Involuntary Commitment for Magistrates

February 10-11, 2025
School of Government, Chapel Hill
Room 2401

Monday, February 10

8:45 a.m.	**Check-in**
9:00 a.m.	**Welcome and Introductions** Mark Botts, School of Government
9:15 a.m.	**Involuntary Commitment Law and Procedure** [1.25 CE] Mark Botts, School of Government
10:30 a.m.	*Break*
10:45 a.m.	**Involuntary Commitment Law and Procedure** *(continued)* [1.25 CE] Mark Botts, School of Government
12:00 p.m.	*Lunch*
12:45 p.m.	**Applying the Judicial Decision-Making Process to IVCs** [1.5 CE] Melanie Crenshaw, School of Government
2:15 p.m.	*Break*
2:30 p.m.	**Living the Role of Fair and Impartial Decision-Maker** [1.5 CE] Shea Denning, School of Government
4:00 p.m.	**Petition Exercise** [0.75 CE] Mark Botts, School of Government
4:45 p.m.	*Recess*
5:30 p.m.	**Optional Group Dinner** (Nantucket Grill – Chapel Hill, 5925 Farrington Road)

Tuesday, February 11

8:30 a.m.	**Recap Day 1/ Community Collaboration and Response** [0.5 CE] Mark Botts, School of Government
9:00 a.m.	**Community Response to Psychiatric Emergencies: Law Enforcement and Human Services Professionals Working Together—Panel Discussion** [1.50 CE] Lieutenant Nate Chambers, Chapel Hill Police Department Sarah Belcher, LCSW, CTM, Police Crisis Unit Supervisor Tammy Shaw, National Alliance on Mental Illness (NAMI) Orange County
10:30 a.m.	*Break*

10:45 a.m.	**Mental Health 101** [1.0 CE] Ken Fleishman, M.D., Cape Fear Valley Health System
11:45 a.m.	*Lunch*
12:30 p.m.	**Mental Health 101 (*continued)*** [1.0 CE] Ken Fleishman, M.D., Cape Fear Valley Health System
1:30 p.m.	**The Hospital Role** [0.75 CE] Ken Fleishman, M.D., Cape Fear Valley Health System
2:15 p.m.	*Break*
2:30 p.m.	**Putting It All Together: Petition Exercise and Assessment** [2.0 CE] Mark Botts, School of Government
4:30 p.m.	**Wrap-Up**
4:45 p.m.	*Adjourn*

MAGISTRATE CE CREDIT HOURS = 13.0 hours
This program will have 13.0 hours of instruction, all of which will qualify for continuing education credit under Rule II.C of Continuing Judicial Education.

Involuntary Commitment: The Procedure for Commitment

Mark Botts

UNC SCHOOL OF GOVERNMENT

1

Involuntary Commitment

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

Because the commitment stat...s provide for a drastic re...edy, those that use the ... do so with "care and ...ness." In re Ingram, 74 ... p. 579 (1985), ...ng Samons, 9 NC App. ... 0).

Court order

2

Topics

- Layperson Petition Procedure
- Clinician Petition Procedure
- Emergency criteria and procedure

3

The Petitioner

The individual who asks the magistrate—through the submission of a sworn affidavit—to commence the commitment process

The affidavit is also called a petition

4

4

The Respondent

The individual who is the subject of the petition and—if the magistrate commences the commitment case—

- Will be examined by a commitment examiner
- Will have the opportunity to respond to the petitioner's allegations at a court hearing

5

5

The Magistrate or Clerk

- Determines whether there are reasonable grounds to believe that
  - the facts alleged in the affidavit are true, and
  - the respondent probably meets the criteria for commitment
- Issues an **Order** that respondent be taken into custody and examined for commitment

Custody Order

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6

Law Enforcement Officer or Designated Person

- Custody and transportation of the respondent during the commitment process
- Return of service to the Clerk.
  - Law-enforcement officer—a sheriff, deputy sheriff, police officer, or State highway patrolman.
  - Designated person—a person other than law enforcement who is authorized by a county transportation plan to carry out all or a portion of the custody and transportation required by the involuntary commitment process.

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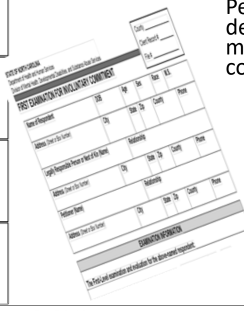
Commitment Examiner



Performs the **1st examination** to determine whether respondent meets the statutory criteria for commitment.

- A physician,
- A PhD psychologist with a health services provider certificate, or
- Any health or mental health professional who is **certified** under G.S. 122C-263.1 to perform the first examination for involuntary commitment

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

8

24-Hour Facility for IVC

- Provides treatment for mental illness or substance abuse in a structured living environment for a period of 24 consecutive hours or more.
- Performs the **second commitment examination**.
- Where respondent is held pending hearing.
- Must be designated by NC DHHS for the custody and treatment of involuntary clients.

9

The Clerk of Superior Court

- Receives the findings and recommendations of commitment examiners
- Receives law enforcement officer's copy of the custody order w/ completed return of service
- Maintains the court record containing the petition, custody order, and commitment examination forms
- Calendars the case for a hearing
- Appoints an attorney to represent the respondent

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The District Court Judge

O**rders** commitment of the respondent if there is clear, cogent, and convincing evidence that the respondent meets the criteria for commitment

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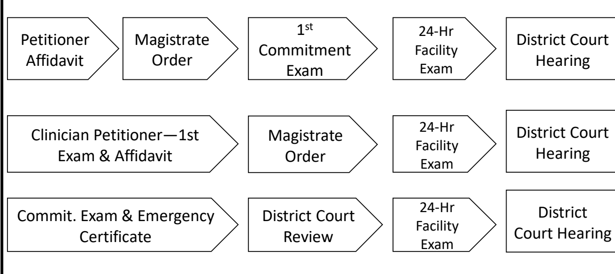
Overview of Commitment Procedure—Three Procedural Pathways



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The Petitioner

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

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Magistrate Role

If the magistrate finds reasonable grounds to believe that the commitment criteria are met for either

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

the magistrate shall issue a custody and transportation order (AOC-SP-302A)

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Custody-GS 122C-261

The magistrate shall issue the order to a

- law enforcement officer or
- other designated person (G.S. 122C-251)

to take the respondent into custody for examination by a commitment examiner

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Custody-GS 122C-261, -251

Upon receipt of the custody order, the law enforcement officer must take the respondent into custody within 24 hours after the order is signed

Without unnecessary delay, the officer must take the respondent to a physician or psychologist for examination.

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Hospital ED Role

Commitment Examination—As soon as possible and w/n 24 hours after respondent is presented

- Outpatient commitment
- Inpatient commitment
- Substance abuse commitment

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Hospital ED Role—Findings and Recommendations

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

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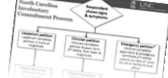
Summary: Procedure for the Layperson

1. Petition
2. Custody Order
3. Custody and Transportation
4. Examination and Health Screen
5. Release or 24-Hour Facility



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The Clinician Petition Procedure

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The Clinician Petition Procedure

- What is the primary procedural feature of the clinician petition process that distinguishes it from the layperson procedure?
- Who is eligible to use the clinician petition procedure?
- Who qualifies as a "commitment examiner?"

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Commitment Examiner Petition

Personal appearance not required if petitioner

- Is a "commitment examiner" who
- Examines the respondent and
- Signs the "Affidavit and Petition" before an official authorized to administer oaths (notary)

❖ Respondent may be examined in the physical presence of the examiner or via telemedicine equipment and procedures

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Electronic Filing

- If the affiant is a commitment examiner filing in a county that has implemented an electronic filing system approved by the AOC
- The commitment examiner or their designee shall
  - file the affidavit and petition,
  - as well as any other supporting documentation required by law,

  through the electronic filing system

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Forms for Clinician Petition

- "First Examination For Involuntary Commitment" (DMH 5-72-19)
  - https://www.ncdhhs.gov/assistance/mental-health-substance-abuse/involuntary-commitments
- "Affidavit and Petition for Involuntary Commitment" (AOC-SP-300)
  - https://www.nccourts.gov/documents/forms?

❖ To petition the magistrate for a custody order under the clinician procedure, a clinician must complete and submit both forms

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Commitment Examiner

- A physician,
- A PhD psychologist with a health services provider certificate, or
- Any health professional or mental health professional who is **certified** under G.S. 122C-263.1 to perform the first examination for involuntary commitment

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

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G.S. 122C-263.1

- The Secretary of Health and Human Services may *individually* certify *other* health, mental health, and substance abuse professionals to perform the first commitment examinations required by G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283.
- A certification . . . shall be in effect for . . . up to three years

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Commitment Examiner

The DHHS Sec'y may individually certify the following professionals:

- licensed clinical social worker (LCSW)
- master's level or higher nurse practitioner (NP)
- physician assistant (PA)
- licensed clinical mental health counselor (LCMHC)
- licensed marital and family therapist (LMFT)
- licensed clinical addictions specialist (LCAS)—for substance abuse commitment only

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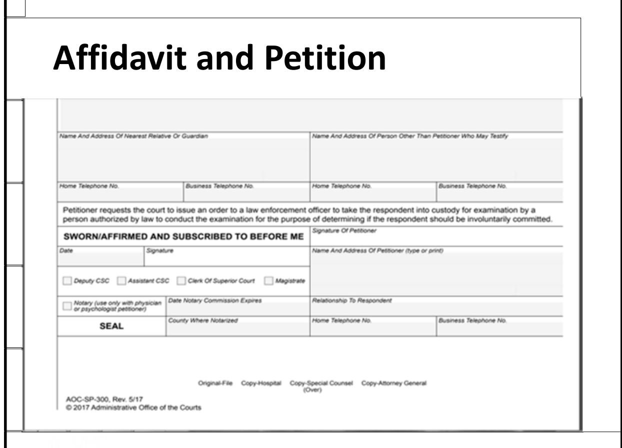
Affidavit and Petition



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/AFFIRMED 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	Relationship To Respondent	
SEAL	County Where Notarized	Home Telephone No.	Business Telephone No.

Original-File Copy-Hospital Copy-Special Counsel Copy-Attorney General
(Over)

AOC-SP-300, Rev. 5/17
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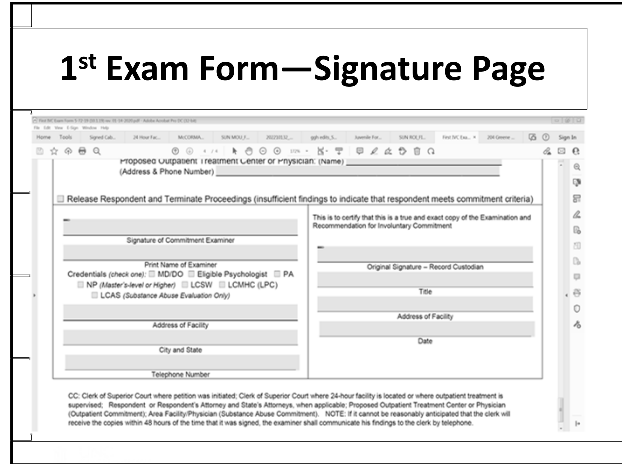
1st Exam Form—Signature Page



Proposed Outpatient Treatment Center or Physician: (Name)
(Address & Phone Number)

☐ Release Respondent and Terminate Proceedings (insufficient findings to indicate that respondent meets commitment criteria)

Signature of Commitment Examiner

Print Name of Examiner

Credentials (check one): ☐ MD/DO ☐ Eligible Psychologist ☐ PA ☐ NP (Master's-level or Higher) ☐ LCSW ☐ LCMHC (LPC) ☐ LCAS (Substance Abuse Evaluation Only)

Address of 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 of Facility

Date

CC: Clerk of Superior Court where petition was initiated; 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 Facility/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 examiner shall communicate his findings to the clerk by telephone.

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G.S. 122C-263.1

No less than annually, the Department shall

- submit a list of certified first commitment examiners to the Chief District Court Judge of each judicial district in North Carolina, and
- maintain a current list of certified first commitment examiners on its Internet Web site.

dmhdsohf.ncdhhs.gov/IVCCredentials/ProviderList

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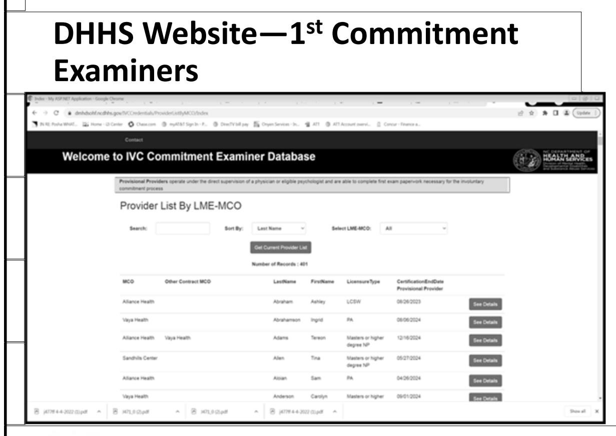
DHHS Website—1st Commitment Examiners



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What are the Clinician Petition Requirements?

- Must the petitioner—the one signing the affidavit—be the same person who signs the first examination form?
- Must the commitment examiner actually examine the respondent?
- Must the commitment examiner perform a face-to face examination of the respondent?

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Telehealth—G.S. 122C-263(c)

- The respondent may either be in the physical face-to-face presence of the commitment examiner or may be examined utilizing telehealth equipment and procedures.
- “Telehealth" means the use of two-way, real-time interactive audio and video where the respondent and commitment examiner can hear and see each other.

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Clinician Petition Procedure—G.S. 122C-261(d)

If the affiant

- Is a commitment examiner who
- Examines the respondent (physical face to face presence or via telemedicine equipment and procedures), and
- Signs the “Affidavit and Petition” before an official authorized to administer oaths (notary),

Then petitioner may file the examination and affidavit forms by delivering copies electronically

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

County ____
Client Record # ____
File # ____

FIRST EXAMINATION FOR INVOLUNTARY COMMITMENT

Name of Respondent	DOB	Age	Sex	Race	M.S.
Address *(Street or Box Number)*	City	State	Zip	County	Phone
Legally Responsible Person or Next of Kin (Name)	Relationship				
Address *(Street or Box Number)*	City	State	Zip	County	Phone
Petitioner (Name)	Relationship				
Address *(Street or Box Number)*	City	State	Zip	County	Phone

EXAMINATION INFORMATION

The First-Level examination and evaluation for the above-named respondent:

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HEALTH SCREENING

A health screening (N.C. G.S. § 122C-3(16a)) does not constitute a medical evaluation† and should be completed at the same location as the first examination or by utilizing telemedicine equipment and procedures (N.C.G.S.§ 122C-263(a1)).

Check box below and sign to attest if a health screening is being replaced by a medical evaluation

☐ Sign/Print Name, Credentials, Date & Time

____

Vital Signs

BP ________ HR ________ RR _______ Temp ________ Date & Time __________

If person taking vitals is different than person completing this form, sign/print name & credentials below:

____

Known/reported medical problems (diabetes, hypertension, heart attacks, sickle cell anemia, asthma, etc.):

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Commitment Examiner—Identify the Recommended Commitment on Exam Form

Section III: Recommendation—page 4 of Examination Form

- Inpatient commitment
- Outpatient commitment
- Substance abuse commitment

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

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Magistrate is Guided by the Clinician's Recommendation

If the petitioning examiner recommends:

- Outpatient commitment, then evaluate the facts presented in the examiner's affidavit according to the outpatient commitment criteria
- Inpatient commitment, then evaluate the facts presented in the affidavit according to the inpatient commitment criteria
- Substance abuse commitment, then evaluate the facts presented in the affidavit according to the substance abuse commitment criteria

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Examiner Role → Magistrate Role

Examiner Recommendation		Magistrate Order
Outpatient commitment	→	Hearing Order 305 (release)
Inpatient commitment	→	Custody Order 302B (inpatient facility)
Substance abuse commitment and hold pending hearing	→	Custody Order 302B (inpatient facility)
Substance abuse commitment and release pending hearing	→	Hearing Order 305 (release)

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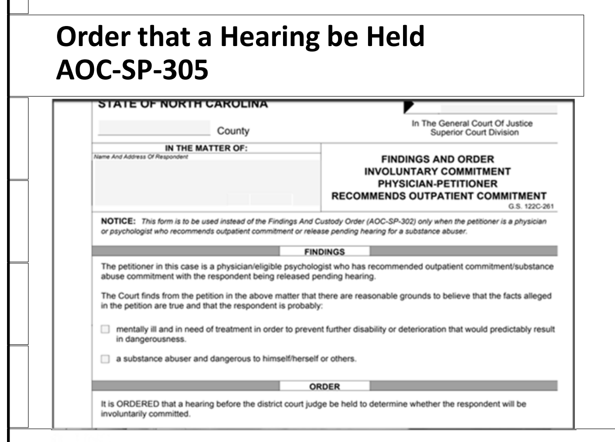
Order that a Hearing be Held AOC-SP-305



STATE OF NORTH CAROLINA

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.

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Custody Order—302B

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 and transport to a 24-hour facility for custody, examination, and treatment pending hearing

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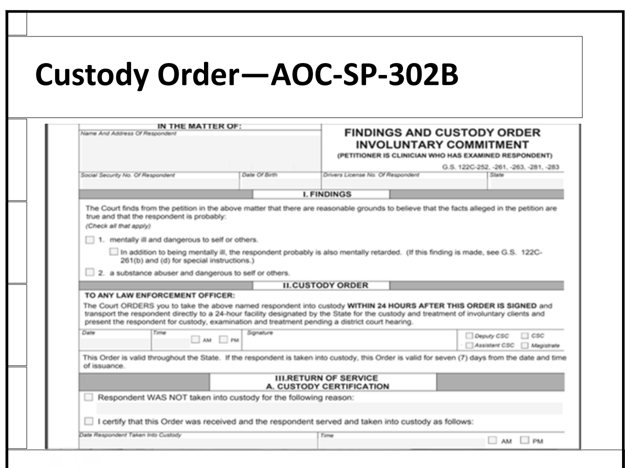

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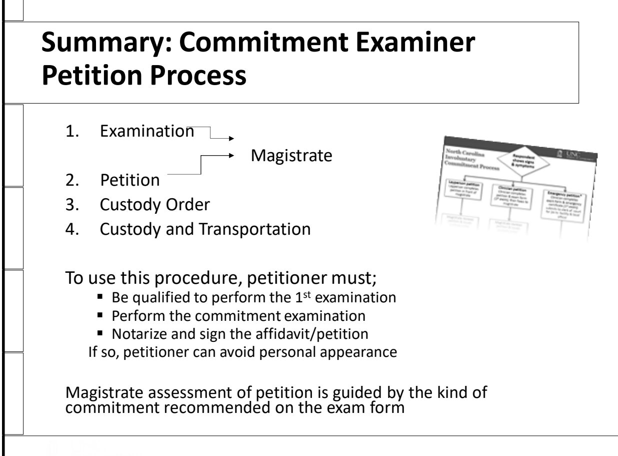

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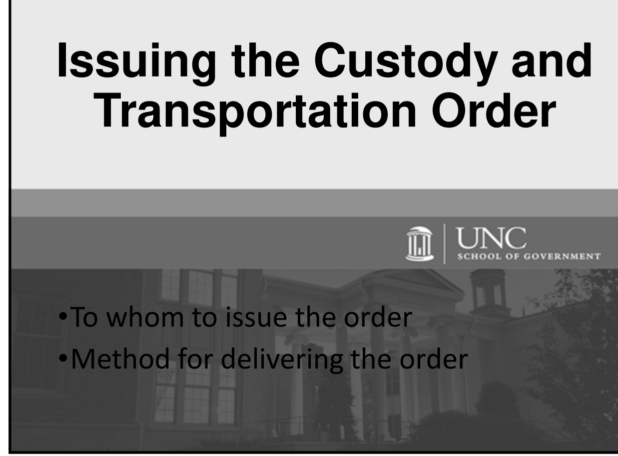

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Issuing the Custody Order

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

to take the respondent into custody . . .

G.S. 122C-261

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Issuing the Custody Order

- Law-enforcement officer—a sheriff, deputy sheriff, police officer, State highway patrolman, or an officer employed by a city or county under G.S. 122C-302 (officers employed and trained to assist individuals who are intoxicated in public). G.S. 122C-3.
- Designated person—a person designated in the transportation plan of a city or county, adopted under G.S. 122C-251(g), to provide a part or all the transportation and custody required by the involuntary commitment process.

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County Transportation Plan

- Every county must adopt a plan for transportation of respondents in involuntary commitment proceedings.
- The plan may designate persons other than law enforcement officers to carry out all or part of the transportation and custody.
- Volunteers and public or private agency personnel other than law enforcement officers may be designated.

G.S. 122C-251(g).

48

How do you deliver the order?

When you issue the custody order to a law enforcement officer or other designated person, how do you deliver the order?

49

GS 122C-210.3

- A custody order may be delivered to the law enforcement officer or other designated person by electronic or facsimile transmission.

- Applies to all custody orders including
  - Transfer from one 24-hour facility to another
  - Outpatient pick up order

50

50

The Seven-Day Time Limit

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Steps Following the First Exam

- After a 1st examination recommending inpatient commitment,
- The law enforcement officer or other designated person must transport the respondent to a 24-hour facility for custody, examination and treatment pending hearing.

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52

However . . .

If a 24-hour facility is not
- Immediately available or
- Medically appropriate

The respondent may be temporarily detained under appropriate supervision at the site of first examination.

