UNC SCHOOL OF GOVERNMENT

Navigating the Capacity and Commitment Process

April 4, 2024
UNC School of Government, Chapel Hill, NC
Co-sponsored by the NC Department of Health and Human Services,
Division of State Operated Healthcare Facilities

8:00-8:30 a.m. *Check In and Registration*

8:30-9:15 a.m. **The ITP Process in Court** (45 min)
John Rubin, Professor of Public Law and Government
UNC School of Government, Chapel Hill, NC

This presentation will cover the procedures required when a criminal defendant's capacity to proceed comes into question. Topics covered will include when capacity should be examined, the role and duties of defense counsel, contested hearings on capacity, and options for when a defendant has been determined to lack capacity to proceed.

9:15-10:00 a.m. **Considerations in Capacity Evaluations: Cognitive Deficits vs Mental Illness** (45 min)
Steve Peters, Psy.D., Forensic Psychologist
NC Department of Health & Human Services

This presentation will help participants gain knowledge about how to differentiate between neurocognitive disorders and severe mental illness in the context of capacity to proceed evaluations, and how different neurocognitive disorders can affect an individual's capacity to proceed and capacity restoration.

10:00-10:15 a.m. *Break*

10:15-11:00 a.m. **The LCFE Program: Nuts and Bolts** (45 min)
Dr. Susan Hurt, Outpatient Evaluation Service, Central Regional Hospital

This section will provide an overview of the characteristics and training of local certified forensic evaluators, what to expect from the LCFE process, and decision trees before, during, and after the evaluation.

11:00-11:45 a.m. **After the Evaluation** (45 min)
Elizabeth Arnette, Assistant Attorney General
NC Department of Justice, Health & Human Services Division
Hilary Ventura, Assistant Attorney General
NC Department of Justice, Health & Human Services Division

This section will review statutes and processes for capacity restoration and reevaluation within state mental health hospital facilities. We will discuss interactions between all stakeholders within that process and compliance with statutes and regulations. Furthermore, the presentation covers common challenges within the current framework of the capacity restoration and reevaluation process.

11:45-12:45 p.m. *Lunch (provided)*

12:45-1:15 p.m. **Information Sharing: Records Access Concerning Mental Health Treatment** (30 min)
Elizabeth Arnette, Assistant Attorney General
NC Department of Justice, Health & Human Services Division
Hilary Ventura, Assistant Attorney General
NC Department of Justice, Health & Human Services Division

This section will discuss the statutory and regulatory restrictions on mental health records, substance abuse records, and civil commitment court proceeding records and how to access them. Review of the capacity restoration statutes and the requirements for information sharing between entities at various levels and how that sharing of information aids in the capacity evaluation and restoration processes.

1:15-1:30 p.m. *Break*

1:30-2:15 p.m. **Review of Capacity Restoration** (30 min)
Steve Peters, Psy.D., Forensic Psychologist
Robert Cochrane, Psy.D., ABPP, Statewide Director of Forensic Services
Division of State-Operated Healthcare Facilities (DSOHF)
NC Department of Health & Human Services

This segment will review the services for capacity restoration and challenges of attending to the needs of this population. Some new pilot programs for capacity restoration will also be presented.

2:15-3:00 p.m. **Review Capacity Reports** (45 min)
Robert Cochrane, Psy.D., ABPP, Statewide Director of Forensic Services
Division of State-Operated Healthcare Facilities (DSOHF)
NC Department of Health & Human Services

This presentation will discuss strategies and tips for reviewing capacity to proceed reports involving neurocognitive disorders will be discussed to assist attorneys in better assessing the quality of these evaluations.

3:00-3:30 p.m. **Roundtable Discussion: Q&A** (30 min)

All presenters

3:30 p.m. *Adjourn*

CLE HOURS: 5.50

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PUBLIC DEFENSE EDUCATION INFORMATION & UPDATES

If your e-mail address is *not* included on an IDS listserv and you would like to receive information and updates about Public Defense Education trainings, manuals, and other resources, please visit the School of Government's Public Defense Education site at:

www.sog.unc.edu/resources/microsites/public-defense-education

(Click *Sign Up for Program Information and Updates*)

Your e-mail address will not be provided to entities outside of the School of Government.

(Public Defense Education)

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PUBLIC DEFENSE EDUCATION COURSE OFFERINGS

Overview

In August 2000, the North Carolina General Assembly enacted the Indigent Defense Services Act, which created the Office of Indigent Defense Services (IDS) and charged it with overseeing and enhancing the provision of legal representation to indigent defendants and others entitled to counsel under North Carolina law. On behalf of the School of Government, the Public Defense Education (PDE) Initiative collaborates with the Office of Indigent Defense Services to meet the requirements of the Indigent Defense Services Act.

January Offerings

- **Child Support Enforcement** (Biennial Even Years): This course provides training for attorneys representing alleged contemnors in child support enforcement proceedings. Past session topics have included civil and criminal contempt, trial skills, and the intersection of IV-D child support collections and foster care. The program is comprised of plenary sessions.

  Lead Faculty: Timothy Heinle, Teaching Assistant Professor

  Duration: Up to 6.0 hours of CLE, including ethics/professional responsibility

- **Civil Commitment** (Biennial Odd Years): This course provides training for public defenders, appellate defenders, and private attorneys who represent respondents in civil commitment proceedings. Past session topics have included evidence needed to show dangerousness, firearms, the National Instant Criminal Background Check System (NICS), commitment hearing advocacy, appellate case updates, and special issues for juveniles in DSS custody. The program is comprised of plenary sessions.

  Lead Faculty: Timothy Heinle, Teaching Assistant Professor

  Duration: Up to 6.0 hours of General CLE

- **Guardianship Proceedings for Appointed Counsel** (Biennial Odd Years): This course provides training for public defenders, appellate defenders, and private attorneys who serve as appointed

guardian ad litem attorneys for respondents in incompetency and guardianship proceedings. Past session topics have included advocating for services and treatment in mental health and substance abuse cases, alternatives to guardianship, pushing back on common assumptions, a lawyer's guide to understanding addiction, and navigating the dual role of the guardian ad litem. The program is comprised of plenary sessions.

Lead Faculty: Timothy Heinle, Teaching Assistant Professor

Duration: Up to 6.0 hours of General CLE

February Offerings

- **Current Developments in Criminal Law** (Annual): This online course provides training to public defenders, private attorneys who do indigent criminal defense work, and any others who are interested in criminal law. Various School of Government faculty discuss recent developments in criminal law. The webinar includes a dynamic visual presentation, live audio, and interactive Q&A session.

  Lead Faculty: Phil Dixon, Jr., Director, Public Defense Education; Teaching Assistant Professor

  Duration: 1.5 hours of General CLE and qualifies for the NC State Bar criminal law specialization credit.

- **Felony Defender** (Annual): This course provides training for public defenders and private attorneys who perform a significant amount of appointed work and who are new to representing defendants charged with felonies in superior court. Past session topics have included discovery and investigation, suppression and other superior court motions, preserving the record, jury instructions, sentencing, and trial skills—including conducting voir dire—necessary to handle felony cases from start to finish. The program is comprised of plenary sessions and intensive small group workshops.

  Lead Faculty: Phil Dixon, Jr., Director, Public Defense Education; Teaching Assistant Professor

  Duration: Up to 16 hours of CLE, including substance abuse/mental health awareness, ethics/professional responsibility, and qualifies for the NC State Bar criminal law specialization credit.

March Offerings

- **Intensive Juvenile Defender** (Biennial Even Years): The course provides training for public defenders and private attorneys who represent juveniles in delinquency proceedings. Past topics include crafting individualized dispositions, identifying new arguments for cases involving juveniles,

disproportionate minority contact, telling your client's story, and cultural competencies. The program is comprised of plenary sessions and intensive small group workshops.

Lead Faculty: Timothy Heinle, Teaching Assistant Professor

Duration: Up to 6.0 hours of General CLE

- **Intensive Parent Defender** (Biennial Odd Years): This course focuses on parent representation at each stage of juvenile abuse, neglect, and dependency proceedings, including reviewing and challenging pleadings, contested adjudications, and parent advocacy through permanency. The program is comprised of plenary sessions and intensive small group workshops.

  Lead Faculty: Timothy Heinle, Teaching Assistant Professor

  Duration: Up to 6.0 hours of General CLE

April Offerings

- **Special Topic Seminar** (Annual): The 2024 seminar is on Navigating the Capacity and Commitment Process.

  Lead Faculty: Phil Dixon, Jr., Director, Public Defense Education; Teaching Assistant Professor

  Duration: Up to 6.0 hours of General CLE depending on topic

May Offerings

- **Spring Public Defender and Investigator Conference** (Annual)**:** This conference includes various topics and tracks for misdemeanor attorneys, felony attorneys, juvenile attorneys, and investigators. Past attorney track sessions have focused on emerging issues in Fourth Amendment law, expert witnesses, and capacity. Past investigator track sessions have included strategies for working with counsel, testifying in jury and non-jury trials, and ethical considerations for investigators.

  Lead Faculty: Phil Dixon, Jr., Director, Public Defense Education; Teaching Assistant Professor

  Timothy Heinle, Teaching Assistant Professor

  Duration: Up to 13.25 hours of CLE, including ethics/professional responsibility, technology, and substance abuse/mental health awareness.

June Offerings

- **Summer Criminal Law Webinar** (Annual): This online course covers recent criminal law decisions issued by the North Carolina appellate courts and the United States Supreme Court and highlights significant criminal law legislation enacted by the North Carolina General Assembly.

  Lead Faculty: Phil Dixon, Jr., Director, Public Defense Education; Teaching Assistant Professor

  Duration: 1.5 hours of General CLE and qualifies for the NC State Bar criminal law specialization credit.

- **Civil Law Webinar** (Annual): Topics vary. In 2024, this new online course will cover issues related to expert testimony in proceedings involving children. Attorneys will learn foundational concepts for offering, challenging, and distinguishing between expert and lay testimony.

  Lead Faculty: Timothy Heinle, Teaching Assistant Professor

  Duration: 1.5 hours of General CLE

July Offerings

- **Defender Trial School** (Annual): Participants will use their own cases to develop a cohesive theory of defense at trial and apply that theory through all stages of a criminal trial, including voir dire, opening, and closing arguments, and direct and cross-examination. The program is comprised of plenary sessions and intensive small group workshops.

