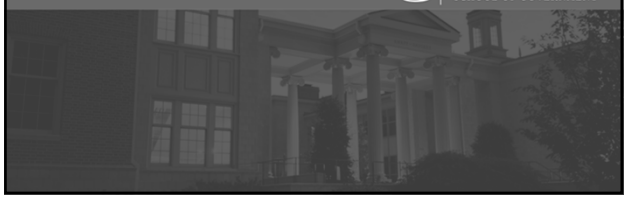
# Involuntary Commitment: The Legal Criteria for Commitment

Mark Botts

UNC SCHOOL OF GOVERNMENT



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## Topics

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

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❖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

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# Understanding the Criteria

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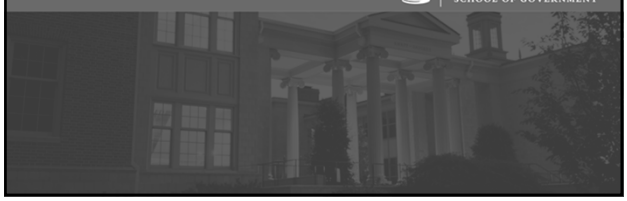

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## The Criteria for Commitment

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


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## 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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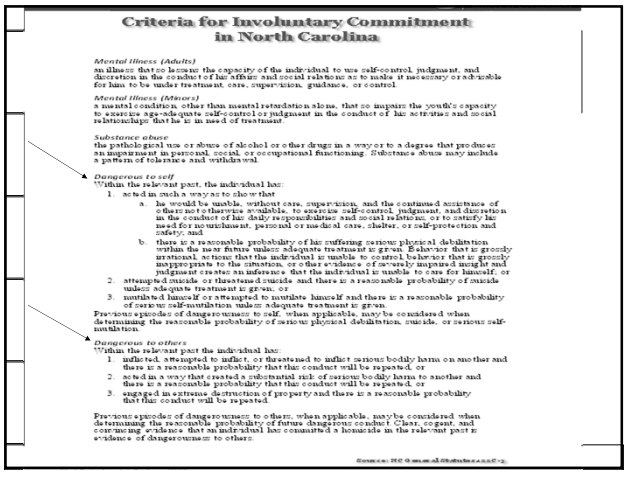

**Criteria for Involuntary Commitment in North Carolina**

*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 that 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 that conduct will be repeated; or
3. engaged in extreme destruction of property and there is a reasonable probability that that 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.

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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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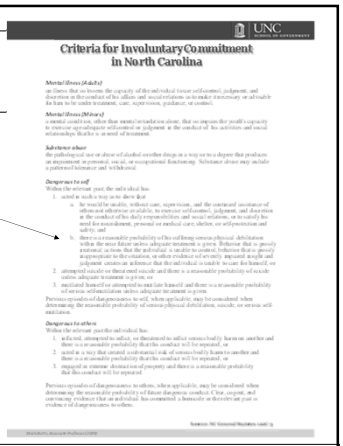
## Commitment Criteria

There is a reasonable probability of the individual suffering serious physical debilitation within the near future . . .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*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 maladaptive pattern of behavior and withdrawal.

*Dangerous to self*

Within the relevant past, the individual has

1. acted or shown 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.

Sources: NC General Statutes, Article 5

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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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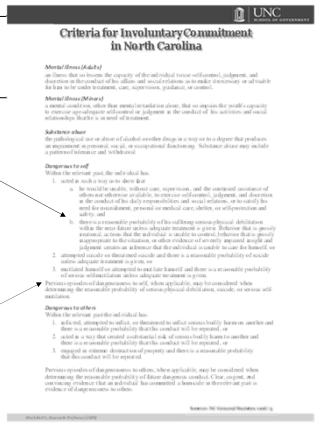
## Commitment Criteria

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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*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 or acts 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
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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
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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.

Sources: NC General Statutes 122C-3

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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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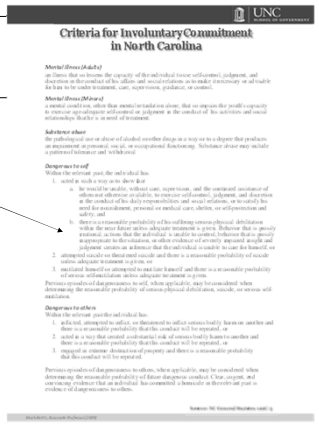
## Commitment Criteria

"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.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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.

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Within the relevant past the individual has:

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Sources: NC General Statutes 122C-3

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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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## Suicide

attempt
or
threat
+
reasonable probability of suicide

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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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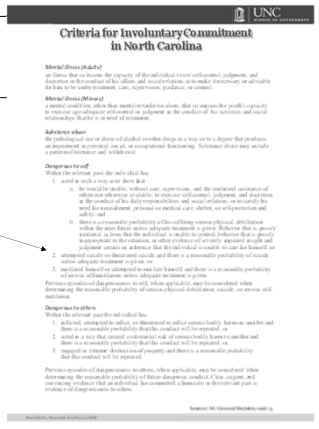
## Commitment Criteria

- Attempted or threatened suicide +
- Reasonable probability of suicide



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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.

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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
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2. attempted suicide or serious self-mutilation and there is a reasonable probability of suicide unless adequate treatment is given; or
3. inflicted himself or attempted to inflict 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*

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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
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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 or threatened past is evidence of dangerousness to others.

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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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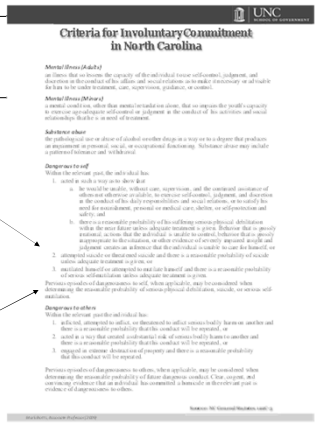
## Commitment Criteria

Attempted or threatened suicide
+
Reasonable probability of suicide

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



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1. acted in such a way as to show that
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   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, in ways that the individual is unable to control, behavior that is grossly inappropriate to the situation, or other evidence of severely impaired insight and judgment can create an inference that the individual is unable to care for himself; or
2. attempted suicide or committed serious self-mutilation 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
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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 or threatened past is evidence of dangerousness to others.

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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

32

## 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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# A Legally Sufficient Petition

UNC SCHOOL OF GOVERNMENT

- Magistrate role
- Petitioner role

34

## 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.*)

35

## 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

36

36

## 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?

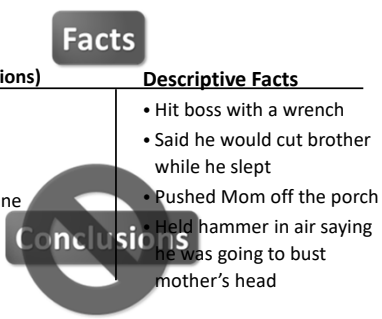
40

## 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).

41

## Information Must Be Factual




42

## 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).

44

## 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)

45

## 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

47

**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.

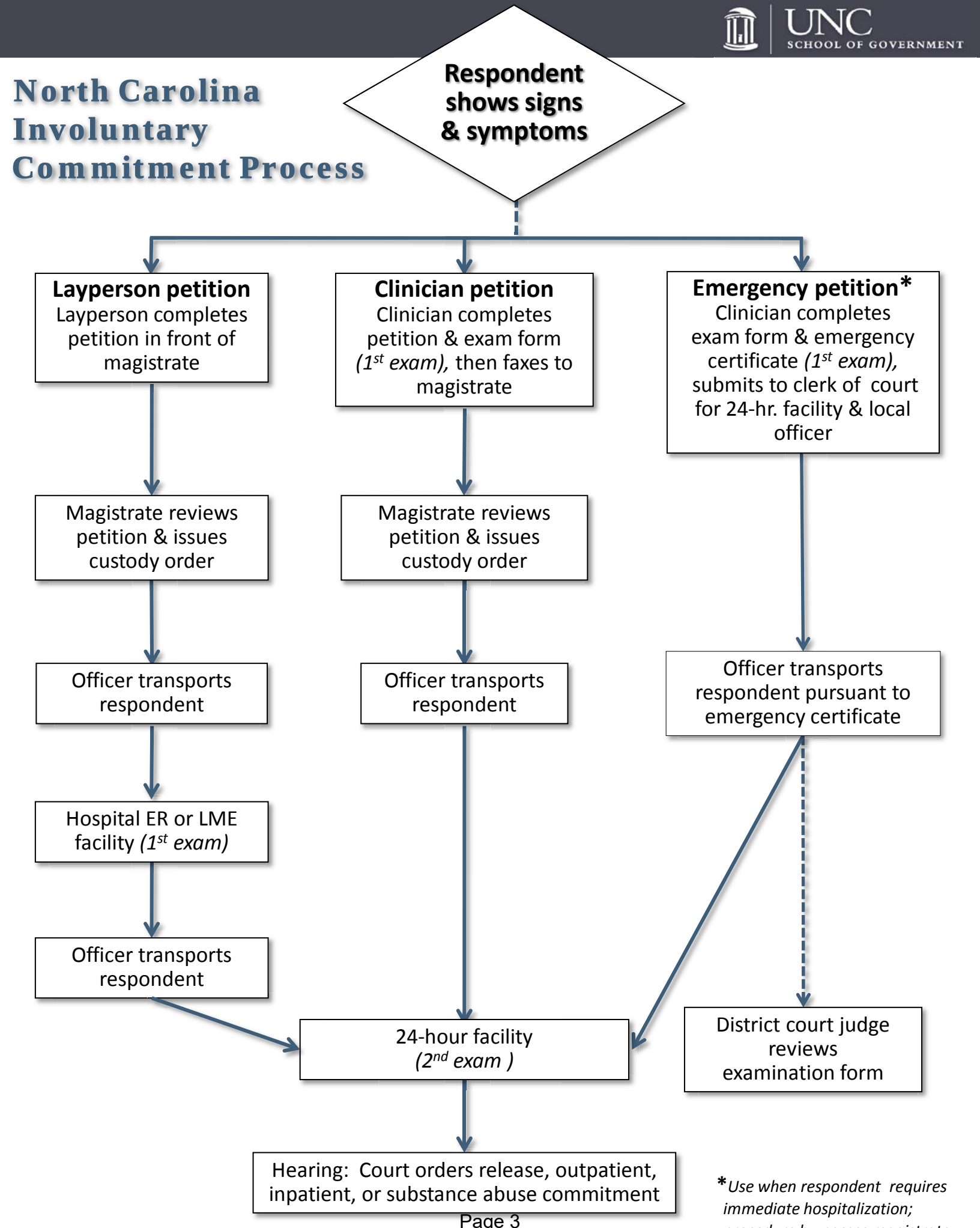
Previous episodes of dangerousness to others, when applicable, may be considered when determining the reasonable probability of future dangerous conduct. Clear, cogent, and convincing evidence that an individual has committed a homicide in the relevant past is evidence of dangerousness to others.



**Source: NC General Statutes 122C-3**

*Mark Botts, Associate Professor (2009)*

# North Carolina Involuntary Commitment Process

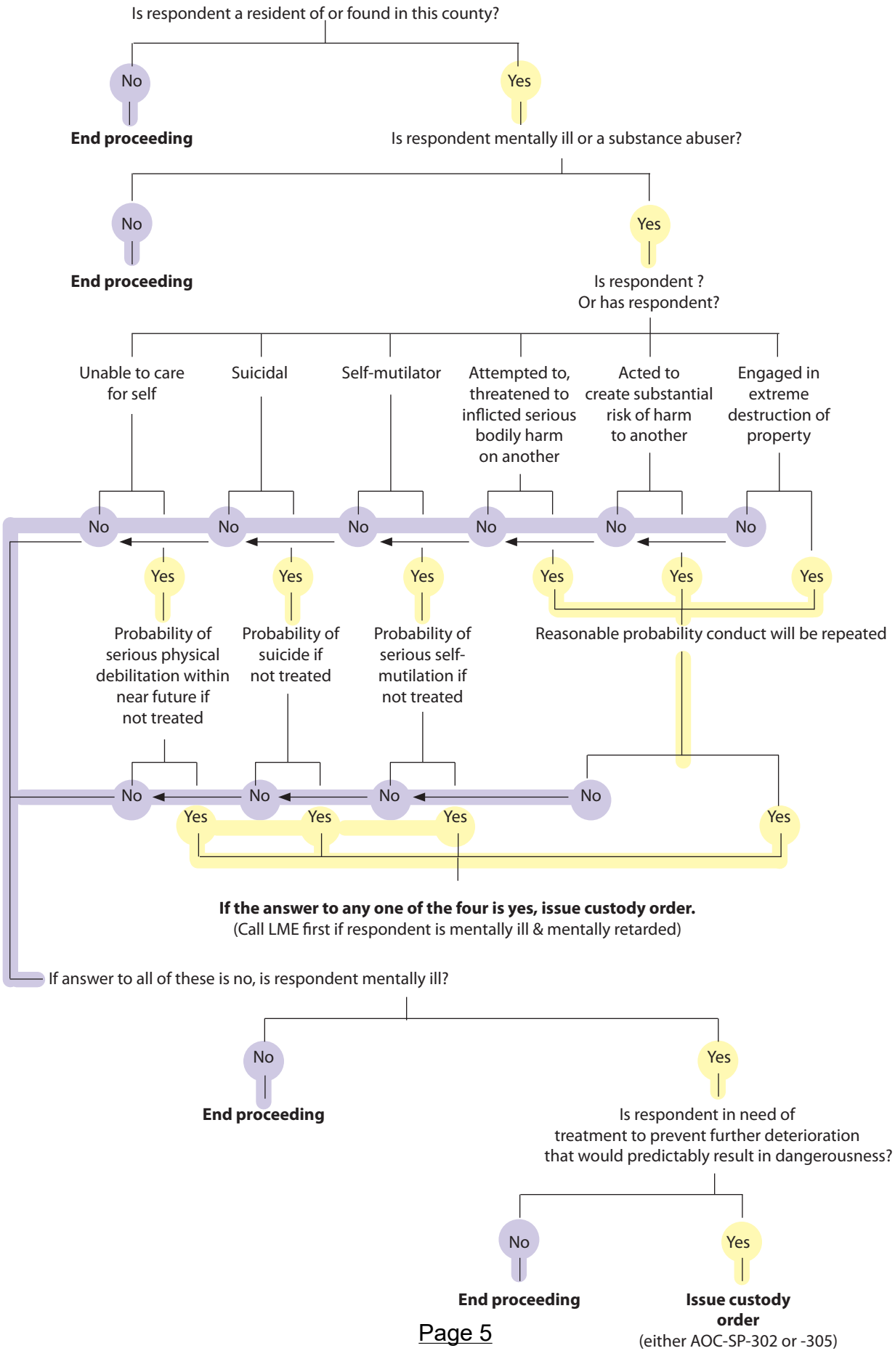



*Use when respondent requires immediate hospitalization; procedure by-passes magistrate.