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Seven Day Limit

- ❑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
- ❑New commitment proceedings may be initiated
  - Requires *new* petition
  - Requires *new* examination if petitioner is clinician
  - Requires *new* custody order

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Change in Respondent's Status

1. If at any time a commitment examiner 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

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Report to Clerk using 1st Exam Form

☐ Respondent was held at first evaluation site pending placement at a 24-hour facility and no longer meets criteria for inpatient commitment:

☐ Terminate proceedings and release respondent

☐ Recommend outpatient commitment

Proposed Outpatient Treatment Center or Physician: (Name) ______

(Address & Phone Number) ______

☐ LME/MCO notified of appointment: (Name of LME/MCO) ______ Date: ______

☐ Release respondent and Terminate Proceedings (insufficient findings to indicate that respondent meets commitment criteria)

Signature of Commitment Examiner

Print Name of Examiner

Credentials *(check one)*: ☐ MD/DO ☐ Eligible Psychologist ☐ PA

☐ NP *(Master's-level or Higher)* ☐ LCSW ☐ LPC

☐ LCAS *(Substance Abuse Evaluation Only)*

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 of Facility

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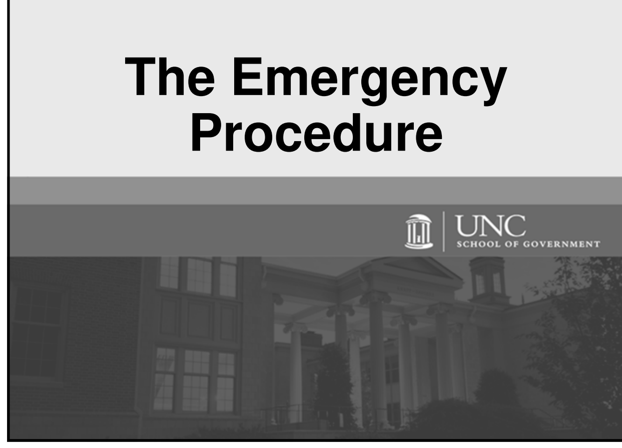

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Criteria for Emergency Commitment—Mental Illness

Mentally ill + Dangerous

+

Requires immediate hospitalization to prevent harm to self or others

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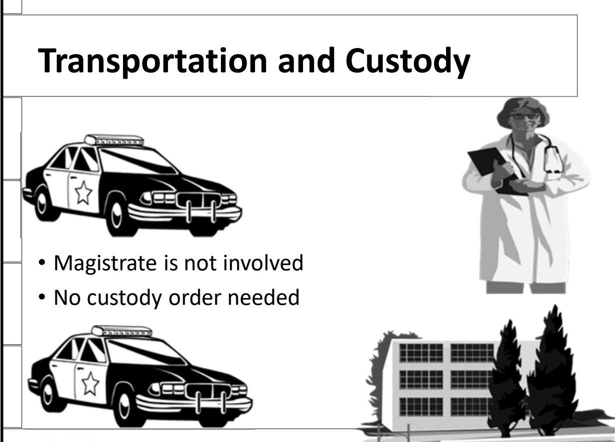
Transportation and Custody



- Magistrate is not involved
- No custody order needed

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Emergency Procedure Forms—Commitment Examiner

- “First Examination For Involuntary Commitment” (DMH 5-72-19)
- “Supplement to Support Immediate Hospitalization” (DMH 572-01-A)

www.ncdhhs.gov/assistance/mental-health-substance-abuse/involuntary-commitments

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Emergency Certificate

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

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Emergency Certificate

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

NORTH CAROLINA
______________ County
Sworn to and subscribed before me this
________ day of __________, 20__

(seal)

____
Notary Public

My commission expires: ______________

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.

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

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Examiner Opts to Petition for a Custody Order

If upon examination of a respondent presented under the emergency procedure, the commitment examiner finds that the respondent

- Does *not* require immediate hospitalization to prevent harm to self or others, but
- *Does* meet the criteria for inpatient commitment
- Then the commitment examiner may petition the magistrate for a custody order in accordance with the clinician petition procedure

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Involuntary Commitment: The Legal Criteria for Commitment

Mark Botts

UNC School of Government

1

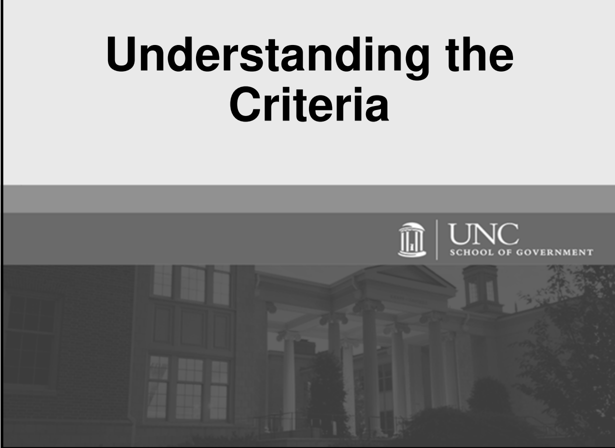
Topics

- Understanding the statutory definitions
- Applying the statutory definitions
- Writing a legally sufficient petition

❖The following are not legally sufficient petitions:

1. SI
2. SI with plan
3. Patient has been off psych meds and reports SI
4. Intoxicated; suicidal
5. Bipolar psychosis and paranoid; making suicidal statements
6. Patient reports SI, auditory/visual hallucinations

2



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The Criteria for Commitment

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

Read the statutory definitions!

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

4

Question

- To issue a custody order, the magistrate must find that the respondent is dangerous to self or others.
  - True
  - False
- If the magistrate finds that the respondent has a mental illness and is either
  - dangerous to self,
  - dangerous to others, or
  - in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness,

  the magistrate shall issue a custody order.

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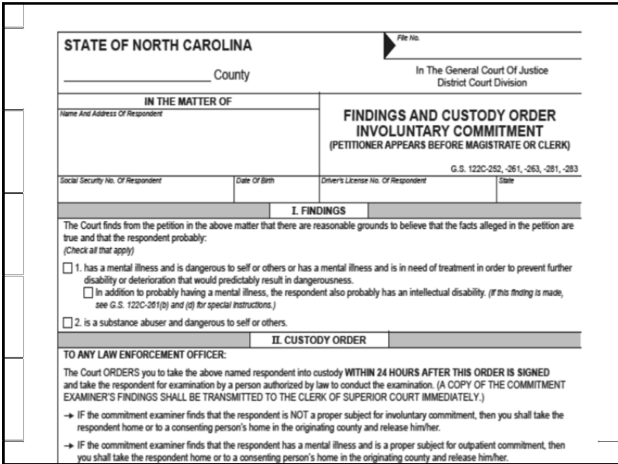

STATE OF NORTH CAROLINA

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	Driver's 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 probably:
(Check all that apply)

☐ 1. has a mental illness and is dangerous to self or others or has a mental illness and is in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness.
☐ In addition to probably having a mental illness, the respondent also probably has an intellectual disability. *(If this finding is made, see G.S. 122C-261(b) and (d) for special instructions.)*

☐ 2. is 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 COMMITMENT EXAMINER'S FINDINGS SHALL BE TRANSMITTED TO THE CLERK OF SUPERIOR COURT IMMEDIATELY.)

→ IF the commitment 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 commitment examiner finds that the respondent has a mental illness and is 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.

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Criteria for Outpatient Commitment

1. Mentally ill
2. Based on psychiatric history, needs treatment to prevent further disability or deterioration that would predictably result in dangerousness
3. Current mental status or nature of illness limits or negates the patient's ability to make an informed decision to seek treatment voluntarily or to comply with recommended treatment
4. Capable of surviving safely in the community with available supervision from family, friends, or others

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Question

In the definition of "dangerous to self" there are three kinds of dangerousness, or three ways that someone can be dangerous to himself or herself.

- True
- False

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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

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Dangerous to Self

Within the relevant past, the individual has:

1. Acted in a way to show **unable to care for self +** reasonable probability of serious physical debilitation in the near future unless adequated treatment is given
2. Attempted or threatened **suicide +** reasonable probability of suicide unless adequate treatment is given
3. Attempted or engaged in **self-mutilation +** reasonable probability of serious self-mutilation uness adquate treatment is given

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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
- Acts that are part of—or connected to—the current or ongoing episode, incident, or situation that help you assess what is happening and what is likely to happen if adequate treatment is not given

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Question

If an individual is unable to exercise self-control, judgment, and discretion in the conduct of her daily responsibilities and social relations, or to satisfy her need for nourishment, personal or medical care, shelter, self-protection, or safety, then the individual meets the statutory definition for “dangerous to self” for purposes of involuntary commitment.

- True
- False

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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).

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Commitment Criteria

There is a reasonable probability of the individual suffering serious physical debilitation within the near future . . .

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Question

When determining whether there is—for someone who lacks self-care ability—a reasonable probability of serious physical debilitation in the near future unless adequate treatment is given (the second prong of the dangerous-to-self definition) you may take into consideration previous episodes of dangerousness to self when applicable.

- True
- False

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Commitment Criteria

Criteria for Involuntary Commitment in North Carolina

There is a reasonable probability of the individual suffering serious physical debilitation in the near future . . .

Previous episodes of dangerousness, when applicable, may be considered when determining reasonable probability of physical debilitation . . .

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Question

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?

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Prima Facie Inference of 1st Prong

- 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 herself.” G.S. 122C-3 (11)(a)(1)(II)
- But the inference that someone is “unable to care for himself” does not necessarily mean that that person is at risk of “suffering serious physical debilitation within the near future.” *In Re C.G.*, 2022-NCSC-123, ¶ 39.

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Commitment Criteria

"Behavior that is so grossly irrational . . . or other evidence of severely impaired insight and judgment creates a prima facie inference . . ."

Prima facie inference: evidence sufficient to establish the existence of something—in this case, that "the individual is unable to care for himself"—unless the inference is rebutted with contrary evidence.

Criteria for Involuntary Commitment in North Carolina

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Example of Prima Facie Inference

- Patient has history of schizophrenia and medication non-compliance.
- Patient says he is hearing voices, seeing shadows, and has not slept the past few days.
- Presents with incoherent statements, e.g., "Are they 4 digits?" "I am here." "I am looking for my boots."
- Police brought patient to hospital ED after finding him jumping around in the median of a road, waving a knife, shouting, and appearing to be responding to external stimuli.
- Says he is agreeable to inpatient treatment.

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Dangerous to Self—Context and Specificity

Hanna lives in a nursing home. She is 85 years old and suffers dementia. She can't remember where she is, doesn't know what day it is, and doesn't know her family. She can't remember to take her medication and is too frail to bathe and dress without assistance.

1. Is Hannah mentally ill?
2. Is Hannah dangerous to self?

➢ Read the definition carefully: ". . . Unable, without the care, supervision, and the continued assistance of others *not otherwise available*, to exercise self-control, judgment, and discretion . . ."

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Danger to Self—Take Aways

Where danger to self is based on

(1) An inability to exercise control, judgment or discretion in daily affairs, or to satisfy need for nourishment, personal or medical care, shelter, or self-protection and safety,

(2) The evidence must show that the inability to care for self, by its nature or degree, *creates or causes* a reasonable probability of *serious physical* debilitation in the *near* future unless adequate treatment given.

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Dangerous to Self—Lack of Self-Care

Respondent suffers from schizophrenia; he refused to take his prescription medication both for his mental illness and an unrelated, serious heart condition; he lost some "unknown amount" of weight but remained at a healthy weight; he warned his guardian to stay away from him or he would sue him; and he was angry, rude and "menacing" to hospital staff after being involuntarily committed.

In re W.R.D., 248 N.C. App. 512, 516 (2016)

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Dangerous to Self—Lack of Self-Care

- Evidence that respondent had been diagnosed with paranoid schizophrenia, that he had health issues related to his heart, and that he refused to take medication for his heart did not demonstrate "that the health risk will occur in the near future ....“
- Although failure to take heart medication "could be deadly," there was nothing to show that "ceasing that medication would create this serious risk 'within the near future.'"
- The evidence must demonstrate "a reasonable probability" that the health risk will occur in the "near future," not simply that it could place the respondent at risk at some future time.

In re W.R.D., 248 N.C. App. 512, 516 (2016)

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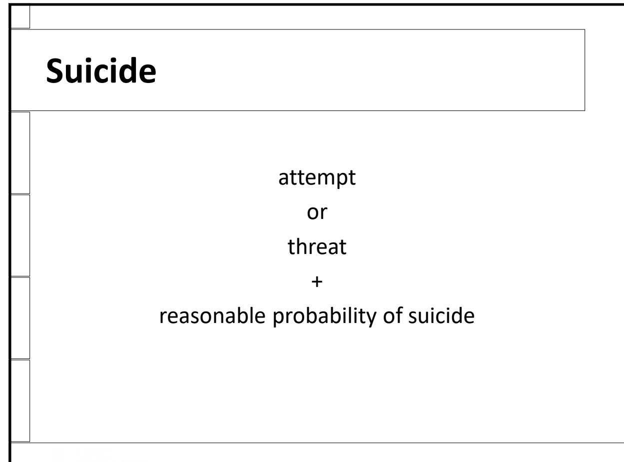

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Sample Case

- Patient with history of paranoid schizophrenia.
- Patient came to ED trying to get back on psychiatric medication. Wants to speak to MD about medications.
- Presented to Hospital ED with “flight of ideas and paranoia.”
- Afraid his girlfriend is trying to kill him.
- Named other people he thinks are trying to kill him. Believed cab driver was plotting to kill him.
- Began to cry and became hysterical.
- Patient “endorses” “suicidal ideation.”

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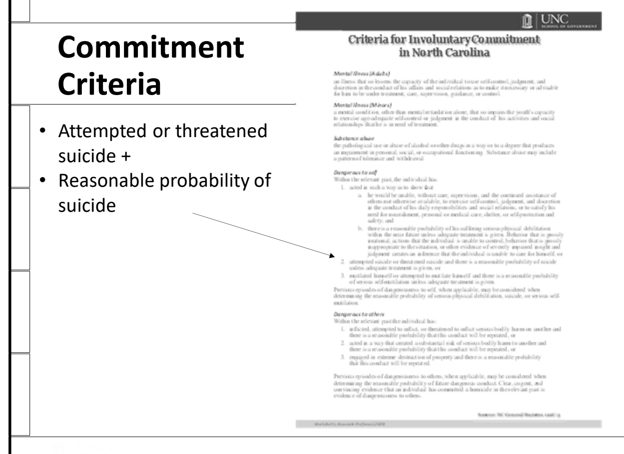

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Suicidal Ideation

"Suicidal ideations" (SI), often called suicidal thoughts or ideas, is a broad term used to describe a range of contemplations, wishes, and preoccupations with death and suicide.

- Varies in intensity, duration, and character.
- Health records often document SI in a binary yes/no fashion, although it encompasses everything from fleeting wishes of falling asleep and never awakening to intensely disturbing preoccupations with self-annihilation fueled by delusions.
- Thoroughly assessing and monitoring the pattern, intensity, nature, and impact of SI on the individual and documenting this accordingly is important for all healthcare professionals.
- Important to reassess SI frequently due to its fluctuating pattern.

Suicidal Ideation, Bonnie Harmer, Sarah Lee, Truc vi H. Duong, Abdolreza Saadabadi

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Sample Case—"Passive" Suicidal Ideation

- Patient says she has been "very depressed" for the last 3 years, but it has "worsened lately."
- Hopeless, sad, worried. Under eating. Difficulty falling asleep. Frequent wakening. Decreased energy. She was tearful throughout and spoke of feelings of worthlessness.
- Says she "does not want to live anymore."
- She first got depressed after separating from her husband 12 years ago. Attempted suicide then by taking pills. Then got therapy and medication, and depression got better.
- She just lost her job with a cleaning company
- Daughter recently asked her to move out of her house

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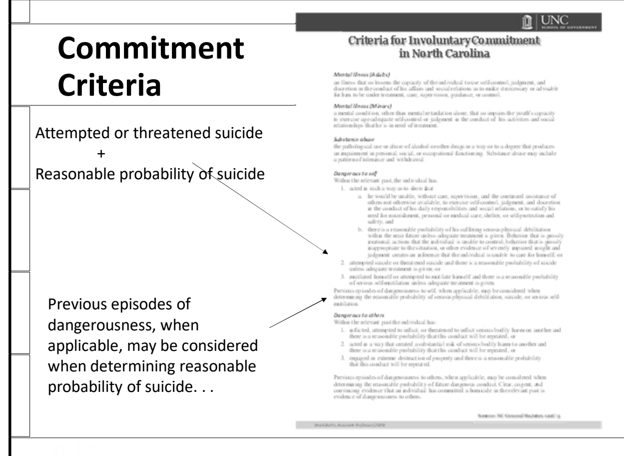

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Self-Mutilation

actual
or
attempted
+
reasonable probability of serious self-mutilation

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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

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Summary of Commitment Criteria

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

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AOC-SP-300

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

Social Security No. Of Respondent (if available)	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" pursuant to G.S. 122C-261.

☐ 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.*)

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The Magistrate Standard

If the magistrate finds *reasonable grounds to believe* that

- the facts alleged in the affidavit are true, and
- the respondent probably meets the criteria for commitment

the magistrate shall issue an order

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Reasonable Grounds to Believe

The *knowledge of facts* that would lead a reasonable person of ordinary intelligence and prudence to believe the respondent probably meets the commitment criteria.

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Reasonable Grounds to Believe

- For you to have reasonable grounds to believe, ***you must have knowledge of facts*** that lead you to that belief.
- To have knowledge of facts that would give reasonable grounds to believe, ***the affiant must give you facts*** by asserting them in the affidavit.
- Mere conclusions or opinions do not suffice to give the magistrate or clerk reasonable grounds to believe, for the magistrate cannot simply adopt the belief of others. Rather, ***the magistrate must come to his or her own belief*** based on facts asserted in the affidavit.

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The Magistrate's Role

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Questions

- "Patient exhibits bizarre behavior"
- "Respondent is suicidal"
- "Patient is mentally ill"
- "Respondent is dangerous"

These statements:

- Are they opinions/conclusions?
- Do they reveal their underlying factual basis?
- Do they help you determine mental illness or dangerousness?
- Are they appropriate for the fact section of the Affidavit/Petition?

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Appellate Court said:

"[The] 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).

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Information Must Be Factual

Facts

Conclusions (Opinions)	Descriptive Facts
Violent	Hit boss with a wrench
Threatening	Said he would cut brother while he slept
Aggressive	Pushed Mom off the porch
Assaulted someone	Held hammer in air saying he was going to bust mother's head

Conclusions

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Dangerous to Others

- Inflicted, attempted, or threatened serious bodily harm + a reasonable probability of conduct repeating
- Evidence that respondent made statements of a "threatening nature" was not sufficient to establish dangerousness to others because the evidence did not indicate "when these statements were made, the nature of the threats they contained, or the danger to petitioner reasonably inferable therefrom." *In re Holt*, 54 N.C. App. 352, 354-55 (1981).

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Dangerous to Self –Lack of Self-Care Ability

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).

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In Re C.G.—Commitment Examiner Affidavit and Petition

- Respondent "presents [as] psychotic and disorganized . . . [Respondent's] ACTT team being unable to stabilize his psychosis in the outpatient treatment."
- "He is so psychotic he is unable to effectively communicate his symptoms and *appears to have been neglecting his own care*."
- "Per [Respondent's] ACTT team he threw away his medications and has not been taking them. He needs hospitalization for safety and stabilization."

In Re C.G., 278 N.C. App. 416 (2021)

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In Re C.G.— 24-Hour Facility Exam

"Patient perseverates on being 'Blessed and highly favored' . . . Talks to other people in the room during interview . . . States 'gods people putting voices in my head' " and "[s]uddenly begins crying without any precipitant."

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Case Studies

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Involuntary Commitment—Case Studies

1. 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?

2. 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 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. 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 (January). 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?

5. 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?

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.

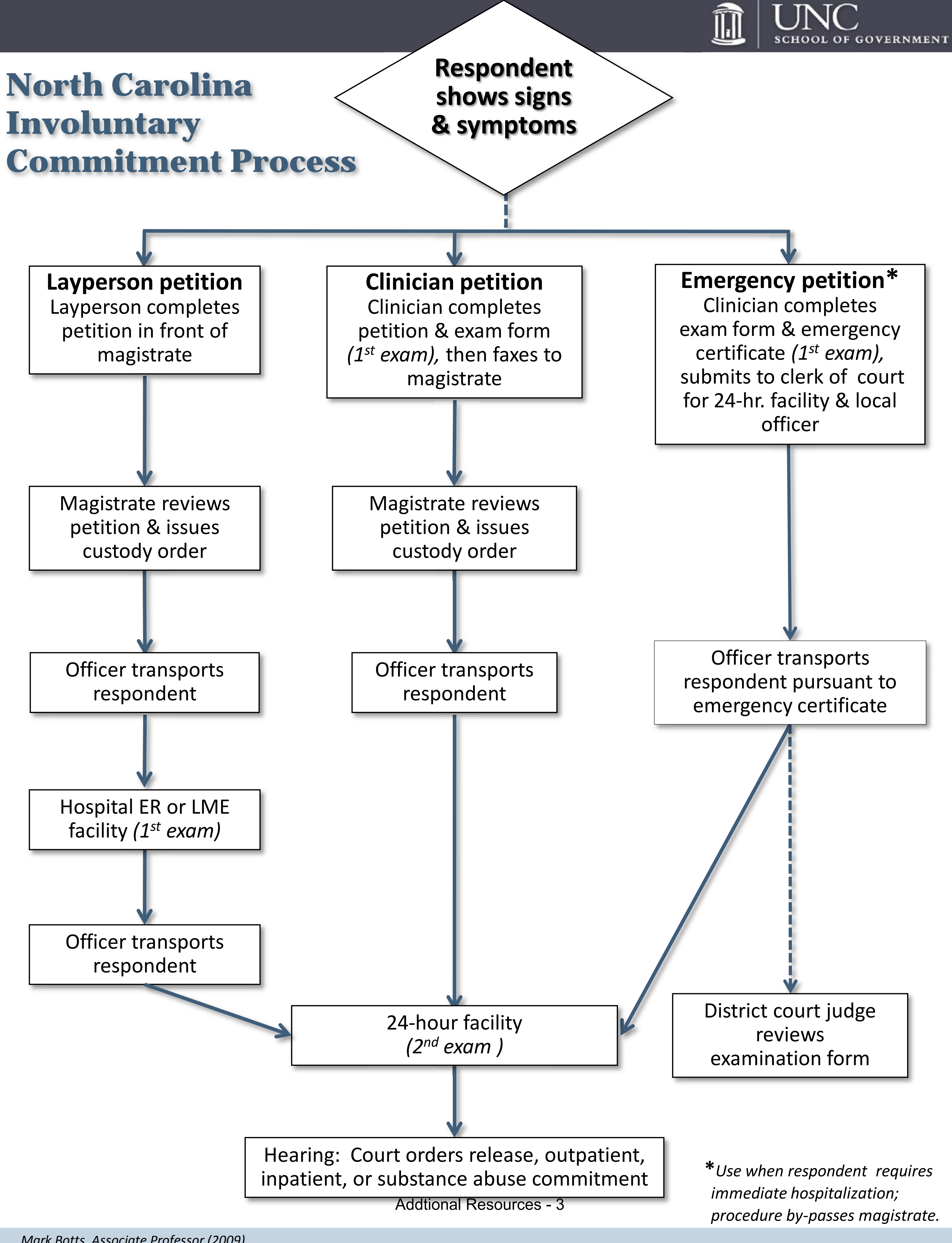
Dangerous to others
Within the relevant past the individual has:

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.

