UNC SCHOOL OF GOVERNMENT

2025 Civil Commitment Conference

January 17, 2025/ Chapel Hill, NC
Co-sponsored by UNC School of Government
& NC Office of Indigent Defense Services

AGENDA

8:45 to 9:00am	**Welcome** *Timothy Heinle, Teaching Assistant Professor* UNC School of Government, Chapel Hill, NC
9:00 to 10:00am	**Nuts, Bolts, and Effective Representation** *Ben Turnage, Special Counsel* Cherry Hospital, Goldsboro, NC
10:00 to 10:15am	*Break*
10:15 to 11:45am	**Strategies for Working Effectively with Clients Facing Civil Commitment** *Dr. Maggie Carraway, Forensic Psych.* New Spark Therapy, Durham, NC
11:45am to 12:30pm	*Lunch*
12:30 to 1:30pm	**So Your Hearing is Finished, What's Next?** *Zach Thayer, Special Counsel* Office of Special Counsel, Raleigh, NC
1:30 to 1:45pm	*Break*
1:45 to 2:45pm	**IVC Appeals: Passing the Baton from Trial to Appellate Counsel** *David Andrews, Assistant Appellate Defender* Office of the Appellate Defender, Durham, NC
2:45 to 3:00pm	*Break*
3:00 to 4:00pm	**E-Courts, IVCs, and an Update from the OSC** (Technology) *Chad Perry, Chief Attorney* *Zach Thayer, Special Counsel* Office of Special Counsel, Raleigh, NC
4:00pm	*End of program*

Estimated 5.5-hours of CLE including 1.0 of Technology CLE, pending bar approval.

NUTS, BOLTS, and Effective Representation

- N.C.G.S. Chapter 122C
- NORTH CAROLINA CIVIL COMMITMENT MANUAL
- NCDHHS.gov/ivc

1

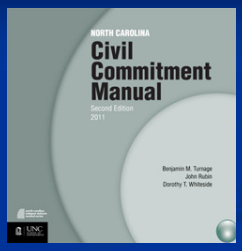
Mission Statement

- For commitment counsel, the **focus is insisting on Due Process** to **ensure the liberty interest** of individuals who are **refusing forced psychiatric care**.
- Like all residents of this state, **respondents** undergoing involuntary commitment are presumed to be **sane and competent**. *In re W.J.M.*, 289 N.C. App. 268 (2023).
- Respondents are **entitled** under the Federal Constitution and **Article I, § 19 of the North Carolina Constitution to liberty and freedom from unlawful restraint**.
- All admissions and commitments shall be accomplished under conditions that protect the dignity and constitutional rights of the individual. 122C-201.

2

https://defendermanuals.sog.unc.edu/defender-manual/4

- In support of our efforts, we have the combined resources of IDS and SOG.
- Together they've produced the Commitment Manual which sets out each type of commitment and admission in a clear and concise format.
- Unfortunately, the manual is significantly outdated at this point, but it continues to be useful as a gateway leading to the various sections contained in 122C.
- I'll direct you to sections in the manual that are useful when you represent a respondent in an IVC proceeding.



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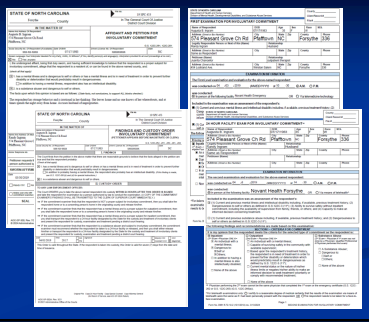
Basic IVC Documents

- You've been appointed to represent Augusta B. Ingram a respondent in IVC custody at a 24-hour facility.
- Ask the clerk to provide:
  - Affidavit and Petition
  - Custody Order
  - At least two forms 5-72 Examination for Involuntary Commitment.
  - Notice of Hearing



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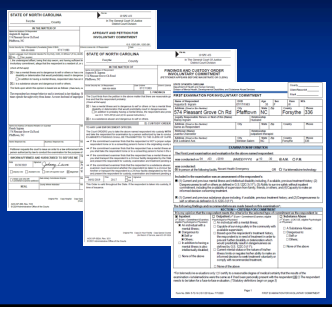
Involuntary Commitment is Form Driven



IVC is form driven.	Evaluate the lawfulness of the process by reviewing these forms.
If these forms are missing, you have a due process argument for dismissal of the case.	The case against your client will build from the petition through to the commitment examination for court.
In working through this example, the dates and times of service and examinations are lawful.	We'll review these documents in detail, so you know where to look.
This process is designed as an expedited process. However, it can be problematic.	The process lends itself to cognitive bias which we'll discuss.