  Lead Faculty: John Rubin, Albert Coates Professor, and Bob Burke, Contract Educator

  Duration: Up to 28 hours of CLE and qualifies for the NC State Bar criminal law specialization credit.

August Offerings

- **Juvenile Defender** (Annual): Provides training for attorneys who represent youth in delinquency proceedings. Past topics have included legislative updates, post-disposition advocacy, issues surrounding recidivism, and more. The program is comprised of plenary sessions.

  Lead Faculty: Timothy Heinle, Teaching Assistant Professor

  Duration: Up to 6.0 hours of CLE, including substance abuse/mental health awareness

- **Parent Attorney** (Annual): This course is for attorneys who represent respondents in abuse, neglect, dependency, and termination of parental rights proceedings. Past topics have included legislative and case updates, substance use and testing, and representing parents with disabilities, and self-care for attorneys working in this often traumatic field. The program is comprised of plenary sessions.

  Lead Faculty: Timothy Heinle, Teaching Assistant Professor

  Duration: Up to 6.25 hours of CLE, including substance abuse/mental health awareness, and qualifies for NC State Bar Child Welfare specialization and Family Law specialization credit.

September Offerings

- **Higher Level Felony** (Annual): This program is for attorneys interested in handling higher-level felony cases at the trial level. Past topics have included preparing for serious felony cases, eyewitness identifications, habitual felons, self-defense, client relations and rapport, sentencing law and advocacy, and mitigation investigation. The program consists of plenary sessions and intensive small group workshops.

  Lead Faculty: Phil Dixon, Jr., Director, Public Defense Education; Teaching Assistant Professor

  Duration: Up to 12.25 hours of CLE, including ethics/professional responsibility, and qualifies for the NC State Bar Criminal Law specialization credit.

October Offerings

- **Appellate Advocacy** (Annual or biennial depending on demand): Using their own cases, participants will learn to develop a cohesive theory of defense on appeal and use that theory in writing a persuasive statement of facts and legal argument. The program consists of plenary sessions and intensive small group workshops.

  Lead Faculty: John Rubin, Albert Coates Professor, and Bob Burke, Contract Educator

  Duration: Up to 18.0 hours of General CLE

November Offerings

- **Misdemeanor Defender** (Annual): This course is an introductory program for attorneys new to misdemeanor cases. Past sessions have included stops and searches, impaired driving, ethical

issues in district court, sentencing and jail credit, probation violations, and other matters in misdemeanor cases. The program also provides instruction on client interviewing, negotiation, and trial skills, including a small group workshop on trial skills. The program is comprised of plenary sessions and intensive small group workshops.

Lead Faculty: Phil Dixon, Jr., Director, Public Defense Education; Teaching Assistant Professor

Duration: Up to 20.0 hours of CLE, including ethics/professional responsibility, and qualifies for the NC State Bar criminal law specialization credit.

December Offerings

- **Winter Criminal Law Webinar** (Annual): This online course covers recent criminal law decisions issued by the North Carolina appellate courts and the United States Supreme Court and highlights significant criminal law legislation enacted by the North Carolina General Assembly.

  Lead Faculty: Phil Dixon, Jr., Director, Public Defense Education; Teaching Assistant Professor

  Duration: 1.5 hours of General CLE and qualifies for the NC State Bar criminal law specialization credit.

Educational Resources

- Indigent Defense Manual Series (Seven Volumes)
- Collateral Consequences Assessment Tool
- Guide to Relief from a Criminal Conviction
- Practice Guides (Defense Motions and Notices in Superior Court; The First Seven Days Series for GALs and Parent Defenders)
- Racial Equity Network Resources (Training Materials)
- On-Demand Defender CLE Library
- NC Criminal Debrief Podcast
- Covid-19 Tool Kit for Defenders
- SOG Criminal Law Blog
- SOG On the Civil Side Blog
- Case Summaries (via listservs) Evidence Chapter in Abuse, Neglect, and Dependency Manual

Capacity and Commitment

Overview

John Rubin
UNC School of Government
March 2024

1

Jackson v. Indiana, 406 U.S. 715 (1972)

"[A] person charged . . . with a criminal offense who is committed solely on account of his incapacity to proceed to trial cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future. If it is determined that this is not the case, then the State must either institute the customary civil commitment proceeding that would be required to commit indefinitely any other citizen, or release the defendant."

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Indigent Defense Manual Series

John Rubin, Editor

UNC SCHOOL OF GOVERNMENT

View Edit

Pretrial Vol. 1 >> 2 Capacity to Proceed

Chapter 2

Capacity to Proceed

2.1 Standard for Capacity to Proceed to Trial 2-3
A. Requirement of Capacity
B. Test of Capacity
C. Medication
D. Time of Determination
E. Compared to Other Standards
F. Burden of Proof
G. Retrospective Capacity Determination
2.2 Investigating Capacity to Proceed 2-9
A. Duty to Investigate
B. Significant Behaviors
C. Sources of Information

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Indigent Defense Manuals Search

Enter a term below (use quotations for phrases); or search a specific manual.

Sections

- 2.0 Contents and Introduction
- 2.1 Standard for Capacity to Proceed to Trial
- 2.2 Investigating Capacity to Proceed
- 2.3 Deciding Whether to Question Capacity
- 2.4 Obtaining an Expert Evaluation
- 2.5 Examination by State Facility or Local Examiner
- 2.6 Post-Examination Procedure
- 2.7 Hearings on Capacity to Proceed
- 2.8 Procedure After Order of Incapacity
- 2.9 Admissibility at Trial of Results of Capacity Evaluation
- Appendix 2-1 Summary of Legislation

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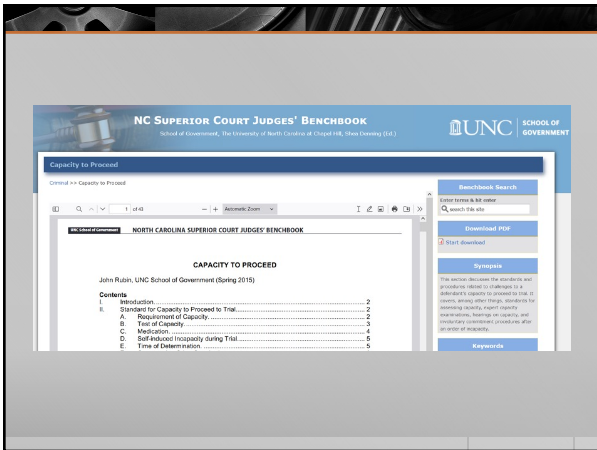

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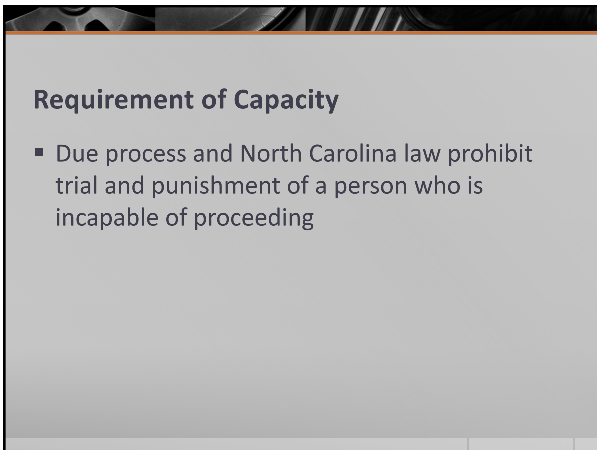

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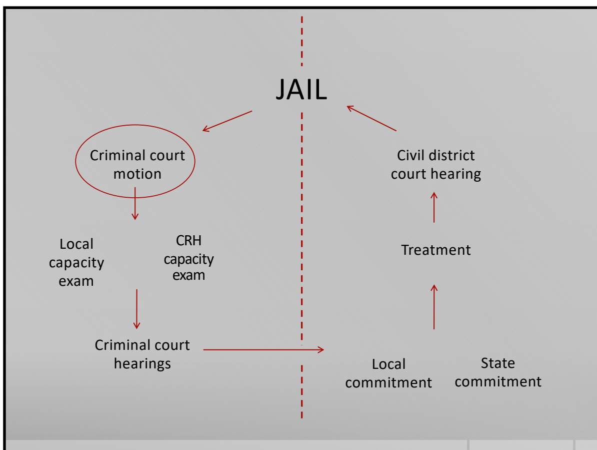

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Capacity Examination

- For misdemeanors, the defendant may be evaluated by:
  1. Local examiner
- In felonies, the defendant may be evaluated by:
  1. Local examiner
  2. State examiner after local exam
  3. State examiner

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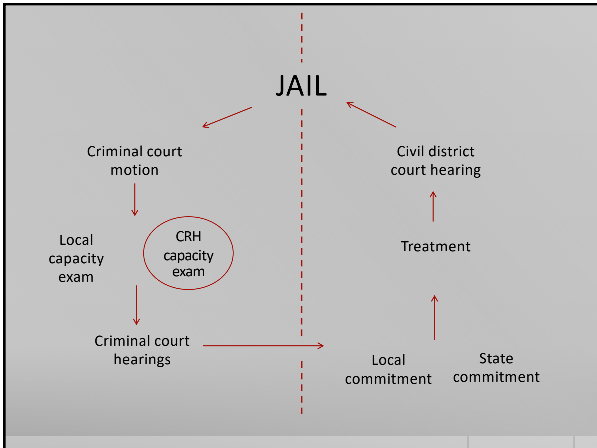

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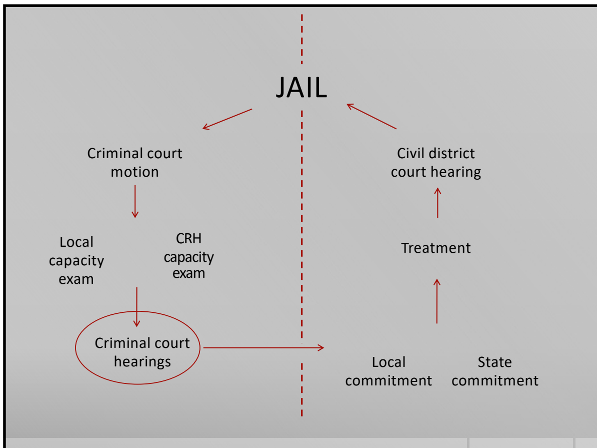