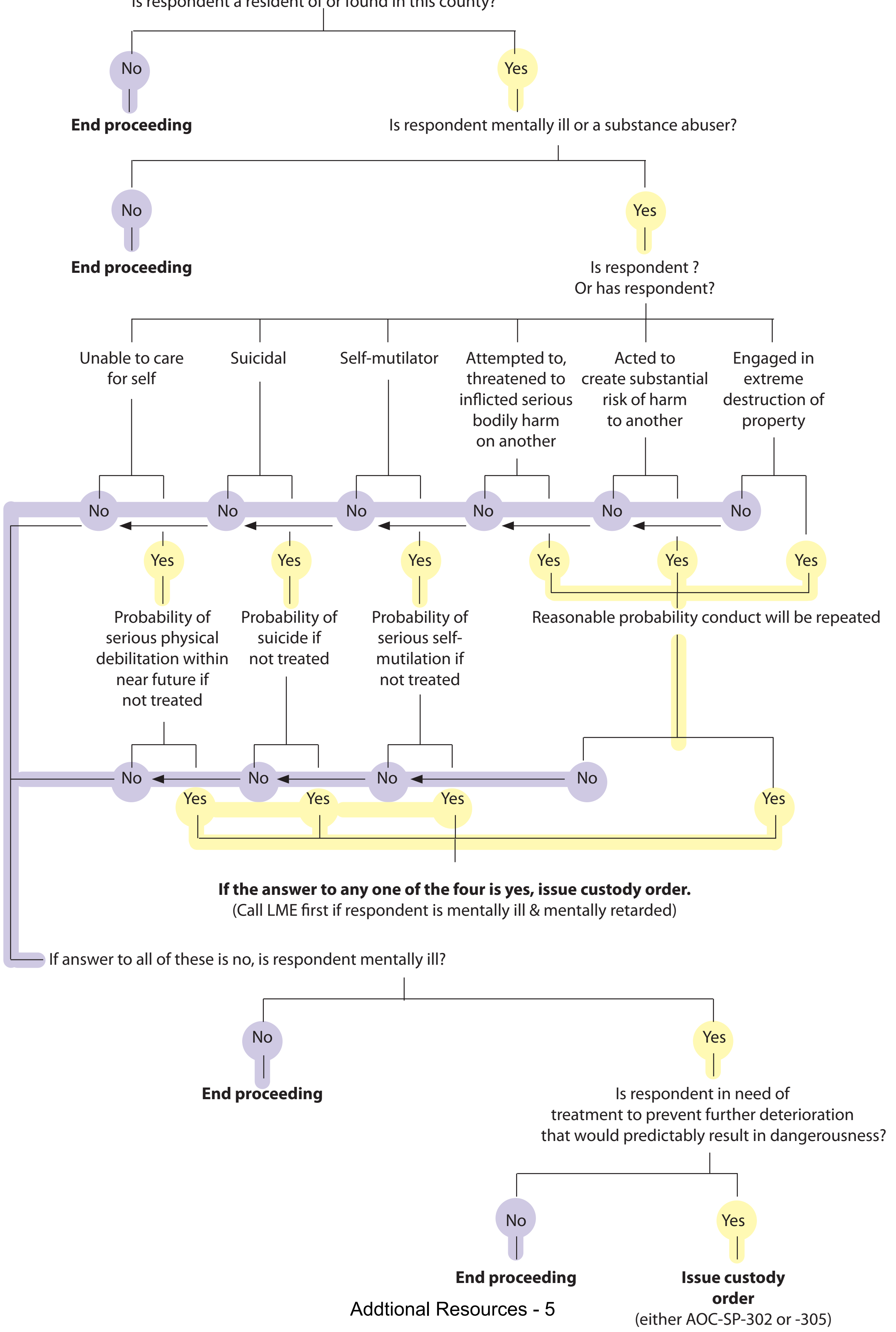
Previous episodes of dangerousness to others, when applicable, may be considered when determining the reasonable probability of future dangerous conduct. Clear, cogent, and convincing evidence that an individual has committed a homicide in the relevant past is evidence of dangerousness to others.

Source: NC General Statutes 122C-3

Mark Botts, Associate Professor (2009)


UNC
SCHOOL OF GOVERNMENT
North Carolina Involuntary Commitment Process
Respondent shows signs & symptoms
Layperson petition
Layperson completes petition in front of magistrate
Clinician petition
Clinician completes petition & exam form (1st exam), then faxes to magistrate
Emergency petition*
Clinician completes exam form & emergency certificate (1st exam), submits to clerk of court for 24-hr. facility & local officer
Magistrate reviews petition & issues custody order
Magistrate reviews petition & issues custody order
Officer transports respondent
Officer transports respondent
Officer transports respondent pursuant to emergency certificate
Hospital ER or LME facility (1st exam)
Officer transports respondent
24-hour facility (2nd exam)
District court judge reviews examination form
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)

Magistrate's Involuntary Commitment Decision Tree



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?)

Involuntary Commitment—Case Studies
(July 2015)

1. You are a magistrate who receives 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 or others? 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?

Involuntary Commitment

"Reasonable Grounds to Believe"

"The affidavit shall include facts on which the affiant's opinion is based." G.S. 122C-261(a).

"The affidavit must set out facts upon which the affiant's opinion is based." In re Hernandez, 46 N.C. App. 265 (1980).

"If the clerk or magistrate finds reasonable grounds to believe that the facts alleged in the affidavit are true and that the respondent [probably meets the commitment criteria], then clerk or magistrate shall issue an order . . . " G.S. 122C-261(b).

Reasonable grounds to believe: The *knowledge of facts* that would lead a reasonable person of ordinary intelligence and prudence to believe.

Reasonable grounds to believe that the respondent probably meets the commitment criteria: The *knowledge of facts* that would lead a reasonable person of ordinary intelligence and prudence to believe the respondent probably meets the commitment criteria.

For the magistrate or clerk to have reasonable grounds to believe, he or she must first have knowledge of facts that lead to that belief. To have knowledge of facts that would give reasonable grounds to believe, the affiant must assert facts (signs and symptoms) in the affidavit. Mere conclusions or opinions do not suffice to give the magistrate or clerk reasonable grounds to believe, for the magistrate cannot simply adopt the belief of others. Rather, the magistrate must come to his or her own belief based on facts asserted in the affidavit.

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.

RESOURCES TO OFFER

NATIONAL ALLIANCE ON MENTAL HEALTH (NAMI) –

https://www.nami.org/Home

https://www.nami.org/your-journey/family-members-and-caregivers

https://www.nami.org/Your-Journey/Family-Members-and-Caregivers/Being-Prepared-for-a-Crisis

https://www.nami.org/Support-Education/Publications-Reports/Guides/Navigating-a-Mental-Health-Crisis

NAMI in North Carolina –

Everyone who needs help or seeks help deserves to receive it. Our NAMI NC Helpline is here to provide helpful resources and a compassionate ear.

Call 800-451-9682 or Text 919-999-6527

Email: helpline@naminc.org

Monday – Friday, 8:30am – 5:00pm; main office location in Raleigh

VIDEO:

When mental illness enters the family | Dr. Lloyd Sederer | TEDxAlbany

This talk was given at a local TEDx event, produced independently of the TED Conferences. What must families know if they have a loved one with a mental illness? In his talk, Dr. Lloyd Sederer discusses the four things we all must know to help those who may be struggling around us. Lloyd I. Sederer, M.D., is Medical Director of the New York State Office of Mental Health

Link: https://www.youtube.com/watch?v=NRO0-JXuFMY

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

Social Security No. Of Respondent (if available)	*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” pursuant to G.S. 122C-261.

☐ 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/AFFIRMED 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*	*Relationship To Respondent*	
SEAL	*County Where Notarized*	*Home Telephone No.*	*Business Telephone No.*

Original-File Copy-Hospital Copy-Special Counsel Copy-Attorney General
(Over)

AOC-SP-300, Rev. 5/17

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	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).*

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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	**AFFIDAVIT AND PETITION FOR INVOLUNTARY COMMITMENT** G.S. 122C-261, 122C-281

Social Security No. Of Respondent (if available)	*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" pursuant to G.S. 122C-261.

☐ 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/AFFIRMED 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*	*Relationship To Respondent*	
SEAL	*County Where Notarized*	*Home Telephone No.*	*Business Telephone No.*

Original-File Copy-Hospital Copy-Special Counsel Copy-Attorney General
(Over)

AOC-SP-300, Rev. 5/17

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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).*

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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	Driver's 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 probably:
(Check all that apply)

☐ 1. has a mental illness and is dangerous to self or others or has a mental illness and is in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness.
  ☐ In addition to probably having a mental illness, the respondent also probably has an intellectual disability. *(If this finding is made, see G.S. 122C-261(b) and (d) for special instructions.)*

☐ 2. is 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 COMMITMENT EXAMINER'S FINDINGS SHALL BE TRANSMITTED TO THE CLERK OF SUPERIOR COURT IMMEDIATELY.)

→ IF the commitment 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 commitment examiner finds that the respondent has a mental illness and is 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 commitment examiner finds that the respondent has a mental illness and is 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 commitment examiner finds that the respondent is a substance abuser and subject to involuntary commitment, the commitment 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 ☐ Assistant CSC	☐ 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.

Original-File Copy-24-Hour Facility Copy-Special Counsel Copy-Attorney General
(for *Return Of Service*, see AOC-SP-302A Return)

AOC-SP-302A, Rev. 3/21
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IN THE MATTER OF	____________________ County	File No.
Name Of Respondent	*Date And Time Of Issuance Of Custody Order*	**NOTE:** *Use this page for the return of a Findings And Custody Order Involuntary Commitment.*

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. 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.*

B. PATIENT DELIVERY TO FIRST EXAMINATION SITE

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

Date Presented	*Time* ☐ AM ☐ PM	*Name Of Commitment 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 commitment 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 commitment examiner found that the respondent has a mental illness 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 facility 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 commitment examiner recommended inpatient commitment and a 24-hour facility was not immediately available or medically appropriate. Upon further examination, a commitment 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 Commitment 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 commitment 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.*

AOC-SP-302A Return, Rev. 3/21
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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*	*Driver's 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 probably:
(Check all that apply)

☐ 1. has a mental illness and is dangerous to self or others.
  ☐ In addition to probably having a mental illness, the respondent also probably has an intellectual disability. *(If this finding is made, see G.S. 122C-261(b) and (d) for special instructions.)*

☐ 2. is 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.

Original-File Copy-24-Hour Facility Copy-Special Counsel Copy-Attorney General
(for *Return Of Service*, see AOC-SP-302B Return)

AOC-SP-302B, Rev. 3/21
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IN THE MATTER OF	____________________ County	File No.
Name Of Respondent	Date And Time Of Issuance Of Custody Order	**NOTE:** *Use this page for the return of a Findings And Custody Order Involuntary Commitment.*

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. 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.*

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 Commitment 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 commitment examiner (petitioning clinician) recommended inpatient commitment and a 24-hour facility was not immediately available or medically appropriate. Upon further examination, a commitment 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 Commitment 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 commitment 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.*

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.*

AOC-SP-302B Return, Rev. 3/21
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STATE OF NORTH CAROLINA
Department of Health and Human Services
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

County ________________
Client Record # _________
File # _________________

FIRST EXAMINATION FOR INVOLUNTARY COMMITMENT

Name of Respondent		DOB	Age	Sex	Race	M.S.

Address (Street or Box Number)	City	State	Zip	County	Phone

Legally Responsible Person or Next of Kin (Name)	Relationship

Address (Street or Box Number)	City	State	Zip	County	Phone

Petitioner (Name)	Relationship

Address (Street or Box Number)	City	State	Zip	County	Phone

EXAMINATION INFORMATION

The First-Level examination and evaluation for the above-named respondent:

was conducted on _____/_____/__________ *(MM/DD/YYYY)* at ______:______ ○ **A.M.** ○ **P.M.**

was conducted:
○ In person at the following facility ____________________________________ OR ○ Via telemedicine technology

Included in the examination was an assessment of the respondent's:

☐ (1) Current and previous mental illness and intellectual disability 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 self or others as defined in G.S.122C-3 (11*).

The following findings and recommendations are made based on this examination^:

SECTION I – CRITERIA FOR COMMITMENT

It is my opinion that the respondent meets the criteria for the selected type of commitment as the respondent is:

☐ **Inpatient**
(1st Exam – Commitment Examiner, eligible Psychologist or Physician)
- ☐ An individual with a mental illness;
- ☐ Dangerous to:
  - ☐ Self *or*
  - ☐ Others;
- ☐ In addition to having a mental illness is also intellectually disabled;
- ☐ None of the above

☐ **Outpatient** *(1st Exam – Commitment Examiner, eligible Psychologist or Physician)*
- ☐ An individual with a mental illness;
- ☐ 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*);
- ☐ Current mental status or the nature of his/her illness limits or negates his/her ability to make an informed decision to seek treatment voluntarily or comply with recommended treatment;
- ☐ None of the above

☐ **Substance Abuse**
(1st Exam – LCAS CE, eligible Psychologist or Physician)
- ☐ A Substance Abuser;
- ☐ Dangerous to:
  - ☐ Self *or*
  - ☐ Others;
- ☐ None of the above

^*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 for a face-to-face evaluation. *(*Statutory definitions begin on page 3)*

Name of Respondent:	DOB:

SECTION II – DESCRIPTION OF FINDINGS

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

Impression/Diagnosis:

HEALTH SCREENING

A health screening (N.C. G.S. § 122C-3(16a)) does not constitute a medical evaluation† and should be completed at the same location as the first examination or by utilizing telemedicine equipment and procedures (N.C.G.S.§ 122C-263(a1)).

☐ **Check box & sign to attest that the health screening is being replaced by a medical evaluation†** skip to Section III

______________________________ Signature

______________________________ Printed Name, Credentials, Date & Time

Vital Signs

BP _________ HR _________ RR ________ Temp _________ Date & Time ___________

If person taking vitals is different than person completing this form, sign/print name & credentials below:

______________________________ Signature

______________________________ Printed Name, Credentials, Date & Time

Known/reported medical problems (diabetes, hypertension, heart attacks, sickle cell anemia, asthma, etc.):

Known/reported allergies:

Known/reported current medications (please list):

If ANY of the below are present, check box and send respondent to an Emergency Department by the most appropriate means:

☐ Chest pain or shortness of breath
☐ Suspected overdose on substances or medications within the past 24 hours (including acetaminophen)
☐ Presence of severe pain (e.g. abdominal pain, head pain)
☐ Disoriented, confused, or unable to maintain balance
☐ Head trauma or recent loss of consciousness
☐ Recent physical trauma or profuse bleeding
☐ New weakness, numbness, speech difficulties or visual changes
☐ Other Rationale (including medical evaluation indicated, but not available at current location):

____

☐ None of the above

Name of Respondent:	DOB:

IF ANY of the below are present, check box and consult° with medical provider‡ within one hour:

☐ Age < 12 or > 65 years old
☐ Systolic BP > 160 or < 100 and/or diastolic > 100 or < 60
☐ Heart Rate >110 or < 55 bpm
☐ Respiratory Rate > 20 or < 12 breaths per minute
☐ Temperature > 38.0 C (100.4 F) or < 36.0 C (96.8 F)
☐ Known diagnosis of diabetes and not taking prescribed medications
☐ Recent seizure or history of seizures and not taking seizure medications
☐ Known diagnosis of asthma or chronic obstructive pulmonary disease and not taking prescribed medications
☐ Visible or reported open sores, wounds, or active bleeding
☐ Severe constipation **or** vomiting **or** diarrhea
☐ Painful urination or new onset incontinence
☐ Known or suspected pregnancy
☐ Used substances of abuse, (e.g. alcohol, opiates, benzodiazepines, cocaine, etc.) or prescription medication not prescribed to them, within the past 48 hours
☐ Other Rationale:

____

☐ None of the above

______________________________ ______________________________
Signature of Person Completing Health Screening   Printed Name, Credentials, Date & Time

†***DEFINITION OF Medical Evaluation***: *Medical history and physical exam performed by a medical provider*
‡***DEFINITION OF Medical Provider***: *MD, DO, PA, or NP licensed in N.C.*
°*Consultation can be via telephone, telemedicine or in person*

***STATUTORY DEFINITIONS for Form No. DMH 5-72-19**

Commitment examiner. - A physician, an eligible psychologist, or any health professional or mental health professional who is certified under G.S. 122C-263.1 to perform the first examination for involuntary commitment described in G.S. 122C-263(c) or G.S. 122C-283(c).

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. Clear, cogent, and convincing evidence that an individual has committed a homicide in the relevant past is prima facie evidence of dangerousness to others.

Dangerous to self. - Within the relevant past the individual has done any of the following: (1) acted in such a way as to show all of the following: (**I**) The individual 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 the individual's daily responsibilities and social relations or to satisfy the individual's need for nourishment, personal or medical care, shelter, or self-protection and safety. (**II**) There is a reasonable probability of the individual 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 herself. (2) The individual has attempted suicide or threatened suicide and that there is a reasonable probability of suicide unless adequate treatment is given. (3) The individual has mutilated himself or herself or attempted to mutilate himself or herself 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.

Health screening. - An appropriate screening suitable for the symptoms presented and within the capability of the entity, including ancillary services routinely available to the entity, to determine whether or not an emergency medical condition exists. An emergency medical condition exists if an individual has acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Name of Respondent:	DOB:

Local management entity/managed care organization or **LME/MCO**. - A local management entity that is under contract with the Department to operate the combined Medicaid Waiver program authorized under Section 1915(b) and Section 1915(c) of the Social Security Act.

Local management entity or **LME.** - An area authority.

Mental illness. - 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 the individual's affairs and social relations as to make it necessary or advisable for the individual to be under treatment, care, supervision, guidance or control. When applied to a minor, a mental condition, other than an intellectual disability alone, that so lessens or impairs the minor's capacity to exercise age adequate self-control and judgment in the conduct of the minor's activities and social relationships so that the minor 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.

SECTION III – RECOMMENDATION FOR DISPOSITION

☐ **Inpatient Commitment** for_______days *(respondent must have a mental illness **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 & 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:_____________________________________

☐ Respondent or Legally Responsible Person Consented to Voluntary Treatment

☐ Respondent was held at first evaluation site pending placement at a 24-hour facility and no longer meets criteria for inpatient commitment:
- ☐ Terminate proceedings and release respondent
- ☐ Recommend outpatient commitment
  Proposed Outpatient Treatment Center or Physician: (Name) _________________________________
  (Address & Phone Number) ____

☐ Release Respondent and Terminate Proceedings (insufficient findings to indicate that respondent meets commitment criteria)

____
Signature of Commitment Examiner

____
Print Name of Examiner

Credentials *(check one)*: ☐ MD/DO ☐ Eligible Psychologist ☐ PA
☐ NP *(Master's-level or Higher)* ☐ LCSW ☐ LCMHC ☐ LMFT
☐ LCAS *(Substance Abuse Evaluation Only)*

____
Address of 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 of Facility

____
Date

CC: Clerk of Superior Court where petition was initiated; 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 Facility/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 examiner shall communicate his findings to the clerk by telephone.

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
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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: ______________________________

NORTH CAROLINA
________________ County
Sworn to and subscribed before me this
________ day of ___________, 20__

(seal)

____
Notary Public

My commission expires:________________

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.

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.

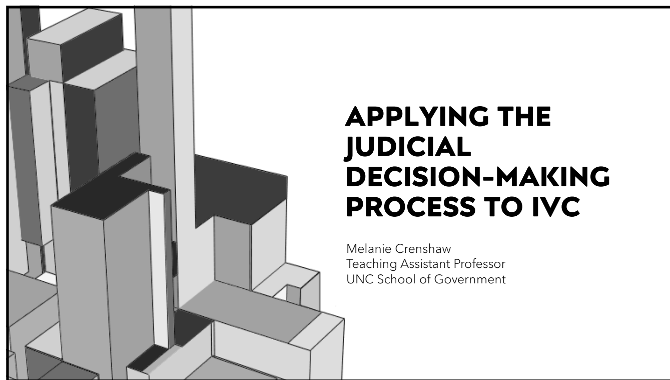
TO LAW ENFORCEMENT: See back side for Return of Service

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*		



APPLYING THE JUDICIAL DECISION-MAKING PROCESS TO IVC

Melanie Crenshaw
Teaching Assistant Professor
UNC School of Government

1

AGENDA

- Introducing the Judicial Decision-Making Process
- Receiving and Assessing Evidence to Find the Evidentiary Facts
- Determining if the Facts Meet the Legal Standard (Conclusions)
- A Word about Discretion

Some images in this presentation were created using Microsoft Bing AI Image Creator.

2

2

THE JUDICIAL DECISION-MAKING PROCESS

3

WHAT IS YOUR DECISION?

4

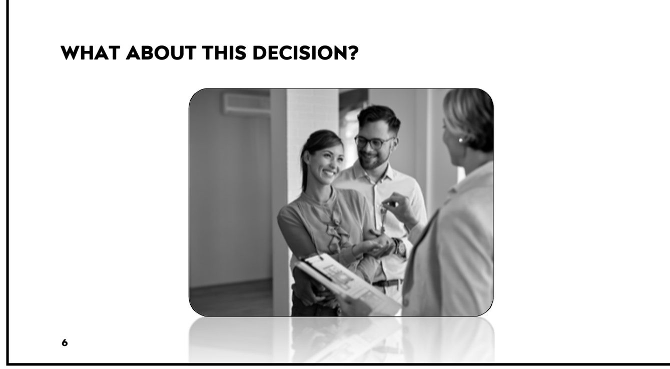
4

WHAT IS YOUR DECISION?

5

5

WHAT ABOUT THIS DECISION?