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

## "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.

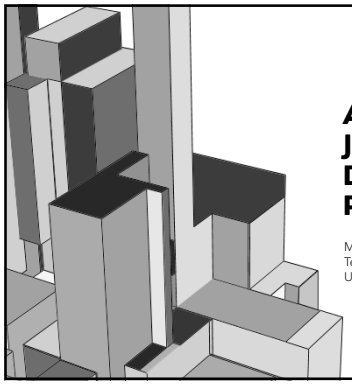
    - *Inpatient commitment*: If the examiner finds the respondent meets the criteria for inpatient commitment, the examiner will recommend inpatient commitment. The law enforcement officer or other designated person must take the respondent to a 24-hour facility.

    - *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.



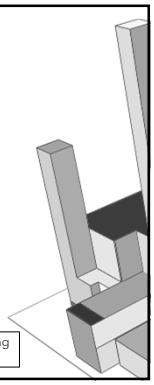
# APPLYING THE JUDICIAL DECISION-MAKING PROCESS TO IVC

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

## THE JUDICIAL DECISION-MAKING PROCESS

3

**WHAT IS YOUR DECISION?**

4

4

**WHAT IS YOUR DECISION?**

5

5

**WHAT ABOUT THIS DECISION?**

6

6

**WHAT ABOUT THIS DECISION?**


7

7

**JUDICIAL DECISION-MAKING PROCESS**

FACTS → LEGAL RULE → CONCLUSIONS

8

**JUDICIAL DECISION-MAKING PROCESS**

- Law: • Know your legal rule.
- Facts: • Determine what the facts are from the evidence.
- Conclusions: • Apply the law at issue to the facts.

9

9

## 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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## 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

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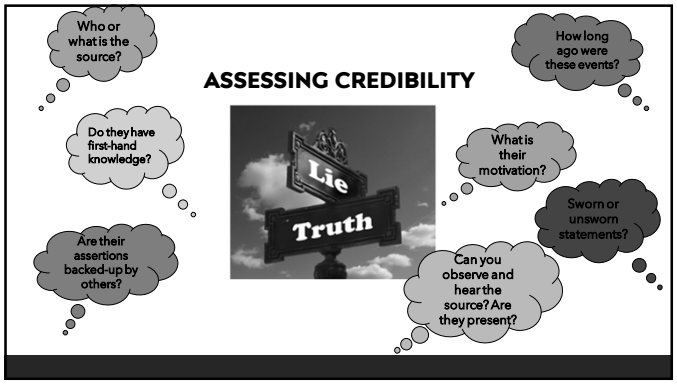
14

**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.

15

15



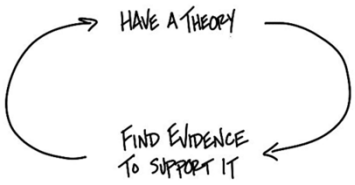

16

## 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

## BEWARE: CONFIRMATION BIAS




Source: Behavior Gap (www.behaviorgap.com)

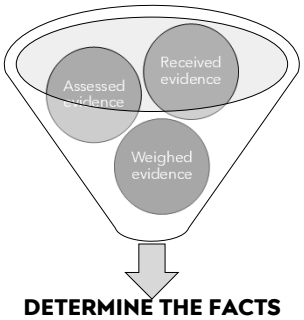
18

## PETITIONER IS CLINICIAN WHO HAS EXAMINED RESPONDENT

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

19

19

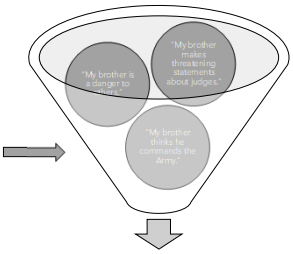



**DETERMINE THE FACTS**

20

## "Finding" a Fact

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



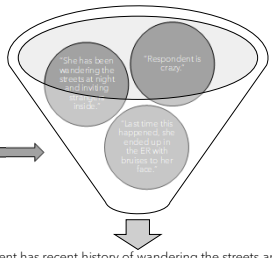

Respondent has grandiose thoughts of commanding the Army.

*In re J.P.S.*, 264 N.C. App. 58 (2019).

21

## "Finding" a Fact

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



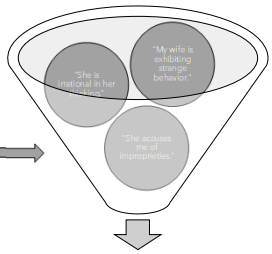

Respondent has recent history of wandering the streets and inviting strangers into her home. The last time she did this, respondent ended up in the ER with bruises to her face.

*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.)



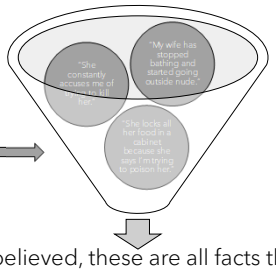

These are conclusions not facts.

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

23

## "Finding" a Fact

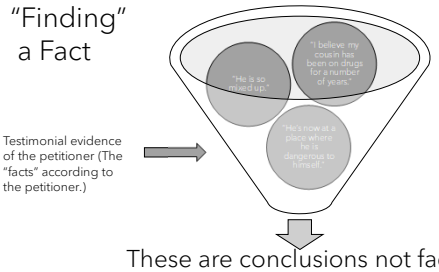
Testimonial evidence of the petitioner (The "facts" according to the petitioner.)




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

24

## "Finding" a Fact




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

These are conclusions not facts.

*In re Reed*, 39 N.C. App. 227 (1978).

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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."


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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
John Doe
123 Main St.
Fayetteland, NC 28301

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

Date Of Birth: 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

Reg. Shakespeare

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

28

28

## 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 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 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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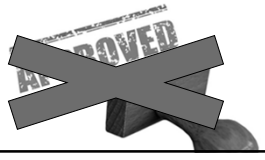
## INDEPENDENT JUDICIAL OFFICIAL

"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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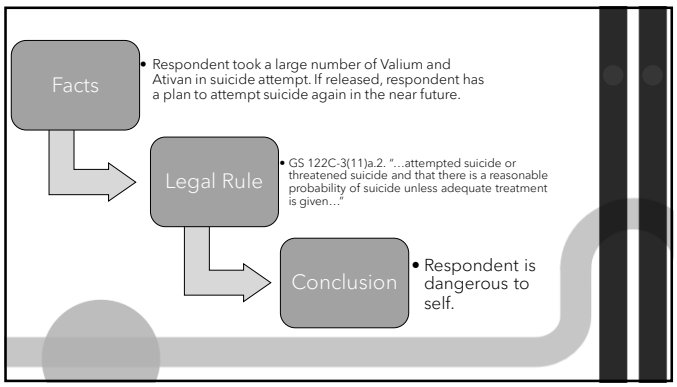
## CONCLUSIONS OF LAW

- Judicial determination requiring the exercise of judgment (i.e., judicial discretion) or the application of legal principles
- Findings of fact may fail to support a conclusion of law if inconsistent with it

31

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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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## 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).

35

35


The space between "Have To" & "Can't


# What is Discretion?

1/21/2026

36

36

**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..."

39

39

## HOW DO YOU GUARD AGAINST UNWANTED INFLUENCES?



Image by Microsoft Bing Image Creator



40


41

## RESOURCES


Trauma Resource Institute


NC Courts


iChill App



42

**"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



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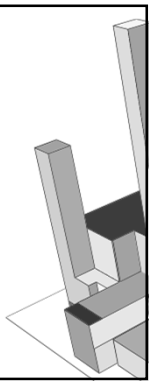
**FINAL TIPS & TAKEAWAYS**

- 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



45

## THANK YOU

Melanie Crenshaw
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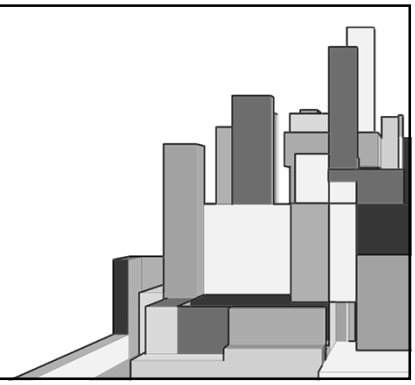

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## INVOLUNTARY COMMITMENT FOR MAGISTRATES

## 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).)

# 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)

## 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).*

# Violence Risk Assessment in Clinical Settings: Enduring Challenges and Evolving Lessons

Debra A. Pinals, MD

**Keywords:** precision medicine, psychiatric settings, risk of harm, violence risk assessment

## THE ROLE OF MENTAL HEALTH PROFESSIONALS IN ASSESSING VIOLENCE RISK AND PROTECTING SOCIETY

*Scenario 1:* An 18-year-old man with no psychiatric history is brought by police to the emergency department at the insistence of his family after he punched a hole in the wall and was yelling at voices that only he could hear.

*Scenario 2:* A 28-year-old woman on probation with a long history of depression and repeated appearances in jails, substance use facilities, and psychiatric inpatient units was admitted to a substance use program as an alternative to incarceration after overdosing on heroin. On admission, she frequently exhibited angry outbursts and once became aggressive. She has a history of early trauma, multigenerational criminal justice involvement, and homelessness.

*Scenario 3:* A 37-year-old woman was acquitted as not guilty by reason of insanity on a charge involving the killing of her baby six years prior. She has mild intellectual disability with a psychotic illness. At the time of the offense, she was experiencing delusional beliefs that her baby needed saving even as voices told her to drown the child. She is now being evaluated for discharge.

*Scenario 4:* A 58-year-old man works for a manufacturing company and is increasingly angry and sullen about a promotion that never came. He also is facing divorce and has been drinking more heavily. As his sense of injustice builds, he is asked to see a psychiatrist after he made some explicit threats toward his employer.

Societal views about an association between mental illness and violence cut across cultures and centuries.[1] Modern research has attempted to decrease stereotypes and myths about this relationship and has illuminated many subtleties in the antecedents of violence. Data support that mental illness alone is not society's greatest threat when it comes to violence. Violence resulting from mental disorders represents only 3% to 5% of violence in the United States.[2] The risk of violence among persons with mental disorders increases, however, when combined with other factors, especially substance use.[3] Variables such as early trauma and childhood conduct disorder are also linked to violence and further complicate the relationship between mental illness and violence, given that individuals with mental illness can be at greater risk of having some of these underlying problems.[4]

Notwithstanding the many factors that can play into a violent act or series of acts, decisions—for example, whether to discharge patients from the emergency room or seek to hospitalize them, to intervene with patients who reveal violent thoughts during psychotherapy sessions, or to conditionally release insanity acquittees or seek mandated outpatient civil commitment—require application of risk concepts to everyday clinical decisions. As an example, to effectuate a civil commitment it is necessary to determine, after a proper clinical assessment, whether a particular patient meets the state statutory criteria for commitment, usually by examining whether the symptoms of mental illness lead to sufficient risk of harm to justify the involuntary commitment intervention.[5] Such risk assessment might also result in determinations that other persons need to be contacted for their own protection—a legally permitted breach of confidentiality.[6] Initial and subsequent decisions related to risk management can change the outcome trajectory for all involved.

Today, as the above scenarios illustrate, psychiatrists are called upon to assess the risk of violence posed by individuals across a variety of clinical and community settings, and to help mitigate and manage the risks identified. The enduring real-world challenge for clinicians is that serious violent behavior is a rare, but costly, adverse outcome that is associated with many nonspecific risk factors; violence is both difficult to ignore and almost impossible to predict. The stakes are high, and mental health professionals are under increasing pressure to be soothsayers, fortune tellers, and agents of control in order to protect the public from all manner of harms—even those for which they may have no special power to predict or eradicate. This article reviews advances from research on assessing the risk of violence, and it highlights the ongoing need for incorporating thoughtful clinical formulations of violence risk into its management across settings.

## APPROACHES TO CLINICAL VIOLENCE RISK ASSESSMENT: CLINICAL ACUMEN AND INSTRUMENTS FOR ASSESSING VIOLENCE RISK

Violence risk assessments across most clinical settings incorporate years of research and clinical advances. Early approaches

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DOI: 10.1097/HRP.0000000000000279

utilized unstructured and less-informed clinical methods. Today's routine comprehensive clinical mental health evaluations factor in an individual's background, including understanding both the recognized "static," or fixed, risk factors associated with violence risk and the "dynamic" variables that can be modified to reduce risk. Prototypical, clinically relevant violence-associated risk factors include the following: past history of violence, prior arrest history, young age at first arrest, history of substance use, prior fire setting, animal cruelty, risk-taking behavior, impulsivity, current mental state circumstances, nonadherence to treatment, access to weapons, dynamics in the household, viewing oneself as a victim, lack of empathy, overt intention to harm, and lack of concern over violent act.[7] In acute settings, hostility and suspiciousness might signal risk of acute aggression.[7]

Research in the field of violence risk assessment has taken steps to examine approaches that go beyond a basic mental health evaluation. This effort has resulted in the promulgation of a range of violence risk assessment instruments (VRAIs) and scales to aid in the work. These have included highly structured actuarial approaches with algorithms for scoring risk factors that calculate stratified risk levels, as well as empirically driven structured guides to aid professional judgment.

