.
Greenville, NC 27858
Phone: 252-695-6400
Fax: 252-215-6881
24-hour Access / Crisis Number: 877-685-2415
Area Director: Leza Wainwright

Clay

Smoky Mountain Center
44 Bonnie Lane
Sylva, NC 28779
Phone: 828-586-5501
Fax: 828-586-3965
24-hour Access / Crisis Number: 800-849-6127
Area Director: Brian Ingraham

Cleveland

Partners Behavioral Health Management Corporate Office
901 South New Hope Road
Gastonia, NC 28054
Phone: 704-884-2501
Fax: 704-854-4809
24-hour Access / Crisis Number: 1-888-235-4673
Administrative Number: 1-877-864-1454
Web
Area Director: W. Rhett Melton

Hickory Regional Office Site:
1985 Tate Blvd. SE Suite 529
Hickory, NC 28602
Phone: 828-327-2595
Fax: 828-325-9826
24-hour Access / Crisis Number: 1-888-235-4673

Elkin Regional Office Site
200 Elkin Business Park Drive
Elkin, NC 28621
Phone: 336-835-1000
Fax: 336-835-1002
24-hour Access / Crisis Number 888-235-4673

Columbus

Eastpointe Corporate Office
514 East Main Street
PO Box 369
Beulaville, NC 28518
Phone: 800-913-6109
Fax: 910-298-7180
Web: www.eastpointe.net
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112
Area Director: Ken Jones

Goldsboro Regional Office
100 S. James St.
Goldsboro, NC 27530
Phone: 800-913-6109
Fax: 910-298-7180
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112

Lumberton Regional Office
450 Country Club Road
Lumberton, NC 28360
Phone: 800-913-6109
Fax: 910-298-7180

24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112

Rocky Mount Regional Office
500 Nash Medical Arts Mall
Rocky Mount, NC 27804
Phone: 800-913-6109
Fax: 910-298-7180
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112

Craven

East Carolina Behavioral Health
1708 E. Arlington Blvd.
Greenville, NC 27858
Phone: 252-695-6400
Fax: 252-215-6881
24-hour Access / Crisis Number: 877-685-2415
CEO: Leza Wainwright

Cumberland

Alliance Behavioral Healthcare
Corporate Office
4600 Emperor Boulevard
Durham, NC 27703
Phone: 919-651-8401
Fax: 919-651-8672
Chief Executive Officer: Ellen S. Holliman

Cumberland Office
711 Executive Place
Fayetteville, NC 28305
Phone: 919-651-8401
Fax: 910-323-0096
24-hour Access/Crisis Number: 800-510-9132

Durham Office
414 East Main Street
Durham, NC 27701
Phone: 919-651-8401
Fax: 919-651-8859
24-hour Access/ Crisis Number: 800-510-9132

Johnston Office
521 North Brightleaf Boulevard
Smithfield, NC 27577
Phone: 919-651-8401
Fax: 919-989-5532
24-hour Access/Crisis Number: 800-510-9132

Wake Office
5000 Falls of Neuse Road
Raleigh, NC 27609
Phone: 919-651-8401
Fax: 919-651-8776
24-hour Access/ Crisis Number: 800-510-9132

Currituck

East Carolina Behavioral Health
1708 E. Arlington Blvd.
Greenville, NC 27858
Phone: 252-695-6400
Fax: 252-215-6881
24-hour Access / Crisis Number: 877-685-2415
CEO: Leza Wainwright

Dare

East Carolina Behavioral Health
1708 E. Arlington Blvd.
Greenville, NC 27858
Phone: 252-695-6400
Fax: 252-215-6881
24-hour Access / Crisis Number: 877-685-2415
CEO: Leza Wainwright

Davidson

Cardinal Innovations Healthcare Solutions
Corporate Office
4855 Milestone Avenue
Kannapolis, NC 28081
Phone: 704-939-7700
Fax: 704-939-7907
24-hour Access / Crisis Number: 800-939-5911
Area Director: Pam Shipman

Alamance Caswell Community Operations Center
2451 South Church Street
Burlington, NC 27215
Phone: 336-513-4222
Fax: 336-513-4225
24-hour Access / Crisis Number: 888-543-1444

Five County Community Operations Center
134 South Garnett Street
Henderson, NC 27536
Phone: 252-430-1330
Fax: 252-431-3463
24-hour Access / Crisis Number: 877-619-3761

Mecklenburg County Community Operations Center
10150 Mallard Creek Rd. Suite 305
Charlotte, NC 28269
Phone: 980-938-4100
Fax: 980-938-4195
24-hour Access / Crisis Number: 800-939-5911

OPC Community Operations Center
201 Sage Rd. Suite 300
Chapel Hill, NC 27514
Phone: 919-913-4000
Fax: 919-913-4001
24-hour Access / Crisis Number: 800-939-5911

Piedmont Community Operations Center
245 LePhillip Court
Concord, NC 28025
Phone: 704-721-7000
Fax: 704-721-7010
24-hour Access / Crisis Number: 800-939-5911

Davie

CenterPoint Human Services
4045 University Parkway
Winston-Salem, NC 27106
Phone: 336-714-9100
Fax: 336-714-9111
24-hour Access/ Crisis Number:
888-581-9988
CEO/Area Director: Betty Taylor

Duplin

Eastpointe Corporate Office
514 East Main Street
PO Box 369
Beulaville, NC 28518
Phone: 800-913-6109
Fax: 910-298-7180
Web: www.eastpointe.net
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112
Area Director: Ken Jones

Goldsboro Regional Office
100 S. James St.
Goldsboro, NC 27530
Phone: 800-913-6109
Fax: 910-298-7180
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112

Lumberton Regional Office
450 Country Club Road
Lumberton, NC 28360
Phone: 800-913-6109
Fax: 910-298-7180
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112

Rocky Mount Regional Office
500 Nash Medical Arts Mall
Rocky Mount, NC 27804
Phone: 800-913-6109
Fax: 910-298-7180
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112

Durham

Alliance Behavioral Healthcare
Corporate Office
4600 Emperor Boulevard
Durham, NC 27703
Phone: 919-651-8401
Fax: 919-651-8672
Chief Executive Officer: Ellen S. Holliman

Cumberland Office
711 Executive Place
Fayetteville, NC 28305
Phone: 919-651-8401
Fax: 910-323-0096
24-hour Access/Crisis Number: 800-510-9132

Durham Office
414 East Main Street
Durham, NC 27701
Phone: 919-651-8401
Fax: 919-651-8859
24-hour Access/ Crisis Number: 800-510-9132

Johnston Office
521 North Brightleaf Boulevard
Smithfield, NC 27577
Phone: 919-651-8401
Fax: 919-989-5532
24-hour Access/Crisis Number: 800-510-9132

Wake Office
5000 Falls of Neuse Road
Raleigh, NC 27609
Phone: 919-651-8401
Fax: 919-651-8776
24-hour Access/ Crisis Number: 800-510-9132

Edgecombe

Eastpointe Corporate Office
514 East Main Street
PO Box 369
Beulaville, NC 28518
Phone: 800-913-6109
Fax: 910-298-7180
Web: www.eastpointe.net
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112
Area Director: Ken Jones

Goldsboro Regional Office
100 S. James St.
Goldsboro, NC 27530
Phone: 800-913-6109
Fax: 910-298-7180
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112

Lumberton Regional Office
450 Country Club Road
Lumberton, NC 28360
Phone: 800-913-6109
Fax: 910-298-7180
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112

Rocky Mount Regional Office
500 Nash Medical Arts Mall
Rocky Mount, NC 27804
Phone: 800-913-6109
Fax: 910-298-7180
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112

Forsyth

CenterPoint Human Services
4045 University Parkway
Winston-Salem, NC 27106
Phone: 336-714-9100
Fax: 336-714-9111
24-hour Access/ Crisis Number:
888-581-9988
CEO/Area Director: Betty Taylor

Franklin

Cardinal Innovations Healthcare Solutions
Corporate Office
4855 Milestone Avenue
Kannapolis, NC 28081
Phone: 704-939-7700
Fax: 704-939-7907
24-hour Access / Crisis Number: 800-939-5911
Area Director: Pam Shipman

Alamance Caswell Community Operations Center
2451 South Church Street
Burlington, NC 27215
Phone: 336-513-4222
Fax: 336-513-4225
24-hour Access / Crisis Number: 888-543-1444

Five County Community Operations Center
134 South Garnett Street
Henderson, NC 27536
Phone: 252-430-1330
Fax: 252-431-3463
24-hour Access / Crisis Number: 877-619-3761

Mecklenburg County Community Operations Center
10150 Mallard Creek Rd. Suite 305
Charlotte, NC 28269
Phone: 980-938-4100
Fax: 980-938-4195
24-hour Access / Crisis Number: 800-939-5911