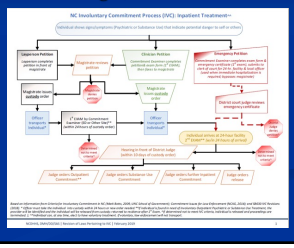
5

Involuntary Commitment Pre-Hearing Process: Custodial Process Prior to District Court Hearing.

Authority for Involuntary Commitment 122C-261

- When **petitioner thinks** another person is **dangerous to themselves or to others**, due at least in part, to **mental illness**, they may **seek a custody order** for IVC.
- There are three types of petitions, as illustrated in Mark Bott's flowchart:
- The petition initiates a judicial process for restraint of respondent's liberty and transportation for commitment examinations at approved facilities. There is a 24-hour limit on service of the custody order. There is a 24-hour limit for each examination required. The clock starts on delivery of respondent to the custody of an examination site.
- Its important to remember that, **at any point** within this flowchart, **any examiner may release** respondent from custody [pursuant to **122C-263(d)(3)**] or release respondent to outpatient treatment. **[263(d)(2)]**.
- The "layperson" initiates the process at the magistrate's office. We will follow a layperson petition through to the initial district court hearing.

Mark Botts IVC Flowchart NCDHHS.gov/ivc



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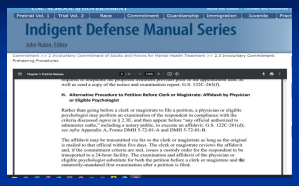
Expedited Process, Clinician Petition: 122C-261(d)(5)

- We're in the manual at section 2.3 H. There is an expedited process for use by clinicians, authorized by 261(d)(5) under strict statutory requirements. We won't see this process in today's example.
- The commitment examiner may fax, or e-file the affidavit and petition once completed and signed before a notary. A 5 72 First Exam must also be filed.
- E-filing and the term commitment examiner are amendments to the statute since publication of the manual.
- Under the process in 122C-261(d)(5), the physician or facility designee (special police) take custody of the respondent and advise the respondent about the lawfulness of the restraint. They must have training in service and return of service to the respondent. Otherwise, the magistrate shall not issue a custody order.

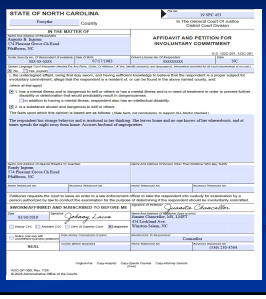


- **Bottom Line: Since all pre-hearing process is ex parte and forced on Respondent without benefit of assigned counsel, the district court judge should require strict compliance with the statute on appropriate motion alleging violation of Due Process under the 14th Amendment to the U.S. Constitution and Article I, § 19 North Carolina Constitution.**

7

Adventure of Respondent Augusta B. Ingram

- The petition was initiated by Juanita Chancellor, LMFT on March 30, stating Juanita's belief that Augusta Ingram is MI/D and SA/D. Randy Ingram is a witness.
- Authority for clinician's disclosures: 122C-55(d) allows a clinician to disclose protected information when there is an imminent danger to the health or safety of the client or there is a likelihood of the commission of a felony or violent misdemeanor.
- The affidavit must be sworn and signed in the presence of the magistrate. Reasonable Grounds Standard.
- Affiant must state the facts, not medical or legal conclusions in support of the petition. You must challenge the affidavit at the first commitment hearing. Moore (2014).
- The "factual basis" is a hypothetical construct based on affiant belief and judicial inference, and it is used to justify a potentially lengthy restraint of liberty despite time limits mentioned on slide 5.
- The affidavit is a pleading, of sorts. Petitioner shouldn't be able to testify to allegations for which we haven't been provided notice. Proof without allegation is no better than allegation without proof, a party cannot recover except on the case made by the pleadings. *Hall v. Poteat*, 257 N.C. 458 (1962).


STATE OF NORTH CAROLINA

Forsyth County

In The General Court Of Justice
District Court Division

IN THE MATTER OF

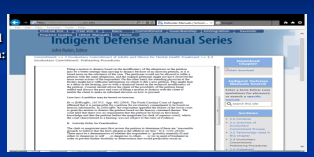
AFFIDAVIT AND PETITION FOR INVOLUNTARY COMMITMENT

8

Hearsay is Admissible at Magistrate's Hearing:

Zollicoffer , 165 N.C. App. 462 (2004)

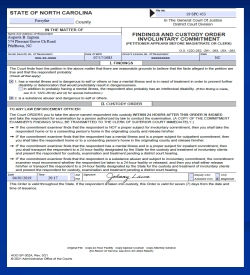
- According to the **Zollicoffer** case discussed in section 2.3A of the manual, **hearsay is allowed at the magistrate's hearing. The justification:** there is a **"mechanism to review the detainment within a reasonable period of time."**
- The **first and second examination** and the **right to a district court hearing** are the "**mechanism**" which is said to provide the respondent with an **adequate assurance that they are not being improperly detained.**



- **Despite Zollicoffer, delays at the first examination** site are possible and **hearsay will continue to infect** the proceedings, even at the district court hearing.