The Violence Risk Appraisal Guide (VRAG-Revised [VRAG-R]), one example of an actuarial tool, is applicable to the assessment of risk of violence and sexual offending.[8] Another actuarial tool that uses a rigorous analysis of weighted variables to generate a risk level is the Classification of Violence Risk (COVR). This tool was designed to examine the risk of violence after discharge of psychiatrically hospitalized patients. It does so by analyzing numerous research-supported risk factors gathered through a review of medical records and a brief interview of the patient. The patient's risk information is entered into a software program that runs iterative algorithms to generate information about whether the patient presents a high or low risk of violence after discharge.[9]

With the advent of actuarial, statistically driven violence risk assessment measures and research on their predictive powers, it has been debated whether they are superior to clinical judgment in assessing violence risk. Some authors argue that clinical methods without structure are susceptible to bias, oversight of important risk factors, and lack of reliability and validity.[10] Others have found actuarial assessments to be limited in that they yield risk stratification but without incorporating contextual and dynamic shifts relevant to an individual's risk presentation.[11] That said, the actuarial instruments were not intended to design interventions in treatment, and recent studies have highlighted that although these tools identify risk levels, they do not provide all that is needed for individualized treatment and release planning.[11–13] Still, clinicians in specific settings, especially within correctional and forensic systems, might use actuarial-type VRAIs to add additional data in the risk assessments needed for decision making.

Another approach to violence risk assessment involves structured professional judgment (SPJ). This method calls for gathering data on empirically recognized risk factors associated with violence and for incorporating it into risk assessment and risk-management planning.[14] One measure that follows the SPJ approach is the Historical Clinical Risk Management (HCR)–20, Version 3, which guides clinicians through historical, clinical, and risk-management variables known to be correlated with violence risk to help clinicians develop a violence risk formulation.[15] In the HCR-20 Version 3, historical items include a history of violence and antisocial behaviors, relationship history, history of serious mental illness, substance use disorder, trauma history, and prior response to supervision, among other factors. Clinical items include insight, violent ideas and intent, current symptoms of major mental illness, and instability, while risk-management variables include items such as whether the individual will be connected to professional and personal supports, or have a problematic living situation. The third version of the HCR-20 also offers a scenario-analysis model to help the evaluator consider how risk might be higher or lower, depending on plans and stressors that the individual may face.

Although a full review of all available tools is beyond the scope of this overview, a range of other tools, in addition to the VRAIs described above, are designed for various uses. For example, the Dynamic Appraisal of Situational Aggression (DASA) is a brief tool used to help with short-term assessment of the risk of harm through analysis of key items that may signal more immediate concerns.[16] Its brevity and design makes it useful in settings such as emergency departments. The Brøset Violence Checklist (BVC) has been shown to be helpful in examining the risk of inpatient violence;[17] it can provide a more structured way to help staff assess patient progress and behavior. Other nuanced or specialized types of risk assessment tools include those that look at specific risk behaviors, such as stalking, sex offending, or domestic violence, or that examine violence risks among specific populations such as youth, older adults, veterans, or individuals in the criminal justice system. Although this column focuses on assessing the risk of violence toward others, much has also emerged in the discourse on suicide risk assessment,[18] which is an important element in assessing a range of risks that a patient may present that could be associated with violence.

VRAIs have advanced our understanding, but they are appropriately applied only to populations and contexts upon which they are normed, and they should be interpreted only within the limits of their reach. As noted by Buchanan and colleagues,[7] they can help aid practitioners to take into account the myriad variables correlated with violence in particular situations, but no one instrument or technique will accurately identify only those who would act violently, and no one approach fits across all settings. That said, future research will continue to help elucidate strategies for risk assessments, especially by incorporating dynamic risks and approaches for mitigating those risks. Technology may also have a role in advancing our ability to assess violence risk blindly and in the absence of bias, such as through artificial intelligence or machine learning.

In the meantime, in everyday clinical practice settings, decisions about admission, discharge, outpatient commitment,

and level of care needed to manage risk must rely upon clinical assessments of violence risk, generally (except in forensic-type settings) in the absence of in-depth, structured VRAIs. Therefore, training general mental health practitioners to understand the field of violence risk assessment and how to address factors associated with violence remains a priority. Most notably, general clinicians need to be able to talk to patients who may have violence histories and to ask questions that elucidate any violent thoughts and fantasies that the patients may harbor.

## VIOLENCE RISK ASSESSMENT IN EVERYDAY SETTINGS: SOCIAL AND ETHICAL CHALLENGES

As noted above, the impact of decisions that might follow violence risk assessments are serious for the individual being assessed and for society. Thus, practitioners need to incorporate a number of considerations into their clinical approaches, including potential ethical and other challenges. Practitioners need to balance beneficence and nonmaleficence, preserve autonomy and the therapeutic alliance insofar as possible, and act to prevent harm when public safety could otherwise be compromised. The clinician's actions that flow out of this balancing can have major consequences, such as compromised confidentiality, new or sustained compulsory hospitalization, or court-ordered outpatient treatment. Each of these actions can have further downstream effects such as disrupted relationships, termination from employment, removal from school, or arrest, to name a few.

Studies pointing to the accuracy of risk assessment across populations have shown that clinicians may do better than chance, especially in short-term predictions, but that there is a risk of overpredicting risk, with high false-positive rates or findings of high risk when the risk is actually not high.[7,19] The complexity arises when one considers how incorrect prediction of risk might result in the involuntary commitment of individuals who would not have become violent or how the decision to release someone might result in an act of serious violence that could have been averted. Often, especially when risk assessment data are somewhat murky, the clinical risk analysis involves "erring on the side of safety" and making decisions that give more weight to preventing harm to others than to individual liberty interests of the patient; unfortunately, such a approach entails accepting some degree of error rate—which might result in an action counter to the patient's wishes.[7]

Another social challenge in violence risk assessment involves principles of distributive justice that are potentially also implicated in the disproportional allocation of intensive mental health services to putatively violent patients, many of whom may not actually be violent in the long run. For example, one study found that individuals who were treated in the forensic system remained hospitalized longer despite being thought to be at no greater risk than a similar group treated in the civil system,[20] resulting in the use of hospital resources that perhaps could have been more appropriately offered to those in greater need. Clinicians looking at the person level may not be tuned into the issues of distributive justice, given that they make decisions regarding individual cases and may not see the overarching systems considerations. It therefore remains possible that the resources used in relation to mental health violence risk assessments (including indications for, and use of, further measures or resource-intensive treatments) could potentially be better used to address other social issues or other populations.

Another serious concern related to violence risk assessment is the potential for biases, such as those regarding race, entering into risk determinations. For example, it is commonly recognized that structural racism is present in both the health care and criminal justice systems—which has recently come into particular focus worldwide. Research indicates that minority populations are more likely to be classified as high risk and thereby subject to outcomes that include being sent to more inherently coercive or secure settings.[21] Ironically, even some structured risk assessment tools, developed and promulgated as "objective" and "unbiased," are now being critiqued for being built upon a foundation of variables fraught with biases and other structural limitations.[22] These challenges highlight the importance of keeping in mind the advantages and limitations of particular approaches to violence risk assessments and the consequences of these assessments.

## CONCLUSION

To return to the scenarios that opened this column:

*Scenario 1:* It may be useful to screen for acute violence risk. Hospitalization will likely be needed, and the clinician may need to pursue a civil commitment petition, followed by ongoing risk mitigation with family and supports. The work in the emergency room with this young man may set him on a positive trajectory for dealing with a lifelong psychiatric illness.

*Scenario 2:* For this woman, a risk assessment might reveal the need for trauma-informed therapeutic approaches and substance use treatment at the proper level of care, including medications to address her likely opioid use disorder and the provision of housing supports to help reduce the likelihood of environmental stressors that could increase her volatility.

*Scenario 3:* Through a clinical risk assessment that included the use of structured professional judgment tool, it was determined that this woman's current risk was low. Her discharge will require supportive staff to foster medication adherence and mental status monitoring, with proper positive functional supports for managing whatever risks may emerge.

*Scenario 4:* A psychiatric assessment revealed that this man needed intensive therapy to help him cope. It also revealed that he owned firearms and had no real intent to use them, but in discussing his anger, he agreed that it was best for him to have his firearms removed. While identifying his sadness over his impending divorce, he desired to focus on positive goals such as reducing his alcohol use, maintaining income through other employment, and rebuilding a positive relationship with his adult children.

The case scenarios above had little in common other than an individual at the center who might have dormant or active mental illness and present some risk. No one violence risk assessment tool

is capable of identifying all the nuances of their risk or of sorting through how to address that risk. Still, guides or instruments may be helpful in analyzing the risk and assisting in various clinical situations. Rather than assess risk for the purpose of predicting violence—and then investigating how such cases play out in the real world—clinical approaches need to focus on assessing patients and on then developing strategies to mitigate and manage risk. Any clinical situation can unfold differently, depending on approaches used, along with any related decisions and responses. Risk mitigation therefore requires evolving decisions informed by outcomes of prior decisions.

In the clinical care of patients and in assessing risk, clinicians should consider—in addition to asking about violent ideation and intent—an individual's self-perception of his or her risk.[23] Clinicians should also take into account other factors such as the individual patient's mental capacity to make reasoned choices to engage in safe behavior versus their tendency toward impulsivity. Clinicians should assess, too, the individual's access to weapons and intent to use them, the operative dynamics of anger, shame, desperation, and fear, and the motivation to refrain from acting, or to act, in a violent way. In approaching plans to address and mitigate risk, clinicians should ascertain the individual's alliance with a treatment provider and available community supports. Taking all that information into account and then selecting the most effective intervention to reduce risk can be a challenge in real-world settings, where the options and resources may be limited.

The weighty task of mental health professionals guarding public safety while delivering care cannot be robotic; it must be informed by critical thinking in clinical contexts and by evolving research on violence risk assessment. Mental health clinicians faced with real-world situations involving violence risk assessment will continue to need to balance tensions between safety, coercion, and fairness as they incorporate ethically, clinically, and empirically sound approaches that will often pivot around statutory and regulatory obligations and limitations as applied to individual circumstances. Case-based scenarios can help practitioners learn to weigh contextual, environmental, personal, and cultural variables that might contribute to violence, as well as the clinical, societal, and ethical challenges involved in managing it. Given the important role of clinical violence risk assessment, discourse on these complicated concepts needs to continue assisting mental health professionals in mitigating the risk of harm to others while supporting individuals in care.

**Declaration of interest:** The author reports no conflicts of interest. The author alone is responsible for the content and writing of the article.

## REFERENCES

1. Monahan J. "A terror to their neighbors": beliefs about mental disorder and violence in historical and cultural perspective. Bull Am Acad Psychiatry Law 1992;20:191–5.
2. Swanson JW. Mental disorder, substance abuse, and community violence: an epidemiological approach. In: Monahan J, Steadman H, eds. Violence and mental disorder. Chicago: University of Chicago Press, 1994:101–36.
3. Steadman HJ, Mulvey EP, Monahan J, et al. Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. Arch Gen Psychiatry 1998;55:393–401.
4. Elbogen EB, Johnson SC. The intricate link between violence and mental disorder: results from the National Epidemiologic Survey on Alcohol and Related Conditions. Arch Gen Psychiatry 2009;66:152–61.
5. Pinals DA, Mossman D. Evaluation for civil commitment. Best practices in forensic mental health assessment. New York: Oxford University Press, 2012.
6. Appel JM. Trends in confidentiality and disclosure. Focus 2019; 17:360–4.
7. Buchanan A, Binder R, Norko M, Swartz M. Resource document on psychiatric violence risk assessment. 2012 [online supplement to Buchanan Alec, Binder R, Norko M, Swartz M. Psychiatric violence risk assessment. Am J Psychiatry 2012;169:340].
8. Harris GT, Rice ME, Quinsey VL, Cormier CA. Violent offenders: appraising and managing risk. 3rd ed. American Psychological Association, 2015.
9. Monahan J, Steadman HJ, Appelbaum PS, et al. The classification of violence risk. Behav Sci Law 2006;24:721–30.
10. Harris GT, Rice ME, Cormier CA. Prospective replication of the Violence Risk Appraisal Guide in predicting violent recidivism among forensic patients. Law Hum Behav 2002;26:377–94.
11. Douglas KS, Kropp PR. A prevention-based paradigm for violence risk assessment: clinical and research applications. Crim Justice Behav 2002;29:617–8.
12. Fazel S, Singh JP, Doll H, Grann M. Use of risk assessment instruments to predict violence and antisocial behavior in 73 samples involving 24,827 people: systematic review and meta-analysis. BMJ 2012;345:e4692.
13. Wong SCP, Gordon A. The validity and reliability of the Violence Risk Scale: a treatment friendly violence risk assessment tool. Psychol Public Policy L 2006;12, 279–309.
14. Melton GB, Petrila J, Poythress NG, et al. Psychological evaluations for the courts: a handbook for mental health professionals and lawyers. 4th ed. New York: Guilford, 2018.
15. Douglas KS, Hart SD, Webster CD, Belfrage H. HCR-20V3: assessing risk of violence—user guide. Burnaby, BC, Canada: Mental Health, Law, and Policy Institute, Simon Fraser University, 2013.
16. Ogloff JRP, Daffern M. The dynamic appraisal of situational aggression: an instrument to assess risk for imminent aggression in psychiatric inpatients. Behav Sci Law 2006;24:799–813.
17. Abderhalden C, Needham I, Dassen T, Halfens R, Haug HJ, Fischer J. Predicting inpatient violence using an extended version of the Brøset-Violence-Checklist: instrument development and clinical application. BMC Psychiatry 2006;6:17.
18. Pinals DA. Liability and patient suicide. Focus 2019;17:349–54.
19. Kisely SR, Campbell LA. Compulsory community and involuntary outpatient treatment for people with severe mental disorders. Cochrane Database Syst Rev 2014;(12):CD004408.
20. Levitt GA, Vora I, Tyler K, Arenzon L, Drachman D, Ramos G. Civil commitment outcomes of incompetent defendants. J Am Acad Psychiatry Law 2010;38:349–58.
21. Pinals DA, Packer IK, Fisher W, Roy-Bujnowski K. Relationship between race and ethnicity and forensic clinical triage dispositions. Psychiatr Serv 2004;55:873–8.
22. Singh JP, Grann M, Fazel S. A comparative study of violence risk assessment tools: a systematic review and metaregression analysis of 68 studies involving 25,980 participants. Clin Psychol Rev 2011;31:499–513.
23. Skeem JL, Manchak SM, Lidz CW, Mulvey EP. The utility of patients' self-perceptions of violence risk: consider asking the person who may know best. Psychiatr Serv 2013;64:410–5.