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After Finding of Incapacity

- Criminal court judge may
  - Find that defendant is not subject to commitment
  - Find that defendant is subject to commitment and order local commitment exam
  - Find that defendant is subject to commitment and, because charged with a violent crime, order state commitment exam

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G.S. 15A-1008

- When a defendant lacks capacity to proceed, the court shall dismiss the charge if
  1. it appears the defendant will not gain capacity
  2. the defendant has been confined for the maximum term for the most serious offense
  3. five years have elapsed in a misdemeanor case and ten years have elapsed in a felony case after a finding of incapacity

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After Finding of Incapacity

- Criminal court judge may
  - Find that defendant is not subject to commitment
  - Find that defendant is subject to commitment and order local commitment exam
  - Find that defendant is subject to commitment and, because charged with a violent crime, order state commitment exam

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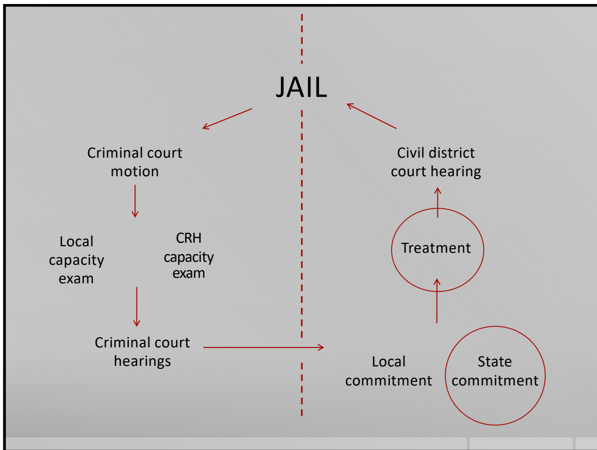

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Definition of Violent Offense

- "[A] violent crime, including a crime involving assault with a deadly weapon." G.S. 15A-1003(a).
  - Whether a crime is "violent" depends on elements. *In re Murdock*, 222 N.C. App. 45 (2012).
  - Whether a crime "involves" assault with a deadly weapon depends on facts. *Id.*

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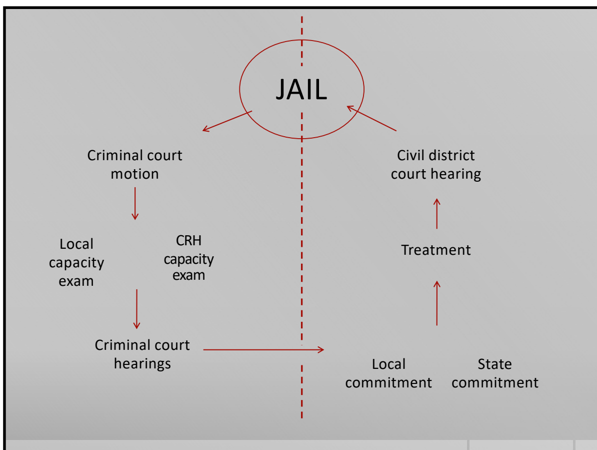

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Additional 2013 Changes

- Capacity exam must be conducted before termination of commitment
- If exam reports that defendant has gained capacity, notice must be given to clerk, who must give notice to DA, defense attorney, and sheriff
- DA must calendar supplemental hearing within 30 days after report of capacity
- Trial must be calendared for earliest practicable time, with continuances beyond 60 days for extraordinary circumstances only

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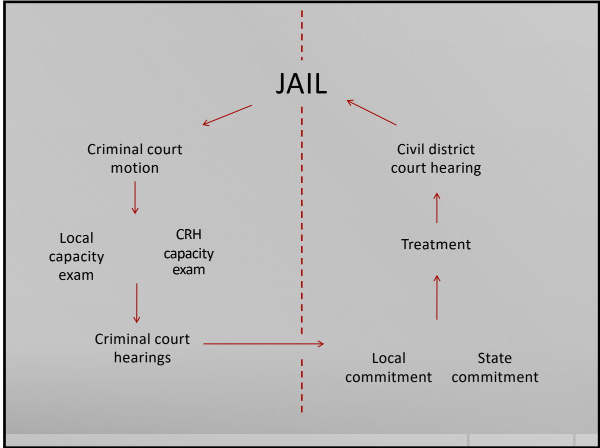

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CONSIDERATIONS IN CAPACITY EVALUATIONS: NEUROCOGNITIVE DISORDERS SEVERE MENTAL DISORDERS

Slide Set developed by:
Stephanie Callaway, PsyD, ABPP
Clinical Psychologist

Presented by Steve Peters, Psy.D.

1

AGENDA

- Review most relevant diagnoses
- Explore severe mental illness vs intellectual developmental disorders vs neurocognitive disorders
- Learn how these disorders can affect capacity to proceed

2

DSM-5 TR (2022)

Official list of mental disorders

- Schizophrenia Spectrum Disorders
- Substance Related Disorders
- Neurocognitive Disorders
- OCD disorders
- PTSD disorders
- Personality Disorders
- Bipolar Related Disorders
- Depressive Disorders
- Neurodevelopmental Disorders
- Anxiety Disorders

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

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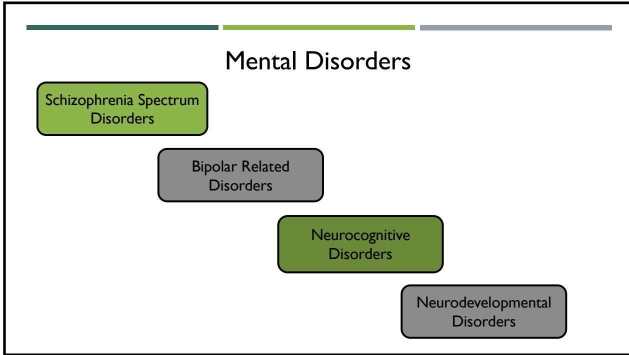

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GENERAL PRINCIPLES ABOUT SEVERE MI

THE YOUNGER THE ONSET, THE MORE SEVERE THE SYMPTOMS
(AND LESS RESPONSIVE TO TREATMENT)
LOT OF VARIABILITY, PERSON TO PERSON…SYMPTOMS AND RESPONSE TO TREATMENT
SYMPTOMS CAN IMPACT COGNITIVE, EMOTIONAL, AND BEHAVIORAL FUNCTIONING
VERY LITTLE (TO NOTHING) IS KNOWN ABOUT CAUSES
GENETICS PLAY A PART

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TYPES OF SYMPTOMS

- Positive Symptoms (Most responsive to meds)
- Negative Symptoms

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SCHIZOPHRENIA
BLULERS FOUR A'S 1908

ASSOCIATIONS
AMBIVALENCE
AFFECT
AUTISTIC

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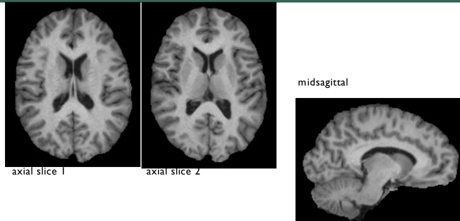
SCHIZOPHRENIA: CHANGE IN BRAIN VOLUME, 2007…



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SCHIZOPHRENIA SPECTRUM DISORDERS & PSYCHOTIC DISORDERS

- Abnormalities in thinking & experience
- Common symptoms include:
  - Hallucinations/hearing voices
  - Paranoia
  - Delusions
  - Disorganized thinking & behavior
  - Negative symptoms (reduced or absence of)

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SCHIZOPHRENIA SPECTRUM DISORDERS & PSYCHOTIC DISORDERS

- Category includes multiple psychotic disorders:
  - Schizophrenia
  - Delusional Disorder
  - Schizoaffective Disorder

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SCHIZOPHRENIA

- Hallucinations
- Disorganized speech
- Grossly disorganized behavior
- Unusual or bizarre behavior
- Negative symptoms (absence of or reduced)
- Delusions

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SCHIZOPHRENIA

- Typical age of onset:
  - Late teens to early 20s for men
  - Late 20s to early 30s for women
- Nature of disorder: episodic & chronic
- Treatment: psychotropic medications & therapy
- Additional features: can affect cognitive functioning
  - Particularly attention & memory

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ANTI-PSYCHOTIC MEDICATION

- Became available in USA 1956
- Two broad categories or families
- Older, Newer, One of each
- Efficacy vs Compliance
- Long Acting Injectables

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SCHIZOAFFECTIVE DISORDER

- Schizophrenia + Depressive Episode or Manic Episode
- Lot of Affect
  - Psychotic symptoms more prominent
  - How much emotion ?
  - 2 week period with only psychotic symptoms
  - Mood related symptoms episodic

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BIPOLAR RELATED DISORDERS

- Manic episodes
  - Periods of great excitement
  - Decreased need for sleep
  - Overactivity
  - Inflated sense of self
  - Racing thoughts
  - Impulsive
- Depressive episodes
  - Depressed mood
  - Less interest in activities
  - Weight loss or gain
  - Sleep problems
  - Trouble concentrating
  - Suicidal thoughts

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BIPOLAR RELATED DISORDERS

- Typical age of onset:
  - Broader range = late adolescence to early adulthood
  - Teenage to mid-20s
- Nature of disorder: episodic & chronic
- Treatment: psychotropic medications & therapy
- Additional features:
  - Can include psychotic symptoms, but isolated
  - Comorbid disorders

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NEUROCOGNITIVE DISORDERS

- Used to be called Delirium, Amnestic, Dementia, & Cognitive Disorders
- Formally referred to as Dementia
- Now includes:
  - Delirium
  - Mild Neurocognitive Disorders
  - Major Neurocognitive Disorders

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ONE OR MORE COGNITIVE DOMAINS AFFECTED

- Complex attention
- Executive function
  - Planning, thinking ahead, self-control, inhibition, & organization
- Learning & memory
- Language & speech
- Perceptual-motor
- Social cognition

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MULTIPLE SUBTYPES / CAUSES

- Traumatic Brain Injury (TBI)
- Alzheimer's disease
- Vascular disease
- Lewy body disease
- Parkinson's disease
- HIV infection
- Substance induced / related

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NEUROCOGNITIVE DISORDERS

- Typical age of onset = Varies greatly
  - Not developmental
  - Represents decline
  - Acquired conditions
    - Often associated with underlying brain pathology
- Nature of disorder:
  - Chronic
  - Not episodic, although exacerbations can occur
  - Decline in functioning over time