9

Layperson Petition to Custody Order

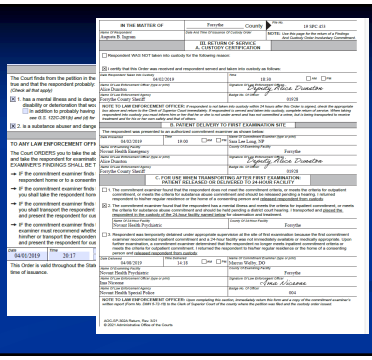


- Left is the Affidavit signature block and on the right is the custody order issued by Judge Laws.
- This is a layperson petition because in our example, Chancellor appeared before Judge Laws.
- Affidavit was sworn and signed on March 30.
- Based on the affidavit, Judge Laws made findings in section I of the custody order: MI/D and a SU/D. DMV issue?
- Judge Laws issued custody order on April 1 at 8:17pm.

10

Custody Certification

- The custody order memorializes the custodial history prior to the district court hearing. Evaluate sufficiency.
- Back of the custody order. Look at the LEO's certification section III.A.: the deputy has 24 hours from issuance to serve or new process initiated.
- Custody Order issued April 1 at 8:17 pm and served April 2 at 6:30pm. Initial hearing required O/B April 12.
- III. B: LEO Delivery of R to Novant Emergency Dept. for first CE: 4/2 @ 7:00pm;
- III. C. 2.: Novant Special Police delivered (R) to custody of 24-hour facility for 2nd CE: 4/8 @ 2:18pm.



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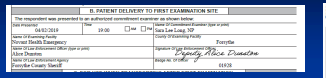
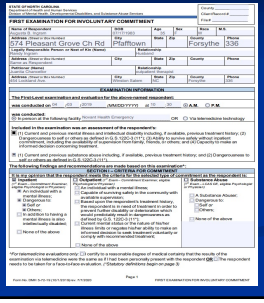
Custody Order to First ERIC





- On the left is Part B from back of the Custody order and on the right is the First Examination.
- Deputy Dunston presented Augusta Ingram 4/2 @ 7:00pm to Novant Health Emergency for a first examination with commitment examiner Sara Lee Long, NP.
- On right, under exam information, Sara Lee Long, NP performed the first examination on 4/3 @ 10:30am. Within 24 hours of presentation: valid.
  - Long's opinion was that Augusta Ingram met criteria for inpatient commitment. MI/DS/DO
  - Long assessed SUD but did not find criteria for ISA.

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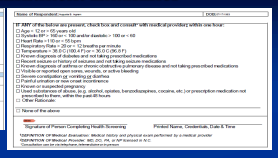
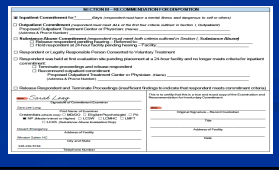
First ERIC: Commitment Examiner

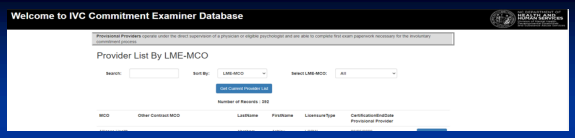




- On left, page 2, above: Description of findings may disclose additional allegations. If CE restates allegations of Petition, shortcut may signal that Zollicoffer adequate assurances have failed, a Due Process argument.
- Health Screening may imply Danger to Self: (e.g., due to untreated diabetes) but that condition alone is not enough for the technical definition. (RPSPDNF)
- Recommendation for disposition of 7 days, sec. III.
- Signature Block: Myriad of disciplines 1st Exam. Statute defines Commitment Examiner

13

Welcome to IVC Commitment Examiner Database



- 122C-3(8a) Commitment Examiner: Any health professional "certified" to perform first examinations for IVC.
- Look up certification status on DHHS website: CE Database

- DHHS posts an annual list:
- Certification is good for 3 years; cert may be rescinded at any time;
- Health professionals must complete training;
- PA, NP, LCSW, LMHC
- Addiction specialists may only examine for substance abuse commitment.
- Marriage and family therapist may not examine the spouse of a patient. (in our example, the LMFT is the affiant, not the CE).