# Correlates of Future Violence in People Being Treated for Schizophrenia

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**Objective:** Violent behavior is infrequent among individuals with schizophrenia but is clinically important. The purpose of this study was to provide data on the correlates of violence, which may allow better risk assessment and care.

**Methods:** A total of 1,435 individuals with schizophrenia who participated in the National Institute of Mental Health's Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study and were followed for 18 months were examined. The dependent variables were self-reported injurious and noninjurious violence during follow-up. The independent variables, assessed at study entry, comprised participants' recent injurious and noninjurious violence, demographic and background variables, childhood risk factors, clinical condition, current circumstances, and recent contact with hospitals and prisons. Proportional hazards models of time to first injurious violence were used to generate bivariable and multivariable hazard ratios for all participants and, separately, for participants with no injurious violence at study entry.

**Results:** Seventy-seven participants (5.4%) reported engaging in injurious violence during follow-up, and 119 (8.3%) reported engaging in exclusively noninjurious violence. In the multivariable analysis, baseline injurious violence (hazard ratio=4.02), recent violent victimization (hazard ratio=3.52), severity of drug use (hazard ratio=2.93), baseline noninjurious violence (hazard ratio=2.72), childhood sexual abuse (hazard ratio=1.85), and medication nonadherence (hazard ratio=1.39) were associated with future injurious violence. For participants with no history of injurious violence at study entry, baseline noninjurious violence was the strongest predictor (hazard ratio=3.02). Recent violent victimization was no longer a significant correlate. The remaining correlates and the strength of their association with future injurious violence were similar to those for all participants.

**Conclusions:** This is the first longitudinal multivariable analysis of predictors of injurious violence in a large cohort of patients with schizophrenia followed over 18 months. The results revealed simultaneous strong effects of baseline injurious violence and recent violent victimization on future injurious violent behavior. Among clinical variables, poor medication adherence, but not baseline symptoms of psychosis or depression, significantly predicted injurious violence. Treatment strategies to reduce risk should emphasize medication adherence.

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Media coverage of catastrophic violence by people thought to have psychiatric disorders raises public alarm and stigmatizes patients. Much of the media coverage fails to acknowledge that serious violence by people diagnosed with mental illness is rare and that psychiatric patients are more often the victims of violence than the perpetrators. The alarmist quality of this reporting notwithstanding, mental health providers have a responsibility to reduce the risk of violence, to the extent that it is possible, through appropriate care. To do this, they need knowledge of the correlates of violence in the populations they treat.

Schizophrenia affects less than 1% of the population, yet it is the fourth leading cause of disability in developed countries among people ages 15–44 (1). Only about 10% of people with schizophrenia will engage in violence during their lifetime (2, 3); however, they are three to four times more likely to act violently compared with the general population, after adjustment for socioeconomic factors (4). Risk factors for violence in the general population, such as youth, a history of childhood abuse, a history of substance use, and, in particular, a recent history of violence (5–7), also apply to people with schizophrenia (2).

Research has not yet clarified whether and to what extent the symptoms and signs of schizophrenia, which often fluctuate in severity, are themselves risk factors for violent behavior (8). Paranoid ideation has been linked to violence in community samples (9), but delusions, including persecutory delusions, have not shown a consistent association (10–12).

*See related feature:* **Editorial** *by Dr. Appelbaum (p. 677)*

Positive symptoms of psychosis, which include hallucinations in addition to delusions (13), were linked to serious violence in one cross-sectional analysis of data from the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study. Negative symptoms, which include blunting of affect and poverty of speech, were associated with less violence in these individuals (14) but not in other cohorts (15).

Why are these findings inconsistent? First, the correlates of violence appear to vary with its severity (4), and research has not always focused on the types of violence that are of greatest concern. Second, research has not always included evidence of recent violent behavior, a recognized risk factor for violence, among independent variables (13).Third, cross-sectional surveys examine risk factors and violence within the same time period, allowing the possibility that some correlates of violent behavior, such as psychotic symptoms, occur after the violent act. Despite their cross-sectional association, for example, positive symptoms have not been found to predict violence in schizophrenia over the subsequent 6-month period (13).

In this study, we sought to identify correlates of violence in schizophrenia. To enable us to address questions unanswered by previous research, we 1) used an outcome that is of particular concern to clinicians and the public, namely, violence that caused injury to others; 2) employed as an independent variable a description of each participant's recent violent behavior corresponding to information available to any assessing clinician in real-world practice; 3) examined separately the predictors of violence in participants who did not describe injurious violence at baseline; and 4) examined correlates of violence only prospectively so that any correlate identified had to have been present before the act.

## METHODS

### Sample and Data

The CATIE schizophrenia trial was a randomized double-blind effectiveness trial of antipsychotic medication conducted at 57 U.S. sites and funded by the National Institute of Mental Health. Data from one site were removed because of quality concerns. The study was approved by the institutional review board at each site. Written informed consent was obtained from the patients or their legal guardians.

The trial collected data on more than 1,400 patients with schizophrenia who were initially considered by their clinicians to need a change in their antipsychotic medication. Assessments of the participants' clinical condition and violent behavior were conducted at baseline and thereafter every 6 months to a maximum of 18 months. Full details of the study, including the measures used and methods of data collection, have been published elsewhere (16–18).

### Measures

*Dependent variable (violent behavior)*. Data on violent behavior were gathered using the 19-item MacArthur Community Violence Interview (13), which assesses the past 6 months. Interview items include questions such as "Have you pushed, grabbed or shoved anyone?"; "Have you kicked, bitten, or choked anyone?"; "Have you tried to force anyone to have sex against their will?"; and "Have you used a knife or fired a gun at anyone?" A positive response to an item triggers a supplementary question about injury: "Was anyone hurt?" A final summary question further asks, "Did you physically hurt or injure anyone?"

We created a dichotomous outcome measure comprising a report of any injurious violence indicated by a positive response to any of the supplementary injury questions or a positive response to the final summary question that asked whether anyone was physically hurt or injured. We generated a second outcome measure reflecting noninjurious violence in which neither any of the supplementary questions nor the final overall injury question was answered in the positive. The third outcome, no violence, comprised negative responses to all items. The assessment of violent behavior was conducted at the time of study entry and at 6, 12, and 18 months.

*Independent variables (risk factors)*. The independent variables were chosen to include correlates of violence identified in previous studies of patients with schizophrenia. With the exception of medication adherence, which was rated from multiple sources (clinical records, patient self-report, and pill counts by independent research assistants), independent variables were based on either self-report or the results of using standardized instruments with established reliability and administered by independent trained raters. When more than one measure of a risk factor with acceptable psychometric qualities was available, as was the case for current substance abuse, we selected the measure that was most practical for use by evaluating clinicians.

The independent variables are summarized in Table 1. Race was self-defined by participants. Vocational activity was rated as present if the participant was regularly engaged in either competitive or supported employment. "Married" included nonmarried cohabitation. Monthly income was dichotomized and rated "yes" if it was above the median for the cohort. Economic scarcity was rated as present if the participant reported having insufficient funds to pay for any one of the following essentials over the past 6 months at any point: food, clothing, housing, or essential travel.

Childhood sexual abuse was rated from the answer to the question, "Before the age of 15, were you ever sexually molested or assaulted?" Feeling listened to was rated from the response to the question, "When you are talking with your family and friends, do you feel you are being listened to most of the time, some of the time, or hardly ever?" Violent victimization over the past 6 months was rated by using the response to the question, "In the past 6 months, were you a victim of any violent crime such as assault, rape, mugging, or robbery?"

Positive and negative symptoms of schizophrenia were measured with subscales of the Positive and Negative Syndrome Scale (PANSS) (19). Depressive symptoms were measured by using a participant's mean item score on the

**TABLE 1. Demographic, clinical, and violence characteristics of the study participants (N=1,435)[a]**

| Characteristic | Violence During Follow-Up Period | | | | | |
|---|---|---|---|---|---|---|
| | No Violence (N=1,239) | | Noninjurious Violence (N=119) | | Injurious Violence (N=77) | |
| | N | % | N | % | N | % |
| Baseline violence | | | | | | |
| No violence | 1,092 | 88.1 | 79 | 66.4 | 44 | 57.1 |
| Noninjurious violence | 97 | 7.8 | 23 | 19.3 | 15 | 19.5 |
| Injurious violence | 50 | 4.0 | 17 | 14.3 | 18 | 23.4 |
| Demographic characteristics | | | | | | |
| Male | 923 | 74.5 | 88 | 74.0 | 53 | 68.8 |
| Caucasian | 757 | 61.2 | 72 | 60.5 | 36 | 47.4 |
| Vocational activity | 165 | 13.3 | 15 | 12.7 | 8 | 10.5 |
| Married | 263 | 21.2 | 16 | 13.5 | 17 | 22.1 |
| Monthly income above the median | 604 | 49.0 | 66 | 55.5 | 45 | 58.4 |
| Economic scarcity | 714 | 57.7 | 68 | 58.1 | 35 | 46.1 |
| | Mean | SD | Mean | SD | Mean | SD |
| Age (years) | 40.9 | 11.1 | 37.5 | 11.2 | 38.3 | 10.6 |
| Education (years) | 12.1 | 2.26 | 11.8 | 1.86 | 11.7 | 2.35 |
| Days worked in past month | 2.44 | 6.03 | 1.97 | 5.35 | 1.84 | 4.76 |
| | N | % | N | % | N | % |
| Childhood risk factors | | | | | | |
| Physical abuse | 229 | 18.5 | 33 | 27.7 | 24 | 31.2 |
| Sexual abuse | 235 | 19.0 | 25 | 21.0 | 29 | 37.7 |
| Conduct problems | 647 | 52.3 | 86 | 72.3 | 52 | 67.5 |
| Current circumstances | | | | | | |
| Living with family | 623 | 50.4 | 65 | 54.2 | 40 | 50.6 |
| Living with nonfamily | 71 | 5.7 | 9 | 7.5 | 10 | 12.7 |
| Violently victimized in past 6 months | 22 | 1.8 | 4 | 3.4 | 8 | 10.5 |
| Nonviolently victimized in past 6 months | 85 | 6.9 | 16 | 13.6 | 8 | 10.5 |
| | Mean | SD | Mean | SD | Mean | SD |
| Feel listened to by family | 1.65 | 0.74 | 1.65 | 0.74 | 1.88 | 0.78 |
| Clinical condition | | | | | | |
| PANSS | | | | | | |
| Total score | 75.2 | 17.4 | 75.8 | 18.0 | 79.7 | 16.7 |
| Positive score | 18.3 | 5.61 | 18.8 | 5.85 | 19.8 | 5.30 |
| Negative score | 20.2 | 6.41 | 19.3 | 6.33 | 20.5 | 6.32 |
| Calgary Depression Scale for Schizophrenia | 1.54 | 0.54 | 1.70 | 0.59 | 1.77 | 0.66 |
| Years in treatment | 16.5 | 10.9 | 15.4 | 11.8 | 17.9 | 10.4 |
| Medication nonadherence | 1.27 | 0.71 | 1.42 | 0.94 | 1.38 | 0.81 |
| Adaptive function[b] | 2.66 | 1.07 | 2.80 | 1.07 | 2.58 | 1.05 |
| Satisfaction with life[b] | 4.34 | 1.39 | 4.34 | 1.39 | 4.20 | 1.53 |
| Drug use severity[b] | 1.34 | 0.70 | 1.44 | 0.76 | 1.66 | 0.95 |
| Alcohol use severity[b] | 1.43 | 0.71 | 1.59 | 0.71 | 1.66 | 0.79 |
| | N | % | N | % | N | % |
| Substance abuse or dependence | 181 | 36.6 | 23 | 35.9 | 25 | 59.5 |
| Supervised accommodation | 545 | 44.0 | 42 | 35.6 | 31 | 40.8 |
| Institutional contact | | | | | | |
| Hospitalizations in past year (>2) | 193 | 15.6 | 24 | 20.2 | 16 | 20.8 |
| Arrested for crime in past 6 months | 229 | 18.5 | 33 | 27.7 | 24 | 31.4 |
| Any time in jail in past 6 months | 69 | 5.6 | 14 | 11.9 | 9 | 11.8 |

[a] The data were collected from month 1 to month 18. The no violence group represents 86.3% of the study cohort, the noninjurious violence group represents 8.3%, and the injurious violence group represents 5.4%. Percentages omit missing values. PANSS=Positive and Negative Syndrome Scale.

[b] Adaptive function was measured with the Quality of Life Scale and the Instrumental Activities of Daily Living Scale. Satisfaction with life was rated on a 7-point scale from the response to the question, "How do you feel about your life in general?" Drug and alcohol use severity were measured using the Dartmouth scale (see the article text).

Calgary Depression Scale for Schizophrenia (20). Substance use was measured first with clinicians' ratings of whether criteria were met for a diagnosis of abuse or dependence and second with clinicians' ratings of the severity of current use on the 5-point Dartmouth scale (21). This scale focuses on persistent and recurrent social, occupational, psychological, and physical problems stemming from substance use.

Years in treatment refers to treatment with antipsychotic medication. Medication adherence was rated for the first month of treatment, applying a 4-point scale. Supervised accommodation was indicated by self-report data indicating that a participant lived in a supervised apartment, a hospital, or a nursing home. Adaptive function was measured with two instruments: the Quality of Life Scale (22), which focuses on the deficits associated with chronic schizophrenia, and the Instrumental Activities of Daily Living Scale (23), which assesses various functions, including personal care and housekeeping. Satisfaction with life was rated with a 7-point scale from the response to the question, "How do you feel about your life in general?" (24).