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MILD VS MAJOR NEUROCOGNITIVE DISORDERS

MILD

- *Moderate* Cognitive Decline
- NO interference with independence
- Not due to delirium
- Not due to other mental disorder

MAJOR

- *Significant* Cognitive Decline
- Interfere with independence
- Not due to delirium
- Not due to other mental disorder

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NEURODEVELOPMENTAL DISORDERS

- Conditions that begins in childhood
- Abnormal brain development
  - Affects how the brain functions
- Include impairments in:
  - Cognition
  - Communication
  - Behavior
  - Motor skills

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SUBTYPES / DIAGNOSES

- Autism Spectrum Disorder
- Attention Deficit Hyperactivity Disorder (ADHD)
- Specific Learning Disorders
- Intellectual Developmental Disorder (Intellectual Disability)
- Language Disorders
- Developmental Coordination Disorder
- Stereotypic Movement Disorder

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INTELLECTUAL DEVELOPMENTAL DISORDER

- Used to be referred to as Mental Retardation (MR)
- Changed to Intellectual Disability (ID)
  - Rosa's Law (2010)
  - DSM-5 (2013)
- Current term modified in TR (2022)
  - IQ test scores de-emphasized, although still important
  - Focus on fuller, more accurate picture of functioning

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3 KEY AREAS OF IMPORTANCE

Deficits in general mental abilities:

- Reasoning
- Problem solving
- Academic learning
- Planning
- Abstract thinking
- Judgment
- Learning from experience

Deficits in adaptive behavior

- Conceptual skills
- Social skills
- Practical skills

Age of onset

- Before age 22?

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ADAPTIVE BEHAVIORS

- Communication skills:
  - Language, self-direction, & literacy
  - Money, time, & number concepts
- Social skills:
  - Interpersonal skills, self-esteem, social responsibility, gullibility, naïveté, social problem solving, ability to follow rules/obey laws, & ability to avoid victimization
- Practical skills:
  - Personal care, travel/transportation, occupational skills, healthcare, schedules/routines, safety, use of money, & use of phone

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INTELLECTUAL DEVELOPMENT DISORDER

- Typical age of onset = developmental period
- Nature of disorder:
  - Life long condition
  - Not episodic
  - Affect multiple areas of functioning
    - Limits ability to learn at an expected level and function in daily life

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INTELLECTUAL DEVELOPMENT DISORDER

- Treatment:
  - Case management
  - Modified education & job programs
  - Therapy
  - Family support
  - Residential options
  - Medications
- Additional features: other mental disorders often present

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DIAGNOSES THAT MOST COMMONLY AFFECT CAPACITY

- Psychotic Disorders
  - Particularly if unmedicated
- Neurocognitive Disorders
- IDD
- Affective Disorders
- Combination of any of the above

Pirelli et al., (2011) & Danzer et al., (2022)

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References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Fishman E. Risk of Developing Dementia at Older Ages in the United States. Demography. 2017 Oct;54(5):1897-1919. doi: 10.1007/s13524-017-0598-7. PMID: 28776169; PMCID: PMC5624986.

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CONTACT INFORMATION

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847 651-4330

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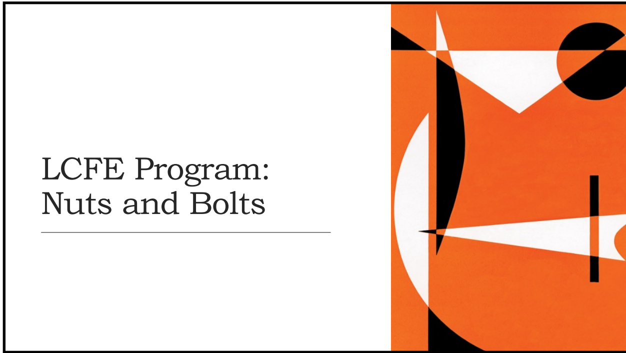

1

Introduction

Susan Hurt, Ph.D., Central Regional Hospital

- Evaluations of capacity to proceed, adult defendants and juvenile respondents
- Evaluations of capacity to proceed *pro se*
- Evaluations of mental state at the time of the alleged offense
- Appropriateness of transfer of juvenile respondents to Superior Court
- **Training and certification of local certified forensic evaluators**

2

Compare and Contrast: Evaluation vs Treatment

Evaluations: Geared toward deriving an answer to the referral question
- E.g., is the defendant currently capable to proceed
- E.g., is the student eligible for special education services
- E.g., is this adult able to manage his or her own financial affairs

Treatment (a/k/a intervention): Geared toward effecting change (improvement)
- Inpatient hospitalization for stabilization and discharge to lower level of care
- Outpatient therapy to improve functioning and maintain progress
- Capacity restoration (combined treatment and psychoeducation)

3

Compare and Contrast: CRH and LCFE

For today's purposes, CRH has two main components:
- Treatment/Intervention (accompanied by Cherry and Broughton Hospitals)
- Evaluations: Pre-trial forensic evaluation unit (unique to CRH)

For all purposes, LCFE's have a single component:
- Evaluations of capacity to proceed

In other words:
- Evaluations may take place at CRH pre-trial unit or by LCFE
- Intervention occurs at CRH but is a different service from evaluations
- LCFEs are not involved in treatment or capacity restoration

4

Our LCFE Evaluators

- **Licensed** clinicians, typically master's level in counseling, psychology, or social work
- **Contracted** with an LME/MCO (these are our regional Medicaid managers)
- **Training** for certification
- No requirement of previous training in forensic mental health evaluations

5

Our LCFE Evaluators: Training

- One day initial training (offered twice per year)
  - Background and context for evaluations of capacity to proceed
  - Methods for evaluations
  - Difficult issues (uncooperative defendants, impression management, conflicting records)
  - Report writing
  - Testimony
- ½ day annual training per year
  - Updates to programming
  - Review and quality improvement of sample reports
  - Spotlight difficult issues (last year focused on uncooperative defendants)

6

Decision Tree: CRH or LCFE?

Misdemeanors only should be directed to LCFE
- Turnaround time is faster
- Individual can be seen in-person locally (no video or transport)
- 15A-1002 (b)(2) reserves CRH for evaluations involving felonies

Mixed cases or felonies only: Your choice

Reasons to initiate evaluation at CRH
- Defendant has been evaluated at CRH before
- Defendant has had capacity restored before
- Serious charges or complicated background
- Likelihood of MSO evaluation in the future

7

LCFE Process

Court order directed to LME for assignment to a certified evaluator

Evaluator will take responsibility for arranging interview

How you can help the process
- Write clear referral questions
  - Is the concern for psychosis and irrationality or presence of school records identifying intellectual disability?
  - Have you experienced specific communication difficulties in working with the defendant?
- Provide charging documents; the evaluator is tasked with assessing the defendant's comprehension of them

8

Turnaround Times

Length of time between LME receipt of Order and LCFE submission of Report (2017-2024)
- Mean = 23 days
- Median = 14 days

Length of time between LCFE Interview and Date of Report (n = 41)
- Mean = 5.2 days
- Range = 0-66 days
- Number of reports completed within 2 days of interview: 25

Delays may occur earlier in process
- Time between Order signed and received by LME
- Time between receipt by LME and assignment to evaluator
- Time between assignment and interview arranged

9

LCFE: Outcomes

The rule requires the LCFE to "answer:"

- What is the defendant's current mental status?
- Is the defendant capable to proceed?
- What is the likelihood the defendant will regain capacity?
- What are the treatment recommendations?

10

If CTP, further evaluation?

Good bases for further evaluation at CRH

- Lack of clarity in how the LCFE conclusion flows from the data
- Multiple contradictory statements in LCFE report
- Known sources of data that were not available to LCFE (and make a difference)

Not as good bases for further evaluation at CRH

- If misdemeanors only, case should not come to CRH
- Desire for a different outcome without known evidence to support one
- "LCFE is not a forensic psychologist"

Additional considerations?

- Will the evidence better service a future issue (affirmative mental state defense, mitigation)
- Narrow/low legal threshold for capacity; narrow lens for the document dump

11

Decision Tree: Incapable to proceed

Invest in capacity restoration?

- Do not use order for further evaluation at CRH if inpatient capacity restoration is desired
  - Use Form # AOC-SP-304B (Involuntary Commitment Defendant Found Incapable to Proceed)
  - The Court Order for involuntary commitment distinguishes between "violent" and non-violent offenses, which are not further defined, giving the Court wide discretion."

Seek dismissal of the charges?

- Credible opinion of non-restorability (rare, but possible)
- Equivalent of "time served" has expired for most serious offense charged

12

Reports: Unable to determine

From the Rules

- "unable to reach a conclusion as to the defendant's capacity to proceed" results in
- the need for further evaluation of the defendant at CRH

What circumstances might result in an LCFE being "unable to reach a conclusion"?

- Typically, some type of mismatch in multiple sources of data
  - E.g., defendant responds "I don't know" to all questions, but no credible evidence of ID is present
  - E.g., defendant complains of hearing voices "all the time" but no objective evidence of psychosis is present
  - E.g., mixed findings of recent substance use and history of psychotic symptoms
- May also result from refusal to cooperate with the interview

13

Decision Tree: Unable to Determine

Seek further evaluation at local level

- Defendant's condition may further resolve with extended time (e.g., substance intoxication, extreme emotional upset over being arrested and detained)
- A second local evaluator may be able to resolve the issue

Seek further evaluation at CRH

- Rules provide for further evaluation at CRH, without reference to felony or misdemeanor
- For misdemeanors only, common for equivalent of "time served" to have expired
- For felony charges, this is an appropriate referral
  - CRH evaluators have more extensive training in distinguishing among recent substance use, mental disorders, and feigning symptoms
  - CRH evaluators have more extensive training in working with uncooperative interview subjects
  - CRH evaluators typically have access to more complete records and other collateral information

14

LCFE: Afterwards

Initial training includes brief introduction to testimony

- No expectation for extensive experience
- Training includes requirement of subpoena

Generally, re-evaluation after capacity restoration will be conducted within the state hospital system and will not involve the initial local evaluator

- May change with development of outpatient/community capacity restoration programs

15

Sample Slides from LCFE Training

1) Initial Training: Boundaries around the Role

2) Annual Training: Quality Control for Reports

16

LCFE Reports: Staying in our role

Forensic mental health evaluators are not responsible for what happens after they have answered the referral question

- The same system of laws that provides for evaluations has provisions for the lawyers to argue and the judge to decide what to do next
  - Yes, some defendants found incapable to proceed will have their charges dismissed. It is their lawyer's role to pursue this, not the mental health professional's
  - Yes, some defendants found incapable to proceed will be admitted to a state hospital for inpatient capacity restoration services. It is the lawyers' job to argue for and against this outcome, not the mental health professional's
  - Yes, some cases will raise concerns for the future safety of other individuals. It is the lawyers' role to argue for and against outcomes, not the mental health professional's
- If you find yourself wanting to control outcomes beyond the referral question, it is important to review your role, including its limitations
- The judge and lawyers in criminal court are there to move cases through the criminal process; they do not have jurisdiction over all civil matters, such as a need for guardianship or disability benefits

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Reports: Substantive Checklist

Does the report:

- Accurately state the North Carolina standard?
- Include sufficient data to describe the defendant's functioning
- Describe the functional abilities under the legal prongs
- (ITP only) Link the deficits to mental disorder
- Remain logical and consistent from observations to conclusions
- (ITP only) Address the question of restorability
- State a firm conclusion with recommendations consistent with the conclusion
- Refrain from extraneous issues or material (e.g., references to functioning at the time of the event, inculpatory statements)

18

LCFEs: An ongoing process

What factors can be added to the initial or annual training to render LCFE's more reliable and useful?