14

Consecutive 7-day Periods of Detainment at First Exam

- Section 2.3J Commitment Manual:
  - Respondent may be temporarily detained at the first examination site while waiting for transport to the 24-hour facility.
- If respondent remains at the first examination site 7 days after issuance of the previous custody order, 122C-263(d)(2), says the examiner **must terminate** the proceedings, period.
- **However**, the Commitment Examiner may initiate a **new** involuntary process with **fresh** allegations and obtain a **new** custody order, if **done on the 7th day after issuance** of the previous custody order.

- **You will not be appointed until the second examination is completed and the respondent is admitted to the 24-hour facility.** There may be a lengthy restraint of liberty at the first examination site based on an ex parte proceeding where hearsay is allowed, and respondent has not been assigned counsel.

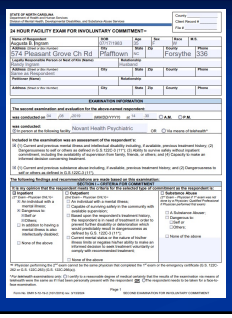
15

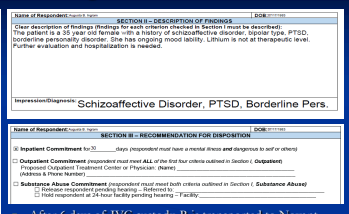
When Respondent Arrives at 24-hour Facility: Second Examination 122C-266

- A physician must perform a second exam within 24 hours of admission;
- The examining physician cannot be the same person who performed the first exam.
- You must object if the second exam isn't performed as required by statute. *In re E.D.* 372 N.C. 111 (2019);
- Although objection must be raised, Respondent is "not required to make a showing of prejudice" where no second exam was performed.
- Admission after second examination allows the 24-hour facility to administer **restraint and seclusion** 122C-60.
- Involuntary admission allows the 24-hour Facility to **force medications** (except ECT) with concurrence of two physicians and under certain conditions that assess the benefit vs. risk of Rx administration. 122C-57(e).
- Admission subjects respondent to **rigid restrictions**, such as medication compliance, dietary restrictions, internet and social media access, cell phone use, possession of personal property, and may limit visitors.

16

Second ERIC: Admitting Examination





- After 6 days of IVC custody, R is transported to Novant Psychiatric on April 8 @ 2:18 pm.
- Welby, DO performed the second exam on April 8 at 2:30pm within 24 hours of delivery.
- Welby recommends involuntary commitment for 30 days

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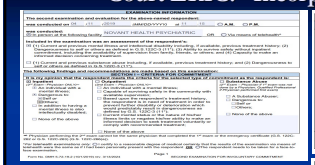
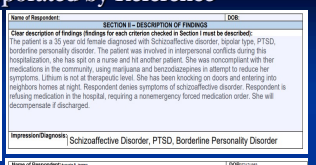
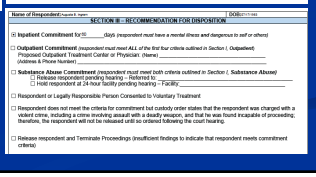
Court ERIC: "Incorporated by Reference"







- Welby prepared the court exam on 4/11 @ 11:15am. Initial Hearing required O/B April 12. Expedited process requires diagnostic shortcuts.
- Disclosures have grown significantly since affidavit.
- Notice is required for Due Process.
  - Object at the initial hearing to testimony outside pleadings and disclosures, citing Notice required for Due Process and Art. I section 19 of NC Constitution. *In re M.L.*, 262 N.C. App. 154 (2018).

18

NC Rule of Ethics 1.14 Client with Diminished Capacity

Maintain a normal lawyer-client relationship. HCPOA/Advance Instruction/GOP are only one piece of the puzzle.

Severe Mental Health Symptoms may impact relationship: Take protective action where necessary.

Consult family, treatment providers, allow for a period of reconsideration to clarify client's condition or to improve outcome.

Consider potential adverse results before discussing confidential matters with others. Limit disclosures accordingly. We don't want the consultant using our words against our client in court.

Evaluate whether client can make adequately considered decisions regarding the legal process.

Can client be Advised and Assisted?
Intrude on client autonomy to the least extent feasible. Allow them a voice and provide validation to improve outcome and satisfaction.