OPC Community Operations Center
201 Sage Rd. Suite 300
Chapel Hill, NC 27514
Phone: 919-913-4000
Fax: 919-913-4001
24-hour Access / Crisis Number: 800-939-5911

Piedmont Community Operations Center
245 LePhillip Court
Concord, NC 28025
Phone: 704-721-7000
Fax: 704-721-7010
24-hour Access / Crisis Number: 800-939-5911

Gaston

Partners Behavioral Health Management Corporate Office
901 South New Hope Road
Gastonia, NC 28054
Phone: 704-884-2501
Fax: 704-854-4809
24-hour Access / Crisis Number: 1-888-235-4673
Administrative Number: 1-877-864-1454
Web
Area Director: W. Rhett Melton

Hickory Regional Office Site:
1985 Tate Blvd. SE Suite 529
Hickory, NC 28602
Phone: 828-327-2595
Fax: 828-325-9826
24-hour Access / Crisis Number: 1-888-235-4673

Elkin Regional Office Site
200 Elkin Business Park Drive
Elkin, NC 28621
Phone: 336-835-1000
Fax: 336-835-1002
24-hour Access / Crisis Number 888-235-4673

Gates

East Carolina Behavioral Health
1708 E. Arlington Blvd.
Greenville, NC 27858
Phone: 252-695-6400
Fax: 252-215-6881
24-hour Access / Crisis Number: 877-685-2415
CEO: Leza Wainwright

Graham

Smoky Mountain Center
44 Bonnie Lane
Sylva, NC 28779
Phone: 828-586-5501
Fax: 828-586-3965
24-hour Access / Crisis Number: 800-849-6127
Area Director: Brian Ingraham

Granville

Cardinal Innovations Healthcare Solutions
Corporate Office
4855 Milestone Avenue
Kannapolis, NC 28081
Phone: 704-939-7700
Fax: 704-939-7907
24-hour Access / Crisis Number: 800-939-5911
Area Director: Pam Shipman

Alamance Caswell Community Operations Center
2451 South Church Street
Burlington, NC 27215
Phone: 336-513-4222
Fax: 336-513-4225
24-hour Access / Crisis Number: 888-543-1444

Five County Community Operations Center
134 South Garnett Street
Henderson, NC 27536
Phone: 252-430-1330
Fax: 252-431-3463
24-hour Access / Crisis Number: 877-619-3761

Mecklenburg County Community Operations Center
10150 Mallard Creek Rd. Suite 305
Charlotte, NC 28269
Phone: 980-938-4100
Fax: 980-938-4195
24-hour Access / Crisis Number: 800-939-5911

OPC Community Operations Center
201 Sage Rd. Suite 300
Chapel Hill, NC 27514
Phone: 919-913-4000
Fax: 919-913-4001
24-hour Access / Crisis Number: 800-939-5911

Piedmont Community Operations Center
245 LePhillip Court
Concord, NC 28025
Phone: 704-721-7000
Fax: 704-721-7010
24-hour Access / Crisis Number: 800-939-5911

Greene

Eastpointe Corporate Office
514 East Main Street
PO Box 369
Beulaville, NC 28518
Phone: 800-913-6109
Fax: 910-298-7180
Web: www.eastpointe.net
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112
Area Director: Ken Jones

Goldsboro Regional Office
100 S. James St.
Goldsboro, NC 27530
Phone: 800-913-6109
Fax: 910-298-7180
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112

Lumberton Regional Office
450 Country Club Road
Lumberton, NC 28360
Phone: 800-913-6109

Fax: 910-298-7180
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112

Rocky Mount Regional Office
500 Nash Medical Arts Mall
Rocky Mount, NC 27804
Phone: 800-913-6109
Fax: 910-298-7180
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112

Guilford

Sandhills Center for MH/DD/SAS
201 N. Eugene St.
Greensboro, NC 27401
Phone: 336-389-6200
Fax: 336-389-6127
24-hour Access/ Crisis Number: 800-256-2452
Chief Executive Officer: Victoria Whitt

Halifax

Cardinal Innovations Healthcare Solutions
Corporate Office
4855 Milestone Avenue
Kannapolis, NC 28081
Phone: 704-939-7700
Fax: 704-939-7907
24-hour Access / Crisis Number: 800-939-5911
Area Director: Pam Shipman

Alamance Caswell Community Operations Center
2451 South Church Street
Burlington, NC 27215
Phone: 336-513-4222
Fax: 336-513-4225
24-hour Access / Crisis Number: 888-543-1444

Five County Community Operations Center
134 South Garnett Street
Henderson, NC 27536
Phone: 252-430-1330
Fax: 252-431-3463
24-hour Access / Crisis Number: 877-619-3761

Mecklenburg County Community Operations Center
10150 Mallard Creek Rd. Suite 305
Charlotte, NC 28269
Phone: 980-938-4100
Fax: 980-938-4195
24-hour Access / Crisis Number: 800-939-5911

OPC Community Operations Center
201 Sage Rd. Suite 300
Chapel Hill, NC 27514
Phone: 919-913-4000
Fax: 919-913-4001
24-hour Access / Crisis Number: 800-939-5911

Piedmont Community Operations Center
245 LePhillip Court
Concord, NC 28025
Phone: 704-721-7000
Fax: 704-721-7010
24-hour Access / Crisis Number: 800-939-5911

Harnett

Sandhills Center for MH/DD/SAS
PO Box 9
West End, NC 27376-0009
Phone: 910-673-9111
Fax: 910-673-6202
24-hour Access / Crisis Number: 800-256-2452
Chief Executive Officer: Victoria Whitt

Haywood

Smoky Mountain Center
44 Bonnie Lane
Sylva, NC 28779
Phone: 828-586-5501
Fax: 828-586-3965
24-hour Access / Crisis Number: 800-849-6127
Area Director: Brian Ingraham

Henderson

Smoky Mountain Center
44 Bonnie Lane
Sylva, NC 28779
Phone: 828-586-5501
Fax: 828-586-3965
24-hour Access / Crisis Number: 800-849-6127
Area Director: Brian Ingraham

Hertford

East Carolina Behavioral Health
1708 E. Arlington Blvd.
Greenville, NC 27858
Phone: 252-695-6400
Fax: 252-215-6881
24-hour Access / Crisis Number: 877-685-2415
CEO: Leza Wainwright

Hoke

Sandhills Center for MH/DD/SAS
PO Box 9
West End, NC 27376-0009
Phone: 910-673-9111
Fax: 910-673-6202
24-hour Access / Crisis Number: 800-256-2452
Chief Executive Officer: Victoria Whitt

Hyde

East Carolina Behavioral Health
1708 E. Arlington Blvd.
Greenville, NC 27858
Phone: 252-695-6400
Fax: 252-215-6881
24-hour Access / Crisis Number: 877-685-2415
CEO: Leza Wainwright

Iredell

Partners Behavioral Health Management Corporate Office
901 South New Hope Road
Gastonia, NC 28054
Phone: 704-884-2501
Fax: 704-854-4809
24-hour Access / Crisis Number: 1-888-235-4673
Administrative Number: 1-877-864-1454
Web
Area Director: W. Rhett Melton

Hickory Regional Office Site:
1985 Tate Blvd. SE Suite 529
Hickory, NC 28602
Phone: 828-327-2595
Fax: 828-325-9826
24-hour Access / Crisis Number: 1-888-235-4673

Elkin Regional Office Site
200 Elkin Business Park Drive
Elkin, NC 28621
Phone: 336-835-1000
Fax: 336-835-1002
24-hour Access / Crisis Number 888-235-4673

Jackson

Smoky Mountain Center
44 Bonnie Lane
Sylva, NC 28779
Phone: 828-586-5501
Fax: 828-586-3965
24-hour Access / Crisis Number: 800-849-6127
Area Director: Brian Ingraham

Johnson

Alliance Behavioral Healthcare
Corporate Office
4600 Emperor Boulevard
Durham, NC 27703
Phone: 919-651-8401
Fax: 919-651-8672
Chief Executive Officer: Ellen S. Holliman

Cumberland Office
711 Executive Place
Fayetteville, NC 28305
Phone: 919-651-8401
Fax: 910-323-0096
24-hour Access/Crisis Number: 800-510-9132

Durham Office
414 East Main Street
Durham, NC 27701
Phone: 919-651-8401
Fax: 919-651-8859
24-hour Access/ Crisis Number: 800-510-9132

Johnston Office
521 North Brightleaf Boulevard
Smithfield, NC 27577
Phone: 919-651-8401
Fax: 919-989-5532
24-hour Access/Crisis Number: 800-510-9132