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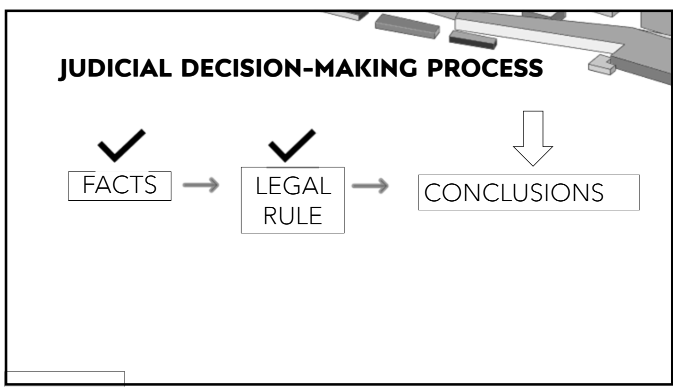

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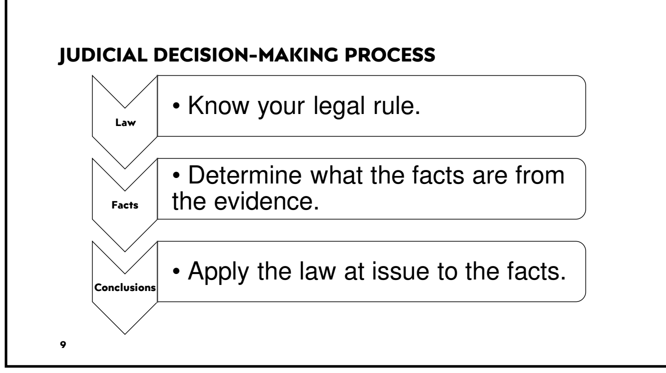

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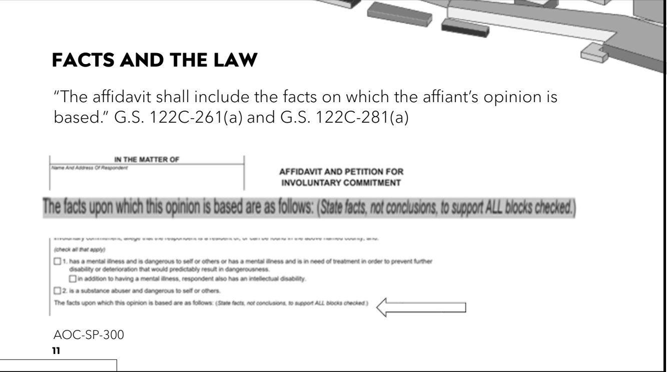
RECEIVING AND ASSESSING EVIDENCE TO FIND THE EVIDENTIARY FACTS

10

FACTS AND THE LAW

"The affidavit shall include the facts on which the affiant's opinion is based." G.S. 122C-261(a) and G.S. 122C-281(a)



IN THE MATTER OF

Name And Address Of Respondent

AFFIDAVIT AND PETITION FOR INVOLUNTARY COMMITMENT

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

(*check all that apply*)

☐ 1. has a mental illness and is dangerous to self or others or has a mental illness and is in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness.

☐ in addition to having a mental illness, respondent also has an intellectual disability.

☐ 2. is 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.*)

AOC-SP-300

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11

PETITIONER APPEARS BEFORE MAGISTRATE

- PETITIONER TESTIMONY
- WITNESS TESTIMONY
- PHOTOGRAPHS OR VIDEOS
- MEDICAL RECORDS
- WHAT ELSE?

12

12

MAKING DECISIONS ABOUT EVIDENCE

Relevant and Reliable

Admission v. Weight

13

13

PETITIONER APPEARS BEFORE MAGISTRATE QUESTIONS TO GET THE INFORMATION YOU NEED

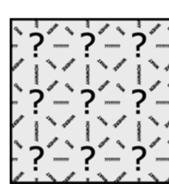
- THREATS OF HARM TO SELF OR OTHERS
- HALLUCINATIONS
- AWARENESS OF SELF AND CIRCUMSTANCES
- PARANOID DELUSIONS
- EXAGGERATED CLAIMS
- SLEEP HABITS
- ALCOHOL/DRUG INTAKE
- PRESCRIBED MEDICATIONS
- APPETITE
- SELF-CARE/NORMAL ACTIVITIES

14

14

ELICITING TRUTHFUL INFORMATION

- Avoid suggesting the answer.
- Use a series of questions, if necessary.
- Slow your pace.
- Pause.
- Ask clarifying questions.
- Use reflective statements to redirect the witness.



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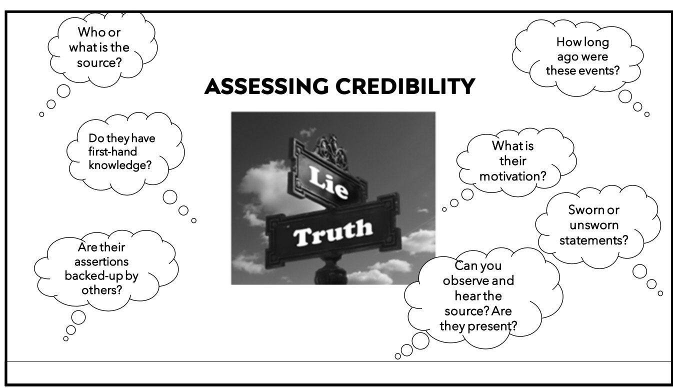

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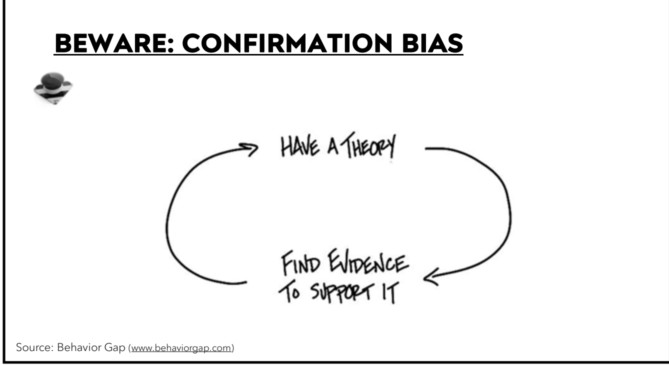
ASSESSING CREDIBILITY

1. Written corroborative evidence
2. Internal and historical consistency
3. Consistency with evidence offered by others
4. Degree to which witness had reason to be attentive and was able to observe
5. Presence or absence of motivation to lie
6. Witness's ability to answer questions related to details
7. Absence of evidence
8. Demeanor?

17



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PETITIONER IS CLINICIAN WHO HAS EXAMINED RESPONDENT

- AFFIDAVIT WITH FACTS
- EXECUTED BEFORE OFFICIAL AUTHORIZED TO ADMINISTER OATHS
- INITIAL EXAMINATION WITH AFFIDAVIT

19

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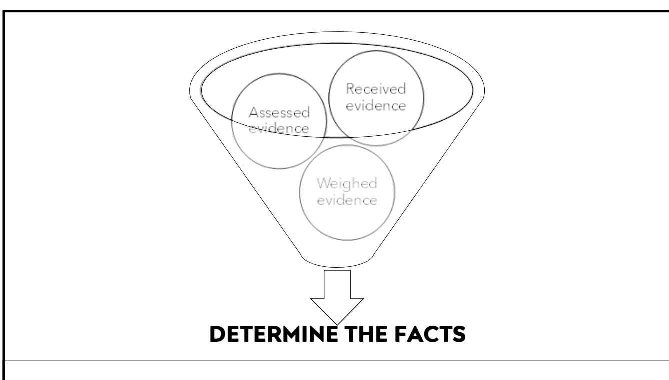

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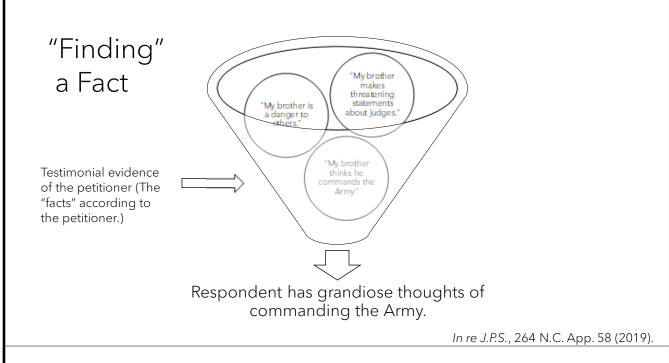

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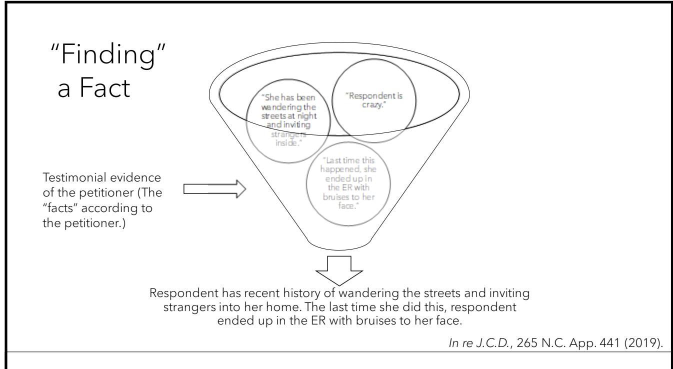
“Finding” a Fact



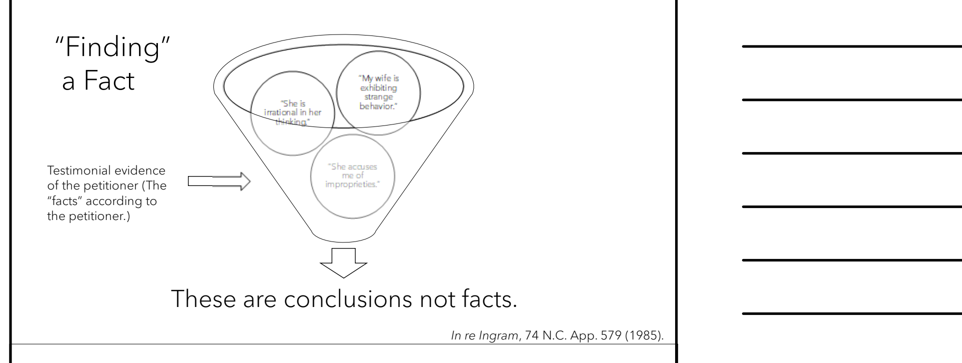
Testimonial evidence of the petitioner (The “facts” according to the petitioner.)

Respondent has recent history of wandering the streets and inviting strangers into her home. The last time she did this, respondent ended up in the ER with bruises to her face.

In re J.C.D., 265 N.C. App. 441 (2019).

22

“Finding” a Fact



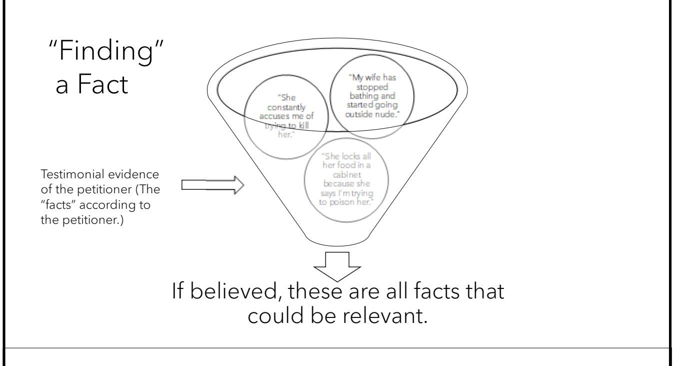
Testimonial evidence of the petitioner (The “facts” according to the petitioner.)

These are conclusions not facts.

In re Ingram, 74 N.C. App. 579 (1985).

23

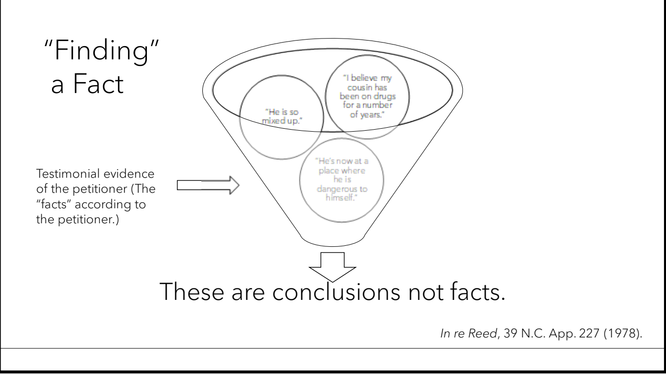
“Finding” a Fact



Testimonial evidence of the petitioner (The “facts” according to the petitioner.)

If believed, these are all facts that could be relevant.

24



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YOUR TURN

- Review the narratives from petitioners.
- Determine if each statement is a relevant fact, an irrelevant fact, or a conclusory statement.
- If it's a relevant fact, identify which involuntary commitment criteria the testimony is relevant to prove. Use the handout "Criteria for Involuntary Commitment in North Carolina."

26

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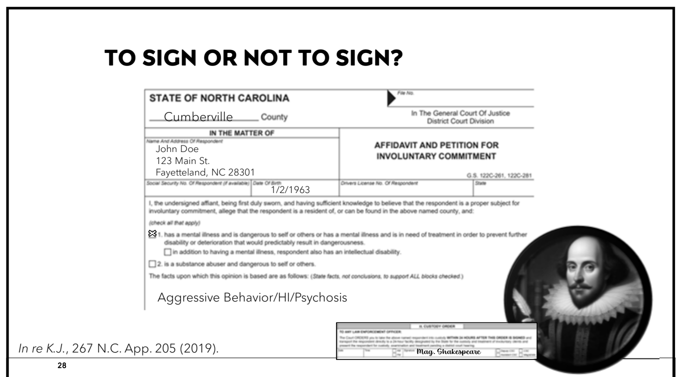
DETERMINING IF THE FACTS MEET THE LEGAL STANDARD (CONCLUSIONS)

27

TO SIGN OR NOT TO SIGN?



STATE OF NORTH CAROLINA

Cumberville County

File No.

In The General Court Of Justice
District Court Division

IN THE MATTER OF

Name And Address Of Respondent
John Doe
123 Main St.
Fayetteland, NC 28301

AFFIDAVIT AND PETITION FOR INVOLUNTARY COMMITMENT

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

Social Security No. Of Respondent (if available)	Date Of Birth	Drivers License No. Of Respondent	State
	1/2/1963		

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:

(check all that apply)

☒ 1. has a mental illness and is dangerous to self or others or has a mental illness and is in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness.

☐ in addition to having a mental illness, respondent also has an intellectual disability.

☐ 2. is 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.*)

Aggressive Behavior/HI/Psychosis

II. CUSTODY ORDER

TO ANY LAW ENFORCEMENT OFFICER:

Mag. Shakespeare

In re K.J., 267 N.C. App. 205 (2019).

28

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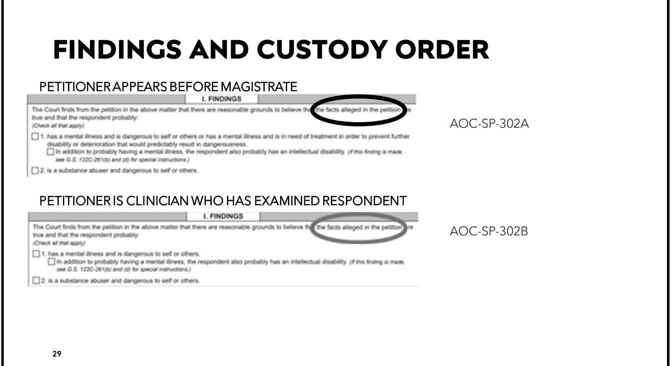
FINDINGS AND CUSTODY ORDER



PETITIONER APPEARS BEFORE MAGISTRATE

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 probably:
(*Check all that apply*)

☐ 1. has a mental illness and is dangerous to self or others or has a mental illness and is in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness.

☐ In addition to probably having a mental illness, the respondent also probably has an intellectual disability. (*If this finding is made, see G.S. 122C-261(b) and (d) for special instructions.*)

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

AOC-SP-302A

PETITIONER IS CLINICIAN WHO HAS EXAMINED RESPONDENT

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 probably:
(*Check all that apply*)

☐ 1. has a mental illness and is dangerous to self or others.

☐ In addition to probably having a mental illness, the respondent also probably has an intellectual disability. (*If this finding is made, see G.S. 122C-261(b) and (d) for special instructions.*)

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

AOC-SP-302B

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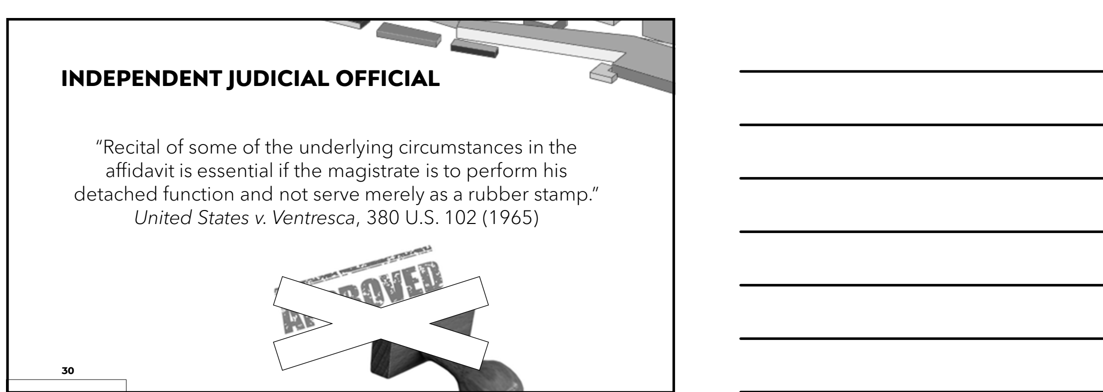
29

INDEPENDENT JUDICIAL OFFICIAL

"Recital of some of the underlying circumstances in the affidavit is essential if the magistrate is to perform his detached function and not serve merely as a rubber stamp."
United States v. Ventresca, 380 U.S. 102 (1965)



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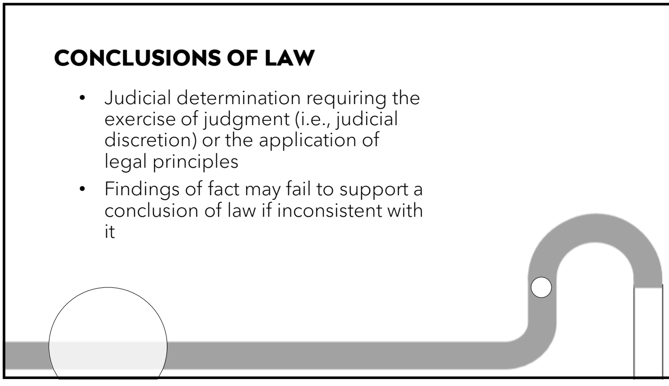

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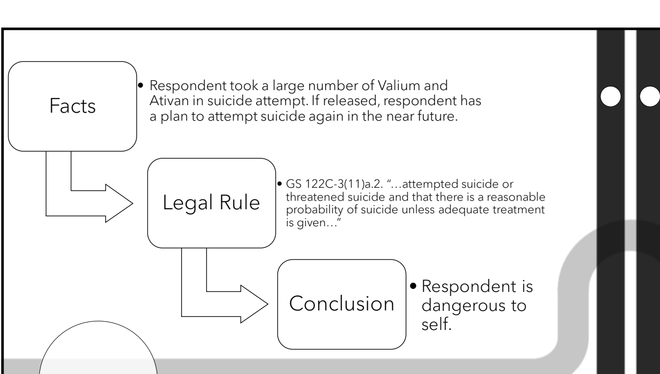

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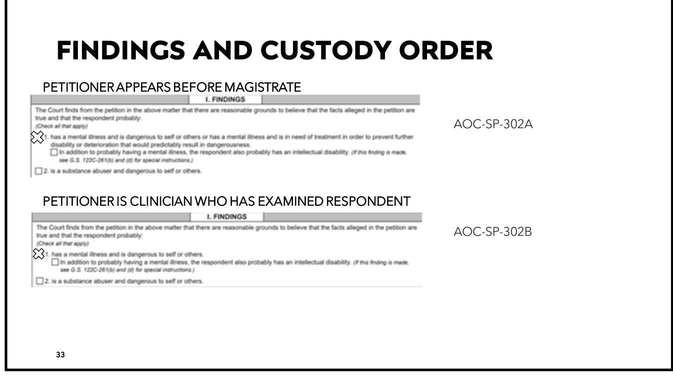

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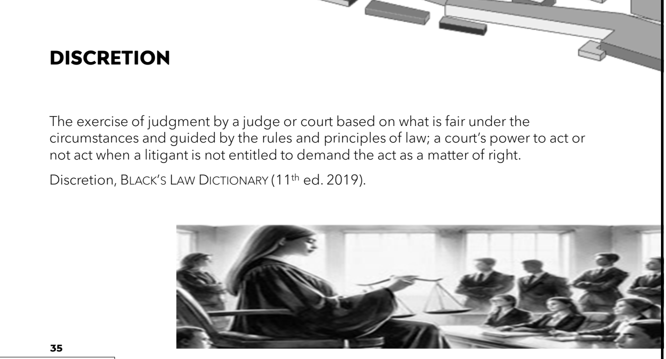
A WORD ABOUT DISCRETION

34

DISCRETION

The exercise of judgment by a judge or court based on what is fair under the circumstances and guided by the rules and principles of law; a court's power to act or not act when a litigant is not entitled to demand the act as a matter of right.

Discretion, BLACK'S LAW DICTIONARY (11th ed. 2019).



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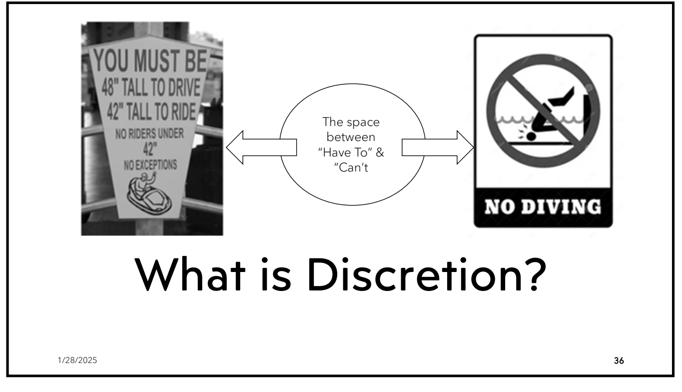

What is Discretion?

1/28/2025

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GS 122C-261(b)

"If the clerk or magistrate finds reasonable grounds to believe that the facts alleged in the affidavit are true and that the respondent probably has a mental illness and is either (i) dangerous to self, ... or dangerous to others, ... or (ii) in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness, the clerk or magistrate shall issue an order to a law enforcement officer or any other designated person …to take the respondent into custody for examination by a commitment examiner."