Other questions/suggestions?

Contact me: susan.hurt@dhhs.nc.gov

19

AFTER THE EVALUATION: CAPACITY RESTORATION AND RE-EVALUATION IN NC STATE PSYCHIATRIC HOSPITALS

PRESENTED BY:
ELIZABETH ARNETTE
HILARY R. VENTURA

1

LCFE SAYS INCAPABLE TO PROCEED: NOW WHAT?

- Capacity hearing
- AOC-SP-304B: fill out correctly
  - Some judges will dismiss order if not filled out correctly.
  - Facts on the order concerning why defendant meets commitment criteria assist hospital in understanding defendant's acuteness
  - Facts on the order concerning offense give forensic team understanding of the crimes

2

AOC-SP-304B INVOLUNTARY COMMITMENT CUSTODY ORDER DEFENDANT FOUND INCAPABLE TO PROCEED

STATE OF NORTH CAROLINA
WAYNE County

File No. 23 CRS 0000
In The General Court Of Justice
District Court Division

IN THE MATTER OF
Name And Address Of Respondent
Jane Doe
1234 Dirt Rd.
Goldsboro, NC

INVOLUNTARY COMMITMENT CUSTODY ORDER DEFENDANT FOUND INCAPABLE TO PROCEED
(For Offenses Committed On Or After Dec. 1, 2013)
G.S. 15A-1003, -1004; 122C-261, -262, -263

3

AOC-SP-304B
INVOLUNTARY COMMITMENT CUSTODY ORDER
DEFENDANT FOUND INCAPABLE TO PROCEED

I. FINDINGS

The respondent has been charged in File No. 23 CRS 0000 with a criminal offense in the above named county and has been found incapable of proceeding to trial under G.S. 15A-1002. The Court considered the opinion of Dr. G.I. Joe *(name of forensic evaluator)* in the report dated 12/01/2022 *(list date of report)* as evidence of incapacity to proceed. A copy of the evaluator's report is attached.

Based on the evidence presented, the Court finds that there are reasonable grounds to believe that the respondent is probably mentally ill and either dangerous to self or others or in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness in that *(insert appropriate findings)*

Defendant has been diagnosed with schizoaffective disorder and has an extensive history of substance abuse. Defendant did not demonstrate an understanding of the court system or her own situation. Defendant refuses medications and has displayed violent behavior in jail.

In addition, the Court finds that the respondent

☐ 1. is probably mentally retarded, in that *(insert appropriate findings)*

☒ 2. is charged with a violent crime in violation of G.S. 14-32, in that *(insert appropriate findings)*

She is alleged to have attempted to kill her mother by stabbing her mother with a knife.

NOTE TO JUDGE: *If this finding is made, you must designate a law enforcement agency below to take custody of the defendant upon release from treatment.*

4

AOC-SP-304B
INVOLUNTARY COMMITMENT CUSTODY ORDER
DEFENDANT FOUND INCAPABLE TO PROCEED

ORDER

To The Sheriff Of Wayne **County:**

1. The Court ORDERS you to take the above named respondent into custody and transport the respondent:
   - ☐ a. to a local person authorized by law to conduct an examination, for examination. *(Use when not charged with a violent crime.)*
   - ☒ b. directly to the 24-hour facility named below for temporary custody, examination and treatment pending a district court hearing. *(Use when charged with a violent crime.)*
2. The Court further ORDERS that you deliver a copy of the forensic evaluation report referenced in the Findings above, by the forensic evaluator named above, to the 24-hour facility named below.

To The Director Of The 24-Hour Facility Named Below:

The Court ORDERS you to deliver a copy of the forensic evaluation report referenced above to the Assistant Attorney General and the Special Counsel at the program where the respondent is to receive capacity restoration and that report is ordered released to them.

Notice To Hospital, Institution, 24-Hour Facility:

Criminal charges are still pending against the respondent. If defendant-respondent is released he/she must be released to the law enforcement agency named below. If the defendant-respondent is not charged with a violent crime and no law enforcement agency is specified, you may release him/her to whomever you think appropriate. You must examine the defendant-respondent to determine whether he/she has gained the capacity to proceed to trial prior to releasing him/her from custody. A report of the examination must be provided to the court pursuant to G.S. 15A-1002.

Name Of Law Enforcement Agency
Wayne County Sheriff's Department

Name And Address Of 24-Hour Facility	*Date*
Cherry Hospital 1401 W. Ash St. Goldsboro, NC 27530 **Pending Bed Availability**	3/10/2024 *Signature Of Judge* Judge Judy
Or Following Facility Designated By Area Authority:	*Name Of Judge (type or print)* Judge Judy

NOTE: *Use AOC-SP-910M for involuntary commitment if defendant found not guilty by reason of insanity.*

(Over)

AOC-SP-304B, Rev. 4/18, © 2018 Administrative Office of the Courts

5

REFERRAL FOR CAPACITY RESTORATION

- North Carolina provides capacity restoration in the three state psychiatric hospitals: Broughton (West), Central Regional (Central), Cherry (East).
- Each hospital serves patients from its own catchment area ONLY.
- NC DHHS initiatives in progress to create other restoration options.

6

AWAITING ADMISSION

- Continue engaging with your client, when possible. It allows attorneys to:
  - Builds rapport,
  - Reduces defendant's frustration in the system, and
  - Allows attorney to understand defendant's condition and whether discontinued drug use and/or psychiatric medication has improved defendant to a point where re-evaluation may be possible.
- If lower-level charges, especially misdemeanors, try to get resolved.
- Some defendants are let out on bond and will need to be reached quickly when called in for admission.

7

AFTER ADMISSION

- Evaluated by psychiatrist within 24 hours of admission and treatment begins.
- Entitled to commitment hearing within 10 days of admission.
- Helpful information to compile for Special Counsel's Office and Forensics Department:
  - time the defendant has spend in jail,
  - the defendant's sentencing level and maximum time that defendant would serve at that level, if convicted,
  - information concerning plea bargains,
  - information regarding bond,
  - if you are pursuing an NGRI defense, and
  - where defendant is in the legal process.

8

REFERRAL FOR CAPACITY RESTORATION

- Once defendant has benefits enough from treatment to be able to meaningfully participate, the team will refer him or her for capacity restoration.
- What is concepts are taught?
  - Explaining what ITP means and how to navigate the process
  - Identifying court personnel and understanding their individual roles
  - Knowing the various plea options and understanding the benefits and consequences of each one
  - Working effectively with your attorney
  - How best to present yourself in court
- What do the classes look like?
  - Group sessions on the unit.
  - Individual sessions with member of the psychology department.
  - Individualized, when necessary, for each participant.

9

WHO GETS RESTORED?

- Nationally 81% of patients are restored within 90-120 days
- What makes restoration **more difficult**?
  - Treatment resistant psychosis
  - Cognitive issues
    - Traumatic Brain Injury
    - Intellectual Disability
    - Intellectual Developmental Disorder

Pirelli, Gianni & Zapf, Patricia & Gottdiener, William & Park, Greystone & Jay, John & Luke, St & Medical, S-Roosevelt. (2011)

10

REFERRAL FOR RE-EVALUATION

- Once the team believes that the defendant has reached maximum treatment benefit, then they submit a referral for re-evaluation of the defendant's capacity to proceed.
- Evaluator will determine if the individual can now understand legal proceedings, comprehend legal situation, assist defense in a rational manner.
- What does the evaluation process look like?
  - A forensic evaluator is assigned who interviews defendant at least once and often several times.
  - Evaluator also reviews records from current admission, capacity restoration, older medical records, school records, previous evaluations, and other information as available.
  - Evaluator will often contact the defense attorney.

11

KEY ELEMENT IN PROCESS: DEFENSE ATTORNEY

- Defense attorney are often the only person that defendants trust in the process.
- Input concerning interactions with the patient can assist the treatment team in determining treatment and readiness for capacity restoration and/or evaluation.
  - Remember: Treatment team is limited in ability to communicate with defense attorney, if defendant does not consent.
- Report of attorney's interactions with the defendant will help to gauge defendant's understanding of the charges and ability to assist attorney in their defense.
  - Remember: Advise Forensics Department about visits.

12

KEY ELEMENT IN PROCESS: DEFENSE ATTORNEY

- Participate in the restoration process:
  - Give feedback to team on concepts where defendant needs more education,
  - Share approaches that have worked with you when engaging with defendant,
  - Review discovery with defendant, if requested.
    - This is generally requested if the defendant is misremembering and misunderstanding the circumstances of their charges.
- Reminder: Participating in the capacity restoration and evaluation process does not preclude a defense attorney from challenging the opinion in the future.
- Keep hospital updated on pending court dates and if charges are dismissed.

13

EVALUATION RESULT: REMAINS INCAPABLE

- Evaluator writes a consultative report (consult) for the treatment team.
- Consult may include suggestions for:
  - Medication changes,
  - Varying method for defendant's restoration,
  - Specific concepts for which defendant needs more education.
- Defendant will continue treatment and capacity restoration.