Wake Office
5000 Falls of Neuse Road
Raleigh, NC 27609
Phone: 919-651-8401

Fax: 919-651-8776
24-hour Access/ Crisis Number: 800-510-9132

Jones

East Carolina Behavioral Health
1708 E. Arlington Blvd.
Greenville, NC 27858
Phone: 252-695-6400
Fax: 252-215-6881
24-hour Access / Crisis Number: 877-685-2415
CEO: Leza Wainwright

Lee

Sandhills Center for MH/DD/SAS
PO Box 9
West End, NC 27376-0009
Phone: 910-673-9111
Fax: 910-673-6202
24-hour Access / Crisis Number: 800-256-2452
Chief Executive Officer: Victoria Whitt

Lenoir

Eastpointe Corporate Office
514 East Main Street
PO Box 369
Beulaville, NC 28518
Phone: 800-913-6109
Fax: 910-298-7180
Web: www.eastpointe.net
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112
Area Director: Ken Jones

Goldsboro Regional Office
100 S. James St.
Goldsboro, NC 27530
Phone: 800-913-6109
Fax: 910-298-7180
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112

Lumberton Regional Office
450 Country Club Road
Lumberton, NC 28360
Phone: 800-913-6109
Fax: 910-298-7180
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112

Rocky Mount Regional Office
500 Nash Medical Arts Mall
Rocky Mount, NC 27804
Phone: 800-913-6109
Fax: 910-298-7180
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112

Lincoln

Partners Behavioral Health Management Corporate Office
901 South New Hope Road
Gastonia, NC 28054
Phone: 704-884-2501
Fax: 704-854-4809
24-hour Access / Crisis Number: 1-888-235-4673
Administrative Number: 1-877-864-1454
Web
Area Director: W. Rhett Melton

Hickory Regional Office Site:
1985 Tate Blvd. SE Suite 529
Hickory, NC 28602
Phone: 828-327-2595
Fax: 828-325-9826
24-hour Access / Crisis Number: 1-888-235-4673

Elkin Regional Office Site
200 Elkin Business Park Drive
Elkin, NC 28621
Phone: 336-835-1000
Fax: 336-835-1002
24-hour Access / Crisis Number 888-235-4673

Macon

Smoky Mountain Center
44 Bonnie Lane
Sylva, NC 28779
Phone: 828-586-5501
Fax: 828-586-3965
24-hour Access / Crisis Number: 800-849-6127
Area Director: Brian Ingraham

Madison

Smoky Mountain Center
44 Bonnie Lane
Sylva, NC 28779

Phone: 828-586-5501
Fax: 828-586-3965
24-hour Access / Crisis Number: 800-849-6127
Area Director: Brian Ingraham

Martin

East Carolina Behavioral Health
1708 E. Arlington Blvd.
Greenville, NC 27858
Phone: 252-695-6400
Fax: 252-215-6881
24-hour Access / Crisis Number: 877-685-2415
CEO: Leza Wainwright

McDowell

Smoky Mountain Center
44 Bonnie Lane
Sylva, NC 28779
Phone: 828-586-5501
Fax: 828-586-3965
24-hour Access / Crisis Number: 800-849-6127
Area Director: Brian Ingraham

Mecklenburg

Cardinal Innovations Healthcare Solutions
Corporate Office
4855 Milestone Avenue
Kannapolis, NC 28081
Phone: 704-939-7700
Fax: 704-939-7907
24-hour Access / Crisis Number: 800-939-5911
Area Director: Pam Shipman

Alamance Caswell Community Operations Center
2451 South Church Street
Burlington, NC 27215
Phone: 336-513-4222
Fax: 336-513-4225
24-hour Access / Crisis Number: 888-543-1444

Five County Community Operations Center
134 South Garnett Street
Henderson, NC 27536
Phone: 252-430-1330
Fax: 252-431-3463
24-hour Access / Crisis Number: 877-619-3761

Mecklenburg County Community Operations Center
10150 Mallard Creek Rd. Suite 305
Charlotte, NC 28269
Phone: 980-938-4100
Fax: 980-938-4195
24-hour Access / Crisis Number: 800-939-5911

OPC Community Operations Center
201 Sage Rd. Suite 300
Chapel Hill, NC 27514
Phone: 919-913-4000
Fax: 919-913-4001
24-hour Access / Crisis Number: 800-939-5911

Piedmont Community Operations Center
245 LePhillip Court
Concord, NC 28025
Phone: 704-721-7000
Fax: 704-721-7010
24-hour Access / Crisis Number: 800-939-5911

Mitchell

Smoky Mountain Center
44 Bonnie Lane
Sylva, NC 28779
Phone: 828-586-5501
Fax: 828-586-3965
24-hour Access / Crisis Number: 800-849-6127
Area Director: Brian Ingraham

Montgomery

Sandhills Center for MH/DD/SAS
PO Box 9
West End, NC 27376-0009
Phone: 910-673-9111
Fax: 910-673-6202
24-hour Access / Crisis Number: 800-256-2452
Chief Executive Officer: Victoria Whitt

Moore

Sandhills Center for MH/DD/SAS
PO Box 9
West End, NC 27376-0009
Phone: 910-673-9111
Fax: 910-673-6202
24-hour Access / Crisis Number: 800-256-2452
Chief Executive Officer: Victoria Whitt

Nash

Eastpointe Corporate Office
514 East Main Street
PO Box 369
Beulaville, NC 28518
Phone: 800-913-6109
Fax: 910-298-7180
Web: www.eastpointe.net
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112
Area Director: Ken Jones

Goldsboro Regional Office
100 S. James St.
Goldsboro, NC 27530
Phone: 800-913-6109
Fax: 910-298-7180
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112

Lumberton Regional Office
450 Country Club Road
Lumberton, NC 28360
Phone: 800-913-6109
Fax: 910-298-7180
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112

Rocky Mount Regional Office
500 Nash Medical Arts Mall
Rocky Mount, NC 27804
Phone: 800-913-6109
Fax: 910-298-7180
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112

New Hanover

CoastalCare Corporate Office:
Website
3809 Shipyard Blvd
Wilmington, NC 28403
or
PO Box 4147
Wilmington, NC 28406
Phone: 910-550-2600
Fax: 910-796-3133
24-hour Access / Crisis Number: 866-875-1757
Customer Services: 855-250-1539
LME Area Director: Foster Norman

Northampton

East Carolina Behavioral Health
1708 E. Arlington Blvd.
Greenville, NC 27858
Phone: 252-695-6400
Fax: 252-215-6881
24-hour Access / Crisis Number: 877-685-2415
CEO: Leza Wainwright

Onslow

CoastalCare Corporate Office:
Website
3809 Shipyard Blvd
Wilmington, NC 28403
or
PO Box 4147
Wilmington, NC 28406
Phone: 910-550-2600
Fax: 910-796-3133
24-hour Access / Crisis Number: 866-875-1757
Customer Services: 855-250-1539
LME Area Director: Foster Norman

Orange

Cardinal Innovations Healthcare Solutions
Corporate Office
4855 Milestone Avenue
Kannapolis, NC 28081
Phone: 704-939-7700
Fax: 704-939-7907
24-hour Access / Crisis Number: 800-939-5911
Area Director: Pam Shipman

Alamance Caswell Community Operations Center
2451 South Church Street
Burlington, NC 27215
Phone: 336-513-4222
Fax: 336-513-4225
24-hour Access / Crisis Number: 888-543-1444

Five County Community Operations Center
134 South Garnett Street
Henderson, NC 27536
Phone: 252-430-1330
Fax: 252-431-3463
24-hour Access / Crisis Number: 877-619-3761

Mecklenburg County Community Operations Center
10150 Mallard Creek Rd. Suite 305
Charlotte, NC 28269
Phone: 980-938-4100
Fax: 980-938-4195
24-hour Access / Crisis Number: 800-939-5911

OPC Community Operations Center
201 Sage Rd. Suite 300
Chapel Hill, NC 27514
Phone: 919-913-4000
Fax: 919-913-4001
24-hour Access / Crisis Number: 800-939-5911

Piedmont Community Operations Center
245 LePhillip Court
Concord, NC 28025
Phone: 704-721-7000
Fax: 704-721-7010
24-hour Access / Crisis Number: 800-939-5911

Pamlico

East Carolina Behavioral Health
1708 E. Arlington Blvd.
Greenville, NC 27858
Phone: 252-695-6400
Fax: 252-215-6881
24-hour Access / Crisis Number: 877-685-2415
CEO: Leza Wainwright

Pasquotank

East Carolina Behavioral Health
1708 E. Arlington Blvd.
Greenville, NC 27858
Phone: 252-695-6400
Fax: 252-215-6881
24-hour Access / Crisis Number: 877-685-2415
CEO: Leza Wainwright