37

37

GS 122C-261(b)

"The clerk or magistrate shall provide the petitioner and the respondent, if present, with specific information regarding the next steps that will occur for the respondent."

38

38

GS 122C-261(d)(4)

"If the commitment examiner recommends inpatient commitment based on the criteria for inpatient commitment set forth in G.S. 122C-263(d)(2) and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for inpatient commitment, the clerk or magistrate shall issue an order to a law enforcement officer to take the respondent into custody for transportation to a 24-hour facility..."

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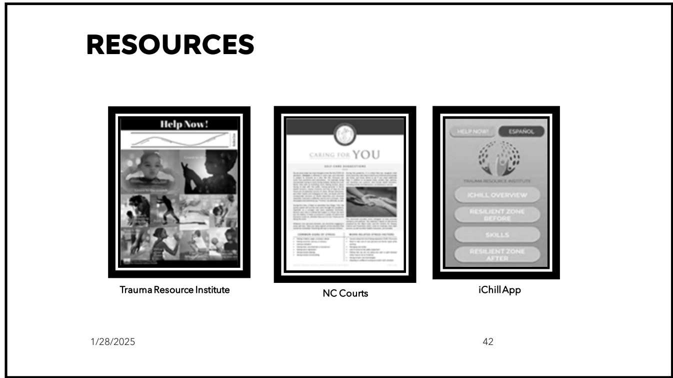

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"DON'T CHANGE WHAT YOU DO FOR THE PEOPLE WHO HATE IT. DO WHAT YOU DO FOR THE PEOPLE WHO LOVE IT."

-NC RABBIT HOLE

Image by Microsoft Bing Image Creator

1/28/2025

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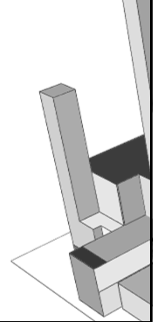
FINAL TIPS & TAKEAWAYS

- Slow down. Remember someone's liberty is at stake.
- Listen to the testimony and ask clarifying questions.
- Don't issue a custody order just because the affidavit is from a clinician.
- Use the judicial decision-making process no matter who the petitioner is.
- Guard against unwanted influences in your decisions.



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FINAL THOUGHT

"I'll always be there. Always. It's not the powers. Not the cape. It's about standing up for justice. For truth. As long as people like you are out there, I'll be there. Always."

-Superman

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45

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INVOLUNTARY COMMITMENT FOR MAGISTRATES

PETITIONER NARRATIVES EXERCISE

Directions: Next to each statement write "RF" if you think it is a relevant fact, "IF" if you think it is an irrelevant fact, or "CS" if you think it is a conclusory statement. If it is a relevant fact (RF), state which involuntary commitment criteria you think it is relevant to prove on the line below the statement.

1. A deputy appears before you and testifies as follows:
    - Respondent was found outside a tire store saying he has "plans for Tennessee."

      ____
    - He was passively resisting officers.

      ____
    - He stated he has "$9,000 to pay for his Tennessee plans" but only had about $3.00 in change.

      ____
    - He refused to comply with officers in regards to information and gave officers incorrect information in regards to identity and date of birth.

      ____

    (*In re M.L.*, 262 N.C. App. 154 (2018) (unpublished).)

2. A psychiatrist with a community response team appears before you and testifies as follows:
    - Respondent has a history of schizoaffective disorder, schizophrenia, and bi-polar disorder for which he is prescribed medications.

      ____
    - Respondent also has substance abuse disorder and engages in significant alcohol and drug use.

      ____
    - When respondent does not take his medications, he is dangerous.

      ____
    - Respondent has not slept for three days.

      ____
    - Respondent stays outside all night guarding the house with a crossbow, even though it is December and the temperatures at night have been below freezing.

      ____
    - Respondent lives with his mother and drained her car battery to prevent her from leaving the house.

      ____
    - Respondent should be involuntarily committed to bring him in compliance with his medications and because he is dangerous to self and others.

      ____

    (*Wynn v. Frederick*, ___ N.C. ___, 895 S.E.2d 371 (2023).)

3. An emergency room doctor faxes over an "Affidavit and Petition for Involuntary Commitment" with the following statement of facts:
    - Respondent has an extensive history of mental illness.

      ____
    - Respondent is noncompliant with medication.

      ____
    - Respondent is currently very psychotic.

      ____
    - She is experiencing paranoid delusions.

      ____
    - She states that someone has implanted tracking devices into her ears, vagina, and uterus.

      ____
    - In an effort to remove the tracking devices, respondent has undergone self-inflicted genital mutilation.

      ____
    - She is also convinced that her gastrointestinal tract is blocked by a snake filled with cocaine.

      ____
    - She takes laxatives multiple times a day to clear the "blockage" although multiple medical professionals have examined her and told her there is no such blockage.

      ____
    - She cannot take care of her medical and physical needs if she is released from the hospital.

      ____
    - If she is not involuntarily committed, she would cease medications which would lead to rapid decompensation.

      ____

    (*In re E.B. AAU/MPU Wards Granville County*, 287 N.C. App. 103 (2022).)

4. An emergency room doctor faxes over an "Affidavit and Petition for Involuntary Commitment" with the following statement of facts:
    - Respondent has been diagnosed with bi-polar disorder.

      ____
    - She has been admitted with psychosis while taking care of her two-month-old child.

      ____
    - She remains disorganized and paranoid.

      ____
    - She is refusing to take her medications.

      ____
    - She clearly represents a danger to herself or others if not treated.

      ____

    (*In re Whatley*, 224 N.C. App. 267 (2012).)

5. An emergency room doctor faxes over an "Affidavit and Petition for Involuntary Commitment" with the following statement of facts:
    - 76 y.o. female presented to ER with bruising on left side of mouth and eyes and rambling speech.

      ____
    - She stated that her daughter hit her and is trying to take advantage of her because she will not sell her house.

      ____
    - Respondent has lived alone for 20 years.

      ____
    - Daughter works at the hospital and reports that respondent has been doing dangerous things.

      ____
    - She reports that Respondent has been seen by neighbors walking long distances to the store in a bad neighborhood, telling strangers her personal business, and inviting strangers into her home.

      ____
    - Daughter also reports that Respondent's guns were taken away from her due to threatening behavior.

      ____
    - Respondent has a history of delusional disorder.

      ____
    - Respondent is mentally ill and dangerous to self and others.

      ____

    (*In re J.C.D.*, 265 N.C. App. 441 (2019).)

PROCEDURAL FAIRNESS/PROCEDURAL JUSTICE

A BENCH CARD FOR TRIAL JUDGES

WHAT IS PROCEDURAL FAIRNESS OR PROCEDURAL JUSTICE?

When we speak of **Procedural Fairness** or **Procedural Justice** (two terms for the same concept), we refer to the perceived fairness of court proceedings. Those who come in contact with the court form perceptions of fairness from the proceedings, from the surroundings, and from the treatment people get.

Research has shown that higher perceptions of procedural fairness lead to better acceptance of court decisions, a more positive view of individual courts and the justice system, and greater compliance with court orders.

Researchers sometimes identify the elements of procedural fairness differently, but these are the ones most commonly noted:

VOICE: the ability of litigants to participate in the case by expressing their own viewpoints.
NEUTRALITY: the consistent application of legal principles by unbiased decision makers who are transparent about how decisions are made.
RESPECT: that individuals were treated with courtesy and respect, which includes respect for people's rights.
TRUST: that decision makers are perceived as sincere and caring, trying to do the right thing.
UNDERSTANDING: that court participants are able to understand court procedures, court decisions, and how decisions are made.
HELPFULNESS: that litigants perceive court actors as interested in their personal situation to the extent that the law allows.

MEASURING FAIRNESS

"Measurements . . . define what we mean by performance."

—Peter Drucker

There are tools to help you measure fairness in your court. You can then see if you can improve over time.

The Center for Court Innovation has *Measuring Perceptions of Fairness: An Evaluation Toolkit*, available at http://goo.gl/TVu42A.

The National Center for State Courts has its CourTools, which includes an Access and Fairness survey in both English and Spanish, available at www.courtools.org.

The Utah Judicial Performance Evaluation Commission has a Courtroom Observation Report, which can be used by courtroom observers to give qualitative feedback, available at http://goo.gl/1bWAVk.

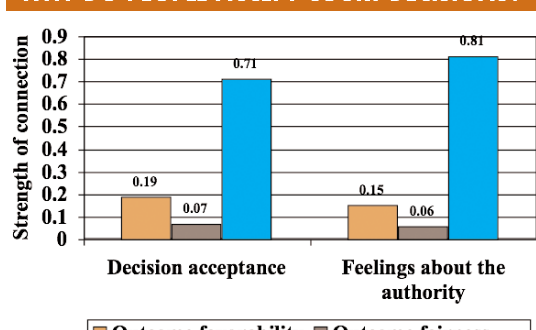
KEEP IN MIND:

- This may be the most important contact with the court system the parties will ever have.
- Filling out forms on the bench may be important, but eye contact and engagement with the parties are critical.
- Trust is not a given. But it can be gained in each hearing through adherence to procedural-fairness principles.
- People make assumptions when they lack knowledge. Explain things.
- Listening is a key skill. Decision acceptance is greater if it's clear you listened—note their key points when ruling.
- Like others, judges can be affected by perceptions, assumptions, and stereotypes—in other words, implicit biases. Be aware.

WHY IS IT IMPORTANT?

Several rigorous evaluations have shown that both acceptance of court decisions and overall approval of the court system are much more closely connected to perceptions of procedural fairness than to outcome favorability (Did I win?) or outcome fairness (Did the right party win?). Studies also show increased compliance with court orders when participants experience procedural fairness.

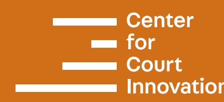
WHY DO PEOPLE ACCEPT COURT DECISIONS?

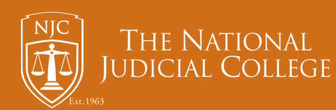


Source: Survey of court users in Oakland and Los Angeles, California, reported generally in Tom R. Tyler & Yuen J. Huo, Trust in the Law (2002).

FOR MORE INFORMATION

ProceduralFairness.org
ProceduralFairnessGuide.org
Center for Court Innovation (www.courtinnovation.org)
National Center for State Courts (www.ncsc.org)





This bench card is jointly produced by the American Judges Association, the Center for Court Innovation, the National Center for State Courts, and the National Judicial College.

BENCH CARD ON PROCEDURAL FAIRNESS

PRACTICAL TIPS FOR COURTROOM PROCEEDINGS

INTRODUCE YOURSELF. Introduce yourself at the beginning of proceedings, making eye contact with litigants and other audience members. Court staff can recite the basic rules and format of the court proceedings at the beginning of each court session. Written procedures can be posted in the courtroom to reinforce understanding.

GREET ALL PARTIES NEUTRALLY. Address litigants and attorneys by name and make eye contact. Show neutrality by treating all lawyers respectfully and without favoritism. This includes minimizing the use of jokes or other communication that could be misinterpreted by court users.

ADDRESS ANY TIMING CONCERNS. If you will be particularly busy, acknowledge this and outline strategies for making things run smoothly. This can help relax the audience and make the process seem more transparent and respectful.

Example: "I apologize if I seem rushed. Each case is important to me, and we will work together to get through today's calendar as quickly as possible, while giving each case the time it needs."

EXPLAIN EXTRANEOUS FACTORS. If there are factors that will affect your conduct or mood, consider adjusting your behavior accordingly. When appropriate, explain the issue to the audience. This can humanize the experience and avoid court users' making an incorrect assumption.

Example: "I am getting over the flu. I'm not contagious, but please excuse me if I look sleepy or uncomfortable."

EXPLAIN THE COURT PROCESS AND HOW DECISIONS ARE MADE. The purpose of each appearance should be explained in plain language. Tell the defendant if and when she will have an opportunity to speak and ask questions. Judges and attorneys should demonstrate neutrality by explaining in plain language what factors will be considered before a decision is made.

Example: "Ms. Smith: I'm going to ask the prosecutor some questions first, then I'll ask your lawyer some questions. After that, you'll have a chance to ask questions of me or your attorney before I make my decision."

USE PLAIN LANGUAGE. Minimize legal jargon or acronyms so that defendants can follow the conversation. If necessary, explain legal jargon in plain language. Ask litigants to describe in their own words what they understood so any necessary clarifications can be made.

MAKE EYE CONTACT. Eye contact from an authority figure is perceived as a sign of respect. Try to make eye contact when speaking and listening. Consider other body language that might demonstrate that you are listening and engaged. Be conscious of court users' body language too, looking for signs of nervousness or frustration. Be aware that court users who avoid making eye contact with you may be from a culture where eye contact with authority figures is perceived to be disrespectful.

ASK OPEN-ENDED QUESTIONS. Find opportunities to invite the defendant to tell his/her side of the story, whether directly or via defense counsel. Use open-ended questions to invite more than a simple "yes" or "no" response. Warn litigants that you may need to interrupt them to keep the court proceeding moving forward.

Example: "Mr. Smith: I've explained what is expected of you, but it's important to me that you understand. What questions do you have?"

EXPLAIN SIDEBARS. Sidebars are an example of a court procedure that can seem alienating to litigants. Before lawyers approach the bench, explain that sidebars are brief discussions that do not go on the record and encourage lawyers to summarize the conversation for their clients afterward.

STAY ON TASK. Avoid reading or completing paperwork while a case is being heard. If you do need to divert your attention briefly, pause and explain this to the audience. Take breaks as needed to stay focused.

Example: "I am going to take notes on my computer while you're talking. I will be listening to you as I type."

PERSONALIZE SCRIPTED LANGUAGE. Scripts can be helpful to outline key points and help convey required information efficiently. Wherever possible, scripts should be personalized–reading verbatim can minimize the intended importance of the message. Consider asking defendants to paraphrase what they understood the scripted language to mean to ensure the proper meaning was conveyed.

Adapted from Emily Gold LaGratta, Procedural Justice: Practical Tips for Courts (2015).

FOR ADDITIONAL READING

Emily Gold LaGratta, Procedural Justice: Practical Tips for Courts (2015), available at https://goo.gl/YbuC3K.

Kevin Burke & Steve Leben, *Procedural Fairness: A Key Ingredient in Public Satisfaction*, 44 Ct. Rev. 4 (2007-2008) (an AJA White Paper), available at http://goo.gl/afCYT.

Pamela Casey, Kevin Burke & Steve Leben, *Minding the Court: Enhancing the Decision-Making Process,* 49 Ct. Rev. 76 (2013) (an AJA White Paper), available at http://goo.gl/RrFw8Y.

Brian MacKenzie, *The Judge Is the Key Component: The Importance of Procedural Fairness in Drug-Treatment Court,* 52 Ct. Rev. 8 (2016) (an AJA White Paper), available at http://goo.gl/XA75N3.

David B. Rottman, *Procedural Fairness as a Court Reform Agenda*, 44 Ct. Rev. 32 (2007-2008), available at https://goo.gl/sXRTW7.

Tom R. Tyler, *Procedural Justice and the Courts*, 44 Ct. Rev. 26 (2007-2008), available at https://goo.gl/UHPkxY.

This bench card is jointly produced by the American Judges Association, the Center for Court Innovation, the National Center for State Courts, and the National Judicial College.

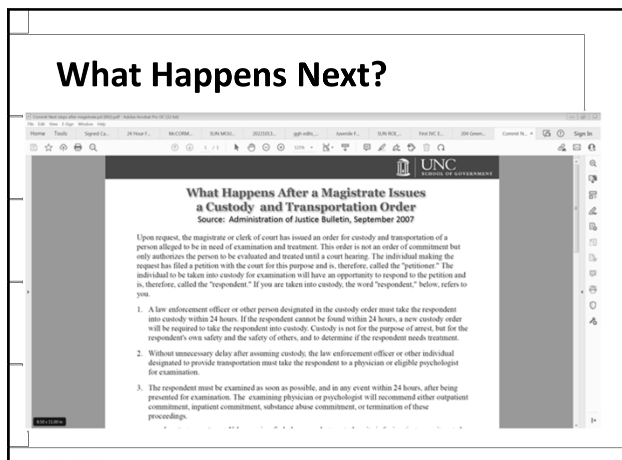
1

If Magistrate Issues Custody Order
AOC-SP-302A

The “magistrate shall provide the petitioner and the respondent, if present, with specific information regarding the next steps that will occur for the respondent.”

G.S. 122C-261(b)

2



UNC
SCHOOL OF GOVERNMENT

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.

3

Other Information

- 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
  - If you don't issue a custody order

4

Resources for Petitioners

What happens next?

Once you are connected to a service provider, they are your "first responder" and will give you contact information so you can reach them at any time in case of a crisis.

Your provider works with you to develop a crisis plan that is unique to you. The plan outlines what you, your family and your friends are to do if a behavioral health crisis occurs in the future.

Want to learn more?

To learn more about behavioral health services in your community, call Partners at 1-888-235-HOPE (4673) or visit our website at www.PartnersBHM.org.

Partners is a Local Management Entity/ Managed Care Organization (LME/MCO) responsible for ensuring access to care for people who need services for mental health, intellectual/developmental disabilities and substance use disorders (MH/IDD/SUD) in central and western North Carolina. Partners manages all Medicaid, state and local funding for MH/IDD/SUD services in our covered areas.

Access to Care: 1-888-235-HOPE (4673)
Administrative Offices: 1-877-864-1454
Website: www.PartnersBHM.org
Email: memberquestions@partnersbhm.org
Corporate Office:
901 S New Hope Rd., Gastonia, NC 28054

Find us on Social Media

Where do you turn when a behavioral health crisis occurs?

PARTNERS

What is a behavioral health crisis?

A behavioral health crisis happens when you are unable to cope with a range of emotions, impulses and behaviors. Below are examples of a behavioral health crisis:

- Feelings of panic or anxiety that cause you to avoid people and decisions.
- Believing people are out to get you or want to hurt you.
- Withdrawal from alcohol or drugs.
- Major changes in alcohol or drug use.
- Seeing or hearing things other people do not see or hear.
- Intense feelings of hopelessness, helplessness or sadness.
- Thinking or talking about hurting yourself or others.

Need help now?

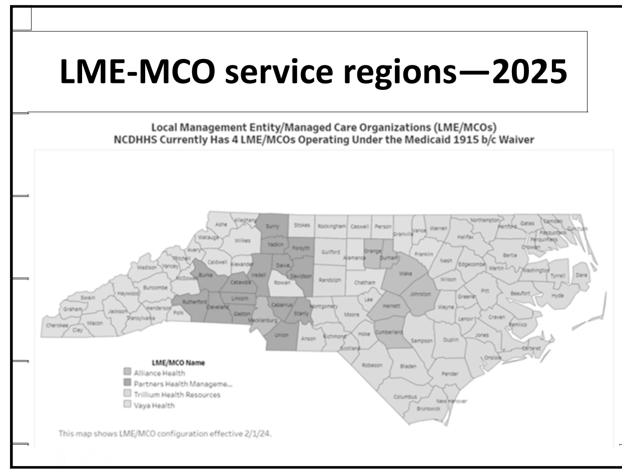
Call 1-888-235-HOPE (4673) anytime day or night. Partners' Access to Care Call Center staff will connect you to services by:

- Scheduling an appointment.
- Directing you to a nearby clinic.
- Sending a crisis professional out to meet you.

Pregnant women using drugs and people injecting drugs receive priority scheduling. If this applies to you, you will receive the first open appointment.

5

LME-MCO service regions—2025



6

LME Community Crisis Plans

- NC's public mental health authorities, a.k.a., "Local Management Entities-Managed Care Organizations (LME-MCOs)" are required by statute to create a "community crisis plan"
- IVC—addresses who transports respondents where
- Must be developed with the participation of acute care hospitals, other first examination facilities, law enforcement agencies, and magistrates

G.S. 122C-202.2

7

LME Community Crisis Plans

- Incorporates the County Transportation Plan that identifies law enforcement agencies (and possibly other *designated persons*) responsible for IVC custody and transportation
- Identifies where respondents shall be taken for the first IVC exam. Intended to divert some respondents from hospital ED to mental health facilities with commitment examiners.
- Identifies training for any "designated persons" named in a County Transportation Plan

8

LME Community Crisis Plans

Must identify—for any non-law enforcement personnel designated in a County Transportation Plan—training that addresses the

- use of de-escalation strategies and techniques
- safe use of force and restraint
- respondent rights relative to involuntary commitment
- location of first examination sites, and
- completion and return of service.

G.S. 122C-202.2

9

Alternative Community Response to Psychiatric Emergencies

Durham HEART Program
- Crisis Call Diversion
- Community Response
- Co-Response
- Care Navigation

Community Safety | Durham, NC

DCSD-pilot-overview_April2024

10

Chapel Hill Crisis Unit

- Crisis Assistance and Engagement Response (CARE) Team—for behavioral health and intellectual developmental disability related calls that are non-emergent and don't require law enforcement response.
  - Crisis counselor embedded in the 911 Call Center.
  - A three-person, mobile team—crisis counselor, peer support specialist, and community EMT
  - Incident follow-up
- Co-Response—Crisis counselors provide 24/7 onsite emergency response with officers to people in crisis situations.

11

Questions?