19

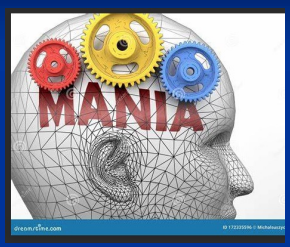
Now, We're Appointed. First impression: rational and reasonable

- Initial Client Interaction:
  - Introduce yourself as the client's attorney.
  - Clarify the representation is limited to hospitalization.
  - Address the client's mention of hiring their own attorney and potential delays.
  - Ask if the client has questions about their legal status in the hospital.
- Explanation of IVC Order:
  - Explain that the IVC is a court order for up to 90 days.
  - Inform the client that the order prevents them from "signing themselves out" of the hospital against medical advice.
  - Discuss the potential discharge process and representation in court.
- Gathering information:
  - Discuss allegations and obtain information about witnesses and defenses.
  - Reassure the client about contacting the doctor and team members for possible release.
  - Ask the client to contact their witnesses and obtain email addresses for Webex to avoid change of venue.
  - Interview witnesses listed by client: Release for confidential information from community providers.

- Court Procedures:
  - Describe the court process including decorum, note taking as a memory aid.
  - Emphasize that commitment is not a sentence.
  - Avoid negotiating diagnosis or medications during the hearing.
  - Explain that the hearing is recorded and avoid discussing criminal allegations or liability for civil damages.
- Consent and Continuance
  - Obtain consent for in-court offer of outpatient commitment.
  - Obtain consent for continuance for release pending hearing or outpatient commitment.
- Appeal is to the Court of Appeals, not a retrial in front of a new judge.
- Collateral consequences: NICS reporting, DMV reporting.

20

How We Do Our Jobs May Make Things Better

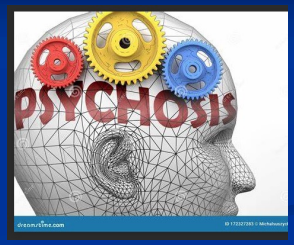


- Always Provide Client Centered Representation. Represent the client's expressed interest, not what others think is best.
- Observe their body language. Listen without thinking of what you're going to say next. Look into their eyes. Repeat back what you hear them saying.
- Try to understand the client's ambivalence surrounding a change in their life. Offering alternatives to hospitalization may make things better.
- From the standpoint of resources and supports that avoid an inference of inability to care for self, what alternatives to hospitalization work for them? Are they on Probation/Parole/Day Treatment? Church Outreach? Community Shelter Program? Family/friends? Bridge Housing with ACTT (assertive community tx), CST (community support).

21

How We Do Our Jobs May Make Things Worse

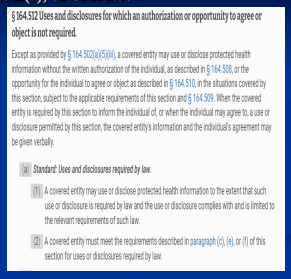
- Can this client be advised and assisted? Can they make rational and reasonable decisions regarding the representation?
- If you're demonstrating compassion as a desire to help, most of the time your client will be on their best behavior with you.
- You can always find a way to validate another person. Their emotions are real whether they fit within the coherence of reason.
- When your client's statements don't seem to match with reality, don't challenge a delusion. It's not only ineffective, but it is invalidating, and it will put them on the defensive. It will lead to unnecessary conflict. That will make things worse for your client. Review hospital records of behaviors since admission.



22

Medical Records and HIPAA
122C-54, 42 CFR 164.512(a), 42 CFR 2.64

- HIPAA doesn't block you from receiving the records because 122C-54(c) is a mandate to the facility which requires production of records to respondent's counsel, "by law."
- Records of Substance Use Disorder may require a court order.
- Historical records of prior admissions will require a court order, unless included in the current chart.
- Discovery "on the fly" G.S. 8C-1, Rule 612:
  - If the expert refers to the chart to refresh recollection, you can review the chart prior to your cross exam.



§ 164.512 Uses and disclosures for which an authorization or opportunity to agree or object is not required.

Except as provided by § 164.502(a)(5)(iii), a covered entity may use or disclose protected health information without the written authorization of the individual, as described in § 164.508, or the opportunity for the individual to agree or object as described in § 164.510, in the situations covered by this section, subject to the applicable requirements of this section and § 164.509. When the covered entity is required by this section to inform the individual of, or when the individual may agree to, a use or disclosure permitted by this section, the covered entity's information and the individual's agreement may be given verbally.

(a) Standard: Uses and disclosures required by law.

(1) A covered entity may use or disclose protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.

(2) A covered entity must meet the requirements described in paragraph (c), (e), or (f) of this section for uses or disclosures required by law.