Pender

CoastalCare Corporate Office:
Website
3809 Shipyard Blvd
Wilmington, NC 28403
or
PO Box 4147
Wilmington, NC 28406
Phone: 910-550-2600
Fax: 910-796-3133
24-hour Access / Crisis Number: 866-875-1757
Customer Services: 855-250-1539
LME Area Director: Foster Norman

Perquimans

East Carolina Behavioral Health
1708 E. Arlington Blvd.
Greenville, NC 27858
Phone: 252-695-6400
Fax: 252-215-6881
24-hour Access / Crisis Number: 877-685-2415
CEO: Leza Wainwright

Person

Cardinal Innovations Healthcare Solutions
Corporate Office
4855 Milestone Avenue
Kannapolis, NC 28081
Phone: 704-939-7700
Fax: 704-939-7907
24-hour Access / Crisis Number: 800-939-5911
Area Director: Pam Shipman

Alamance Caswell Community Operations Center
2451 South Church Street
Burlington, NC 27215
Phone: 336-513-4222
Fax: 336-513-4225
24-hour Access / Crisis Number: 888-543-1444

Five County Community Operations Center
134 South Garnett Street
Henderson, NC 27536
Phone: 252-430-1330
Fax: 252-431-3463
24-hour Access / Crisis Number: 877-619-3761

Mecklenburg County Community Operations Center
10150 Mallard Creek Rd. Suite 305
Charlotte, NC 28269
Phone: 980-938-4100
Fax: 980-938-4195
24-hour Access / Crisis Number: 800-939-5911

OPC Community Operations Center
201 Sage Rd. Suite 300
Chapel Hill, NC 27514
Phone: 919-913-4000
Fax: 919-913-4001
24-hour Access / Crisis Number: 800-939-5911

Piedmont Community Operations Center
245 LePhillip Court
Concord, NC 28025
Phone: 704-721-7000
Fax: 704-721-7010
24-hour Access / Crisis Number: 800-939-5911

Pitt

East Carolina Behavioral Health
1708 E. Arlington Blvd.
Greenville, NC 27858
Phone: 252-695-6400
Fax: 252-215-6881
24-hour Access / Crisis Number: 877-685-2415
CEO: Leza Wainwright

Polk

Smoky Mountain Center
44 Bonnie Lane
Sylva, NC 28779
Phone: 828-586-5501
Fax: 828-586-3965
24-hour Access / Crisis Number: 800-849-6127
Area Director: Brian Ingraham

Randolph

Sandhills Center for MH/DD/SAS
PO Box 9
West End, NC 27376-0009
Phone: 910-673-9111
Fax: 910-673-6202
24-hour Access / Crisis Number: 800-256-2452
Chief Executive Officer: Victoria Whitt

Richmond

Sandhills Center for MH/DD/SAS
PO Box 9
West End, NC 27376-0009
Phone: 910-673-9111
Fax: 910-673-6202
24-hour Access / Crisis Number: 800-256-2452
Chief Executive Officer: Victoria Whitt

Robeson

Eastpointe Corporate Office
514 East Main Street
PO Box 369
Beulaville, NC 28518
Phone: 800-913-6109
Fax: 910-298-7180
Web: www.eastpointe.net
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112
Area Director: Ken Jones

Goldsboro Regional Office
100 S. James St.
Goldsboro, NC 27530
Phone: 800-913-6109
Fax: 910-298-7180
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112

Lumberton Regional Office
450 Country Club Road
Lumberton, NC 28360
Phone: 800-913-6109
Fax: 910-298-7180
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112

Rocky Mount Regional Office
500 Nash Medical Arts Mall
Rocky Mount, NC 27804
Phone: 800-913-6109
Fax: 910-298-7180
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112

Rockingham

CenterPoint Human Services
4045 University Parkway
Winston-Salem, NC 27106
Phone: 336-714-9100
Fax: 336-714-9111
24-hour Access/ Crisis Number:
888-581-9988
CEO/Area Director:Betty Taylor

Rowan

Cardinal Innovations Healthcare Solutions
Corporate Office
4855 Milestone Avenue
Kannapolis, NC 28081
Phone: 704-939-7700
Fax: 704-939-7907
24-hour Access / Crisis Number: 800-939-5911
Area Director: Pam Shipman

Alamance Caswell Community Operations Center
2451 South Church Street
Burlington, NC 27215
Phone: 336-513-4222
Fax: 336-513-4225
24-hour Access / Crisis Number: 888-543-1444

Five County Community Operations Center
134 South Garnett Street
Henderson, NC 27536
Phone: 252-430-1330
Fax: 252-431-3463
24-hour Access / Crisis Number: 877-619-3761

Mecklenburg County Community Operations Center
10150 Mallard Creek Rd. Suite 305
Charlotte, NC 28269
Phone: 980-938-4100
Fax: 980-938-4195
24-hour Access / Crisis Number: 800-939-5911

OPC Community Operations Center
201 Sage Rd. Suite 300
Chapel Hill, NC 27514
Phone: 919-913-4000
Fax: 919-913-4001
24-hour Access / Crisis Number: 800-939-5911

Piedmont Community Operations Center
245 LePhillip Court
Concord, NC 28025
Phone: 704-721-7000
Fax: 704-721-7010
24-hour Access / Crisis Number: 800-939-5911

Rutherford

Smoky Mountain Center
44 Bonnie Lane
Sylva, NC 28779
Phone: 828-586-5501
Fax: 828-586-3965
24-hour Access / Crisis Number: 800-849-6127
Area Director: Brian Ingraham

Sampson

Eastpointe Corporate Office
514 East Main Street
PO Box 369
Beulaville, NC 28518
Phone: 800-913-6109
Fax: 910-298-7180
Web: www.eastpointe.net
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112
Area Director: Ken Jones

Goldsboro Regional Office
100 S. James St.
Goldsboro, NC 27530
Phone: 800-913-6109
Fax: 910-298-7180
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112

Lumberton Regional Office
450 Country Club Road
Lumberton, NC 28360
Phone: 800-913-6109
Fax: 910-298-7180
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112

Rocky Mount Regional Office
500 Nash Medical Arts Mall
Rocky Mount, NC 27804
Phone: 800-913-6109

Fax: 910-298-7180
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112

Scotland

Eastpointe Corporate Office
514 East Main Street
PO Box 369
Beulaville, NC 28518
Phone: 800-913-6109
Fax: 910-298-7180
Web: www.eastpointe.net
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112
Area Director: Ken Jones

Goldsboro Regional Office
100 S. James St.
Goldsboro, NC 27530
Phone: 800-913-6109
Fax: 910-298-7180
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112

Lumberton Regional Office
450 Country Club Road
Lumberton, NC 28360
Phone: 800-913-6109
Fax: 910-298-7180
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112

Rocky Mount Regional Office
500 Nash Medical Arts Mall
Rocky Mount, NC 27804
Phone: 800-913-6109
Fax: 910-298-7180
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112

Stanly

Cardinal Innovations Healthcare Solutions
Corporate Office
4855 Milestone Avenue
Kannapolis, NC 28081
Phone: 704-939-7700
Fax: 704-939-7907
24-hour Access / Crisis Number: 800-939-5911
Area Director: Pam Shipman

Alamance Caswell Community Operations Center
2451 South Church Street
Burlington, NC 27215
Phone: 336-513-4222
Fax: 336-513-4225
24-hour Access / Crisis Number: 888-543-1444

Five County Community Operations Center
134 South Garnett Street
Henderson, NC 27536
Phone: 252-430-1330
Fax: 252-431-3463
24-hour Access / Crisis Number: 877-619-3761

Mecklenburg County Community Operations Center
10150 Mallard Creek Rd. Suite 305
Charlotte, NC 28269
Phone: 980-938-4100
Fax: 980-938-4195
24-hour Access / Crisis Number: 800-939-5911

OPC Community Operations Center
201 Sage Rd. Suite 300
Chapel Hill, NC 27514
Phone: 919-913-4000
Fax: 919-913-4001
24-hour Access / Crisis Number: 800-939-5911

Piedmont Community Operations Center
245 LePhillip Court
Concord, NC 28025
Phone: 704-721-7000
Fax: 704-721-7010
24-hour Access / Crisis Number: 800-939-5911

Stokes

CenterPoint Human Services
4045 University Parkway
Winston-Salem, NC 27106
Phone: 336-714-9100
Fax: 336-714-9111
24-hour Access/ Crisis Number:
888-581-9988
CEO/Area Director: Betty Taylor

Surry

Partners Behavioral Health Management Corporate Office
901 South New Hope Road
Gastonia, NC 28054
Phone: 704-884-2501
Fax: 704-854-4809
24-hour Access / Crisis Number: 1-888-235-4673
Administrative Number: 1-877-864-1454
Web
Area Director: W. Rhett Melton