- Mark Botts
  - 919.923.3229 (cell)
  - botts@sog.unc.edu

12

Answers to common questions about the HEART crisis response programs

	Crisis Call Diversion (CCD)	Community Response Teams (CRT)	Co-Response (COR)	Care Navigation (CN)
What does this program do?	CCD adds clinicians to our 9-1-1 call center so we can quickly connect you to a mental health professional when you or a loved one is experiencing a behavioral health crisis	CRT dispatches unarmed, 3-person teams as first responders instead of police when you call 9-1-1 about non-violent mental health crises or quality of life concerns	COR dispatches clinicians along with CIT (Crisis Intervention Team) -trained police officers to higher risk 911 calls involving mental health crises or quality of life concerns	CN provides in-person or phone-based follow-up within 48 hours after meeting with one of our responders when you need additional support connecting to care
Who is staffing each program?	Mental health clinicians	Mental health clinicians, peer support specialists, and EMTs	Mental health clinicians (in partnership with Durham Police officers)	Mental health clinicians and peer support specialists
When might I interact with this program?	When you call 9-1-1	When you need an in-person response to a 911 call and live within Durham city limits.		When you need more support connecting to services after engaging one of our teams.
Can I request this response?	Residents should not worry about how to request the right response. Please continue to call 9-1-1 and Call Takers will route the call to the appropriate responder based on their protocol questions and the needs of the caller.			
Where does this program operate?	As of October 23, 2023, all programs operate citywide in Durham.			
What are the hours of service?	7 days a week, 9am–9pm	7 days a week, 9:15am–11:45pm	7 days a week, 6am–9pm	7 days a week, 9am–9pm

Answers to common questions about the HEART crisis response programs

	Crisis Call Diversion (CCD)	**Community Response Teams** (CRT)	**Co-Response** (COR)	**Care Navigation** (CN)
What kinds of calls are eligible for this program?	Suicide threat, Mental Health Crisis, and other calls involving behavioral health concerns	Suicide Threat, Mental Health Crisis, Trespass, Welfare Check, Intoxicated Person, Prostitution, Public Indecency, and Assist Person calls *where the person is not in possession of a weapon or physically violent toward others*	Attempted suicide; Custody issue; Involuntary commitment; and any of the following where there is an increased risk of violence and/or a weapon is present: Trespass; Intoxicated person; Panhandling / nuisance; Indecency / lewdness; Prostitution; Physical / verbal disturbance; Harassment; Threat; Reckless activity; Abuse; Threat; Domestic violence	CN follows up with our neighbors after they have had an initial interaction with one of our staff from CCD, CRT, or COR.
Is Durham the first to do this?	No. Durham is the first in NC, but other U.S. cities with this program include Houston, Charleston, Austin, and Philadelphia.	No. Durham is the first in NC, but other U.S. cities with this program include San Francisco, Denver, Portland, and Albuquerque.	No. Other U.S. cities with this program include Denver, Houston, Raleigh, among others. While many co-response programs run entirely out of Police or Fire depts., Durham partners two public safety depts., Community Safety and Police.	No. Some other U.S. cities with this program include Raleigh, Greensboro, and San Francisco.
How were programs developed?	All programs have been developed with a lot of careful planning that was, and continues to be, community-informed, highly collaborative, data-driven and evidence-based.			
How can I stay informed?	HEART's online dashboard provides a lot of data and information on each program. View the up-to-date dashboard at www.durhamnc.gov/HEART-data			
How can I identify HEART?	HEART responders wear matching teal shirts with distinctive logos to help you identify them in the community. View this visual identity on the following page.			

Visit Durham Community Safety's website to learn more:
www.durhamnc.gov/HEART

1 Crisis Call Diversion

[CCD] This program puts clinicians in our 911 call center so we can quickly connect you to a mental health professional when you or someone you know is experiencing a mental/ behavioral health crisis.

2 Community Response Team

[CRT] This program dispatches unarmed, 3-person teams as first responders instead of police when you call 911 about non-violent mental health crises or quality of life concerns.

3 Co-Response

[COR] This program sends a mental health clinician with a CIT (Crisis Intervention Team)-trained police officer to respond to higher risk calls involving behavioral health or quality of life concerns.

4 Care Navigation

[CN] This program provides in-person and/or phone- based follow-up as soon as possible after meeting with one of our first responders when you need support connecting to care.

Keep an eye out for HEART responders!
We wear the HEART logo on our teal shirts and on our white City of Durham vehicles. For certain 911 calls, you may see us instead of police or other first responders. *Pictured: Abena Bediako & Leigh Mazur, HEART's Clinical Managers*

How can you reach HEART?

Call 911 for all emergencies.

For non-emergencies, you can call 919-560-4600.

Both numbers will reach a Durham Emergency Communications Call Taker. In general, while you may request a specific kind of response, 911 Dispatchers will send the response that is most appropriate given the needs of the caller and based on whether HEART is available.

HEART is an official City of Durham program within the Community Safety Department.

HEART is a team of first responders (made of mental health clinicians, peer support specialists, and EMTs) operating out of the City of Durham's Community Safety Department. We provide care for 911 calls that may involve behavioral/mental health needs and other quality of life concerns.

What services does HEART provide?

Why the name HEART?

Holistic When supporting our neighbors, we take into account the *whole person* and their environment, working with each individual to help find the right care for their needs.

Empathetic We love our Durham Neighbors. HEART strives to always be person-centered, trauma-informed & equity-focused in our work.

Assistance HEART assists our Neighbors in moments of crisis and follows up with them afterward to help make sure they are able to connect with the right support and resources.

Response Like other first responders, HEART is dispatched to certain 911 calls, arriving as quickly as possible when we are needed.

Team HEART responders function in teams made up of a mental health Clinician, a Peer Support Specialist, and an EMT.

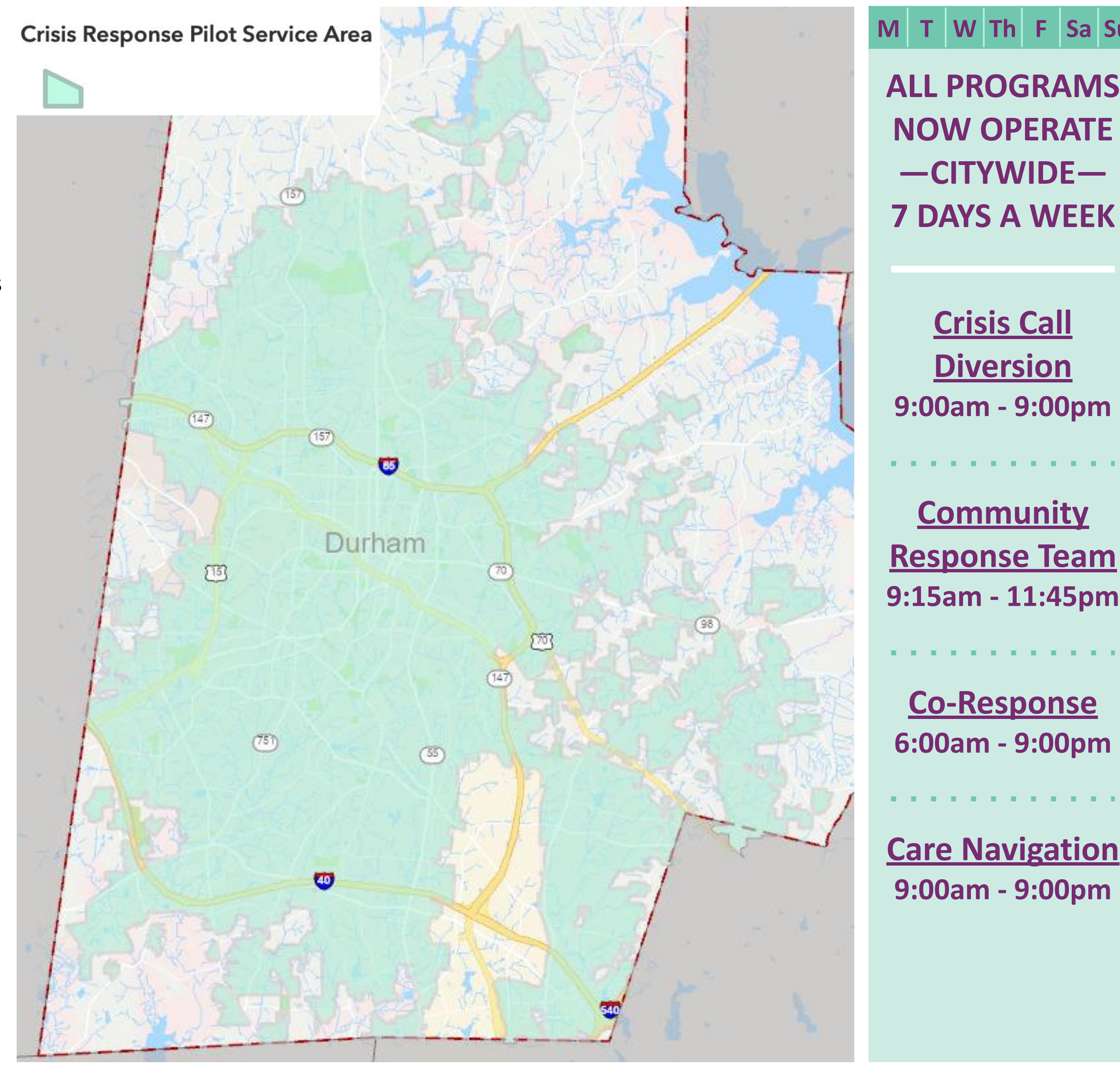
Visit our website to stay updated.

This brochure was printed in October 2023. Some program details, including operation hours, may change over time. Visit the Durham Community Safety Department website for more information, including answers to Frequently Asked Questions and ongoing updates on how HEART programs are going:

DurhamNC.gov/HEART

When and where does HEART operate?

As of October 23rd, 2023, all HEART services are available citywide. That means no matter where you are in the city of Durham, a HEART response is now an option for certain 911 calls for service. View the service map below in more detail: bit.ly/HEARTservicearea



The Alternative Responder Project

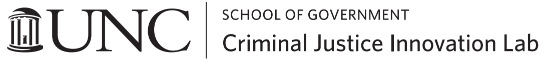
Final Report
July 2023

Jessica Smith, W.R. Kenan, Jr. Distinguished Professor & Director, Criminal Justice Innovation Lab, UNC School of Government

C. Ross Hatton, Research Specialist, Criminal Justice Innovation Lab, UNC School of Government

Leisha DeHart-Davis, Professor, UNC School of Government

Maggie A. Bailey, Assistant Director, Criminal Justice Innovation Lab, UNC School of Government



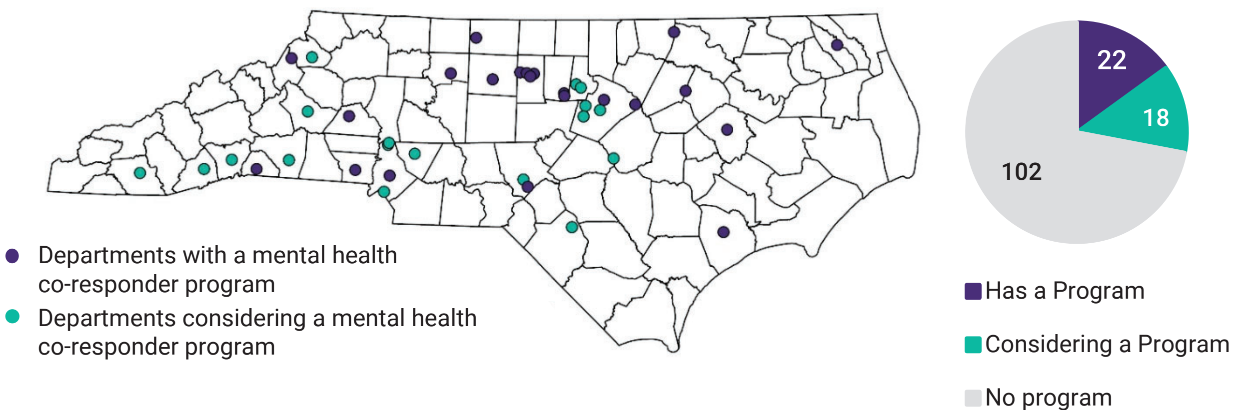
Specific Program Models

Mental Health Co-Responder Programs

Mental health co-responder programs involve mental health professionals responding with police to service calls, either arriving with officers or being called to the scene later.

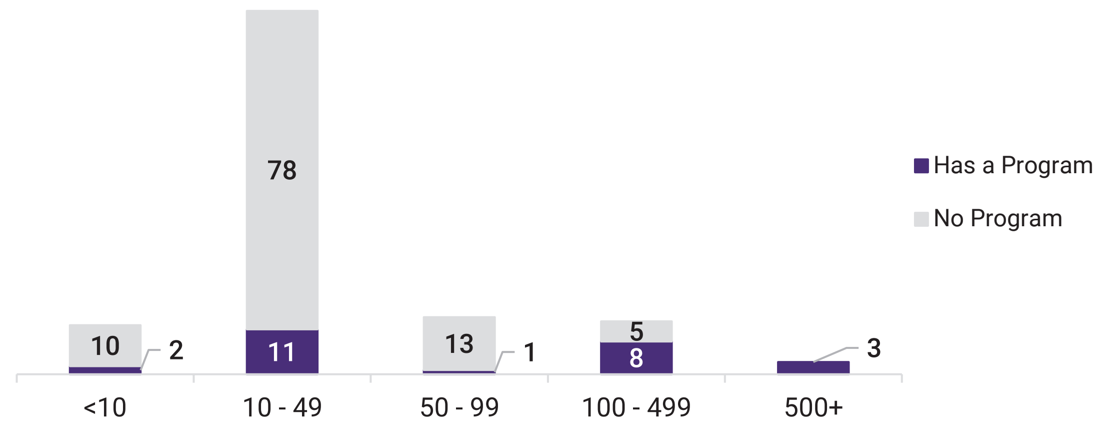
Location & Frequency of Mental Health Co-Responder Programs

Forty police departments (28% of survey respondents) report that they have or are considering implementing a mental health co-responder program. Those departments are located throughout the state and in diverse communities.



Mental Health Co-Responder Programs by Department Size

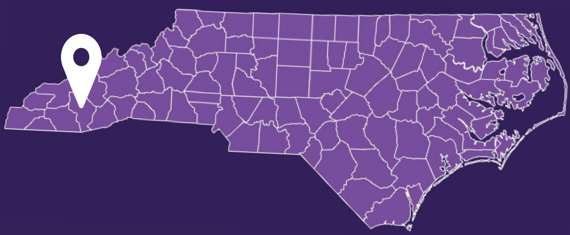
Larger police departments are more likely to have a mental health co-responder program. However, because smaller departments are more common, half of all programs are in departments with less than fifty sworn officers.



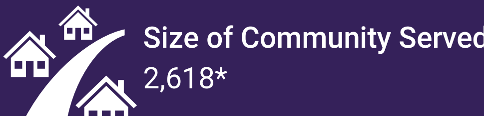
Program Highlight
Sylva Police Department Community Care Program

Leveraging local resources in a small community

Town of Sylva



Department Size
15 Sworn Officers



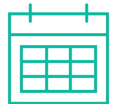
Size of Community Served
2,618*

*Source: U.S. Census Bureau

What is it? Created in 2021 in partnership with Western Carolina University (WCU), a master's-level social work intern is embedded in the department as Community Care Liaison, providing support, case management, and referrals to people in crisis. By serving as a field placement site for WCU's Master of Social Work Program, the program comes with no extra cost to the town, a key consideration for a small jurisdiction with limited resources. Officers make a referral to the liaison after interacting with someone who might need services. The liaison also co-responds to calls involving people who lack housing, are experiencing a mental health crisis, or otherwise need support, stepping in once the officer has assessed safety risk.

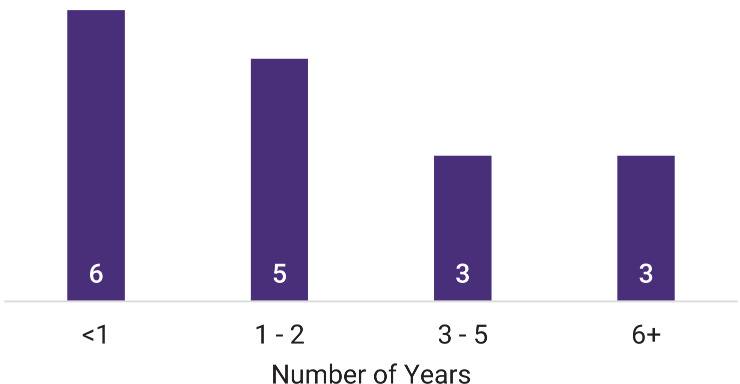
What's the impact? The department says the program is well received by officers and the community. Officers regularly make referrals to the liaison and value the liaison's skills during co-response. The department receives positive comments from those served by the program and the broader community. The department estimates that the program served forty to fifty people in its first year.

What's next? The department has received grant funding to hire a full-time Community Care Liaison. At least three other police departments aim to replicate the program.



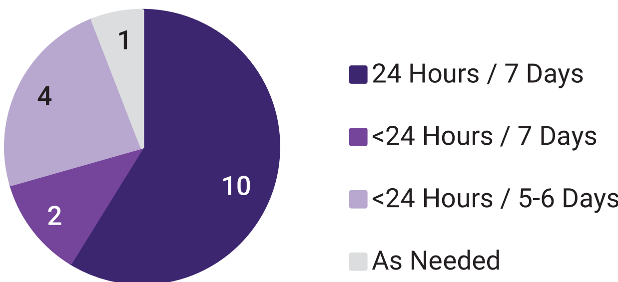
Mental Health Co-Responder Program Age

Most programs are relatively new and are less than two years old.



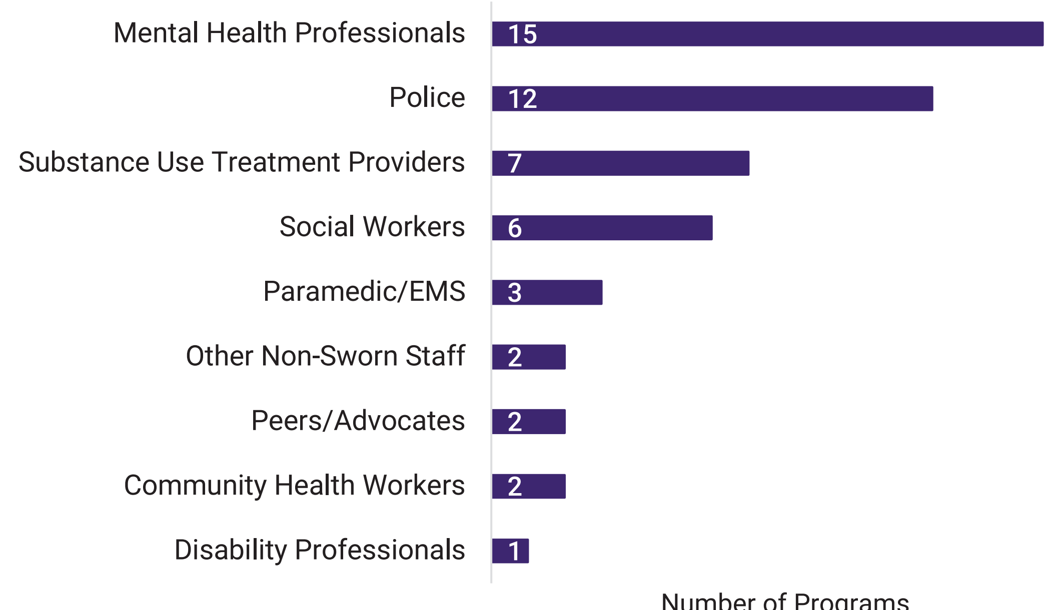
Hours of Operation of Mental Health Co-Responder Programs

Most programs operate 24/7, and nearly all operate most days of the week.



Mental Health Co-Responder Program Staffing

Mental health co-responder programs are most commonly staffed with mental health professionals, police, substance use treatment providers, and social workers.



Program Highlight
Charlotte-Mecklenburg Police Department Community Police Crisis Response Teams

Building on co-response to expand alternative responder programs

City of Charlotte & Mecklenburg County

Department Size
1,942 Sworn Officers

Size of Community Served
1,145,392*

*Source: U.S. Census Bureau

What is it? Created in 2019, the Community Police Crisis Response Team program is a partnership between the Charlotte-Mecklenburg Police Department, which serves the City of Charlotte and surrounding Mecklenburg County, and local behavioral health services. Twelve teams consisting of a police officer and a mental health provider serve as first responders for low-level mental health-related calls. They also provide follow-up services, particularly for people with a history of law enforcement interactions. Follow-up can occur at the scene or later, providing longer-term support through resources and case management services to help avoid future crises.

What's next? The department is launching a new pilot. Rather than dispatching an officer for low-level calls involving mental health crises or homelessness, an EMT and a mental health care provider will respond.

Want to Learn More?

Read the case studies of three mental health co-responder programs:

Burlington Law Enforcement Crisis Counselor Program

Chapel Hill Crisis Response Unit

Jacksonville Crisis Response Program

These departments report having a mental health co-responder program:

Aberdeen Police Department	Greensboro Police Department
Beech Mountain Police Department	Greenville Police Department
Burlington Police Department	Haw River Police Department
Catawba Valley Medical Center Co. Police	Jacksonville Police Department
Chapel Hill Police Department	Madison Police Department
Charlotte-Mecklenburg Police Department	Raleigh Police Department
Columbus Police Department	Rocky Mount Police Department
Elizabeth City Police Department	Littleton Police Department
Elon Police Department	UNC Hospitals Police Department
Gaston College Campus Police	Winston-Salem State University Police Department
Graham Police Department	Zebulon Police Department

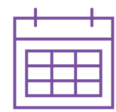
Chapel Hill Crisis Response Unit

An established program that has been scaled over time

Quick Facts

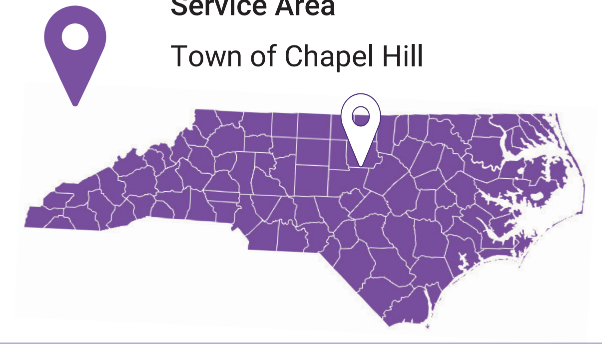
Program Type

Mental health co-responder



Program Start Date

1973



Service Area

Town of Chapel Hill

Staffing

8 full-time employees:

6 Crisis Counselors

1 Peer Support Specialist

1 Transit Crisis Counselor

Department Size

102 Sworn Officers

Size of Community Served

61,128

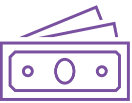
(Source: U.S. Census Bureau)

Hours of Operation

24/7 coverage

Office hours: 7 AM to 12:30 AM

After hours, staff rotate being on call

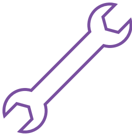


Funding

Funded by the Town of Chapel Hill

Key Partners

Orange County Rape Crisis Center; Orange County Community Paramedics; Orange County Criminal Justice Resource Department; UNC & Duke Hospitals; The University of North Carolina at Chapel Hill; Interfaith Council for Social Service; Compass Center; Freedom House Recovery Center; Alliance Health



Equipment

Radios, computers, databases, 3 vehicles, cell phones, office phones & bullet-proof vests

Call Volume

In 2022, the Crisis Response Unit responded to 3,522 events.