14

EVALUATION RESULT: CAPABLE

- Formal evaluation report is written for the court. Hospital sends a copy of report to the prosecutor and defense attorney, as well.
- Defendant generally discharged back to jail to proceed to trial or otherwise resolve charges.
  - Goal: Move forward as quickly as possible with the capacity hearing and resolution for charges to avoid decompensation.
  - **NCGS § 15A-1007**
    - Capable defendants returned for court must be calendared for a hearing within 30 days
    - When the Court finds the defendant capable, the case must be calendared for trial within 60 days. Continuances extending beyond 60 days "shall be granted only in extraordinary circumstances when necessary for the proper administration of justice, and the court shall issue a written order stating the grounds for granting the continuance."

15

CAPACITY HEARING FOLLOWING CAPABLE EVALUATION

- Team may recommend that defendant remain in the hospital while legal situation is resolved.
  - Avoid decompensation.
  - If the defendant is expected to accept plea and not receive active sentence, hospital may allow defendant to stay and be placed.
    - Benefit: Once charges resolved, hospital can assist in locating and arranging outpatient services that defendant would not have if released directly from jail.
    - Reminder: Bed space is limited, and this process needs to happen quickly to avoid defendant being discharged back to jail.

16

OUTPATIENT SERVICES

- Patients are often assigned an Assertive Community Treatment team (ACTT) to support their mental health needs upon discharge.
  - These include a psychiatrist, nurse, social worker.
- Placements must be in the least restrictive setting that is medically appropriate to be funded.
- Transition to Community Living (TCL) housing is more prevalent than group or adult care homes because it provides participants with independent living while also having housing support and tenancy management.
  - The need for TCL placements exceed availability, and participants are often placed in Bridge Housing with TCL until a permanent placement is located.
  - Bridge Housing is generally at local hotels or motels.
  - The hospital does not decide whether the participant goes to Bridge Housing or permanent housing through TCL. That is the LME/MCO who administers the TCL program.

17

EVALUATION RESULT: NON-RESTORABLE

- Formal evaluation report is written for the court and distributed to the parties.
- Evaluation will say that the defendant is incapable to proceed and non-restorable.

NCGS § 15A-1008

- Mandates dismissal of the charges without prejudice if the court determines that the defendant will not gain capacity.
- Motion to dismiss can be made by court, prosecutor, or defendant.

- While awaiting dismissal, defendants may remain in the hospital for further treatment, but they may also be discharged back into custody. Communication and, again, quick movement toward resolution is key.

18

WHILE THIS IS HAPPENING IN THE BACKGROUND: COMMITMENT COURT

INITIAL HEARINGS

- Upon admission, defendants have the right to a hearing within 10 days.
- Defendant can agree to the commitment recommendation, or they can contest.
- If the defendant contests, they are entitled to a commitment hearing.
- What does the commitment hearing look like?
  - District court in the county where the hospital is located.
  - State is represented by the assistant attorney general assigned to that hospital (NC DoJ employee).
  - Defendant/respondent is represented by Special Counsel (IDS employee).
  - Treating physician is the State's main witness.
  - Hearing are closed, pursuant to statute.

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WHILE THIS IS HAPPENING IN THE BACKGROUND: COMMITMENT COURT

- INITIAL HEARINGS, CONTINUED
- Court will decide whether the State proved by clear, cogent, and convincing evidence that the defendant/respondent meets commitment criteria (mentally ill and dangerous).
- The maximum time allowed for an initial commitment is 90 days.

- REHEARING
- After each commitment order expires, the defendant/respondent will have the opportunity to decide again whether or not he/she wants to agree to the commitment recommendation or contest.

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WHILE THIS IS HAPPENING IN THE BACKGROUND: COMMITMENT COURT

- Important to remember that any time that defendant/respondent contests that there is a risk that the court will discharge them back to jail.
- Defendant would remain incapable to proceed and would likely require readmission to restart treatment and capacity restoration.
- When a defendant/respondent contests, Special Counsel or the treatment team may reach out to defense attorney for assistance in explaining the ITP process to their client and why discharge back to jail would be harmful.

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OTHER REASONS DEFENSE ATTORNEY MAY BE CONTACTED

- Dismissal under NCGS § 15A-1008
  - When the defendant has been in custody equal to or in excess of the maximum term "for a prior record Level VI for felonies or Prior Level III for misdemeanors for most serious offense charged" (dismissed w/o leave)
  - Upon the expiration of a period of 5 years from the date determined incapable for a misdemeanor, or 10 years for a felony (dismissed w/o prejudice)

22

INFORMATION SHARING AND RECORDS ACCESS CONCERNING MENTAL HEALTH TREATMENT AND DEFENDANT CAPACITY

Presented by:
Elizabeth Arnette
Hilary R. Ventura
Assistant Attorneys General
North Carolina Department of Justice

1

OBJECTIVES

- Learn requirements for accessing an individual's mental health and substance abuse records and records of civil commitment court proceedings.
- Review information sharing requirements concerning defendants found incapable to proceed.

2

MENTAL HEALTH RECORDS

3

CLIENT'S RIGHT TO CONFIDENTIALITY

- "Client" here refers to "patient."
- N.C. Gen Stat. § 122C-52(C): "Except as provided by G.S. 122C-53 through G.S. 122C-56, each client has the right that no confidential information acquired be disclosed by the facility."
- Exceptions:
  - Client. § 122C-53
  - Abuse reports and court proceedings. § 122C-54
  - Care and treatment. §122-55
  - Research and planning. §122-56

4

CLIENT EXCEPTION - §122C-53

- Signed release from the client or the client's legally responsible person. § 122C-53(a).
  - The release must: 1) Be for a specified length of time; and 2) be subject to revocation by the client.
  - Form DHHS-1000: Authorization to Disclose Health Information
- Who is the "legally responsible person?"
  - Guardian for adults who have been adjudicated incompetent or health care agents for adults with a health care power of attorney. §122C-3(20)(i)&(iii)
  - Parent, guardian, custodian for juveniles. § 122C-3(20)(ii)
- Information that the treating physician or facility director deems potentially injurious to the physical or mental well-being of the client will not be released. §122C-53(c)&(d)

5

COURT PROCEEDINGS EXCEPTION - §122C-54

- "A facility shall disclose confidential information if a court of competent jurisdiction issues an order compelling disclosure." § 122C-54(a)
- **FAQ**
  - **Is a subpoena enough to obtain mental health records?** No.
  - **What if the subpoena was signed by a judge?** An accompanying court order is still necessary.
  - **When must a subpoena accompany a court order?** If the language of the court order authorizes disclosure of confidential information but does not compel it.

6

ACCESSING RECORDS CONCERNING APPLICATIONS TO REMOVE FIREARMS BAR- § 14-409.42

- District attorneys must produce any and all evidence showing that lifting a petitioner's firearm bar would be against the public interest.
- To meet this requirement, the district attorney may access any mental health records, juvenile records, and criminal history of the petitioner.
- The petitioner must sign a release allowing the district attorney to obtain these records.

7

SUBSTANCE ABUSE RECORDS

8

FEDERAL PREEMPTION

- "No provision of G.S. 122C-205 and G.S. 122C-53 through G.S. 122C-56 permitting disclosure of confidential information may apply to the records of a client when federal statutes or regulations applicable to that client prohibit the disclosure of this information." G.S. § 122C-52(d)
- HIPAA – 45 C.F.R. Part 2: Confidentiality of Substance Abuse Patient Records
  - Applies to not only records from substance abuse treatment facilities, but also mental health records that include references to substance abuse disorders and treatment.

9

PART 2 INFORMATION – 42 U.S.C. § 290DD-2

- No records or testimony containing or concerning Part 2 information may be used in a civil, criminal, or administrative context unless they are released, pursuant to:
  - Consent of individual. 42 U.S.C. § 290dd-2(b)(1)
  - Court order. 42 U.S.C. § 290dd-2(b)(2)(C)
    - Required contents of the order:
      - Show good cause, including the need to avert a substantial risk of death or serious bodily harm.
      - In assessing good cause, the court must weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services.
      - Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

10

CIVIL COMMITMENT COURT PROCEEDINGS & RECORDS

11

COURT HEARINGS - §§ 122C-268(H) & 269

- Civil commitment hearings are held in the county in which the facility is located, unless there is an objection as to venue.
- Civil commitment hearings held at the state psychiatric hospitals are closed to the public, unless the respondent requests otherwise.
- **FAQ**
  - **Is the Assistant District Attorney entitled to attend the hearing?** No
  - **Is the defense attorney entitled to attend the hearing?** No
  - **Are attorneys from other stake holder agencies and organizations (e.g. LME/MCOs) entitled to attend the hearing?** No

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COURT RECORDS - § 122C-54(D)

- To obtain court records or court files from civil commitment court, a person must file a motion in the cause setting out why the information is needed.
- The judge may issue an order releasing the information if he or she finds:
  - the order is appropriate under the circumstances;
  - that it is in the best interest of the individual; or
  - that it is in the best interest of the public.

13

RECORDS WHEN VENUE CHANGES- § 122C-54(C)

- If venue is challenged, then the venue is changed to the county where the petition is initiated (§ 122C-269(a)) or in the county in which the client was found incapable to proceed (§ 122C-269(c)).
- The hospital must provide the client's attorney, the State's attorney, and the court:
  - Certified copies of written examinations done in the course of the current commitment or admission.
  - Upon request, information collected, maintained, or used in attending or treating the respondent during the current commitment or admission.
  - Any other records can only be provided by court order.

14

ITP RECORDS

15

RECORDS FOR INITIAL MENTAL EXAMINATION - §15A-1002(B)(4)

- The court ordering the initial examination shall order the release of confidential information to the *examiner*, including:
  - Warrant and indictment, arrest records, the law enforcement incident report, the defendant's criminal record, and jail records;
  - Prior medical and mental health records; and
  - School records.

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RESULTS OF INITIAL EXAMINATION - §§ 122C-54(B) & 15A-1002(D)

- The facility or person conducting the mental examination sends the results to:
  - the clerk of court;
  - the prosecuting attorney;
  - the defense attorney or defendant, if unrepresented.
- If the defendant is in custody, then a copy of the covering statement is sent to the sheriff.