Hickory Regional Office Site:
1985 Tate Blvd. SE Suite 529
Hickory, NC 28602
Phone: 828-327-2595
Fax: 828-325-9826
24-hour Access / Crisis Number: 1-888-235-4673

Elkin Regional Office Site
200 Elkin Business Park Drive
Elkin, NC 28621
Phone: 336-835-1000
Fax: 336-835-1002
24-hour Access / Crisis Number 888-235-4673

Swain

Smoky Mountain Center
44 Bonnie Lane
Sylva, NC 28779
Phone: 828-586-5501
Fax: 828-586-3965
24-hour Access / Crisis Number: 800-849-6127
Area Director: Brian Ingraham

Transylvania

Smoky Mountain Center
44 Bonnie Lane
Sylva, NC 28779
Phone: 828-586-5501
Fax: 828-586-3965
24-hour Access / Crisis Number: 800-849-6127
Area Director: Brian Ingraham

Tyrrell

East Carolina Behavioral Health
1708 E. Arlington Blvd.
Greenville, NC 27858
Phone: 252-695-6400
Fax: 252-215-6881
24-hour Access / Crisis Number: 877-685-2415
CEO: Leza Wainwright

Union

Cardinal Innovations Healthcare Solutions
Corporate Office
4855 Milestone Avenue
Kannapolis, NC 28081
Phone: 704-939-7700
Fax: 704-939-7907
24-hour Access / Crisis Number: 800-939-5911
Area Director: Pam Shipman

Alamance Caswell Community Operations Center
2451 South Church Street
Burlington, NC 27215
Phone: 336-513-4222
Fax: 336-513-4225
24-hour Access / Crisis Number: 888-543-1444

Five County Community Operations Center
134 South Garnett Street
Henderson, NC 27536
Phone: 252-430-1330
Fax: 252-431-3463
24-hour Access / Crisis Number: 877-619-3761

Mecklenburg County Community Operations Center
10150 Mallard Creek Rd. Suite 305
Charlotte, NC 28269
Phone: 980-938-4100
Fax: 980-938-4195
24-hour Access / Crisis Number: 800-939-5911

OPC Community Operations Center
201 Sage Rd. Suite 300
Chapel Hill, NC 27514
Phone: 919-913-4000
Fax: 919-913-4001
24-hour Access / Crisis Number: 800-939-5911

Piedmont Community Operations Center
245 LePhillip Court
Concord, NC 28025
Phone: 704-721-7000

Fax: 704-721-7010
24-hour Access / Crisis Number: 800-939-5911

Vance

Cardinal Innovations Healthcare Solutions
Corporate Office
4855 Milestone Avenue
Kannapolis, NC 28081
Phone: 704-939-7700
Fax: 704-939-7907
24-hour Access / Crisis Number: 800-939-5911
Area Director: Pam Shipman

Alamance Caswell Community Operations Center
2451 South Church Street
Burlington, NC 27215
Phone: 336-513-4222
Fax: 336-513-4225
24-hour Access / Crisis Number: 888-543-1444

Five County Community Operations Center
134 South Garnett Street
Henderson, NC 27536
Phone: 252-430-1330
Fax: 252-431-3463
24-hour Access / Crisis Number: 877-619-3761

Mecklenburg County Community Operations Center
10150 Mallard Creek Rd. Suite 305
Charlotte, NC 28269
Phone: 980-938-4100
Fax: 980-938-4195
24-hour Access / Crisis Number: 800-939-5911

OPC Community Operations Center
201 Sage Rd. Suite 300
Chapel Hill, NC 27514
Phone: 919-913-4000
Fax: 919-913-4001
24-hour Access / Crisis Number: 800-939-5911

Piedmont Community Operations Center
245 LePhillip Court
Concord, NC 28025
Phone: 704-721-7000
Fax: 704-721-7010
24-hour Access / Crisis Number: 800-939-5911

Wake

Alliance Behavioral Healthcare
Corporate Office
4600 Emperor Boulevard
Durham, NC 27703
Phone: 919-651-8401
Fax: 919-651-8672
Chief Executive Officer: Ellen S. Holliman

Cumberland Office
711 Executive Place
Fayetteville, NC 28305
Phone: 919-651-8401
Fax: 910-323-0096
24-hour Access/Crisis Number: 800-510-9132

Durham Office
414 East Main Street
Durham, NC 27701
Phone: 919-651-8401
Fax: 919-651-8859
24-hour Access/ Crisis Number: 800-510-9132

Johnston Office
521 North Brightleaf Boulevard
Smithfield, NC 27577
Phone: 919-651-8401
Fax: 919-989-5532
24-hour Access/Crisis Number: 800-510-9132

Wake Office
5000 Falls of Neuse Road
Raleigh, NC 27609
Phone: 919-651-8401
Fax: 919-651-8776
24-hour Access/ Crisis Number: 800-510-9132

Warren

Cardinal Innovations Healthcare Solutions
Corporate Office
4855 Milestone Avenue
Kannapolis, NC 28081
Phone: 704-939-7700
Fax: 704-939-7907
24-hour Access / Crisis Number: 800-939-5911
Area Director: Pam Shipman

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Piedmont Community Operations Center
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Concord, NC 28025
Phone: 704-721-7000
Fax: 704-721-7010
24-hour Access / Crisis Number: 800-939-5911

Washington

East Carolina Behavioral Health
1708 E. Arlington Blvd.
Greenville, NC 27858
Phone: 252-695-6400
Fax: 252-215-6881
24-hour Access / Crisis Number: 877-685-2415
CEO: Leza Wainwright

Watauga

Smoky Mountain Center
44 Bonnie Lane
Sylva, NC 28779
Phone: 828-586-5501
Fax: 828-586-3965
24-hour Access / Crisis Number: 800-849-6127
Area Director: Brian Ingraham

Wayne

Eastpointe Corporate Office
514 East Main Street
PO Box 369
Beulaville, NC 28518
Phone: 800-913-6109
Fax: 910-298-7180
Web: www.eastpointe.net
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112
Area Director: Ken Jones

Goldsboro Regional Office
100 S. James St.
Goldsboro, NC 27530
Phone: 800-913-6109
Fax: 910-298-7180
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112

Lumberton Regional Office
450 Country Club Road
Lumberton, NC 28360
Phone: 800-913-6109
Fax: 910-298-7180
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112

Rocky Mount Regional Office
500 Nash Medical Arts Mall
Rocky Mount, NC 27804
Phone: 800-913-6109
Fax: 910-298-7180
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112

Wilkes

Smoky Mountain Center
44 Bonnie Lane
Sylva, NC 28779
Phone: 828-586-5501
Fax: 828-586-3965
24-hour Access / Crisis Number: 800-849-6127
Area Director: Brian Ingraham

Wilson

Eastpointe Corporate Office
514 East Main Street
PO Box 369
Beulaville, NC 28518

Phone: 800-913-6109
Fax: 910-298-7180
Web: www.eastpointe.net
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112
Area Director: Ken Jones

Goldsboro Regional Office
100 S. James St.
Goldsboro, NC 27530
Phone: 800-913-6109
Fax: 910-298-7180
24-hour Access/Crisis Number: 800-913-6109
TTY: 888-819-5112

Lumberton Regional Office
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Fax: 910-298-7180
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TTY: 888-819-5112

Yadkin

Partners Behavioral Health Management Corporate Office
901 South New Hope Road
Gastonia, NC 28054
Phone: 704-884-2501
Fax: 704-854-4809
24-hour Access / Crisis Number: 1-888-235-4673
Administrative Number: 1-877-864-1454
Web
Area Director: W. Rhett Melton

Hickory Regional Office Site:
1985 Tate Blvd. SE Suite 529
Hickory, NC 28602
Phone: 828-327-2595
Fax: 828-325-9826
24-hour Access / Crisis Number: 1-888-235-4673

Elkin Regional Office Site
200 Elkin Business Park Drive
Elkin, NC 28621
Phone: 336-835-1000
Fax: 336-835-1002
24-hour Access / Crisis Number 888-235-4673

Yancey

Smoky Mountain Center
44 Bonnie Lane
Sylva, NC 28779
Phone: 828-586-5501
Fax: 828-586-3965
24-hour Access / Crisis Number: 800-849-6127
Area Director: Brian Ingraham

CRISIS SOLUTIONS NORTH CAROLINA

AN INITIATIVE OF THE NC DEPARTMENT OF HEALTH AND HUMAN SERVICES - DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

Do You or Someone You Know Need Help with a Crisis?

CALL 911 if this is a medical or life threatening emergency. If you need the police, ask for a CIT officer. They have received extra training on handling these situations. If this is NOT a medical or life threatening emergency, look in the directory below for resources in your county.