Background

The Town of Chapel Hill Police Department's Crisis Response Unit may be one of the oldest of its kind in the United States. Established in 1973, the unit was originally staffed by one social worker, who worked on domestic and family disputes and with justice-involved and at-risk juveniles. The unit's size and role has evolved, and its longevity has ingrained co-response into department culture, with most officers not knowing any other policing model. As one officer put it, "co-response is second nature to us."

Program Scope & Responsibilities

The Crisis Response Unit is staffed by eight individuals: six Crisis Counselors, one Peer Support Specialist, and a Transit Crisis Counselor. Crisis Counselors' primary role is to stabilize people in crisis, assess their immediate and ongoing needs, and connect them with resources and services. The Peer Support Specialist fills a similar role but brings a lens of personal experience with recovery from mental health and/or substance use disorders. Because of this, the Peer Support Specialist can connect with individuals who might otherwise be mistrustful of treatment or struggling to recover. The Crisis Counselors and the Peer Support Specialist are embedded within the police department. The Transit Crisis Counselor is embedded in the town's Transit Department, which operates Chapel Hill's fare-free transit system. The Transit Counselor trains transit staff on de-escalation strategies and responds to crises that occur on the system's buses.

The unit becomes involved in calls for service in a few ways. First, officers may call the unit and ask someone to respond to the scene if the subject of the call is in crisis or if victims need emotional or mental health support. Second, the unit monitors dispatches and reaches out to officers on the scene to provide information on people they know or to ask if officers want the unit at the scene. After a unit member arrives, officers might remain on the scene, depending on the circumstances. Finally, Crisis Counselors receive calls from community partners and residents and will either initiate a response with officers or provide support in other ways (e.g., phone consultations, referrals to partners).

The unit also has other functions. After a crisis incident, the unit checks in with community members and provides additional support. They review police reports and reach out to individuals who did not require immediate crisis response, such as checking in with burglary victims. The Peer Support Specialist builds relationships with people experiencing homelessness, sometimes providing basic needs and connecting them with other services. Unit members serve on various community boards and participate in community events to build relationships and stay informed of available resources. The unit also conducts trainings for officers to help them respond to people in crisis.

Benefits

The department reports that the unit benefits the department and the broader community. Staff note that connecting people with services to address the root causes of behavior is a better outcome for the community. The warm hand off from responding officers to unit members who can connect people to services offers options beyond the jail or the hospital.

> "Officers run from call to call … get the information, write the report, move on to the next one. Crisis counselors help community members find the resources they need."

Officers perceive that mental health-related calls are increasing in the community and feel that having a responder who is not wearing a law enforcement uniform and who has specialized

knowledge of available resources improves community trust in the police. The unit also enables a more efficient and effective use of resources, freeing up officers to focus on law enforcement, rather than addressing situations they may not be equipped to handle.

"[Officers] are not trained to be a licensed therapist or a licensed counselor, and, in some instances, you don't know how to respond to someone who is crying. Because you're not just here to respond and stop any violence or react to the crimes that are happening. Nobody really trained you on how to handle a mother who's just lost her son."

The unit supports officers in their high-stress roles, whether as an informal confidant or through an official debrief. Crisis Counselors are certified to lead critical incident debriefs after traumatic calls and when high-profile police-involved shootings make the news.

"Having the co-responders there to be able to talk about it and debrief in an almost informal manner [is helpful] because a lot of times officers are resistant to come and sit together after the fact, and say, hey, we're going to debrief, and we're going to talk about how we feel our emotions."

Factors for Success

Organizational Integration

Being located in the police department has allowed strong partnerships to develop between officers and unit members, which staff believe boosts officer use of the unit and the quality of the services provided to the public. Officers note that unit members have taught them better approaches for responding to individuals in crises, and they have taught unit members safety protocols.

"I think we've been fortunate that we can cultivate the relationships between the crisis unit and officers much easier because of the crisis unit's location in the police department. … [T]here's a level of trust there too, with them working closely with law enforcement."

Community Relationships

The unit builds relationships with community organizations to facilitate referrals and help clients navigate complex services. Some service providers or health care organizations might be mistrustful of sharing information with law enforcement agencies; having staff with social work credentials helps alleviate these concerns and promotes coordination between the unit and providers. Building trust with providers and raising awareness of local resources improves the services for community members.

Service Availability

Unit members acknowledge that there are gaps in the system. Health care services for mental health and substance use are limited and difficult to navigate, particularly for uninsured or underinsured individuals. Insufficient housing is also a challenge. Without adequate services, people may cycle back into crisis.

Multidisciplinary Team

Having a team of responders helps prevent burn out, as the responsibility for crisis response and follow-up does not fall entirely on one staff member. Unit members encourage each other to take care of themselves and pitch in when a member needs a break. Additionally, the team can draw on each other's skills and strengths to handle different situations. They have varied backgrounds in psychology and social work, and the Peer Support Specialist has the training and life experience to build rapport with people in crisis. This diverse expertise enables a more holistic approach to crisis response.

Chapel Hill and Orange County Launch 'Holistic' Crisis Response Team

Posted by Brighton McConnell | May 21, 2024 | Health, Instagram, Local Government, Safety

For 50 years, the Chapel Hill Police Department's Crisis Unit has been working to provide a different type of response during emergency calls than traditional law enforcement. Now, the program has expanded its footprint into a different local government — as it has partnered with the Orange County government to bring its diversion strategies to a mobile team separate from police officers.

After having been in development for one year, the Crisis Assistance, Response, and Engagement (CARE) Team officially hit the streets this month. The group consists of four people: a crisis counselor, a peer support specialist, and an emergency medical technician (EMT) travelling to calls, plus another crisis counselor taking calls in the Orange County 911 call center.

Chapel Hill Police Chief Celisa Lehew says the idea came around, in part, because of the long-standing success of the department's own crisis unit. She said when it comes to behavioral and mental health incidents, those responders have proved their methods often better serve the affected people than having law enforcement respond and detain them.

"Our police officers are not subject-matter experts in those types of things," says Lehew, "so really having that right person or right team of people to respond is really going to help that person in crisis."

(From left to right) Jennifer Melvin, Heather Palmateer, RuthAnne Winston, and Mari Hall make up the initial CARE Team run out of Chapel Hill Police and the Orange County 911 call center. (Photo via the Town of Chapel Hill.)

Chapel Hill Police hired peer support specialist Jennifer Melvin and crisis counselor Heather Palmateer and funded their positions within the CARE Team, while the 911 center's counselor – Mari Hall – also has experience with the police department's current diversion strategies. Hall worked in the crisis unit before transitioning to the new role with Orange County Emergency Services.

"That was important to us," says Lehew, "because we wanted somebody in there with some experience with how our crisis team operates and what that call response could look like."

The EMT member, RuthAnne Winston, also marks the first medical technician from Orange County Emergency Services dedicated to working in mobile crisis diversion and response.

Compared to Chapel Hill's Crisis Unit, which also still responds to calls with police officers, the CARE Team will take on cases from the source. The 911 crisis counselor will assess the situation from the call center before sending the other three members to the person in distress – without police involved.

"And then once that CARE Team is on site," says the Chapel Hill Police chief, "it's really wraparound services. Somebody who has lived experience, immediate medical assessment opportunity, and then that follow-up crisis response. We've worked through what those calls look like coming into the 911 center and what responses the CARE Team can go to, safely, and have this holistic [approach]."

Chair of the Orange County Commissioners Jamezetta Bedford shared support for the program during her weekly interview with 97.9 The Hill. She particularly pointed to the de-escalation strategies and providing of care on-site as critical benefits.

"It should reduce cost," Bedford said, "and it should be more friendly and less dangerous for everyone involved. It's sort of like the HEART team in Durham and it's a really positive step forward."

The CARE Team is just one way the county government is using strategies and treatments alternative to law enforcement or the criminal justice system. Orange County is planning a crisis diversion facility as a destination for people undergoing behavioral health crises and needing resources instead of local jails or hospitals being where they end up. While a site in Hillsborough has been identified, the county is still working out the funding and timeline of the project.

In the meantime, Bedford said the elected officials' hope is this launch will be the start of an extended impact brought by the CARE Team.

"Yes, we would like to expand it," the board chair said. "But we need to get this part working first and then we'd love to work with the other police departments as well."

Lehew says the current pilot of the CARE Team is set to last two years, with the UNC School of Government helping review how effective its work is as the initiative moves forward. But the goal is to continue scaling up the model outlined by her department.

"Chapel Hill is of course the biggest municipality within the county, and with our crisis team built in, we thought that the pilot team made sense for Chapel Hill to begin [this]," she says. "But, really, the hope is to bring this throughout the county."

Editor's Note: An earlier version of this story incorrectly said Heather Palmateer is working as the 911 call center crisis counselor. That has since been updated to correctly reflect Mari Hall is in that role.

Featured photo via the Town of Chapel Hill.

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CRISIS UNIT | 919-968-2806

The Chapel Hill Police Crisis Unit is a 24-hour co-responder team that provides onsite emergency response with officers to people in crisis situations.

COMMUNITY PARTNERS

Housing Helpline – 919-245-2655

Call Homeless Info Line 919-245-2655, 10am-4pm to speak with a person. For information about cold weather cots available when the temperature is projected to be 39 degrees or below, press 2 for men and press 3 for women.

Street Outreach, Harm Reduction, and Deflection Program (SOHRAD) – Phone: 919-886-3351, Cell: 919-748-2625

The Street Outreach, Harm Reduction and Deflection (SOHRAD) program connects people experiencing homelessness in Orange County with housing and services.

Community Empowerment Fund (CEF) - 919-200-0233

Savings opportunities, bank accounts, one-on-one employment assistance, financial education, connection to other needed services; 208 N. Columbia St., Ste. 100, Chapel Hill; Accessible from most Chapel Hill Transit routes M-F 9am-5pm, Thursday 5pm-7pm.

Orange County Department of Social Services - (919) 245-2800

The Orange County Department of Social Services exists to provide protection to vulnerable children and adults, economic support to low-income individuals and families in crisis, and intervention services to at-risk persons residing in Orange County. The agency is the access point for most state and federal human services programs; 113 Mayo St., Hillsborough, NC 27278; 2501 Homestead Road, Chapel Hill; M-F 8am-5pm.

Orange County Health Department – Main: 919-245-2400, Dental: 919-945-2435

Health, dental & mental health services; 300 W Tryon St., Hillsborough; 2501 Homestead Rd., Chapel Hill; M-Th 8am-5pm, F 8am-12pm

Freedom House Recovery Center/Orange-Person County Mobile Crisis - 919-967-8844

Walk-in crisis and detox, residential and outpatient mental health, substance use treatment for adults and children at 104 New Stateside Dr., Chapel Hill.

UNC Counseling and Psychological Services (CAPS) - 919-966-3658

Addresses the mental health needs of a diverse student body through timely access to consultation and connection to clinically appropriate services; James A. Taylor Building, CB# 7470, 320 Emergency Room Drive, Chapel Hill, NC 27599; caps@unc.edu.

988 Suicide & Crisis Lifeline - Dial 988

The 988 Suicide & Crisis Lifeline is a national network of local crisis centers that provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week in the United States.

Alliance Orange County - 800-510-9132

24-hour Care Access Line for people who use Medicaid and those who do not have insurance.

CRISIS UNIT | 919-968-2806

The Chapel Hill Police Crisis Unit is a 24-hour co-responder team that provides onsite emergency response with officers to people in crisis situations.

COMMUNITY PARTNERS

NAMI Orange County - 1-800-950-NAMI (6264)

This is an organization of families, friends and individuals whose lives have been affected by mental illness. Together, we advocate for better lives for those individuals who have a mental illness. NAMIHelpLine is available M - F, 10 a.m. – 10 p.m.

LGBTQ Center of Durham - https://www.lgbtqcenterofdurham.org/mental-health/

Online guide to therapists.

Veterans Crisis Line - 1-800-273-8255

24/7 confidential crisis support for Veterans and their loved ones. You don't have to be enrolled in VA benefits or health care to connect.

Duke Hospice Unicorn Bereavement Center - 919-620-3853

Support for those who are coping with the loss of a loved one. They offer short-term individual grief counseling, support groups, and grief workshops, as well as programs tailored for children and teens.

El Futuro - 919-688-7101 ext. 600

Mental health/substance use treatment and services for Latinos; available M, W-F, 9 a.m.-5 p.m., Tu, 9 a.m. - 7 p.m. at 136 E. Chapel Hill St., Durham

Healing Transitions - 919-838-9800

Substance use treatment; available M - F 8 a.m.- 5 p.m. at Women's Campus: 3304 Glen Royal Rd., Raleigh; Men's Campus: 1251 Goode St., Raleigh

Orange County Rape Crisis Center (OCRCC) - 866-WE LISTEN or 919-967-7273

The mission of the OCRCC is to stop sexual violence and its impact through support, education and advocacy. Services include 24-hour helplines; support groups; free, short-term trauma-informed therapy; advocacy; resources and education and outreach.

Compass Center for Women and Families - 919-929-7122

Helps all people navigate their journey to self-sufficiency, safety and health. Services include career and financial education, domestic violence crisis and prevention programs, assistance with legal resources and youth health programs.

Inter-Faith Council for Social Services - 919-929-6380

Shelter and housing services; Community Kitchen (110 W. Main St., Carrboro) meals offered M-F 11:15am-12:30pm and 5:15pm-6pm, Sat. and Sun. 11:15am - 12pm; food pantry; and emergency financial assistance.

"MENTAL HEALTH 101"

Introduction to Psychiatric Illness
Magistrate Training
February 11, 2025

Ken Fleishman, MD
Chairman of Psychiatry and Behavioral Healthcare
Cape Fear Valley Health System

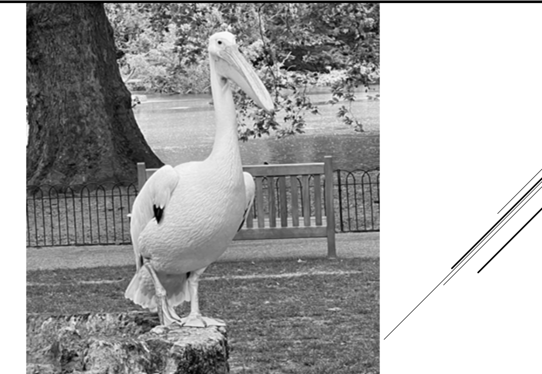
1

DISCLOSURES

I have no financial support from commercial interests, outside vendors, governmental entities or overinvolved family members.

Information for this presentation has been gathered from the following:
www.psychiatry.org - Website: The American Psychiatric Association
www.cdc.gov - Website: Centers for Disease Control and Prevention
www.mayoclinic.org – Website: The Mayo Clinic

2



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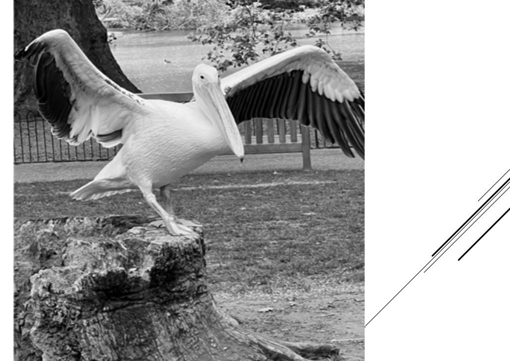

4

MENTAL ILLNESS

- **Health conditions involving changes in emotion, thinking or behavior (or any combination of these).**
- **Has no connection to level of intelligence**
- **Most are chronic, none are contagious**
- **Likely associated with distress and/or problems functioning in social, work or family activities depending on the severity of the illness**
- **Most have no association with violence**
- **Most are associated with a biological illness that responds to treatment**
- **Not to be confused with a weakness of character**

5

MENTAL ILLNESS

- **In a Given Year in the U.S.A**
  1 in 5 (23.1%) adults experience some form of mental illness
  1 in 5 (21.8%) children (3 -17) are assessed for mental illness/behavior disorder
  15%-60% Prevalence of mental health problems in children (Exposure to Risk)
  1 in 24 (4.1%) has a serious mental illness
  1 in 12 (8.5%) has a diagnosable substance use disorder.
- **Mental Illness is Treatable**. The vast majority of individuals with mental illness continue to function in their daily lives.

6

PSYCHIATRIC DISORDERS

- **ANXIETY DISORDERS: Generalized Anxiety Disorder, Panic Disorder, Obsessive Compulsive Disorder, Social Anxiety Disorder**
- **MOOD DISORDERS: Major Depressive Disorder*, Bipolar Disorder* (Type I & II)**
- **NEUROCOGNITIVE DISORDERS: Dementia, Delirium**
- **PERSONALITY DISORDERS: Borderline Personality, Narcissistic, Antisocial**
- **PSYCHOTIC DISORDERS: Schizophrenia, Schizoaffective Disorder (Bipolar & Depressive Type), Psychotic Disorder Unspecified**
- **TRAUMA AND OTHER STRESSOR RELATED DISORDERS: Post Traumatic Stress Disorder, Adjustment Disorders, Acute Stress Response**
- **SUBSTANCE USE DISORDERS**

7

ANXIETY DISORDERS

- **In any given year the estimate percent of U.S. adults with various anxiety disorders are:**
  - **SPECIFIC PHOBIA: 8% - 12%**
  - **SOCIAL ANXIETY DISORDER: 7%**
  - **PANIC DISORDER: 2% - 3%**
  - **AGORAPHOBIA: 1-2.9% in Adolescents and Adults**
  - **GENERALIZED ANXIETY DISORDER: 2%**
  - **SEPARATION ANXIETY DISORDER: 0.9% - 1.9%**
- **Episode may last minutes to hours, occur often, may or may not have triggers**
- **Rapid heart rate, rapid & shortness of breath, intense fear, feelings of doom, chest pain, repetitive thoughts, extreme worry of re-experiencing again and again and again….**

8

ANXIETY DISORDERS

- **30% of adults at sometime in their lives**
- **Women are more likely than men to experience anxiety disorders.**
- **2.4% GREATER RISK OF SUICIDE Males slightly greater risk than females**
- **TREATMENT**
  Psychotherapy
  Medications

9

MOOD DISORDERS

▸ **MAJOR DEPRESSIVE DISORDER: "MDD", "Depression"**

- **Feeling sad or having a depressed mood**
- **Loss of interest or pleasure in activities once enjoyed**
- **Changes in appetite — weight loss or gain unrelated to dieting**
- **Trouble sleeping or sleeping too much**
- **Loss of energy or increased fatigue**
- **Increase in purposeless physical activity (e.g., hand-wringing or pacing) or slowed movements and speech (actions observable by others)**
- **Feeling worthless or guilty**
- **Difficulty thinking, concentrating or making decisions**
- **Thoughts of death or suicide**

For greater than 2 weeks duration

10

MOOD DISORDERS

▸ MAJOR DEPRESSIVE DISORDER:

- In the past year 16 million American adults, about 7% of the population has experienced the symptoms of Major Depression.
- An estimated 21 million (8.4% of the population) adults in the United States had at least one Major Depressive episode.
- All ages, races, ethnicities and socioeconomic background have Major Depression
- Women are more 70% more likely than men to experience Major Depression
- Adults age 18-25 are 60% more like likely to have Major Depression than those 50+

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MOOD DISORDERS

MAJOR DEPRESSIVE DISORDER:

TREATMENT:

Medications – Antidepressants, Mood Stabilizers, Antipsychotic Medications

Psychotherapy – Cognitive Behavioral Therapy, Family-Focused Therapy, Interpersonal Therapy

Brain Stimulation – Electroconvulsive Therapy or repetitive Transcranial Magnetic Stimulation

Light Therapy

Exercise

Alternative Therapies – Acupuncture, Meditation and Nutrition

Self Management Strategies and Education

Mind/Body/Spirit Approaches – Medication, Faith and Prayer

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MOOD DISORDERS

- **Bipolar Disorder** - Mood Swings with Depressive Episodes to Manic Episodes
- Mania – Feeling very up, "super happy", "on top of the world"
  - Extreme irritability/on edge
  - Little to no sleep for 3-5+ days
  - Feeling unusually important, having special powers, better than others
  - Increased impulsivity, reduced judgment
  - Excessive appetite for food, drinking, sex, or other pleasurable activities
  - Talking very fast, loud, without direction, interrupting others
  - Racing thoughts, Unrelated ideas
  - Feeling able to do many things at once without getting tired

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MOOD DISORDERS

- **Bipolar Disorder** - **Mood Swings - Depressive Episodes to Manic Episodes**
- **Effects ~5.7 million adult Americans, or ~2.6% of the U.S. population age 18 and older every year.**
- **The median age of onset for bipolar disorder is 25 years, however the illness can start in early childhood or as late as the 40's and 50's.**
- **An equal number of men and women develop bipolar illness and in all ages, races, ethnic groups and social classes.**
- **Some 20% of adolescents with major depression develop bipolar disorder within 5 years of the onset of depression.**
- **The sixth leading cause of disability in the world..**
- **Bipolar disorder results in 9.2 years reduction in expected life span**

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MOOD DISORDERS

- **Bipolar Disorder - Mood Swings with Depressive Episodes to Manic Episodes**

- **Rate of Suicide 10-30% greater than the general population.**
- **Up to 20% of (mostly untreated) patients end their life by Suicide.**
- **20-60% of patients attempt Suicide.**
- **Suicidal thinking in patients is 43%(last year prevalence) versus the general population, 9.2%(life time prevalence).**
- **Lethality Index: Ratio of Suicide attempts to Suicide Completion 3 to 1 compared to the general population 35 to 1.**
- **Account for about 3-14% of all Suicide deaths**

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MOOD DISORDERS

- **Bipolar Disorder** - **Mood Swings - Depressive Episodes to Manic Episodes**

TREATMENT:

Medications – Mood stabilizers, Antipsychotic Medications, Antidepressants

Psychotherapy – Cognitive Behavioral Therapy, Family-Focused Therapy, Interpersonal Therapy

Brain Stimulation – ECT or rTMS

SUPPORTIVE (but will not resolve the episodes or prevent them in themselves)

Exercise, Alternative Therapies – Acupuncture, meditation and nutrition

Self Management Strategies and Education

Mind/Body/Spirit Approaches – Medication, Faith and Prayer

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NEUROCOGNITIVE DISORDERS

- **Dementia – COGNITIVE, PSYCHOLOGICAL, FUNTIONAL DETERIORATION**
- **Cognitive changes**
  - **Memory loss, which is usually noticed by someone else**
  - **Difficulty communicating or finding words**
  - **Difficulty with visual and spatial abilities, such as getting lost while driving**
  - **Difficulty reasoning or problem-solving**
  - **Difficulty handling complex tasks**
  - **Difficulty with planning and organizing**
  - **Difficulty with coordination and motor functions**
  - **Confusion and disorientation**

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NEUROCOGNITIVE DISORDERS

- **Dementia – COGNITIVE, PSYCHOLOGICAL, FUNCTIONAL DETERIORATION**
- **Psychological changes**
  - **Personality changes – irritability, disinhibition, impulsivity**
  - **Depression**
  - **Anxiety**
  - **Inappropriate Behavior**
  - **Paranoia**
  - **Agitation**
  - **Hallucinations**

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NEUROCOGNITIVE DISORDERS

- **Dementia** – COGNITIVE, PSYCHOLOGICAL, FUNCTIONAL DETERIORATION
- More than 6,200,000+ Americans of all ages have Dementia
- 72% are greater than age 75
- 1 in 7 Americans over age 70 have Dementia
- Greater than 50,000,000 people throughout the world suffer
- Every year there are more than 10,000,000 new cases throughout the world
- Can affect all genders, races, ethnicities
- Increasing rate of mortality 30.5 deaths per 100,000 in 2000 to 66.7 deaths per 100,000 in 2017
- 2 x greater risk of suicide in people 65+ compared to those without Dementia

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NEUROCOGNITIVE DISORDERS

- **Dementia** – COGNITIVE, PSYCHOLOGICAL, FUNCTIONAL DETERIORATION
- TREATMENT
- Medications
- Therapies: Early to Middle Progression
- Occupational therapy: Make your home safer and teach coping behaviors. The purpose is to prevent accidents, such as falls; manage behavior and prepare you for the dementia progression.
- Modifying the environment: Reducing clutter and noise can make it easier for someone with dementia to focus and function. You might need to hide objects that can threaten safety, such as knives and car keys. Monitoring systems can alert you if the person with dementia wanders.
- Simplifying tasks: Break tasks into easier steps and focus on success, not failure. Structure and routine also help reduce confusion in people with dementia.