17

ACCESSING INITIAL EXAMINATION RESULTS & RECORDS USED FOR EXAMINATION - § 15A-1002(D)

- Clinicians at the program where the defendant is receiving capacity restoration are entitled to:
  - The full initial examination report AND
  - All of the records ordered released to the examiner under § 15A-1002(b)(4):
    - Warrant and indictment, arrest records, the law enforcement incident report, the defendant's criminal record, and jail records;
    - Prior medical and mental health records; and
    - School records.

18

AFTER ADMISSION FOR CAPACITY RESTORATION - § 15A-1003(C) & 1004(D)

- Evidence used in the hearing to determine whether a defendant has capacity to proceed may be used in the involuntary commitment hearings for the defendant. § 15A-1003(c)
- At the time of a patient's initial commitment and re-commitment, the hospital must report the condition of the patient to the clerk. § 15A-1004(d)

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CAPACITY RE-EVALUATION - § 15A-1004(D)

- The hospital must immediately report to the clerk when a patient regains capacity.

20

OTHER REPORTING OBLIGATIONS - § 15A-1005

- The clerk of court in which the criminal proceeding is pending must keep a docket of the defendants who have been determined incapable to proceed.
- The docket must be provided to the senior resident superior court judge in that district at least semi-annually.

FAQ

- **Is this docket the same as the waiting list that the hospital maintains?** No.
- **Are others entitled to access to this docket?** This is confidential information and should only be released by court order.

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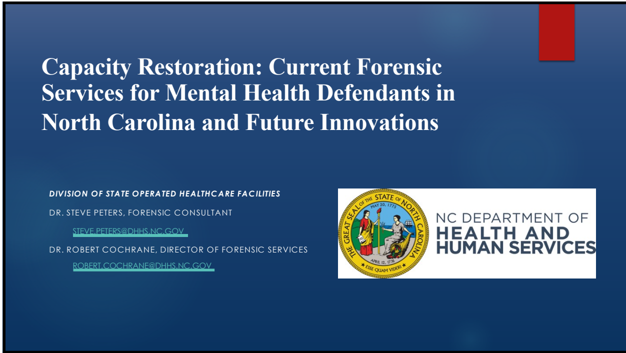

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DISCLAIMER

The opinions expressed in the materials provided and orally in this presentation are those of the authors and do not represent the opinion of the North Carolina Department of Health and Human Services.

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OBJECTIVES

Explain	The current legal process and model of care for defendants whose capacity to stand trial is questioned.
Increase	Awareness of the problems and need for improvement of the current system of care for these individuals.
Present	Innovative options for capacity restoration in Detention Centers and in the Community.

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Abbreviations

Label	Meaning
D	Defendant
ITP	Incapable to proceed to trial
SPH	State Psychiatric Hospital
IVC	Involuntary Commitment
CBCRP	Community Based Capacity Restoration Program
DCCRP	Detention Center Capacity Restoration Program

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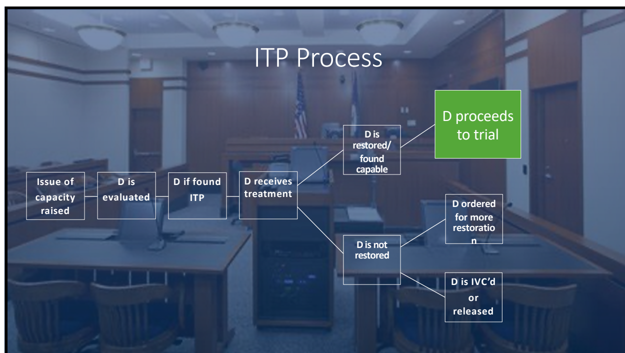

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Restoration Outcomes

- D is restored and returns to court for trial
- D is still incapable; court orders further treatment
- If non-restorable at pilot site, hospitalization will likely be of no further benefit.
- D is non-restorable
  - Civil commitment AND/*OR*
  - Charges dismissed
  - Connection to community services
  - Placement challenges

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Grounds for Dismissal: G.S. 15A-1008(a)

(1)	(2)	(3)
D will not gain capacity to proceed (without prejudice)	D has been deprived of liberty for a period equal to the maximum term of imprisonment (without leave)	5 years from incapacity for misdemeanor or 10 years for felony (without prejudice)

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Restoration Treatment – SPH's

- Unit based and/or "treatment mall"
- Individualized Treatment Plans
- Typical interventions:
  - Psychoeducation – group using revised Florida CompKit; individual if indicated
  - Psychiatric medication, as needed
  - Psychotherapy and substance use treatment, as indicated
  - Milieu - recreational and social activities
- National inpatient restoration rate = ~80% within 90-120 days
  - Jail-based = 45-85% in 60-90 days

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Challenges with the ITP Process

1. Staffing Shortages/Bed space
2. Increase ITP referrals
3. Wait lists and wait times
4. Level of Care not matching need
5. Revolving Door
6. Misdemeanor Cases and recidivism

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State Psychiatric Hospitals

Broughton Hospital

Central Regional Hospital
*(Forensic Evaluation Center)

Cherry Hospital

This map shows LME/MCO configuration as of 2/1/22.

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Staffing Shortages

- Nationwide healthcare shortages
- COVID impact – lost 100+ employees
- Non-competitive pay

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Hospital Bed Space

- Over 2,000 evaluations requested yearly
- Approximately 60% are found ITP…1,200 patients/year
- ITP's have steadily increased in the last several years
- ~670 SPH beds available in 2023

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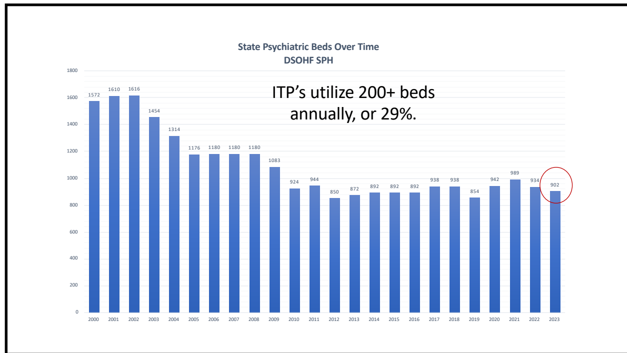

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Increase in Capacity Evaluations

Year	Alliance	Trillium	Sandhills	Eastpointe	Vaya	Partners	CRH	Total
2015	115			22	8	60 (6mo.)	808	
2016	260	80		63	23	101	816	
2017	245	140		72	29	139	816	
2018	275	90	310	60	100	150	896	1881
2019	260	98	336	55	150	155	816	1870
2020	240	87	327	37	135	125	816	1642
2021	270	60	301	40	200	172	835	1706
2022	320	52 (9mo.)	228	30	270	160 (9mo.)	940	2066

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ITP State Psychiatric Hospital (SPH) Wait List, Wait Times, and Admissions

ITP Number on Waitlist	
Aug-22	150
Sep-22	158
Oct-22	178
Nov-22	192
Dec-22	197
Jan-23	195
Feb-23	195
Mar-23	203
Apr-23	197
May-23	207
Jun-23	213
Jul-23	193
Aug-23	192
Sep-23	184
Oct-23	172
Nov-23	168
Dec-23	174

Waitlists in Other States: TX=2500; GA=360; VA=75; OK=200

Referral to Acceptance SPH Wait Times Days		
	Average	Maximum
Broughton	250	471
Cherry	266	462
CRH	52	150

Current ITP Admissions
Broughton = 63
Cherry = 39
CRH = 79

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Levels of Care

Danger to self or others

- GS § 15A-1003 - Currently courts routinely order all ITP defendants to SPH.
- There are no other options to get CR for ITP's.
- Defendants who do not require hospital level of care are none-the-less admitted to SPH.

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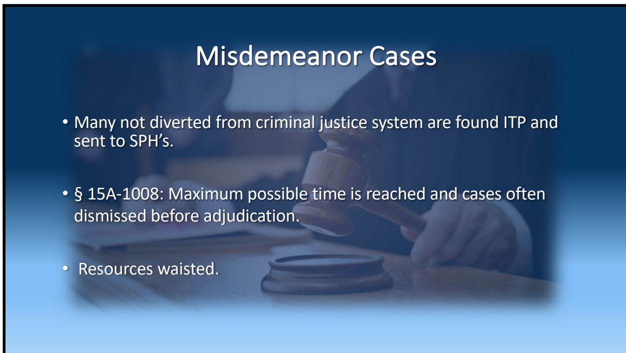

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Negatively Impacts…

- Courts
- Jails
- SPH's
- Prisons
- Emergency Departments
- Other hospitals/crisis units
- Defendants!

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Solutions to ITP and SPH Problem

- Provide more community MH services
- Offer more diversion for misdemeanants
- Hire more SPH staff/build more hospitals
- Implement "capacity dockets"
- ***Alternative Capacity Restoration Locations***
  - ***CBCRP***
  - ***DCCRP***

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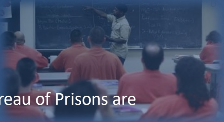
NC Initiatives

CBCRP and DCCRP Overview:

- Growing number of states and Federal Bureau of Prisons are utilizing CBCRP and DCCRP (N=18)
- Research showing greater access to care, reduced use of SPH, >/= restoration rates, and faster time to restoration
- SAMHSA support – GAINS TA and Learning Collaborative



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Goals

1. Reduce the number of ITP defendants in jails by offering CBCRP.
2. Quicker access to care for ITP defendants in jail.
3. Reduce jail time and resolve cases more quickly.
4. Reduce SPH admissions and wait times by providing DCCRP.
5. Cost and resource savings by limiting SPH care to those who need it.
6. Decrease recidivism for lower-level offenders through greater engagement.