FINDING HELP FOR SOMEONE IN A CRISIS RELATED TO MENTAL ILLNESS OR SUBSTANCE USE

Behavioral health crises can be serious but most **do not** require an evaluation at a hospital emergency department. Accessing other specialized crisis services may help you avoid a lengthy visit to an emergency department and connect you more quickly to ongoing resources to support your recovery.

North Carolina's publicly funded crisis services—which may be used by anyone regardless of insurance status or an ability to pay—are managed by Local Management Entities-Managed Care Organizations (LME-MCOs). Start by calling your LME-MCO's 24-hour toll-free number. The LME-MCO staff can help you find the right kind of evaluation for your specific needs.

Select County

Crisis Solutions for Individuals and Families

Prevention and Planning

Many crisis events can be prevented or have fewer negative consequences with a good plan and a well informed support system. To head off a crisis:

- Keep your regular appointments and work with your doctor and treatment team to develop a plan that will work for you. Call them first if you are experiencing any problems. They know you best.
- Keep contact information for the family and friends who can be a support to you.
- Develop a written crisis plan. There are excellent planning tools available to guide you and your providers and other supports.

Helpful links for Crisis Planning:

- Person Centered Crisis Prevention and Intervention Plan
- Wellness Recovery Action Plan
- Psychiatric Advance Directives

During your Crisis Planning, you might consider making a **Psychiatric Advance Directive**.

Psychiatric Advance Directives are legal instruments that may be used to provide a record of a competent person's specific instructions or preferences regarding future mental health treatment, in preparation for the possibility that the person may lose capacity to give or withhold informed consent to treatment during acute episodes of psychiatric illness. A Psychiatric Advance Directive can help you to stay empowered even in a crisis and is another useful tool for managing your recovery and preferences for care.

For more information on the Crisis Planning and the Psychiatric Advance Directive, visit the sites in the "Helpful Links for Crisis Planning" box.

Early Intervention

When you need professional help for a behavioral health crisis, you have options. Behavioral health crises can be serious but most do not require an evaluation at a hospital emergency department. Accessing other specialized crisis services may help you avoid a lengthy visit to an emergency department and connect you more quickly to ongoing resources to support your recovery. Select your county in the list to the left to discover the providers who work in your area.

Helpful links:

- For people with Intellectual/Developmental Disabilities – NCSTART
- For Veterans
- Crisis Intervention Hotline

Guide to using emergency resources.
Guide to getting help for a loved one.

Emergency Resources and the Involuntary Commitment Process

It is always best if a person in crisis agrees to seek treatment on his or her own. However, there may be instances when a person lacks insight or good judgment about their need for treatment. Individuals living with mental illness or addictive disorders are sometimes unable to understand the severity of their illness, may refuse to take their prescribed medications, and may become a danger to themselves or others. Families and other caregivers may need to use one of the following options to tend to the immediate safety and well being of the person in crisis and others.

Dial 911

1. This is always the first choice for a medical emergency.
2. This is also a good choice if law enforcement is needed for safety reasons. When calling for law enforcement, ask for a "CIT officer". Most North Carolina communities have certain officers who receive advanced training on mental illness, substance abuse, and intellectual/developmental disabilities and the crisis intervention skills helpful to people in a crisis episode.
3. EMS or law enforcement can assist you in the next steps toward a crisis evaluation.

Take the person in crisis to a facility

1. **Walk-in Centers:** Some communities have specialized centers to assist individuals in a mental health or substance abuse crisis. Select your county in the list to the left to discover the center in your area.
2. **Hospital Emergency Departments:** Emergency Departments are open 24 hours per day, however be aware that waits may be long and most hospitals do not have behavioral health specialists available.
3. **Admissions unit of a treatment facility:** In some cases you may be able to pre-arrange admission to a psychiatric unit or detox center. Be sure that all arrangements are made in advance so you know a bed is available and that your insurance will cover any costs before your arrival.

Use the Involuntary Commitment process

North Carolina law allows for an individual to be evaluated and hospitalized against his/her own wishes. In order for this to happen there must be clear evidence the person is dangerous to self or others.

Initiating an involuntary commitment is usually a choice of "last resort". There are multiple steps in the process. If you decide to file a petition you should be prepared to be available by phone or in person to assist the professionals involved along the way.

1. Anyone with knowledge that a person is dangerous to himself or others due to mental illness and/or substance abuse may go to the local magistrate's office to file a petition which starts the involuntary commitment process.
2. When the magistrate finds the criteria are met, s/he will issue an order for custody and transportation of the person alleged to be in need of examination and treatment (this person will be called the "respondent"). This is not an order of commitment yet. It authorizes a law enforcement officer to take the respondent into custody and to transport him to a doctor or other mental health professional for examination. (Custody is not for the purpose of arrest. It is for the respondent's own safety and the safety of others, and to get him to the examiners who

3. A law enforcement officer will take the person to a facility for the examination. This may be to a Walk-in Center designated for this purpose or to a local hospital emergency department. The magistrate will provide directions and further instructions to the petitioner.

4. If the examiner (doctor) finds the respondent meets the criteria for inpatient commitment, the staff of the crisis center or hospital emergency department will search for a bed in a psychiatric facility. This may take a short time and the patient may be admitted to a facility close to home. On the other hand, the person may be held for hours or even days in the crisis center or emergency department until a bed is available somewhere in the state. Inpatient bed availability depends on numerous factors including the individual's diagnosis and symptoms, financial resources, and the number of open beds at any particular time.

5. When a bed is available the person will again be transported by a law enforcement officer to the 24-hour inpatient facility. Another examination must be performed at admission or within 24 hours of arrival.

6. The process may be terminated at any time if the examiner finds the person does not meet the criteria for commitment. When this occurs the law enforcement officer will release the person from custody and return him to his residence.

This civil procedure can be an extremely difficult process — for both the individual and the caregiver, but it may also be the ultimate life-saving choice. Committing a individual does not mean that you are giving up on him or her. If anything it shows that you are determined to help them get onto a path of recovery and stability.

NC DMH/DD/SAS
CERTIFIED FIRST COMMITMENT EVALUATORS

LME MCO	*Last Name*	*First Name*	*Licensure*	*Certification End Date*
ALLIANCE BEHAVIORAL HEALTH				
	Betuker	Stephen	LCSW	1/31/2017
	Daniels	Anita	LCSW	9/20/2016
	Holliday	Marie	LCAS	6/23/2017
	Mastridge	Ben	LCSW	11/4/2016
CARDINAL INNOVATIONS				
	Baker	Elizabeth	LCSW	9/30/2016
	Baker	Ross	LCSW	9/30/2016
	Benson	Melissa	LCSW, LCAS	1/28/2018
	Bezner	Ann P.	LCAS	12/10/2016
	Brown	Frankie	LCAS	10/27/2017
	Cross	Kim	LCSW	12/18/2015
	Griffith	Stacey	LCSW	3/11/2017
	Kindley	Kara	LCSW	9/12/2016
	Harrington Melton	Mary "Meg"	LCSW	3/25/2017
	Jordan	Rob	LCSW	7/8/2017
	Montgomery	Judy	LCSW	9/2/2017
	Parsons	Melodie B.	LCSW	3/29/2015
	Ramos	Caroline	LCSW	9/12/2016
	Robinson	Kimberly	LCSW	8/8/2015
	Swanzey	Kathy	LCSW/LCAS	7/8/2017
	Trafton	Emily	LCSW	9/12/2016
	White	DeAn	LCAS	3/25/2017
	Whitling	Terry	LCSW/LCAS	7/17/2017
CENTERPOINT				
	Major	Catherine	MSN	8/20/2017
	Roscoe	Takiya R.	LCSW	6/6/2017
COASTALCARE				
	Sturman	Leigh D.	LCSW	5/6/2016
EASTPOINTE BEHAVIORAL HEALTH				
	Carr	George	LCSW	9/6/2016
	Chu	Cindy	LCSW	9/6/2016
	Freeland Sperati	Karen	LCSW	2/20/2015

PARTNERS BEHAVIORAL HEALTH

Billings	Cheryl	LCSW	9/27/2016
Elam	Doug	LCAS	9/27/2016
Hallisey	Barbara	LCSW	10/1/2016
Pringle	Connie	LCSW	8/27/2016
Sigmon	Sharon	LCSW	9/27/2016
Utt	Jerry	LCSW	9/27/2016

SANDHILLS

Allen	Jamie	LCSW	8/19/2016
Brone	Karissa	LCSW	8/25/2017
Herbst	Shawna	LCSW	2/26/2017
Pontius	Sandra	LCSW	8/19/2016
Rickard	Elizabeth	LCSW	8/19/2016