23

DISTRICT COURT
INITIAL HEARING

Hearing is required within 10 days of service of custody on the most recent involuntary commitment custody order; May be continued;

Closed to Public; absent objection and good cause, may be held via audio and video transmission: 7A-49.6;

It may be error to allow R to represent themselves. In re Watson 209 N.C. App. 507 (2011) In re B.S. 2022-NCCOA 743: 122C-268(d);

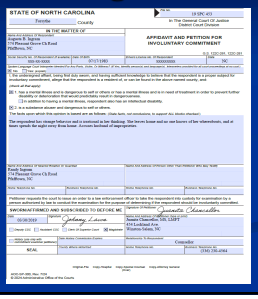
The trial judge plays distinct roles: First as Gatekeeper then as Adjudicator. The rules of evidence apply. NCRE, Rule 1101.

268(f): To support an inpatient commitment order, the court shall find by clear, cogent, and convincing evidence that respondent is mentally ill and dangerous to self or dangerous to others. The court shall record the facts that support its findings.

24

Motion to Dismiss on Pre-hearing Process

- If you find that there is a defect in the Affidavit or in the examination process, file a written motion to dismiss at the initial hearing. Serve opposing counsel, if any, prior to hearing (Attach a Certificate of Service). Hand the motion to the clerk at the call of the case.
- In re Ingram, 74 N.C. App. 579 (1985). The allegations do not provide specific facts illustrating mental illness and dangerousness.
- Delay in issuance of the Custody Order after the petition is accepted is a Due Process violation.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IN THE MATTER OF

AFFIDAVIT AND PETITION FOR INVOLUNTARY COMMITMENT

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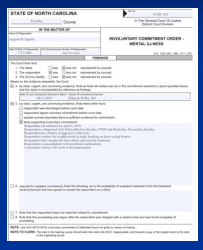
Begin Trial with the End in Mind


STATE OF NORTH CAROLINA

In The General Court Of Justice
District Court Division

IN THE MATTER OF

INVOLUNTARY COMMITMENT ORDER - MENTAL ILLNESS

- Your client's defense is important. But, if your client is committed, the COA will not re-weigh all the evidence despite the respondent making a great case for discharge. In re: J.L.K.O., 285 N.C. App. 246 (2022).
- Begin with the strategy to limit the court's findings to the affidavit and narratives from examinations. Understand how those documents fail to prove the elements of the cause. To the extent possible, object on constitutional grounds to any offer of evidence outside those documents and to any offer of inadmissible evidence.
- Begin with an understanding of appellate cases reversing commitment orders for error on the issues of Reasonable Probability of Serious Physical Debilitation Near Future and Reasonable Probability of Future Dangerous Conduct.
- Take sufficient notes during the hearing that will provide a reasonable basis from which to evaluate the judge's findings of fact supporting involuntary commitment.

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MENTAL ILLNESS

122C-3(21): An illness which so lessens the capacity of the individual to use self control, judgment, and discretion in the conduct of affairs and social relations as to make it necessary or advisable for them to be under treatment, care, supervision, guidance or control.

Not Vague because definition can be understood and objectively applied through use of medical experts. In re Salem, 31 N.C. App. 57 (1976), *habeas* granted by 683 F.2d 1132.

To avoid excessive use of police powers of the state there should be CCC evidence of a high level of cognitive or volitional impairment which directly influences the individual's ability for self control, judgment and discretion.

Aggie is presumed competent. She made a personal visit to the neighbor's home to save Randy. Apparently, she knocked on the door. In the hospital setting, Aggie became upset because a patient was going through Aggie's personal belongings. Aggie has been diagnosed with a personality disorder, Borderline Personality. A personality disorder is a pervasive pattern of learned behavior, Forced hospitalization may not be the least restrictive intervention to address a learned behavior. The public benefit of Aggie's involuntary hospitalization is not enough to justify depriving her of liberty.

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Nuts and Bolts of Defending Against Opinions of Medical Experts

Since the COA is relying on Medical Experts to prevent arbitrary enforcement of the (perhaps, otherwise vague and overbroad) statutory definition of "Mental Illness," we will:

Address	Address the Court in its Gatekeeper Function: 8C-1, Rule of Evidence 104(a)
Address	Address the Relevance and Reliability of the Expert Opinion as required under Rule 702 and Daubert: focusing on the categories in the DSM-5TR
Address	Address the Court's acceptance of hearsay as the basis for Expert Opinion. 122C-268.(f) Confrontation Statute
Address	Address Cognitive Bias at work in the Expert's Opinion: Focus on Confirmation Bias

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Addressing Trial Judge as Gatekeeper

State v. McGrady 368 N.C. 880 (2016) Gatekeeper evaluation is a more stringent and exacting evaluation of Relevance and Reliability under Rule 702 than the former blind faith standard.