### Statistical Analyses

We examined data on 1,435 participants for whom both baseline and follow-up information on violence was available. The statistical approach was selected in part to address attrition in the course of the CATIE study (14). The analyses used a proportional hazards model of time to first injurious violence, generating bivariable and multivariable hazard ratios associated with the baseline predictors (independent variables). We then conducted the same analyses for participants who did not report engaging in injurious violence at baseline. We censored participants who discontinued their participation at the point where no further follow-up data were available.

## RESULTS

Participants' basic demographic and clinical characteristics and rates of injurious and noninjurious violence over the 18-month follow-up period are summarized in Table 1; detailed demographic and behavioral characteristics have been published elsewhere (13, 14). All participants met or had met DSM-IV diagnostic criteria for schizophrenia. Their illnesses were long-standing and relatively unstable. At baseline, the mean time since the first treatment with antipsychotic medication was 16.5 years (SD=10.9). Only 13.1% of participants were engaged in vocational activity, as defined here to include supported employment, and 43.1% lived in supported accommodation.

The participants' mean age was 40.5 years (SD=11.1); 74.2% were male, 60.4% were Caucasian, and 20.6% were married or cohabiting. The mean number of years in education was 12.1 (SD=2.23), which is consistent with previous reports on this sample showing that 25% had less than a high school education and 39% attended college (13). Victimization was common. Approximately 20.2% of the sample reported a history of sexual victimization before the age of 15, and at study entry, 2.4% reported being the victim of a crime such as assault, rape, mugging, or robbery in the past 6 months.

Altogether, 37.8% of participants met criteria for substance abuse or dependence in addition to their diagnosis of schizophrenia. At study entry, participants were moderately symptomatic; 16.3% had been admitted to the hospital more than twice in the past 12 months. The mean positive symptom score on the PANSS was 18.4 (SD=5.61) (possible range, 7–49), and the mean negative symptom score was 20.1 (SD=6.40) (possible range, 7–49). The mean item score on the Calgary Depression Scale for Schizophrenia was 1.57 (SD=0.55) (possible range, 1–4).

At study entry, 85 participants (5.9%) reported having inflicted injurious violence in the past 6 months, and 135 (9.4%) reported having engaged only in noninjurious violence. During the 18-month follow-up period, 77 participants (5.4%) reported having engaged in injurious violence, and 119 (8.3%) reported having engaged only in noninjurious violence.

Employing a proportional hazards model of baseline predictors to the time of first injurious violence and using a p value of 0.01 as a threshold for significance because of the large number of variables evaluated, the following baseline measures were associated with future injurious violence in the bivariable analysis (Table 2): baseline injurious violence (hazard ratio=7.29) and baseline noninjurious violence (hazard ratio=3.94); childhood physical abuse (hazard ratio=1.92), sexual abuse (hazard ratio=2.58), and conduct problems (hazard ratio=1.89); not feeling listened to by one's family (hazard ratio=1.54) and having been violently victimized in the past 6 months (hazard ratio=5.79); positive symptoms of psychosis (hazard ratio=1.06) and depressive symptoms (hazard ratio=1.77); severity of current drug (hazard ratio=1.84) and alcohol (hazard ratio=1.53) use and current medication nonadherence (hazard ratio=1.46); and having been arrested for a crime in the past 6 months (hazard ratio=1.92).

For all participants, baseline injurious violence (hazard ratio=4.02), recent violent victimization (hazard ratio=3.52), severity of drug use (hazard ratio=2.93), baseline noninjurious violence (hazard ratio=2.72), childhood sexual abuse (hazard ratio=1.85), and medication nonadherence (hazard ratio=1.39) remained significantly associated with future injurious violence in the multivariable analysis (Table 3).

When the analysis was limited to patients with no history of engaging in injurious violence at baseline, every significant bivariable correlate, with the exception of a diagnosis of substance abuse or dependence, was also a significant predictor in the analysis of all participants (Table 2). In the multivariable analysis (Table 3), baseline noninjurious violence (hazard ratio=3.02) and only three additional variables—childhood sexual abuse (hazard ratio=2.13), severity of drug use (hazard ratio=1.63), and medication nonadherence (hazard ratio=1.48)—remained significantly associated with injurious violence.

Survival analysis of time to first injurious violence (Figure 1) confirmed that participants with injurious violence at baseline had by far the highest rates of future injurious

**TABLE 2. Proportional hazards model (bivariable) of baseline predictors of time to first injurious violence (months 1–18)**

| | All Participants | | | Participants With No Injurious Violence at Baseline | | |
|---|---|---|---|---|---|---|
| Variable | Hazard Ratio | 95% CI | p | Hazard Ratio | 95% CI | p |
| Baseline violence | | | <0.0001 | | | <0.0001 |
| No violence | 1 | | | 1 | | |
| Noninjurious violence | 3.94 | 2.19, 7.08 | | 3.96 | 2.20, 7.12 | |
| Injurious violence | 7.29 | 4.21, 12.61 | | | | |
| Demographic characteristics | | | | | | |
| Age (years) | 0.98 | 0.96, 1.00 | | 0.98 | 0.96, 1.00 | |
| Male | 0.78 | 0.48, 1.27 | | 0.72 | 0.42, 1.25 | |
| Caucasian | 0.52 | 0.33, 0.81 | | 0.56 | 0.34, 0.94 | |
| Education (years) | 0.91 | 0.83, 1.00 | | 0.88 | 0.80, 0.98 | |
| Vocational activity | 0.75 | 0.36, 1.55 | | 0.70 | 0.30, 1.63 | |
| Days worked in past month | 0.98 | 0.94, 1.03 | | 0.98 | 0.94, 1.03 | |
| Married | 0.98 | 0.46, 2.07 | | 1.25 | 0.55, 2.84 | |
| Monthly income above median | 0.68 | 0.43, 1.07 | | 0.63 | 0.38, 1.06 | |
| Economic scarcity | 1.70 | 1.09, 2.68 | | 1.57 | 0.94, 2.62 | |
| Childhood risk factors | | | | | | |
| Physical abuse | 1.92 | 1.19, 3.11 | <0.01 | 1.72 | 0.97, 3.05 | |
| Sexual abuse | 2.58 | 1.63, 4.10 | <0.0001 | 2.72 | 1.60, 4.61 | <0.001 |
| Conduct problems | 1.89 | 1.17, 3.04 | <0.01 | 2.38 | 1.35, 4.18 | <0.01 |
| Current circumstances | | | | | | |
| Living with family | 0.92 | 0.59, 1.44 | | 1.15 | 0.69, 1.92 | |
| Living with nonfamily | 1.79 | 0.86, 3.72 | | 0.89 | 0.28, 2.84 | |
| Feel listened to by family | 1.54 | 1.14, 2.08 | <0.01 | 1.27 | 0.90, 1.79 | |
| Violently victimized in past 6 months | 5.79 | 2.78, 12.1 | <0.0001 | 6.85 | 3.11, 15.1 | <0.0001 |
| Nonviolently victimized in past 6 months | 1.62 | 0.78, 3.37 | | 1.62 | 0.70, 3.76 | |
| Clinical condition | | | | | | |
| PANSS[a] | | | | | | |
| Total score | 1.01 | 1.00, 1.03 | | 1.01 | 1.00, 1.03 | |
| Positive score | 1.06 | 1.02, 1.10 | <0.01 | 1.05 | 1.00, 1.09 | |
| Negative score | 1.00 | 0.97, 1.04 | | 1.02 | 0.98, 1.06 | |
| Calgary Depression Scale for Schizophrenia | 1.77 | 1.26, 2.49 | <0.01 | 1.87 | 1.28, 2.74 | <0.01 |
| Substance abuse or dependence | 1.25 | 0.78, 2.01 | | 3.12 | 1.49, 6.54 | <0.01 |
| Drug use severity[b] | 1.84 | 1.45, 2.34 | <0.0001 | 1.83 | 1.39, 2.41 | <0.0001 |
| Alcohol use severity[b] | 1.53 | 1.17, 1.98 | <0.01 | 1.51 | 1.12, 2.04 | <0.01 |
| Years in treatment | 1.01 | 0.99, 1.03 | | 1.01 | 1.00, 1.04 | |
| Medication nonadherence | 1.46 | 1.11, 1.94 | <0.01 | 1.53 | 1.12, 2.10 | <0.01 |
| Supervised accommodation | 1.16 | 0.73, 1.83 | | 1.36 | 0.80, 2.30 | |
| Adaptive function[b] | 0.90 | 0.73, 1.11 | | 0.89 | 0.70, 1.13 | |
| Satisfaction with life[b] | 0.92 | 0.79, 1.08 | | 0.94 | 0.78, 1.12 | |
| Institutional contact | | | | | | |
| Hospitalizations in past year (>2) | 1.60 | 1.05, 2.45 | | 1.53 | 0.79, 2.94 | |
| Arrested for a crime in past 6 months | 1.92 | 1.19, 3.11 | <0.01 | 1.72 | 0.97, 3.05 | |
| In jail in past 6 months | 2.19 | 1.09, 4.40 | | 2.60 | 1.18, 5.72 | |

[a] PANSS=Positive and Negative Syndrome Scale.
[b] Adaptive function was measured with the Quality of Life Scale and the Instrumental Activities of Daily Living Scale. Satisfaction with life was rated on a 7-point scale from the response to the question, "How do you feel about your life in general?" Drug and alcohol use severity were measured using the Dartmouth scale (see the article text).

violence, followed by individuals with noninjurious violence at baseline. For all groups, violence continued at a constant rate throughout the follow-up period.

## DISCUSSION

Previous studies of violence in this sample have either focused on medication effects (14) or examined all correlates of violence, not just those that preceded a violent act, where a stronger case can be made that the correlate was directly or indirectly causal (13). This study is therefore the first, to our knowledge, to describe the correlates of subsequent injurious violence among patients being treated for schizophrenia in which the independent variables included recent violence toward others. Independent and dependent variables were rated by trained raters using reliable instruments.

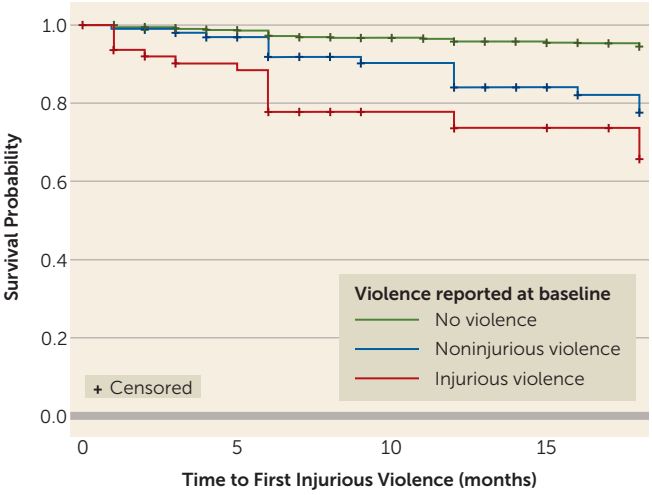
These methodological differences generate results that are significantly different from those generated by other studies. In the multivariable analysis, a history of engaging in injurious violence in the 6 months before baseline evaluation and recent violent victimization were the most powerful predictors of subsequent injurious violence, with hazard ratios >3.5. The few additional significant predictors in the multivariable analysis were severity of drug use, baseline noninjurious violence, childhood sexual abuse, and medication nonadherence.

For participants with no history of engaging in injurious violence at baseline, baseline noninjurious violence was the strongest predictor in the multivariable analysis, followed by childhood sexual abuse, severity of drug use, and medication nonadherence.

**TABLE 3. Proportional hazards model (multivariable) of baseline predictors of time to first injurious violence (months 1–18)**

| Variable | Multivariable Hazard Ratio | 95% Wald CI |
|---|---|---|
| All participants | | |
| Baseline injurious violence | 4.02 | 2.12, 7.60 |
| Violently victimized in past 6 months | 3.52 | 1.62, 7.64 |
| Drug use severity | 2.93 | 1.65, 5.18 |
| Baseline noninjurious violence | 2.72 | 1.45, 5.09 |
| Childhood sexual abuse | 1.85 | 1.12, 3.05 |
| Medication nonadherence | 1.39 | 1.04, 1.86 |
| Participants without injurious violence at baseline | | |
| Baseline noninjurious violence | 3.02 | 1.63, 5.58 |
| Childhood sexual abuse | 2.13 | 1.22, 3.72 |
| Drug use severity | 1.63 | 1.21, 2.21 |
| Medication nonadherence | 1.48 | 1.07, 2.04 |

**FIGURE 1. Survival plot of time to first injurious violence for three categories of violence at baseline.**




### Comparison With Other Studies: Rates of Violence

The overall rate of violence in schizophrenia reported here is comparable to that reported elsewhere (2), but the rate of serious violence is higher. The 6-month prevalence of injurious violence at baseline was 5.9% in our study, compared with a 6-month prevalence of serious violence at baseline of 3.6% in an earlier analysis of the same participants (13). The most likely explanation lies in the broader definition of the dependent variable used in our study. Previous research on these participants used a definition of serious violence that was limited to positive responses to two items on the MacArthur Community Violence Interview: "Have you used a knife or fired a gun at anyone?" and "Did you physically hurt or injure anyone?"

Rates of violence declined after baseline assessment. The 5.4% rate of injurious violence for the subsequent 18 months, for example, was lower than the rates of injurious violence for the 6 months before study entry. Three factors are likely to have contributed. First, patients were enrolled in the CATIE study because their treatment was considered suboptimal (13). If one reason for this was recent violence, one would expect a decline in the rate as a result of regression to the mean. Second, treatment during the trial was associated with reduced symptoms on multiple measures (18) and may have reduced violence. Third, 54% of participants had stopped providing data by month 18 (25). Nonadherence to treatment is a correlate of violence in psychosis (15). Participants who engaged in violence may have been more likely to drop out of the study.