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CBCRP Pilots

Mecklenburg
Atrium Health

Wake
Elwyn Adult BH Services

Cumberland
CommuniCare

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CBCRP

Staffing	Programming and Service
Forensic Program Manager	Psychoeducation (5 sessions/week; 1 individual)
Clinical Restoration Staff	Medication
Peer Support Specialist	Counseling
Forensic Navigator	Substance use treatment, if indicated
Psychiatry	Housing, transportation, food support

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DBCRP Pilots

- Mecklenburg County
- *Wake County**
- *Pitt County?*

* Anticipated launch May 2024

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Mecklenburg (NC RISE) Outcomes

2023

- 10 bed unit; served 35+ defendants
- Average days to admission:
  - BEFORE NC RISE = 186
  - AFTER NC RISE = 23
- 80% restoration rate
- Avg time to restoration = 50 days
  - BSH avg = >180 days*
- Waitlist Prior to NC RISE: 23
  - Current waitlist: 9
- Participant and Stakeholder Surveys

*BSH has more acute patients

Poor, Fair, Good, Very Good, Excellent

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Restoration Settings

Hospital	Jail	Community
• Acute psychiatric symptoms, including severe psychosis • Refuses treatment • Recent suicidal or self-injurious behavior • Recent or history of severe aggression/violence • High risk of re-offending • Acute medical ailments or disabilities • Substance detox needed	• Ineligible for bond (certain categories of offenses) or willing to waive • Likely to comply with treatment • Low suicide risk • Likely restorable within 60-90 days • Awaiting admission to or already discharged from SPH	• Eligible for bond • Likely to comply with treatment • Low risk for re-offending • Misdemeanor or non-violent offense

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Referral Process

DCCRP:

- Those on waiting list for SPH are screened for eligibility
- Courts can order into the program
- Attorneys and court are notified of admittance
- D remains on waitlist and will still go if cannot be restored in detention

CBCRP:

- LCFE evaluator makes recommendation
- If D is eligible for bond, Court can order D into the program
- 30-day updates are provided
- If/when restored, independent evaluation

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Contact Information

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DCCRP Providers:

- Mecklenburg (NC RISE): Dr. Nathan Andrews, nandrews@wellpath.us.

CBCRP Providers:

- Cumberland County (CommuniCare): Kenneth Smith, ksmith@cccommunicare.org
- Wake County (Elwin Adult Behavioral Health Services): Samantha Wilson, samantha.wilson@elwyn.org
- Mecklenburg County (Atrium Behavioral Health): Yolonda Tindal, caprestorationprogramreferral@atriumhealth.org

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Questions?

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CONSIDERATIONS IN CAPACITY EVALUATIONS: KEY ELEMENTS OF REPORTS

Robert Cochrane, PsyD, ABPP
Statewide Director of Forensic Services, DHHS

Slides by: Stephanie Callaway, PsyD, ABPP

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AGENDA

- Review types of reports
- Discuss the impact of diagnoses and symptoms
- Identify essential capacity elements in reports
- Discuss the impact of feigning/malingering

2

TYPES OF REPORTS

- Because I'm a doctor
- But they have a serious mental illness
- They can't be faking it
- The whole kitchen sink
- Jargon overload

3

CAPACITY TO PROCEED

- § 15A-1001: Lacks capacity to proceed if, by reason of mental illness or mental defect, they are unable to:
  - understand the nature and object of the proceedings;
  - comprehend his or her situation in reference to the proceedings; or
  - assist in his or her defense in a rational or reasonable manner

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THRESHOLD ISSUE

- Mental illness or mental defect:
  - Symptoms described in detail
  - Diagnosis not required but typically included
  - Nexus between symptoms/deficits & capacity-related abilities

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AUTOMATICALLY INCAPABLE?

- Capacity = ability to learn, understand, & comprehend
  - Prior knowledge or experience is not required
- Not automatically incapable if:
  - Mental illness or defect
  - Lack experience in system
  - Unwillingness
  - Lack of effort or motivation
  - Decisions driven by frustration or stubbornness

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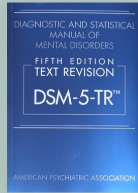
DIAGNOSES THAT MOST COMMONLY AFFECT CAPACITY

- Psychotic Disorders
- Neurocognitive Disorders
- Intellectual and Development
- Affective Disorders
- Combination of any of the above



Pirelli et al., (2011) & Danzer et al., (2022)

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HOW SYMPTOMS CAN AFFECT CAPACITY RELATED ABILITIES

- Psychosis & Bipolar Disorder:
  - Delusions directly related to charges & allegations
  - Symptoms interfere with ability to carry on a conversation or give reality-based responses
  - Hearing voices that disrupt attention & ability to converse
  - Accompanying cognitive deficits
  - Can't stay on task
  - Speak rapidly without pause

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EXAMPLE

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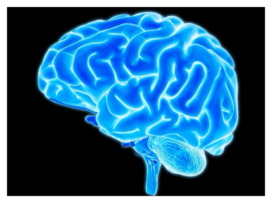
HOW SYMPTOMS CAN AFFECT CAPACITY RELATED ABILITIES



- Neurocognitive Disorders
  - Lack ability to:
    - Use logical thinking and reasoning
    - Effectively formulate and communicate decisions
    - Maintain focus & attention for sustained periods
    - Recall important details of alleged offense
    - Retain information from one hearing to another

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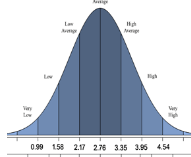
HOW SYMPTOMS CAN AFFECT CAPACITY RELATED ABILITIES

- Intellectual Developmental Disorder
  - Lack ability to:
    - Learn new concepts/terms
    - Use logical thinking and reasoning
    - Effectively formulate and communicate decisions
    - Maintain focus & attention for sustained periods
    - Appreciate consequences of decisions
    - Retain information from one hearing to another



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HOW SYMPTOMS CAN AFFECT CAPACITY RELATED ABILITIES

- Affective Disorders (Depression, Anxiety)
  - Too depressed and unmotivated to mount a defense
  - Actively suicidal and internally preoccupied
  - Frequent panic attacks
  - Socially anxious

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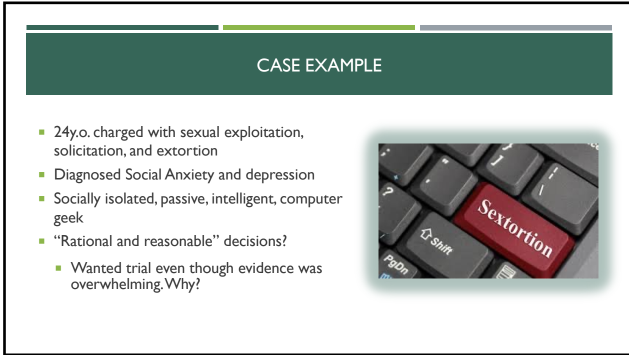

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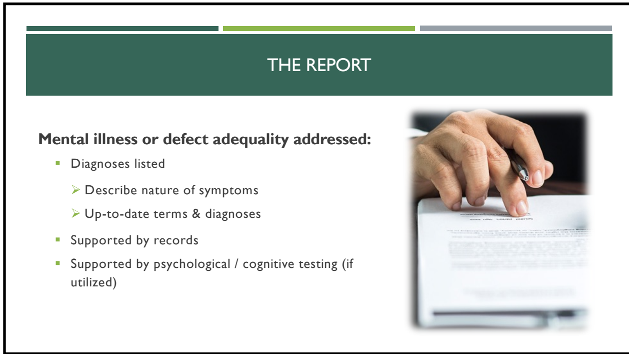

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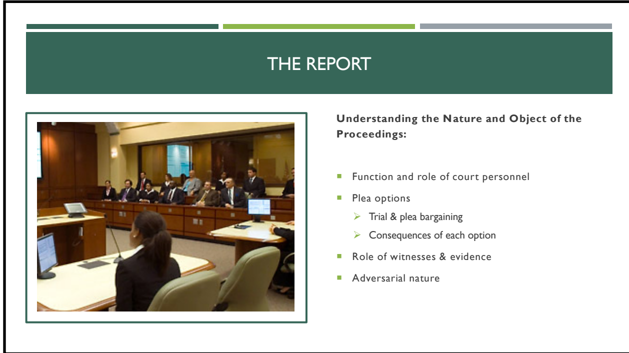

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THE REPORT

Comprehending Their Situation In Reference to Proceedings:

- Know & understand their charge(s)
- Understand allegations
- Appreciate potential penalties
- Appraise evidence
- Capacity to testify relevantly

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THE REPORT

Assist in Their Defense in Rational and Reasonable Manner:

- Rationally discuss how they want to proceed
- Trusts attorney/best interest
- Communicate their version and relevant info
- Consider attorney's advice in rational manner
- Weigh options & consequences and make reasoned choices
- Maintain focus and comport behavior

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FEIGNING AND/OR EXAGGERATION

- 20-25 % rates of feigning in CTP evaluations
- Standard in the field is to assess
  - Effort
  - Feigning
  - Exaggeration

Rubenzer, S (2018)

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WHAT IS TYPICALLY FEIGNED AND/OR EXAGGERATED?

- Psychotic symptoms
- Cognitive deficits
- PSTD symptoms
- Ignorance of the court system
- Lack of recall for their history
- Amnesia for the alleged offense
- Limited knowledge about their charges / allegations

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WHY MIGHT THERE BE FEIGNING AND/OR EXAGGERATION?

- Avoid prosecution / conviction
- Go to a hospital
- Get medications
- Secure better treatment
- Getting charges dropped
- Cry for help
- Avoid assaults
- More desirable housing
- Stall the process
  - Witnesses disappear / become compromised
- Frustrate the process
- Set up for an NGRI defense
- Assist in disability claim

Rubenzer, S (2018)

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HOW MIGHT IT BE FEIGNED AND/OR EXAGGERATED

- Claimed ignorance
  - Common / rote knowledge
  - "I don't know" syndrome
- Inconsistencies:
  - In history
  - Within interview
  - Across interviews
- Silence / avoidance
- Issues with effort
  - Low, mixed, or inconsistent
- Atypical symptoms / impairments
- Draw attention to symptoms
- Uncooperativeness
- Variable knowledge
  - Personal history vs case / court

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ASSESSMENT STRATEGIES

- Interview strategies
- Psychological testing
  - Performance or symptom validity testing
  - Assess feigning lack of legal knowledge
- Reported symptoms / behaviors vs treatment records
- Observations in inpatient setting
- Collateral interviews

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MULTIPLE PERMUTATIONS

- Feigning
- Cognitive disorder + feigning
- Mental illness + feigning
- Mental illness + cognitive disorder + feigning

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OTHER KEY ELEMENTS OF CTP REPORTS

- Spoke with attorney
- Only address issue requested/ordered
- Avoidance of prejudicial & irrelevant information
  - Limit self-disclosures related to crime
- Limited jargon
- Avoidance of bias

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OTHER KEY ELEMENTS OF CTP REPORTS

- Capacity to learn & retain tested
- Cultural & language issues addressed
- Clearly articulate opinion
- Appropriate tests used
  - Explain tests & results in understandable way
- Recommendations about restoration

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