Expert testimony is required for IVC. Defining a mental illness requires evaluation of behavioral clues to speculate as to function of the brain.

MH Experts, in the context of IVC, consider the probability that a patient lacks insight, and depend heavily on the veracity of collateral information in formulating Ds and Ts. The expert formulates a hypothetical construct from collateral sources designed to justify IVC, medication admin and to predict future behavior.

Whether the court will receive the evidence or have it stricken from the record is a preliminary question for the judge under 8C-1, N.C. R. Evid 104(a). In answering that question, the trial judge is not bound by the rules of evidence. You may use almost any information to persuade the court under the rule.

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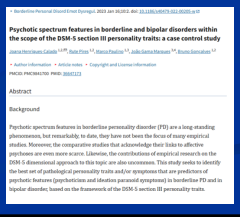
Trial Judge as Gatekeeper:

- The judge's task is not to accept Dr. Welby's opinion at face value, but to analyze the basis Welby has for stating the opinion. Affiant belief/judicial inference was good enough at the petition. Now, the judge must apply stringent and exacting standards for admission of expert opinion. With §8C-1, NCRE 104(a) and 702:
  - Use chart entries to question Dr. Welby about the 80 or so hours of calm compliance since Aggie's admission to Novant Psychiatric.
  - Use chart entries to show that the 'P's non-emergency forced medication order (-57(c)) wasn't used because Aggie didn't present a danger to self or others. Welby primarily wants IVC to adjust medications.
  - Use chart entries to show that records of past admissions are irrelevant when admission was voluntary (-208) and are not reliable as the primary diagnoses and symptoms changed across various admissions.
  - Use publications to question reliability. Ask Welby about the diagnostic principle: a major mental illness with active symptoms will overshadow a personality disorder. By diagnosing Borderline Personality, by implication, symptoms of Schizoaffective disorder are no longer active.



Psychotic spectrum features in borderline and bipolar disorders within the scope of the DSM-5 section III personality traits: a case control study

Abstract

Background

Psychotic spectrum features in borderline personality disorder (PD) are a long-standing phenomenon, but remarkably, to date, they have not been the focus of many empirical studies. Moreover, the comparative studies that acknowledge their links to affective psychoses are even more scarce. Likewise, the contributions of empirical research on the DSM-5 dimensional approach to this topic are also uncommon. This study seeks to identify the best set of pathological personality traits and/or symptoms that are predictors of psychotic features (psychoticism and ideation paranoid symptoms) in borderline PD and in bipolar disorder, based on the framework of the DSM-5 section III personality traits.

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Addressing Relevance and Reliability : DSM-5 TR

- We'll challenge the relevance and reliability of expert opinion at its source. The expert may admit that they've referred to the DSM for the diagnosis.
- In the U.S. diagnosis is determined largely by reference to the *Diagnostic and Statistical Manual of Mental Disorders (DSM).* The current version is DSM-5 TR (Text Revision).
- DSM organizes information about disorders and dysfunction.
- Subject to criticism because litigants are encouraged to over-pathologize everyday experiences.

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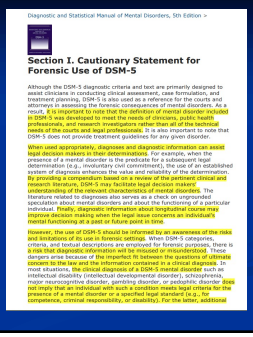
DSM-5 Cautionary Statement

- The DSM warns that its clinical guidance does not imply the legal criteria for a mental illness.
- Having a diagnosis does not demonstrate that a particular individual is unable to control their behavior at a particular time.
- Diagnoses are not entities in themselves; they are hypotheses that necessarily involve the subjective impressions on the part of the examiner, and mental distress is variable over time.
- Uncovering the sources of the expert's subjective impressions will impact the relevance and reliability of the expert testimony required by Rule 702 to establish the criteria for commitment.



Diagnostic and Statistical Manual of Mental Disorders, 5th Edition >

Section I. Cautionary Statement for Forensic Use of DSM-5

Although the DSM-5 diagnostic criteria and text are primarily designed to assist clinicians in conducting clinical assessment, case formulation, and treatment planning, DSM-5 is also used as a reference for the courts and attorneys in assessing the forensic consequences of mental disorders. As a result, it is important to note that the definition of mental disorder included in DSM-5 was developed to meet the needs of clinicians, public health professionals, and research investigators rather than all of the technical needs of law norms and legal professionals. It is also important to note that DSM-5 does not provide treatment guidelines for any given disorder.