### Comparison With Other Studies: Correlates of Violence

Simultaneous large effects, in multivariable longitudinal analysis, of baseline injurious violence and recent victimization have not been shown previously in patients with schizophrenia. Previous studies suggest a shared relationship, as antecedents of violent behavior, between experiencing and perpetrating harm (15). Victimization ceases to be a correlate of violence when baseline injurious violence is removed from the analysis. Further research is required to establish whether people with schizophrenia who both experience and perpetrate injurious violence do so during the same incidents. The remaining findings in the present multivariable analysis are less new. Both childhood sexual abuse and substance abuse have been replicated risk factors for violence (4).

The 85 participants who described recent injurious violence at baseline comprised only 5.9% of the study sample but 23% of all participants with injurious violence at follow-up. We anticipated that individuals who acted violently only during the follow-up period would differ from the study sample as a whole in terms of the antecedent predictors of violence. Contrary to our expectations, removing the hazard ratio associated with injurious violence for the whole sample was not associated with compensatory increases in the hazard ratios for other risk factors (and the hazard ratio for severity of drug use decreased). The corollary would seem to be that predicting injurious violence will be even more difficult for the group without violence at baseline, because the most helpful hazard ratio for the purposes of prediction is lacking.

Of the significant associations we observed in the bivariable analysis, childhood conduct problems have previously been linked to general criminality or less serious violence in this study sample (14) as well as in other samples, albeit inconsistently (26, 27). Depression, too, has previously been linked to violence in this (14) and other samples (2). Antidepressants now appear to be of limited efficacy in treating depression in schizophrenia (28). Alternative forms of treatment, in addition to helping improve patients' mood, may reduce rates of violence.

Previous longitudinal studies found negative symptoms of schizophrenia to be negatively correlated with violence (14). We found no association between negative symptoms and injurious violence in bivariable or multivariable analysis. Previous cross-sectional research has also linked positive symptoms to violence (13), but again, we found no correlation. Cross-sectional methods allow the possibility that symptoms follow, rather than precede, violence, and the absence of a significant association using a prospective method suggests that symptoms such as delusions are sometimes a consequence, rather than a cause, of violence. One possibility is that such symptoms reflect clinical deterioration under the stress of police and legal involvement.

### Implications for Risk Assessment and Management

The hazard ratios associated with baseline violence and recent victimization represent large effects by conventional criteria (29) and are larger than those reported for psychosis as a whole (15). The association with treatment adherence, while smaller in hazard ratio terms, persists in multivariable analysis and speaks to the important contribution of maintaining a therapeutic alliance in the management of violence risk.

Neither of these points, however, should distract from the overall picture of violence in schizophrenia. Nineteen out of every 20 participants in this unstable sample described no violence of any kind during the follow-up period. Even among the 85 individuals with baseline injurious violence, most did not report any violence during follow-up. While these results have implications for our understanding of the causes of violence in schizophrenia, they do not suggest that violence risk could be more successfully managed by identifying individuals who will act violently and by admitting them to the hospital. These results do not challenge previous suggestions that if this approach were to be attempted, false positive rates, false negative rates, or both would be unacceptably high (30, 31).

### Limitations

There are several limitations to this study. First, we relied on self-reported data to identify violent acts. Although self-report, used prospectively, is a more sensitive measure of violence than official reports and is similar in sensitivity to using multiple sources of information simultaneously (32), information from collateral sources might have added validity to the dependent variable. Second, the maximum period of follow-up was 18 months. Clinicians are frequently concerned with shorter-term risk. Although not shown empirically, it is possible that the same risk factors act differently at different times and that our findings would have been somewhat different had we restricted follow-up to, say, 6 months. Larger numbers would be required to explore this possibility.

Third, although the dependent variable, violence, was measured throughout the follow-up period, the independent variables were measured only at baseline. Some of these variables would likely have changed during the follow-up period. Some people would have found independent accommodation and some would have found work. Clinical changes, and in particular reductions in posttraumatic stress disorder symptoms and substance use, have been shown to be associated with reductions in violence in other patient groups (33, 34). We did not investigate the correlates of these changes in this sample.

Finally, our 6 monthly follow-up, while shorter than those used in many studies of mental disorder and violence, may have been too long to detect some effects. The absence of an association between positive symptoms, including delusions, and engaging in injurious violence over the ensuing 6 months, for example, is an important finding for the purposes of assessing risk. It could still be the case, however, that in some circumstances delusions cause violence and that the effect is too transitory to be detected using this design. Correlations between delusions and violence that are found only in cross-sectional studies could be the result of mental state changes that follow violence, as suggested here, but could also be caused by short-term effects.

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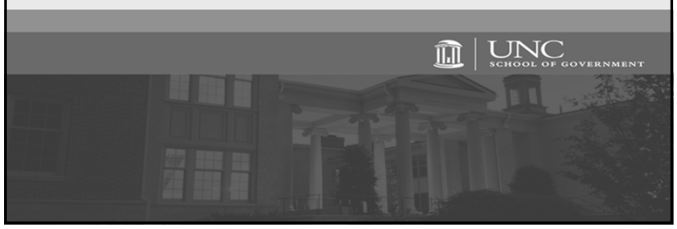
## REFERENCES

1. Murray C, Lopez A: The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability from Diseases, Injuries, and Risk Factors in 1990 and Projected to 2020. Cambridge, Mass., Harvard University Press, 1996
2. Swanson JW, Holzer CE 3rd, Ganju VK, et al: Violence and psychiatric disorder in the community: evidence from the Epidemiologic Catchment Area surveys. Hosp Community Psychiatry 1990; 41: 761–770
3. Elbogen EB, Johnson SC: The intricate link between violence and mental disorder: results from the National Epidemiologic Survey on Alcohol and Related Conditions. Arch Gen Psychiatry 2009; 66: 152–161

4. Fazel S, Gulati G, Linsell L, et al: Schizophrenia and violence: systematic review and meta-analysis. PLoS Med 2009; 6:e1000120. 10.1371/journal.pmed.1000120
5. Otto RK: Assessing and managing violence risk in outpatient settings. J Clin Psychol 2000; 56:1239–1262
6. Tardiff K, Marzuk PM, Leon AC, et al: A prospective study of violence by psychiatric patients after hospital discharge. Psychiatr Serv 1997; 48:678–681
7. Buchanan A, Binder R, Norko M, et al: Resource Document on Psychiatric Violence Risk Assessment. Washington, DC, American Psychiatric Association, 2012
8. Peterson JK, Skeem J, Kennealy P, et al: How often and how consistently do symptoms directly precede criminal behavior among offenders with mental illness? Law Hum Behav 2014; 38:439–449
9. Ullrich S, Keers R, Shaw J, et al: Acting on delusions: the role of negative affect in the pathway towards serious violence. J For Psychiatry Psychol. 2018; 29:691–704
10. Coid JW, Ullrich S, Kallis C, et al: The relationship between delusions and violence: findings from the East London first episode psychosis study. JAMA Psychiatry 2013; 70:465–471
11. Appelbaum PS, Robbins PC, Monahan J: Violence and delusions: data from the MacArthur Violence Risk Assessment Study. Am J Psychiatry 2000; 157:566–572
12. Stompe T, Ortwein-Swoboda G, Schanda H: Schizophrenia, delusional symptoms, and violence: the threat/control override concept reexamined. Schizophr Bull 2004; 30:31–44
13. Swanson JW, Swartz MS, Van Dorn RA, et al: A national study of violent behavior in persons with schizophrenia. Arch Gen Psychiatry 2006; 63:490–499
14. Swanson JW, Swartz MS, Van Dorn RA, et al: Comparison of antipsychotic medication effects on reducing violence in people with schizophrenia. Br J Psychiatry 2008; 193:37–43
15. Witt K, van Dorn R, Fazel S: Risk factors for violence in psychosis: systematic review and meta-regression analysis of 110 studies. PLoS One 2013; 8:e55942
16. Swartz MS, Perkins DO, Stroup TS, et al: Assessing clinical and functional outcomes in the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) schizophrenia trial. Schizophr Bull 2003; 29:33–43
17. Stroup TS, McEvoy JP, Swartz MS, et al: The National Institute of Mental Health Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) project: schizophrenia trial design and protocol development. Schizophr Bull 2003; 29:15–31
18. Lieberman JA, Stroup TS, McEvoy JP, et al: Effectiveness of antipsychotic drugs in patients with chronic schizophrenia. N Engl J Med 2005; 353:1209–1223
19. Kay SR, Fiszbein A, Opler LA: The Positive and Negative Syndrome Scale (PANSS) for schizophrenia. Schizophr Bull 1987; 13:261–276
20. Addington D, Addington J, Schissel B: A depression rating scale for schizophrenics. Schizophr Res 1990; 3:247–251
21. Drake RE, Osher FC, Noordsy DL, et al: Diagnosis of alcohol use disorders in schizophrenia. Schizophr Bull 1990; 16:57–67
22. Heinrichs DW, Hanlon TE, Carpenter WT Jr: The Quality of Life Scale: an instrument for rating the schizophrenic deficit syndrome. Schizophr Bull 1984; 10:388–398
23. Lawton MP, Brody EM: Assessment of older people: self-maintaining and instrumental activities of daily living. Gerontologist 1969; 9:179–186
24. Lehman A: A quality of life interview for the chronically mentally ill. Eval Program Plann 1988; 11:51–62
25. Rosenheck RA, Leslie DL, Sindelar J, et al: Cost-effectiveness of second-generation antipsychotics and perphenazine in a randomized trial of treatment for chronic schizophrenia. Am J Psychiatry 2006; 163:2080–2089
26. Rosenberg SD, Lu W, Mueser KT, et al: Correlates of adverse childhood events among adults with schizophrenia spectrum disorders. Psychiatr Serv 2007; 58:245–253
27. Cannon M, Huttunen MO, Tanskanen AJ, et al: Perinatal and childhood risk factors for later criminality and violence in schizophrenia: longitudinal, population-based study. Br J Psychiatry 2002; 180:496–501
28. Gregory A, Mallikarjun P, Upthegrove R: Treatment of depression in schizophrenia: systematic review and meta-analysis. Br J Psychiatry 2017; 211:198–204
29. Azuero A: A note on the magnitude of hazard ratios. Cancer 2016; 122: 1298–1299
30. Buchanan A: Risk of violence by psychiatric patients: beyond the "actuarial versus clinical" assessment debate. Psychiatr Serv 2008; 59:184–190
31. Cartwright JK, Desmarais SL, Johnson KL, et al: Performance and clinical utility of a short violence risk screening tool in US adults with mental illness. Psychol Serv 2018; 15:398–408
32. Steadman HJ, Mulvey EP, Monahan J, et al: Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. Arch Gen Psychiatry 1998; 55: 393–401
33. Buchanan A, Nich C, Douglas KS, et al: Risk factors of violence during a 4-week period in a psychiatric outpatient population. J Nerv Ment Dis 2013; 201:1021–1026
34. Buchanan A, Stefanovics E, Rosenheck RA: Correlates of reduced violent behavior in patients receiving intensive treatment for post-traumatic stress disorder. Psychiatr Serv 2018; 69:424–430

# Iryna's Law

Mark Botts




1

## Pre-Trial Release → IVC Exam

Effective Dec. 1, 2026, when setting conditions of pretrial release, the judicial official—in particular circumstances prescribed by statute—must order that the defendant receive an involuntary commitment examination.

UNC SCHOOL OF GOVERNMENT

2

## When to Order an IVC Exam under Iryna's Law—GS 15A-533(b1), eff. 12/1/2026

| IF CHARGED WITH A VIOLENT OFFENSE | IF CHARGED WITH ANY OFFENSE |
|---|---|
| ❖ You determine the defendant has been subject to an "order of involuntary commitment" w/n the prior 3 years | ❖ You have reasonable grounds to believe the defendant is "dangerous to themselves or others." |
| ➢ Applies to an involuntary commitment order issued by a district court judge | ➢ Applies to any offense, whether violent or nonviolent. |
| ➢ A magistrate custody and transportation order is not sufficient | ➢ Applies whether or not there is prior IVC order |

UNC SCHOOL OF GOVERNMENT

3

## How will you know if there is a prior IVC order?

- ❑ Through "a search of the court records for the defendant."

  How will you search the court records?

- ❑ By December 1, 2026, the AOC shall "provide a method for judicial officials to determine if a defendant has a prior order of involuntary commitment, pursuant to Article 5 of Chapter 122C of the General Statutes . . . ." Section 1.(h) of S.L. 2025-93

  Must be able to search records for all counties.

UNC SCHOOL OF GOVERNMENT 4

4

## Danger to Self or Others

- How do you define "danger to themselves or others" for purposes of applying G.S. 15A-533(b1)?
- Do you use the definitions for dangerous to self and dangerous to others in G.S. 122C-3?

UNC SCHOOL OF GOVERNMENT 5

5

## Reasonable Grounds to Believe

The *knowledge of facts* that would lead a reasonable person of ordinary intelligence and prudence to believe the individual is dangerous to self or others.

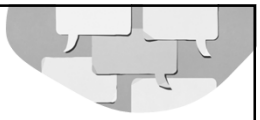
To form the belief, you need information!

.

UNC SCHOOL OF GOVERNMENT

6

## What information is available for determining danger?



- Upon arrest , a law enforcement officer "[m]ust inform any judicial official determining conditions of pre-trial release . . . of ***any relevant behavior*** of the defendant observed by the officer prior to, during, or after the arrest that may provide reasonable grounds for the judicial official to believe the defendant is a dangerous to themselves or others." Section 1.(a) of S.L. 2025-93.

  *You depend on the arresting officer to be forthcoming and thorough. Ask questions! Use the skills you have honed when receiving IVC petitions.*

- Defendant's behavior and demeanor as they appear before you
- Criminal history report

UNC SCHOOL OF GOVERNMENT 7

7

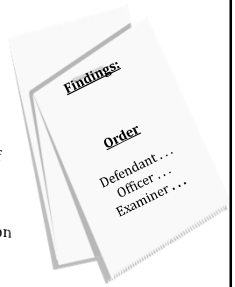
## The Order for IVC Examination

1. **Order** defendant to receive a commitment examination.
2. **Order** the arresting officer or officer of the arresting officer's agency to transport defendant to a hospital ED or other crisis facility that has a certified commitment examiner.
3. **Order** the commitment examiner, after performing the IVC exam, to either
   - Petition for involuntary commitment if there are grounds to do so, or
   - Provide written notice to the judicial official that entered the order for IVC exam that there the defendant does not meet the IVC criteria

8

## Form Order

- The AOC must develop or modify any forms necessary to implement the law.
- For any provision where a written finding of fact is required, the form must provide a blank area for those written findings to be entered. Section 1.(i) of S.G. 2025-93.
- The failure of a magistrate to make "statutorily required" written findings is grounds for suspension or removal. Sec. 3.(b) of SL 2025-93.