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NEUROCOGNITIVE DISORDERS

- **Delirium**– ACUTE CHANGE IN MENTAL STATUS

- Reduced awareness of surroundings:

  May result in
- Trouble focusing on a topic or changing topics
- Getting stuck on an idea rather than responding to questions
- Being easily distracted
- Being withdrawn, with little or no activity or little response to surroundings

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NEUROCOGNITIVE DISORDERS

- **Delirium – ACUTE CHANGE IN MENTAL STATUS**

- **Poor thinking skills**
  May appear as:
- **Poor memory, such as forgetting recent events**
- **Not knowing where they are or who they are**
- **Trouble with speech or recalling words**
- **Rambling or nonsense speech**
- **Trouble understanding speech**
- **Trouble reading or writing**

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NEUROCOGNITIVE DISORDERS

- **Delirium – ACUTE CHANGE IN MENTAL STATUS**
- **Behavior and emotional changes**
  May include:
- **Anxiety, fear or distrust of others, Depression**
- **A short temper or anger, A sense of feeling elated**
- **Lack of interest and emotion, Quick changes in mood**
- **Personality changes**
- **Hallucinations (Responding to unseen and unheard others)**
- **Being restless, anxious or combative**
- **Calling out, moaning or making other sounds**
- **Being quiet and withdrawn — especially in older adults**
- **Slowed movement or being sluggish**
- **Switched night-day sleep-wake cycle, Changes in sleep habits**

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NEUROCOGNITIVE DISORDERS

Delirium:

Commonly presents in the elderly BUT can occur at any age as it is a serious alteration in mental status caused by a medical condition not previously diagnosed

Causes:

Substance Intoxication or Withdrawal,

Medication Side Effects,

Infection, Surgery, Pain,

Severe Constipation or Urinary Retention.

TREATMENT: RESOLVE THE UNDERLYING MEDICAL ISSUE

Reduce Stimulation, Quiet Environment, Maximize Sleep at Night

Calm Visitor or Aide, Encourage Mobility, Appropriate Nutrition

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PERSONALITY DISORDERS

- Exhibits an unchanging, rigid and unhealthy pattern of thinking, functioning and behaving
- Trouble perceiving and relating to situations and people outside of themselves
- Experiences significant problems and limitations in relationships, social activities, work and school
- Often the person does not realize they have a personality disorder because their way of thinking and behaving seems natural to them.
- Frequently they blame others for the challenges or disappointments they face.
- Without treatment the symptoms and behaviors can be long lasting
- Personality disorders usually become apparent in the teenage years or early adulthood. There are 10 different types of personality disorders in the DSM-5-TR

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PERSONALITY DISORDERS

- **Borderline Personality Disorder**
  - Intense fear of abandonment, may use extreme measures to avoid real or imagined separation/rejection
  - Pattern of unstable intense relationships, often idealizing someone one moment then without apparent cause believing the person doesn't truly care or is cruel
  - Rapid changes in self-identity/self-image including life goals/values, seeing themselves as bad or not existing at all
  - Periods of stress-related paranoia & loss of contact with reality, lasting from minutes to hours
  - Impulsive/risky behavior, such as gambling, reckless driving, unsafe sex, spending sprees, binge eating and/or drug abuse
  - Sabotaging success by suddenly quitting a good job and/or ending a positive relationship
  - Suicidal threats or behavior or self-injury (cutting, etc), often in response to fear of separation or rejection
  - Wide mood swings from hours to days, including intense happiness, irritability, shame or anxiety
  - Ongoing feelings of emptiness
  - Inappropriate, intense anger, such as frequently losing your temper, being sarcastic or bitter, or having physical fights

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PERSONALITY DISORDERS

- **Borderline Personality Disorder**

TREATMENT:

Psychotherapy

- Dialectical Behavior Therapy(DBT),
- Psychoanalytic/Psychodynamic Transference-Focused Therapy
- Cognitive Behavioral Therapy(CBT),
- Group Therapy,
- Psychoeducation for the patient & the family to discuss diagnosis, symptoms, coping strategies

Medications

Self Management Strategies and Education

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PSYCHOTIC DISORDERS

- IMPORTANT DEFINITIONS

- **Psychosis:** A group of symptoms exemplified by a **loss of touch with reality** due to alterations in how the brain processes information. Thoughts and perceptions are disturbed. Frequent difficulty understanding what is real and what is not.
- **Delusions**: Fixed false beliefs held despite clear or reasonable evidence they are not true.
- **Hallucinations**: Experience of hearing, seeing, smelling, tasting, or feeling things that are not there
- **Disorganized thinking and speech:** Thoughts & speech that are jumbled and/or don't make sense
- **Disorganized or abnormal motor behavior:** Movements ranging from childlike silliness to unpredictable agitation and/or repeated movements without purpose.
- **Negative symptoms**: Abnormally lacking or absent in the person with a psychotic disorder. Examples: Impaired emotional expression, decreased speech output, reduced desire to have social contact or to engage in daily activities, and decreased experience of pleasure

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PSYCHOTIC DISORDERS

- **Schizophrenia**

- **Affects ~24 million people or 1 in 300 worldwide**
- **1 of the top 15 leading causes of disability worldwide**
- **People with Schizophrenia die at a younger age the general population.**
  - **Estimated average potential life lost for these people in the U.S. is 28.5 years.**
  - **Co-occurring medical conditions, such as heart disease, liver disease, and diabetes, contribute to the higher premature mortality rate. Possible reasons for this excess early mortality are increased rates of these medical conditions and under-detection and under-treatment of them.**
  - **~4.9% of people with schizophrenia die by suicide, with the highest risk early after diagnosis.**
- **Men often experience initial symptoms in their late teens or early 20s**
- **Women tend to show first signs of the illness in their 20s and early 30s**.

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PSYCHOTIC DISORDERS

- **Schizophrenia**

- **Hallucinations: Most common are Auditory (Voices).**
- **Delusions: Most common are Paranoid.**
- **Disorganized thinking and speech**
- **Disorganized or abnormal motor behavior**
- **Negative symptoms**

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PSYCHOTIC DISORDERS

- **Schizophrenia**

- **Treatment**
- **Medication: Antipsychotic medication**
- **Therapy/Psychosocial Supports**
  - **Provide training in social skills, cope with stress, identify early warning signs of relapse**
  - **Psychosocial Rehabilitation (PSR): Organized program to carry out the training**
  - **Vocational and Educational Training**
  - **Support and Psychoeducation**
  - **Family Support and Psychoeducation**

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PSYCHOTIC DISORDERS

- **Schizoaffective Disorder**

  Symptoms of Mood Symptoms including Bipolar Disorder and Depression and Schizophrenia
- **About 1/3 as common as Schizophrenia**
- **Treatment is a combination of medication for both disorders focusing on the more frequent and or most recent presentation**
- **Social Supports and Therapy as is necessary**

- **Brief Psychotic Disorder**
- **Psychotic Disorder, Unspecified**

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TRAUMA AND STRESSOR RELATED DISORDERS

- **Post Traumatic Stress Disorder, Adjustment Disorders, Acute Stress Response**

- **Post Traumatic Stress Disorder (PTSD)**
- **Experienced or witnessed a traumatic event, series of events or set of circumstances.**
- **Experience this as emotionally or physically harmful or life-threatening and may affect mental, physical, social, and/or spiritual well-being.**
- **Examples include natural disasters, serious accidents, terrorist acts, war/combat, rape/sexual assault, historical trauma, intimate partner violence and bullying**

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TRAUMA AND STRESSOR RELATED DISORDERS

▸ **Post Traumatic Stress Disorder**

- **Any ethnicity, nationality or culture, and at any age.**
- **~3.5 percent of U.S. adults every year.**
- **The lifetime prevalence in ages 13-18 is 8%.**
- **~1 in 11 people will be diagnosed with PTSD in their lifetime.**
- **Women are 2x as likely as men to have PTSD**
- **Three ethnic minorities — U.S. Latinos, African Americans, and Native Americans/Alaska Natives — are disproportionately affected and have higher rates of PTSD than non-Latino whites.**

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TRAUMA AND STRESSOR RELATED DISORDERS

▸ **Post Traumatic Stress Disorder**

1. **Intrusion**

Intrusive thoughts of the traumatic event.

- **Repeated, involuntary memories;**
- **Distressing dreams**
- **Flashbacks**

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TRAUMA AND STRESSOR RELATED DISORDERS

▸ **Post Traumatic Stress Disorder**

2. Avoidance

Avoiding reminders of the traumatic event that may trigger distressing memories

- **Avoiding people,**
- **Avoiding places,**
- **Avoiding activities,**
- **Avoiding objects**
- **Avoiding situations=**

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TRAUMA AND STRESSOR RELATED DISORDERS

- **Post Traumatic Stress Disorder**

3. Alterations in Thinking and Mood

- **Inability to remember important aspects of the event**
- **Negative thoughts and feelings leading to ongoing and distorted beliefs about oneself or others**
- **Distorted thoughts about the cause or consequences of the event leading to wrongly blaming self or others**
- **Ongoing fear, horror, anger, guilt or shame**
- **Much less interest in activities previously enjoyed**
- **Feeling detached or estranged from others**
- **Being unable to experience positive emotions (a void of happiness or satisfaction)**

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TRAUMA AND STRESSOR RELATED DISORDERS

- **Post Traumatic Stress Disorder**

4. Alterations in Arousal and Reactivity

- **Irritability & having angry outbursts**
- **Behaving recklessly, self-destructive**
- **Being overly watchful of one's surroundings in a suspecting way**
- **Being easily startled**
- **Having problems concentrating or sleeping**

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TRAUMA AND STRESSOR RELATED DISORDERS

POST TRAUMATIC STRESS DISORDER

TREATMENT:

Psychotherapy – CBT, CPT, PET, EMDR, Group Therapy

Medications – Antidepressants, Anxiety Reduction, Reactivity Reduction

Alternative Therapies – acupuncture, yoga and animal-assisted therapy.

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SUBSTANCE USE DISORDERS (SUD)

Complex condition - Uncontrolled use of a substance despite harmful consequences

Substances:

- Alcohol
- Marijuana
- PCP, LSD and other hallucinogens
- Inhalants, such as, paint thinners and glue
- Opioid pain killers, such as codeine and oxycodone, heroin
- Sedatives, hypnotics and anxiolytics (medicines for anxiety such as tranquilizers)
- Cocaine, methamphetamine and other stimulants
- Tobacco

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SUBSTANCE USE DISORDERS

- People keep using when they know it is causing or will cause problems.
- Most severe SUDs are usually called addictions.
- Often distorted thinking and behaviors.
- Changes In the brain's structure and function are what cause people to have intense cravings, changes in personality, abnormal movements, and other behaviors.
- Brain imaging studies show changes in the areas of the brain that relate to judgment, decision making, learning, memory, and behavioral control.

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SUBSTANCE USE DISORDERS

- **Symptoms**

- **Impaired control: a craving or strong urge to use the substance; desire or failed attempts to cut down or control substance use.**
- **Social problems: substance use causes failure to complete major tasks at work, school or home; social, work or leisure activities are given up or cut back because of substance use.**
- **Risky use: substance is used in risky settings; continued use despite known problems.**
- **Drug effects: tolerance (need for larger amounts to get the same effect); withdrawal symptoms (different for each substance)**

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SUBSTANCE USE DISORDERS

- 14.5% of Americans 12 and over used drugs in the last month, a 3.8% increase year-over-year (YoY).
- 59.277 million or 21.4% of people 12 and over have used illegal drugs or misused prescription drugs within the last year.
- 138.543 million or 50.0% of people aged 12 and over have illicitly used drugs in their lifetime.
- 138.522 million Americans 12 and over drink alcohol.
- 28.320 million or 20.4% of them have an alcohol use disorder.
- 25.4% of illegal drug users have a drug disorder.
- 24.7% of those with drug disorders have an opioid disorder; this includes prescription pain relievers or "pain killers" and heroin).
- Accidental drug OD is a leading cause of death among persons under the age of 45.
- Over 70,000 drug OD deaths occur in the US annually.

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SUBSTANCE USE DISORDERS

TREATMENT: RECOVERY PLAN – Unique to each individual

- Hospitalization for medical withdrawal management (detoxification).
- Therapeutic communities (highly controlled, drug-free environments) or sober houses.
- Outpatient medication management and psychotherapy.
- Intensive outpatient programs.
- Residential treatment ("Rehab").
- Many people find mutual-aid groups helpful (Alcoholics Anonymous, Narcotics Anonymous, SMART Recovery).
- Self-help groups that include family members(Al-Anon or Nar-Anon Family Groups).

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SUICIDE

- 2nd leading cause of death (after accidents) for people aged 10 to 34
- In 2020 in the United States, over 45,000 people died by suicide.
- An estimated 1.4 million adults attempt suicide each year, according to the CDC.
- More than 1 in 5 people who died by suicide had expressed their suicide intent.
- Men are more than 3 times more likely than women to take their lives.
- Firearms are the most common method of suicide (used in ~ 50% of all suicides).

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SUICIDE RISKS

Certain events and circumstances may increase risk
(not in particular order, except first one).

- Previous suicide attempt(s) – Primary Risk
- A history of suicide in the family
- Substance misuse
- Mood disorders (Depression, Bipolar Disorder)
- Access to lethal means (e.g., keeping firearms at home, open access to medication)
- Losses and other events (e.g., the breakup of a relationship or a death, academic failures, legal difficulties, financial difficulties, bullying)
- History of trauma or abuse
- Chronic physical illness, including chronic pain
- Exposure to the suicidal behavior of others

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SUICIDE

- In some cases, a recent stressor or sudden extreme event or failure can leave people feeling desperate, unable to see a way out, and become a "tipping point" toward suicide.
- While a mental health condition may be a contributing factor for many people, many factors contribute to suicide among those with and without known mental health conditions. A relationship problem was the top factor contributing to suicide, followed by crisis in the past or upcoming two weeks and problematic substance use.
- CDC reports that about half, 54 percent, of people who died by suicide did not have a known mental health condition. However, many of them may have been dealing with mental health challenges that had not been diagnosed or known to those around them.

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SUICIDE WARNING SIGNS

- Often talking or writing about death, dying or suicide
- Making comments about being hopeless, helpless or worthless
- Expressions of having no reason for living; no sense of purpose in life; saying things like "It would be better if I wasn't here" or "I want out."
- Increased alcohol and/or drug misuse
- Withdrawal from friends, family and community
- Reckless behavior or more risky activities, seemingly without thinking
- Dramatic mood changes
- Talking about feeling trapped or being a burden to others

SUICIDAL IDEATION VS SUICIDE INTENT/ATTEMPT:
GET CONCRETE, BE SPECIFIC!

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Questions?

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THE ROLE OF THE HOSPITAL ED

Magistrate Training
February 11, 2025

Ken Fleishman, MD
Chairman of Psychiatry and Behavioral Healthcare
Cape fear Valley Health System

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THE ROLE OF THE HOSPITAL ED

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THE ROLE OF THE HOSPITAL ED

Untangling the Chaos

Emergency Department/Room – Life in the Fast Lane

Patient presents to the ED with LEO after being served with an A & P by a LEO* - 24 HOUR CLOCK TICKING
Patient presents to the ED with LEO on "Emergency Evaluation"
Patient presents to the ED via Ambulance, Family, Self

At all times the patient is under nursing staff observation

1) **They arrive in handcuffs under law enforcement supervision.**
2) **They are placed in a ligature free environment.**
3) **All their belongings(including cell phone) are removed and secured.**

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THE ROLE OF THE HOSPITAL ED

Untangling the Chaos

4) **They will be directed to remove their clothing & jewelry.**
5) **They receive a body search and assessment.**
6) **They are dressed in a hospital gown (likely ligature free).**
7) **They have lab tests to assess blood counts, metabolic functions, urinalysis, urine drug screen, alcohol level and others as appropriate.**
8) **They may have a CT Scan or MRI of their brain**

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THE ROLE OF THE HOSPITAL ED

Untangling the Chaos

9) **ED provider performs a brief history and physical exam, may complete 1st IVC evaluation and determine if medically clear for ED Psychiatry assessment or requires medical admission with Psychiatry consult. (ED provider may use an evidenced based assessment tool to aid in determining level of risk)**
10) **WAIT…….(**may require special interventions)**
11) **They will be evaluated by nursing staff then a Social Worker (if available). (Nursing Staff or Social Worker will VERY likely use an evidence based assessment tool)**
12) **WAIT…….. LIKELY WAIT SOME MORE…(**may require special interventions)**
13) **A psychiatrist/psychiatric provider reviews the A & P, any other information available from the EHR and contact the petitioner or other family, etc.**
14) **Psychiatrist* interviews the patient then completes the first evaluation with the determination of their status, Discharge vs IVC. May be held overnight or plan for admission to a 24 hour receiving facility. (Psychiatric Provider should use an evidence based assessment tool with any patient expressing or showing risk of suicide per JCAHO)**

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THE ROLE OF THE HOSPITAL ED

Untangling the Chaos

- **If the patient is discharged, as appropriate the patient will be provided with aftercare appointments, prescriptions and information about diagnosis, crisis plan, etc. If appropriate, the petitioner may be called to make them aware the patient will be released.**
- **If the patient is to be admitted immediately, held overnight for reassessment or placed on transfer status, they will be ordered to have medication appropriate for their symptoms, illness and medical needs.**
- **On occasion the IVC paperwork is refused by the magistrate and must be redone. Contact with the magistrate is preferable to determine the refusal.**

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THE ROLE OF THE HOSPITAL ED

IVC DATA FROM THE MAGISTRATE'S OFFICE OF CUMBERLAND COUNTY

INCLUDES CAPE FEAR VALLEY HOSPITAL, WOMACK ARMY HOSPITAL, V.A. HOSPITAL

CALENDAR YEAR 2022		
CASES/IVC PAPERWORK FILED	2756	
COMMMITTED IN CUMBERLAND COUNTY	63	2.3%
JUDICIAL TRANSFERS	50	1.8%
UNSERVED	71	2.6%

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THE ROLE OF THE HOSPITAL ED

Questions?

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THE 24 HOUR FACILITY

FURTHER ASSESSMENT & TREATMENT

Patient will be transported to the 24 hour facility by the hospital system or LEO
24 Hour clock ticking at the time of admission
Nursing staff meet the patient to explain patient rights and unit rules
Full Nursing Assessment, Nursing Care Plan, Master Treatment Plan initiated
Body search and skin assessment
Full History and Physical Exam by a Physical Medicine Provider - MTP
Psychosocial Evaluation by Social Work Staff – MTP
Psychiatric Evaluation including review of IVC documents, EHR

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THE 24 HOUR FACILITY

FURTHER ASSESSMENT & TREATMENT

Psychiatrist and/or social work contacts the petitioner, family, guardian, outpatient treatment providers

Psychiatrist determines the outcome of the 2nd Evaluation. The new electronic system for cataloging IVC may require re-initiation once in a 24 hour receiving facility.

If the patient is discharged, as appropriate the patient will be provided with aftercare appointments, prescriptions and information about diagnosis, crisis plan, etc. If appropriate, the petitioner may be called to make them aware the patient will be released Psychiatrist meets with the treatment team, reviews the treatment plan then signs

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THE 24 HOUR FACILITY

FURTHER ASSESSMENT & TREATMENT

If patient is retained under IVC or patient signs in voluntarily then they are expected to participate daily in group therapy, recreation therapy, community groups, individual therapy, psychiatric assessment and discharge planning.

Daily assessment by psychiatrist involves their review of IVC criteria pertaining to the patient. If the patient no longer meets criteria the patient is presented with the option for continued treatment by signing themselves in as a voluntary patient or discharge. Discharge may be considered Against Medical Advice (AMA) in some situations.

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THE 24 HOUR FACILITY

FURTHER ASSESSMENT & TREATMENT

If a patient signs in as a voluntary patient at admission then refuses to take medication that is medically necessary for their symptoms to improve, and their medical decision making capacity is lacking , an order for an Enforced Medication Consultation cane be placed. A second physician will interview to the patient to determine their capacity with respect to medication. If the request for Enforced Medication is approved then the patient will be placed under IVC with the A & P and 1st Evaluation completed by the treating Psychiatrist. The 2nd Evaluation must be completed within 24 hours.

If a patient continues to meet criteria for IVC when they have been held for 7 days* or when they appear on the mental health court list. The treating Psychiatrist and the patient must appear in court before a Judge to determine if further treatment is required under IVC status, and the potential duration until the next court hearing.

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THE 24 HOUR FACILITY

Questions?

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THE END

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