SMOKY MOUNTAIN CENTER

Brooks	Anne	LCSW	9/10/2016
Cannon	Paula	LCSW	10/24/2016
Halpern	Migs	LCSW	4/4/2015
Hobson	Robert	LCSW	9/10/2016
Jordan	Cindy	LCAS	4/4/2015
Keyes	Sharon	LCSW	5/31/2016
Leggett	Sarah	LCSW	3/3/2017
Lowe	Suzanne	LCSW	9/16/2016
Lyons	Alfred	LCSW	9/27/2016
Melton	Adrianne	LCSW	4/4/2015
Morris	Andrea	LCSW	4/4/2015
Phelan	Amy	LCSW	9/10/2016
Putnam	Elizabeth	LCSW	9/10/2016
Richardson	Molly	LCSW, LCAS	10/1/2016
Sargent	Julie	LCSW	9/27/2016
Skigen	Donna	LCSW	4/4/2015
Smith	Desaray	LCSW	9/10/2016
Trantham	Doug	LCSW	10/1/2016
Weiner	David	LCSW	5/31/2016
Youngblood	Beth	LCSW	5/13/2016

Tab 4:

References & Resources

Request for an issuance of an Involuntary Commitment

[Please Print Clearly]

Respondent's Information [Person Being Committed]

Name_____
First Middle Last

Address_____

_____ Phone #_____

Date of Birth_____

Respondent's Next of Kin Information

Name_____ Relationship_____
First Middle Last

Address_____

_____ Phone#_____

Petitioner's Information [Person requesting the commitment]

Name_____ Relationship_____
First Middle Last

Address_____

_____ Phone#_____

List the facts that lead you to believe this person is a threat to themselves and/ or the community. Please include diagnoses, medications and any actions or statements by the person that would be considered dangerous to them or others.

_____

_____

_____

_____

_____

_____

_____

_____

Petitioner's Signature_____ **Date**_____.

Request for Involuntary Commitment Order

NAME OF PERSON WHO NEEDS EVALUATION:

_____

PERSON'S DATE OF BIRTH_____

HEIGHT:_____ WEIGHT:_____ RACE_____ Gender: M / F (CIRCLE ONE)

Does this person have any visible scars, tattoos or other unique identifying features? If so, please describe below.

_____

DOES THIS PERSON USUALLY CARRY A WEAPON, AND IF SO, WHAT KIND?

_____

PERSON'S HOME ADDRESS:_____

_____

IF NOT AT HOME, ADDRESS WHERE PERSON IS CURRENTLY LOCATED:
(Must be within Mecklenburg County to initiate a commitment in this county)

_____

_____

YOUR NAME: _____

YOUR ADDRESS: _____

_____

YOUR PHONE NUMBER: Work:_____ Home: _____ Mobile: _____

YOUR RELATIONSHIP TO PERSON: -- PARENT -- SPOUSE -- CHILD --SIBLING
IF OTHER, PLEASE DESCRIBE: _____

HAS THIS PERSON BEEN DIAGNOSED WITH A MENTAL ILLNESS, IF SO, WHAT MENTAL ILLNESS?

_____

HAVE YOU MADE ARRANGEMENTS WITH A MENTAL HEALTH FACILITY TO EVALUATE THIS PERSON, AND IF SO, WHAT FACILITY? _____

IF THIS PERSON IS A SUBSTANCE ABUSER, WHICH SUBSTANCES ARE ABUSED, AND APPROXIMATELY HOW OFTEN? _____

_____

***ON THE BACK OF THIS FORM GIVE A BRIEF STATEMENT REGARDING THIS PERSON'S RECENT BEHAVIOR WHICH INDICATES THAT HE/SHE IS IMMINENTLY DANGEROUS TO SELF AND/OR OTHERS.

Joan Brannon
Institute of Government

COMMON QUESTIONS TO ASK TO OBTAIN INFORMATION FOR THE PETITION FOR INVOLUNTARY COMMITMENT

1. Has the person harmed or threatened to harm himself or others within the past 24 hours? Week? Month? 3 months?
   (a) What did he/she do to you?
   (b) What did he/she do to others?

2. Is the person hallucinating (seeing or hearing things that other people don't see or hear)?
   (a) What is he/she seeing or hearing?

3. Can the person identify the day, where he is, his name, and his age?

4. Does the person have unreasonable thoughts that people are talking about him or are going to kill or hurt him?

5. Is the person making elaborate, exaggerated claims about himself? Such as:
   (a) Being on a special mission;
   (b) Being another important and powerful person;
   (c) Being a part of a powerful organization.

6. Does the person have trouble sleeping at night? How long since the person had a normal night's rest?

7. Has the person consumed more than 1 pint of alcohol per day for the past 3-10 days?

8. Is the person taking any medication?
   (a) What is it?
   (b) Has the person taken any illegal drugs within the past 24 hours? Week? Month? 3 months?
      (1) What kind of drug?
      (2) How much?

9. Has there been any change in the person's appetite? More? Less? Not eating?

10. Is the person working and doing his/her normal activities?

11. Is the person not able to take care of himself of his mental condition? (Eat, sleep, dress, bathe, use the toilet, stay out of traffic?)

INFORMATION TO OBTAIN FOR CONSIDERING AN INVOLUNTARY COMMITMENT

I. BEHAVIORS

A. hostile vs. passive -- acting out in destructive ways vs. withdrawn, quiet, apathetic
B. erratic, excitable -- sensitive to slight irritation, unpredictable, agitated
C. combative, violent -- destructive, physically and/or verbally abusive
D. incontinence --poor control of urine and feces
E. inappropriate social judgment -- behaviors usually considered in poor taste and usually rejected or found offensive by other people

II. MOVEMENTS

A. overactivity, restlessness, agitation -- parts of body in constant motion, repetitive, activity beyond reasonable level
B. involuntary movements -- parts of body jerk, shake or activated without apparent reason
C. underactivity -- immobile, stuporous, sluggish
D. general muscle tension -- parts of body held taut (e.g., clenched teeth), possibly small tremors, rigid posture or walking stance

III. SPEECH

A. overtalkative vs. mute -- constant talking vs. unresponsive, "pressure of speech"
B. unusual speech -- strange words, "word salad," disconnected speech
C. assaultive/suicidal content -- words that suggest harmful intent

IV. EMOTIONS

A. flat or inappropriate emotions -- little change in expression or expression that doesn't fit occasion (e.g., happy but angry, crying when happy)
B. mood swings -- dramatic changes from dejection to elation
C. general overapprehension --anxiety in most areas of life
D. depression, apathy, hopelessness -- withdrawal and minimal interest in activities of daily life
E. euphoric -- grandiose and unrealistic feelings, often of feeling indestructible

V. THOUGHTS

A. disturbed awareness -- unaware of self or others or time or place
B. disturbed memory --impairment of short term and/or long term memory
C. disturbed reasoning/judgment -- impaired logic or decisions not tied to common thinking
D. confused thoughts -- inconsistent and/or combination of unrelated thoughts

E. poor concentration and/or attention

F. low intellectual functioning

G. slow mental speed

VI. ABNORMAL MENTAL TRENDS

A. false perceptions (hallucinations) -- experiences in visual, hearing, smelling, tasting or skin sensations without real basis

B. false beliefs (delusions) -- usually persecutory or grandiose thoughts without real basis

C. paranoid ideas -- involves suspiciousness or belief that one is persecuted or unfairly treated

D. body delusion -- delusion involving body functions (e.g., "my brain is rotting," a 60 year-old insisting she is pregnant)

E. feelings of unreality or depersonalization -- sense of own reality is temporarily lost, so body parts distorted or sensing self from a distance

F. repetitious behaviors/thoughts/speech

G. extreme fears -- especially when seriously impairing activities of daily life

VII. PREVIOUS EVIDENCE

A. psychiatric assessments or treatment

B. prior petitions or associated legal difficulties

VIII. COURSE OR DISTURBANCE

A. chronic

B. gradual onset

C. C. acute episode

(insert local court information & address here)

INVOLUNTARY COMMITMENT INFORMATION FOR PETITIONERS AND FAMILY MEMBERS

After you file a Petition for Examination for Involuntary Commitment:

Go directly to (insert local evaluation site name here) when the respondent is transported there. Speak with an (insert type of professional here—i.e. intake counselor, triage nurse, etc.) The information you provide about the respondent will help the examining clinician understand the situation beyond what is written in the petition.

(Insert here the address, phone #, directions to the evaluation site.)

What to expect at the examination site:
(Insert here material from the site, similar to this example.)

Expect to provide information to the clinicians.
Expect to provide support to the respondent.
Parents or guardians or care providers will need to stay with the respondent throughout the process.
Expect delays. The average waiting time may be as much as XX hours.