UNC SCHOOL OF GOVERNMENT 9

9

*Excerpt*

**SESSION LAW 2025-93**
**HOUSE BILL 307**

**SECTION 1.(c)** G.S. 15A-533 reads as rewritten:
"**§ 15A-533. Right to pretrial release in capital and noncapital cases.**

(a) . . .

(b) . . .

(b1) If a defendant is (i) charged with a violent offense and, after a search of the court records for the defendant, the judicial official determines that the defendant has previously been subject to an order of involuntary commitment, pursuant to Article 5 of Chapter 122C of the General Statutes, within the prior three years, or (ii) charged with any offense and the judicial official has reasonable grounds to believe the defendant is a danger to themselves or others, the judicial official shall set conditions of pretrial release in accordance with this Article and shall issue an order that includes all of the following:

(1) Require the defendant to receive an initial examination by a commitment examiner, as defined in G.S. 122C-3, to determine if there are grounds to petition for involuntary commitment of the defendant pursuant to Article 5 of Chapter 122C of the General Statutes. This examination shall comply with and satisfy the requirements of the initial examination as provided in G.S. 122C-263(c).

(2) Require the arresting officer to immediately transport, or cause to be transported by an officer of the arresting officer's agency, the defendant to a hospital emergency department or other crisis facility with certified commitment examiners for the initial examination. If the defendant has met all other conditions of pretrial release, the transporting officer may release the defendant after the initial examination is conducted if one of the following criteria is met:

a. No petition for involuntary commitment is filed pursuant to Article 5 of Chapter 122C of the General Statutes.

b. A petition for involuntary commitment is filed pursuant to Article 5 of Chapter 122C of the General Statutes, but no custody order is issued pursuant to G.S. 122C-261.

(3) Require the commitment examiner, after conducting the initial examination, to do one of the following:

a. Petition for involuntary commitment of the defendant pursuant to Article 5 of Chapter 122C of the General Statutes, if there are grounds for that petition.

b. Provide written notice to the judicial official that entered the order for initial examination that there are no grounds to petition for involuntary commitment of the defendant.

(4) Provide that, except as provided in subdivision (5) of this subsection, whether or not the defendant has met all other conditions of pretrial release, if a petition for involuntary commitment is filed pursuant to Article 5 of Chapter 122C of the General Statutes, the custody of the defendant shall be determined pursuant to the provisions of that Article during the pendency of that petition and any hearings and orders issued pursuant to that Article.

(5) Provide that if a defendant has not met all other conditions of pretrial release, if one of the following criteria is met, the defendant shall be transported to and held in the local confinement facility of the county where the conditions of pretrial release were set until all conditions of pretrial release have been met:

a. A petition for involuntary commitment is not filed pursuant to Article 5 of Chapter 122C of the General Statutes.

b. A custody order is not issued pursuant to G.S. 122C-261.

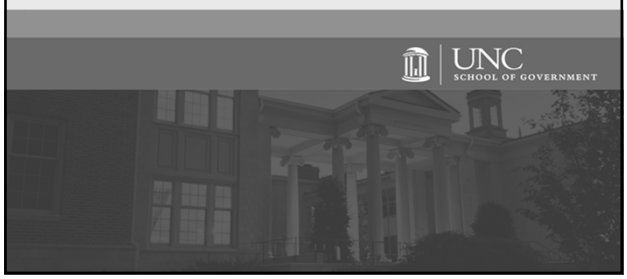
c. At any other time, the provisions of Article 5 of Chapter 122C of the General Statutes would result in the release of the defendant. (c) A judge may determine in his discretion whether a defendant charged with a capital offense may be released before trial. If he determines release is warranted, the judge must authorize release of the defendant in accordance with G.S. 15A-534.

(c) . . .

(d) . . .

(e) . . .

# LME-MCO Community Crisis Plans

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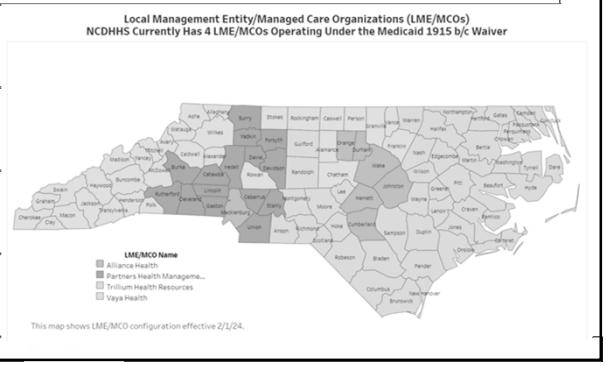
## LME Community Crisis Plans

- 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

2

## LME-MCO service regions—2025

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## 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

4

## LME Community Crisis Plans

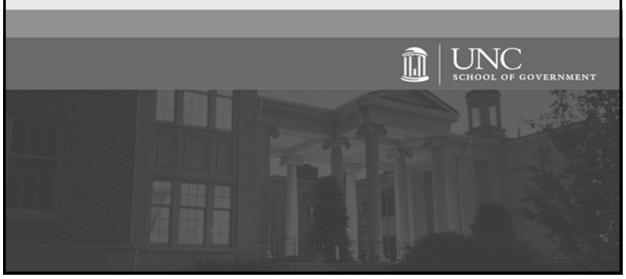
Must identify—for any non-law enforcement personnel designated in a County Transportation Plan—training that addresses the

- 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

5

## Alternative Response Programs

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## 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

7

## 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.

8

## Questions?

- Mark Botts
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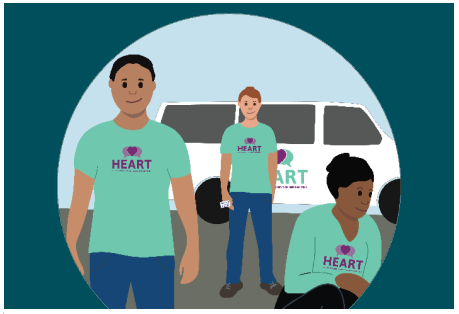
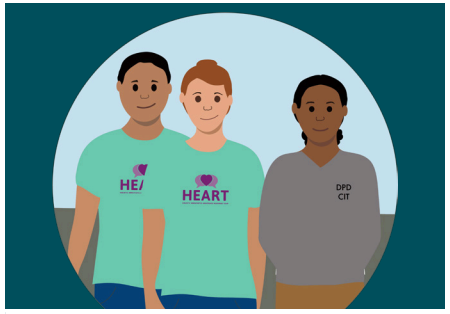
  - botts@sog.unc.edu

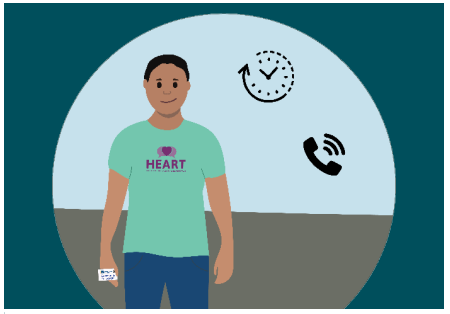
9

Answers to common questions about the HEART crisis response programs

**COMMUNITY SAFETY**
CITY OF DURHAM

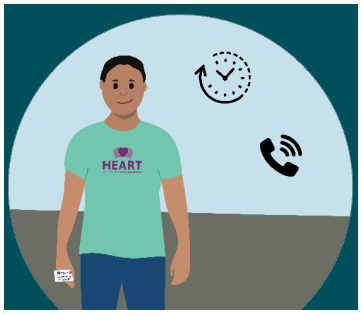




| | **Crisis Call Diversion** (CCD) | **Community Response Teams** (CRT) | **Co-Response** (COR) | **Care Navigation** (CN) |
|---|---|---|---|---|
| **What does this program do?** | CCD adds clinicians to our 9-1-1 call center so we can quickly connect you to a mental health professional when you or 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

**COMMUNITY SAFETY**
CITY OF DURHAM




| | **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. | | | |

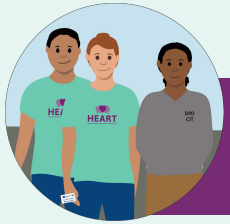
*Visit Durham Community Safety's website to learn more:*
**www.durhamnc.gov/HEART**


## 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.

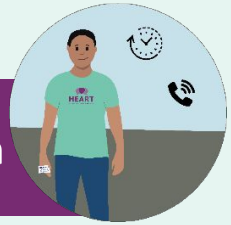
## 2 Community Response Team

**[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.*

COMMUNITY SAFETY
CITY OF DURHAM

# HEART

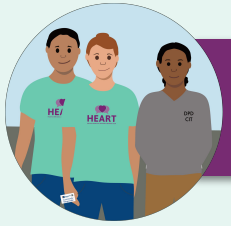
HOLISTIC EMPATHETIC ASSISTANCE RESPONSE TEAM

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.

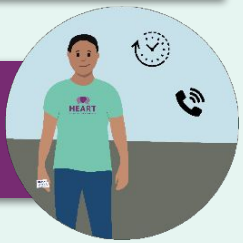
## What services does HEART provide?


1 Crisis Call Diversion

2 Community Response Team



3 Co-Response



4 Care Navigation

## 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.

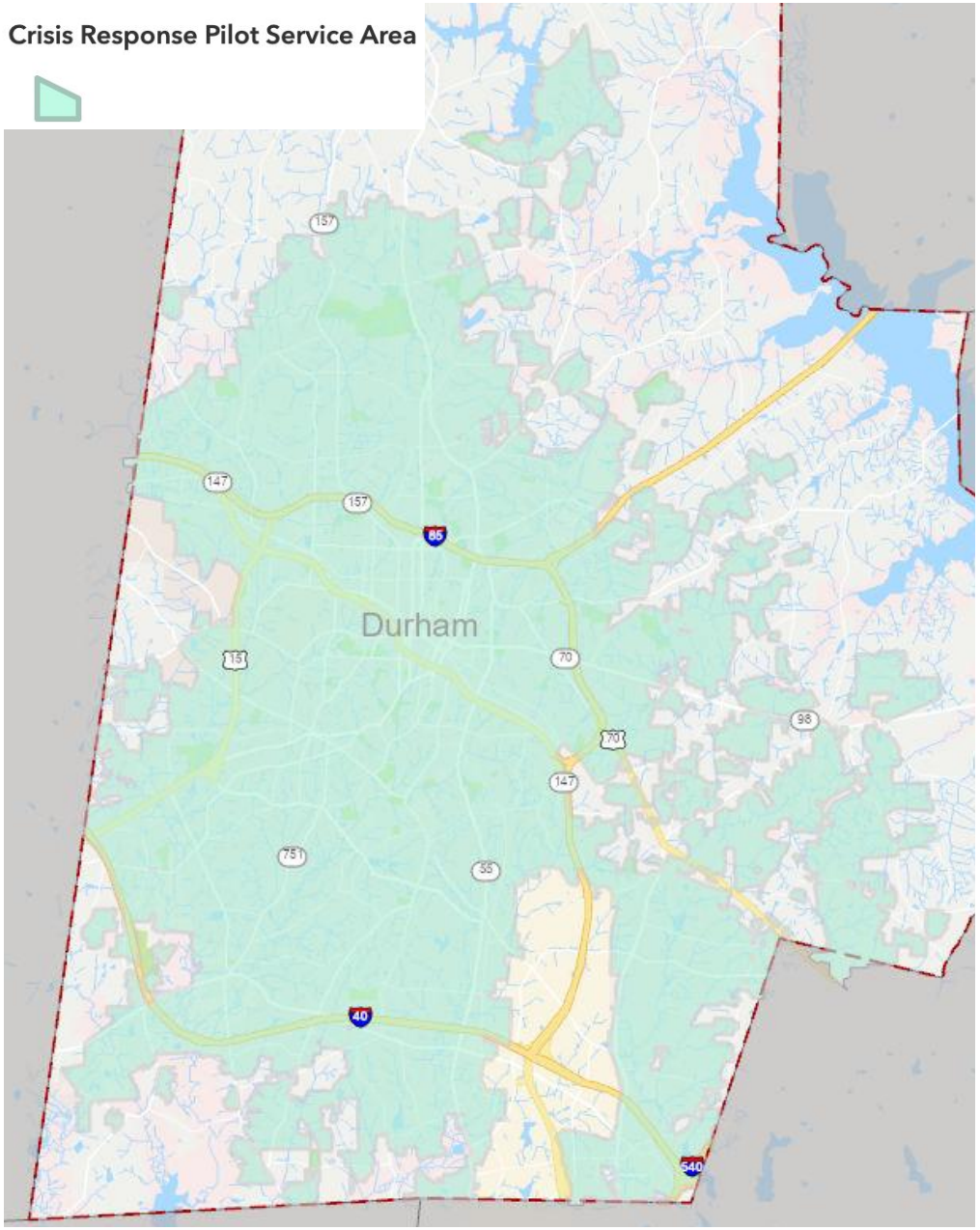
## Visit our website to stay updated.

**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




M T W Th F Sa Su

**ALL PROGRAMS NOW OPERATE —CITYWIDE— 7 DAYS A WEEK**

**Crisis Call Diversion**
9:00am - 9:00pm

**Community Response Team**
9:15am - 11:45pm

**Co-Response**
6:00am - 9:00pm

**Care Navigation**
9:00am - 9:00pm

# 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

UNC | SCHOOL OF GOVERNMENT
Criminal Justice Innovation Lab

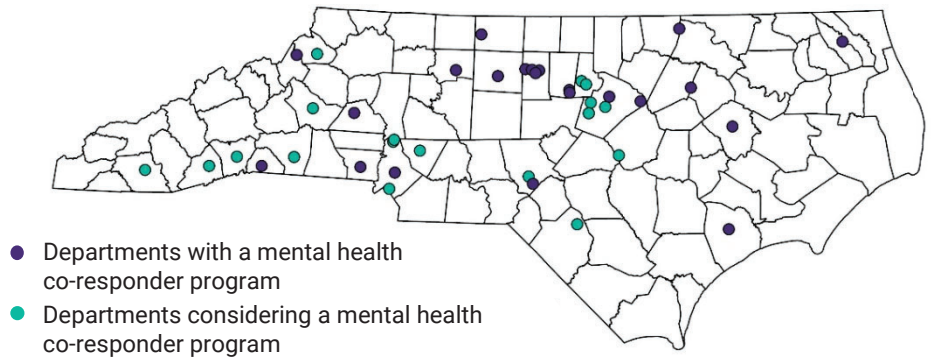
# Specific Program Models

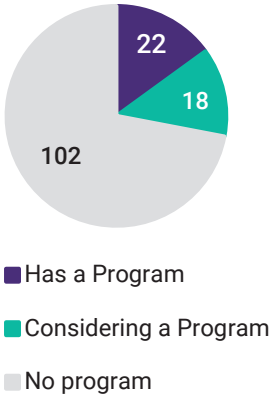
## Mental Health Co-Responder Programs

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

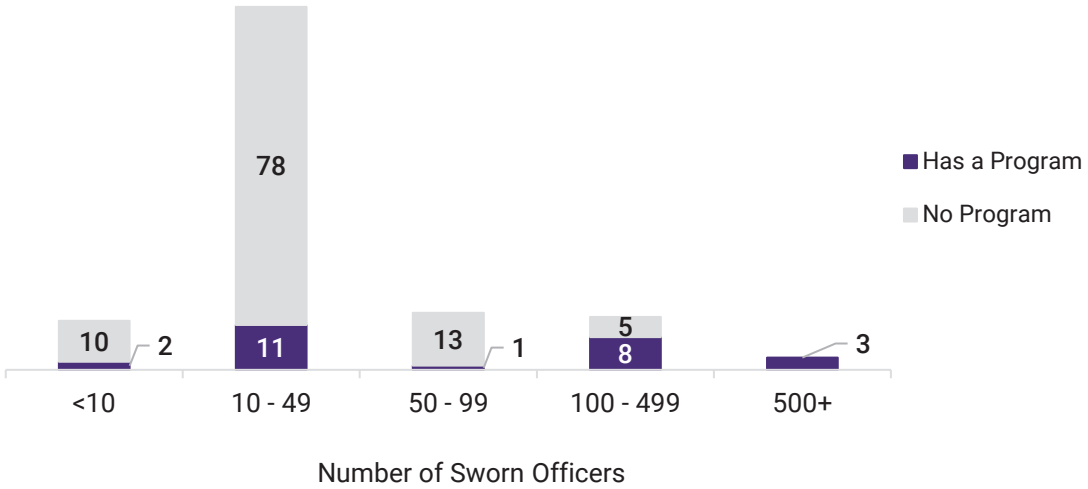
Forty police departments (28% of survey respondents) report that they have or are considering implementing a mental health co-responder program. Those departments are located throughout the state and in diverse communities.




### 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.

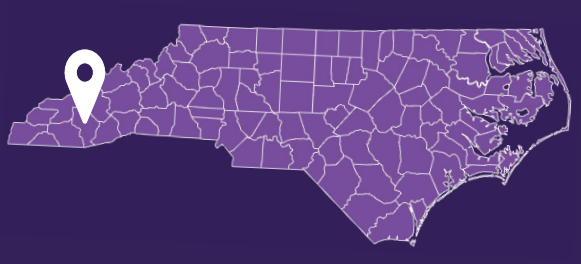


## Program Highlight

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

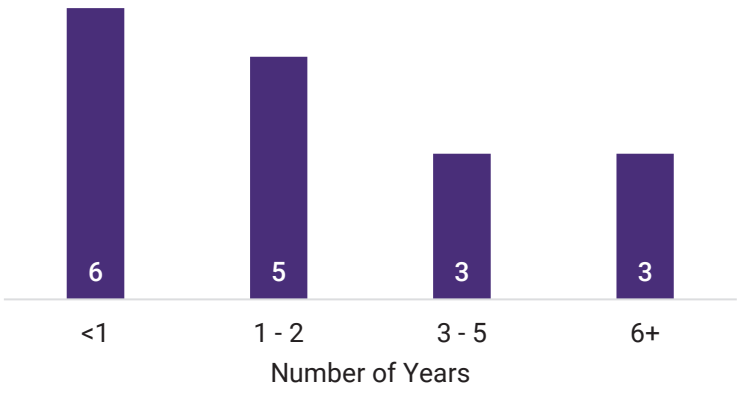
**What is it?** Created in 2021 in partnership with Western Carolina University (WCU), a master's-level social work intern is embedded in the department as Community Care Liaison, providing support, case management, and referrals to people in crisis. By serving as a field placement site for WCU's Master 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.

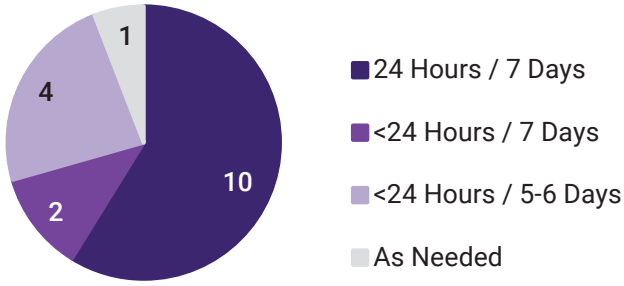
### Mental Health Co-Responder Program Age

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



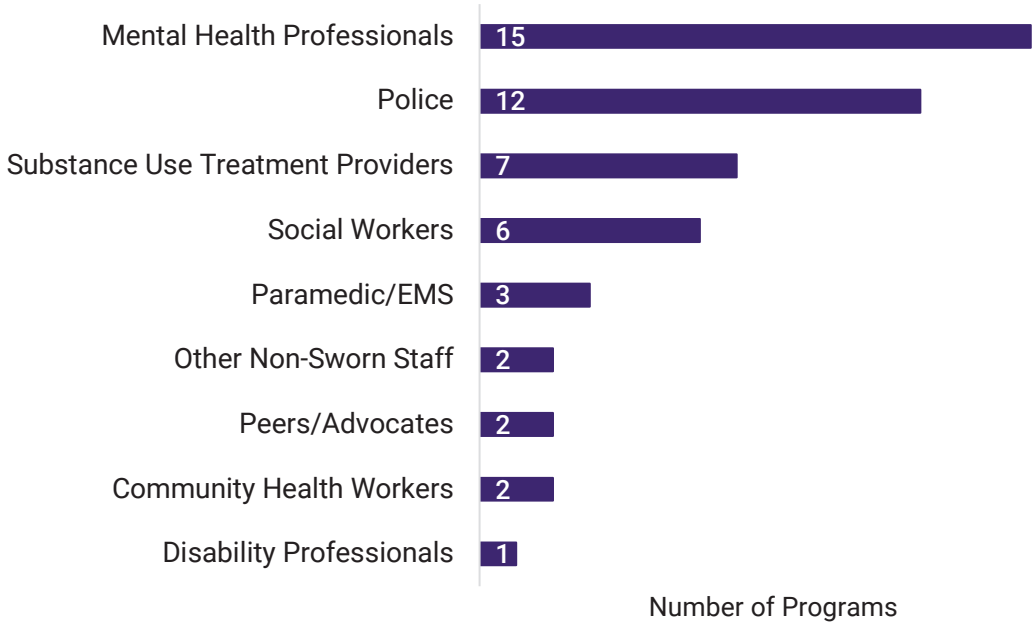
## Hours of Operation of Mental Health Co-Responder Programs

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**

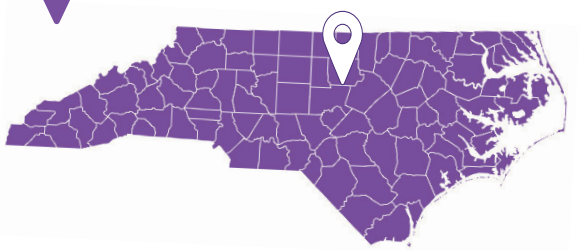
Mental health co-responder

**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.

# 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

# "MENTAL HEALTH 101"

**Introduction to Psychiatric Illness**
**Magistrate Training**
**February 10, 2026**

**Ken Fleishman, MD**
**Chairman of Psychiatry and Behavioral Healthcare**
**Cape Fear Valley Health System**
**Fayetteville, North Carolina**

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## DISCLOSURES

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

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

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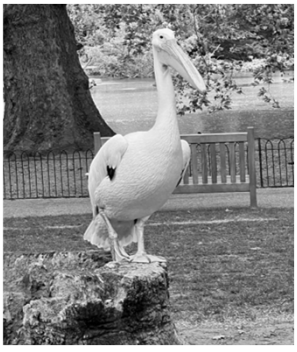

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## MENTAL ILLNESS

- **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**

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## 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.

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## 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

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## 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….

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## 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

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## 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

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## 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 - 70% more likely than men to experience Major Depression
  - Adults age 18-25 - 60% more like likely to have Major Depression than those 50+
  - Risk of suicide is 20x greater in Depressed people than the general public

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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 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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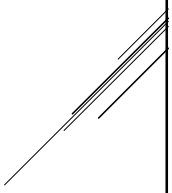
## NEUROCOGNITIVE DISORDERS

- **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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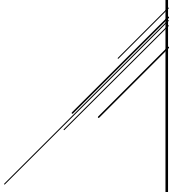
## NEUROCOGNITIVE DISORDERS

- **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,

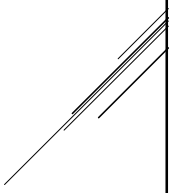
Infection, Surgery, Pain,

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,
- Psychoed for the patient & family - discuss Dx, Sx, 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, Psilocybin with 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: 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 2023.
- 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. (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.
- 60% of people completing suicide had a Mood Disorder (Depression or Bipolar Disorder)
- Firearms are the most common method of suicide (~ 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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# FASTEN YOUR SEAT BELTS, THE RIDE MAY GET BUMPY

**IVC in the Emergency Department & 24 Hour Facility**
**Magistrate Training**
**February 10, 2026**

**Ken Fleishman, MD**
**Chairman of Psychiatry and Behavioral Healthcare**
**Cape Fear Valley Health System**
**Fayetteville, North Carolina**

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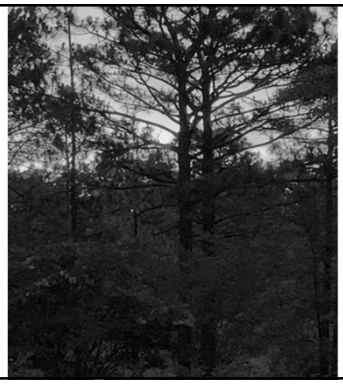

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# IVC IN THE HOSPITAL ED

Magistrate Training
February 10, 2026

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

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## THE ROLE OF THE HOSPITAL ED

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## THE ROLE OF THE HOSPITAL ED

**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, likely 1:1.**

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

6

## THE ROLE OF THE HOSPITAL ED

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

7

## THE ROLE OF THE HOSPITAL ED

- 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/ER most likely is using an evidenced based assessment tool to aid in determining level of risk. (Provider may administer….)
- CSSRS – Columbia Suicide Severity Rating Scale
- Safe-T Assessment
- WAIT…….(**may require special interventions)

8

## THE ROLE OF THE HOSPITAL ED

- They will be evaluated by nursing staff then a Social Worker (if available).

  (Nursing Staff or Social Worker administer an evidence based assessment tool)
- CSSRS – Columbia Suicide Severity Rating Scale
- Safe-T Assessment
- WAIT……. LIKELY WAIT SOME MORE…(**may require special interventions)

9

## THE ROLE OF THE HOSPITAL ED

- A psychiatrist/psychiatric provider reviews the A & P, any other information available from the EHR and contact the petitioner or other family, etc.
- 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)

10

## THE ROLE OF THE HOSPITAL ED

- 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?**

13

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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**

- **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 can 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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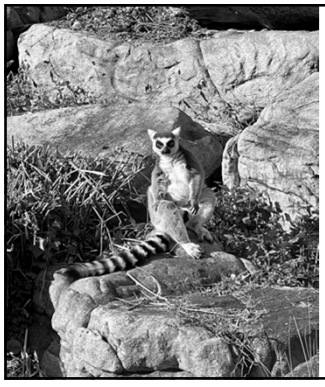

## THE END

21

# 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)

## PETITIONER'S WAIVER OF NOTICE OF HEARING

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

| *Signature Of Witness* | *Date* |
|---|---|
| | *Signature Of Petitioner* |

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

**STATE OF NORTH CAROLINA**

File No.

_____ County

In The General Court Of Justice
District Court Division

**IN THE MATTER OF**

*Name And Address Of Respondent*

# FINDINGS AND CUSTODY ORDER INVOLUNTARY COMMITMENT

**(PETITIONER APPEARS BEFORE MAGISTRATE OR CLERK)**

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

| *Social Security No. Of Respondent* | *Date Of Birth* | *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)

| 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.*

**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*

# 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* | ☐ 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-302B Return)

| 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.*

**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 <u>Emergency Department</u> 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: | FINDINGS AND ORDER<br>INVOLUNTARY COMMITMENT<br>PHYSICIAN-PETITIONER<br>RECOMMENDS OUTPATIENT COMMITMENT |
|---|---|
| *Name And Address Of Respondent* | 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*<br>☐ *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.*

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

# CERTIFICATE

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

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

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

_____
**Signature of Physician or Eligible Psychologist**

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

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

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

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

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

**(seal)**

_____
**Notary Public**

**My commission expires:**_____

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

**TO LAW ENFORCEMENT: See back side for Return of Service**

| | RETURN OF SERVICE | |
|---|---|---|

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

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

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