The following can happen after the examination:

1. The process may be terminated if the clinician does not find the person meets criteria to continue. If this happens the person will be transported back to the location where they were picked up.

2. When the clinician finds the person meets inpatient criteria, the staff will work to find a hospital that will provide a second examination and admit the person. This process may happen immediately or may take many hours. When a hospital is identified a law enforcement officer will transport the person there. The staff will advise you of the destination and of what assistance you may provide in the process.

A second examination by a physician at the hospital is necessary to complete the commitment process. When this physician determines hospitalization is necessary the person will be admitted. Should the physician determine the criteria for commitment are not met the person will be returned home.

MENTAL STATUS EXAMS

A mental status examination (MSE) is an assessment of a patient's level of cognitive (knowledge-related) ability, appearance, emotional mood, and speech and thought patterns at the time of evaluation. It is one part of a full neurological (nervous system) examination and includes the examiner's observations about the patient's attitude and cooperativeness as well as the patient's answers to specific questions.

Appearance. The examiner notes the person's age, race, sex, civil status, and overall appearance. These features are significant because poor personal hygiene or grooming may reflect a loss of interest in self-care or physical inability to bathe or dress oneself.

Movement and behavior. The examiner observes the person's gait (manner of walking), posture, coordination, eye contact, facial expressions, and similar behaviors. Problems with walking or coordination may reflect a disorder of the central nervous system.

Affect. Affect refers to a person's outwardly observable emotional reactions. It may include either a lack of emotional response to an event or an overreaction.

A patient's affect is defined in the following terms: expansive (cheerfully contagious), euthymic (normal), constricted (limited variation), blunted (minimal variation), and flat (no variation).

Mood. Mood refers to the underlying emotional "atmosphere" or tone of the person's answers.

Speech. The examiner evaluates the volume of the person's voice, the rate or speed of speech, the length of answers to questions, the appropriateness and clarity of the answers, and similar characteristics.

Thought content. The examiner assesses what the patient is saying for indications of hallucinations, delusions, obsessions, symptoms of dissociation, or thoughts of suicide or harm to others.

Dissociation refers to the splitting-off of certain memories or mental processes from conscious awareness. Dissociative symptoms include feelings of unreality, depersonalization, and confusion about one's identity.

Types of hallucinations include auditory (hearing things), visual (seeing things), gustatory (tasting things), tactile (feeling sensations), and olfactory (smelling things). Command hallucinations are auditory and instruct the patient to take some action, often harmful to self or others.

Delusions include grandiose (delusions of grandeur), religious (delusions of special status with God), persecution (belief that someone wants to cause them harm), erotomanic (belief that someone famous is in love with them), jealousy (belief that everyone wants what they have), thought insertion (belief that someone is putting ideas

or thoughts into their mind), and ideas of reference (belief that everything refers to specifically to them, such as messages from the TV or radio).

Thought process. Thought process refers to the logical connections between thoughts and their relevance to the main thread of conversation. Irrelevant detail, repeated words and phrases, interrupted thinking (thought blocking), and loose, illogical connections between thoughts, may be signs of a thought disorder.

The process of thoughts can be described with the following terms: looseness of association (irrelevance), flight of ideas (change topics), racing (rapid thoughts), tangential (departure from topic with no return), circumstantial (being vague, ie, "beating around the bush"), word salad (nonsensical responses, ie, jabberwocky), derailment (extreme irrelevance), neologism (creating new words), clanging (rhyming words), punning (talking in riddles), thought blocking (speech is halted), and poverty (limited content).

Cognition. Cognition refers to the act or condition of knowing. The evaluation assesses the person's orientation (ability to locate himself or herself) with regard to time, place, and personal identity; long- and short-term memory; ability to perform simple arithmetic (counting backward by threes or sevens); general intellectual level or fund of knowledge (identifying the last five Presidents, or similar questions); ability to think abstractly (explaining a proverb); ability to name specified objects and read or write complete sentences; ability to understand and perform a task (showing the examiner how to comb one's hair or throw a ball); ability to draw a simple map or copy a design or geometrical figure; ability to distinguish between right and left.

Judgment. The examiner asks the person what he or she would do about a commonsense problem, such as running out of a prescription medication.

Insight. Insight refers to a person's ability to recognize a problem and understand its nature and severity.

Other Common Terms and Abbreviations

Activities of Daily Living (ADL's). Self-care activities such as feeding one's self, bathing, dressing, grooming) work, homemaking, and leisure.

Anhedonia. Loss of interest in pleasurable activities.

Chief Complaint (CC). Usually in quotation marks, the reason the patient gives for the evaluation. Presenting problem.

Drug of Choice (DOC). Preferred drug (including alcohol) used in an addiction.

History of Present Illness (HPI). Description of the onset of the set of signs and symptoms that comprise the current problem.

Neuro-vegetative symptoms. Alterations in sleep, appetite, and energy.

Obsessive-compulsive disorder (OCD). A disorder characterized by obsessive thoughts and compulsive actions, such as cleaning, checking, counting, or hoarding.

Orientation. Awareness of surroundings, including self, place, time, and situation/event. Often abbreviated, **"O x 3" or "O x 4", or AO x3** (alert, and oriented to person/place/time).

Phobias. Fears that cause avoidance of certain situations, panic and other anxiety symptoms.

Post-Traumatic Stress Disorder (PTSD). A disorder characterized by nightmares, flashbacks, difficulty sleeping, and feelings of detachment, usually occurring after experiencing or witnessing threatening events such as combat, natural disasters, serious accidents, or physical or sexual assaults.

"Serial 7's". Exercise which tests for concentration and attention span, asking for the patient to subtract 7 from 100, and then to repeat from the response.

Serious and Persistent Mental Illness (SPMI).

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."

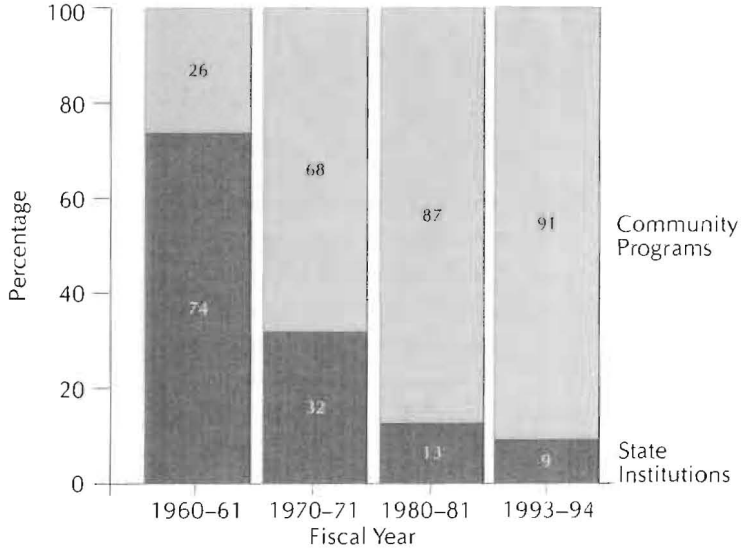
Dorothea Dix, 1848

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. I (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]

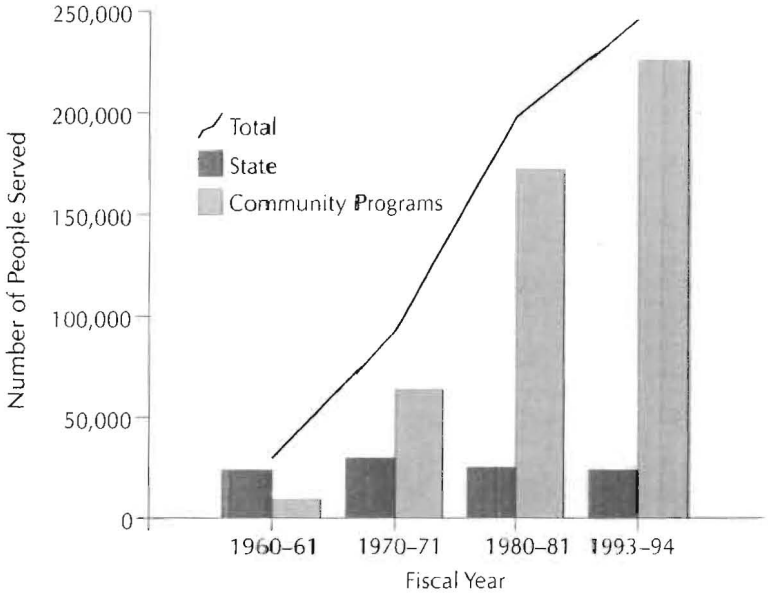
Federal Role in Spurring Local Efforts

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.