When used appropriately, diagnoses and diagnostic information can assist legal decision makers in their determinations. For example, when the presence of a mental disorder is the predicate for a subsequent legal determination (e.g., involuntary civil commitment), the use of an established diagnostic system can contribute to the reliability of that determination. By providing a compendium based on a review of the pertinent clinical and research literature, DSM-5 may facilitate legal decision makers' understanding of the relevant characteristics of mental disorders. The literature related to diagnoses also serves as a check on ungrounded speculation about mental disorders and about the functioning of a particular individual. Finally, diagnostic information about longitudinal course may improve decision making when the legal issue concerns an individual's mental functioning at a past or future point in time.

However, the use of DSM-5 should be informed by an awareness of the risks and limitations of its use in forensic settings. When DSM-5 categories, criteria, and textual descriptions are employed for forensic purposes, there is a risk that diagnostic information will be misused or misunderstood. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis. In addition, the clinical diagnosis of a DSM-5 disorder (for example, intellectual disability (intellectual developmental disorder), schizophrenia, major neurocognitive disorder, gambling disorder, or pedophilic disorder does not imply that an individual with such a condition meets legal criteria for the presence of a mental disorder or a specified legal standard (e.g., for competence, criminal responsibility, or disability). For the latter, additional

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Addressing the Court's Acceptance of Hearsay as a Basis for Expert Opinion: 122C-268(f)

- We must insist on our client's right to confront and cross examine witnesses offering evidence for involuntary commitment pursuant to N.C.G.S. 122C-268(f).
- In re Q.L., 271 N.C. App. 179, 840 S.E. 2d 539 (2020), 122C-268(f) is a civil statute. **You must object** to admission of reports where the author doesn't testify if report is testimonial, and truthfulness is at issue.
- UDS analysis, Occupational Therapist Reports, Forensic evaluations, Physical therapist reports, biopsychosocial reports, Level of Care Utilization Report, etc.
- In re V.O., 264 N.C. App. 249, 823 S.E. 2d 694 (2019), the statutory right to confrontation applied to a statement by respondent's daughter who refused to appear. If Randy won't appear, object to Welby offering an opinion based on information provided by Randy citing 268(f), In re V.O., and Due Process.

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Addressing Cognitive Bias in Expert Opinion

- Biases are a natural tendency of the human mind to create shortcuts when faced with highly variable and voluminous content.
- In the context of IVC, the expert has been cued that respondent is in distress and needs help. The expert will look for a disorder based on collateral sources. They will locate an historical diagnosis (e.g. EPIC Care Link) and use that as a starting point.
- They only have 10 days from date of service of the custody order to produce something for the initial district court hearing.
- Point out that the expert arrived at the conclusion that is worst for the client without acknowledging numerous other possibilities.

Confirmation Bias

Impacts the Collection of data.

The expert establishes a diagnosis, then gives greater weight to behavior that confirms the diagnosis.

The expert misinterprets ambiguous or even negative evidence as supportive.

The expert disregards or dismisses counterevidence.

Looking for confirmation of a diagnosis requires less structured effort than attempting to falsify it.

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Voir Dire/Cross Examination on Rule 702 and Bias in the Expert Opinion

Please tell me the method used to reach your conclusion.

Methodically question the sequence of information gathering, focus on: Personal examination vs. collateral sources. Empirical vs. anecdotal. Distinguish inferential and speculative from the concrete and verifiable.

Initial judgments should be made without the influence of potentially biasing information.

- Did expert document their impressions prior to reviewing collateral information?
- Error Rate
- Empirical evidence or anecdotal?
- Boundary with no mental health signs/symptoms

What alternative explanations were uncovered during the process?

Question changes in expert's impressions after they've reviewed each new piece of collateral information.

- What is the error rate of collateral sources?
- Is there a confrontation issue with the collateral source?
- Can we determine bias of a collateral source?
- Better safe than sorry?

On redirect, petitioner may outline a method the expert prefers to minimize confirmation bias.

- What are the steps of that method?
- If not forthcoming, argument can focus on lack of systematic method for minimizing bias and the due process concerns of the expert's unexamined reliance on collateral sources.

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DANGEROUS TO SELF G.S. 122C-3(11)a

(11) Dangerous to self or others.
a. Dangerous to self. – Within the relevant past, the individual has done any of the following:
1. The individual has 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's suffering serious physical debilitation within the near future unless adequate treatment is given pursuant to this Chapter. 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 pursuant to this Chapter.
3. The individual has mutilated himself or herself or has attempted to mutilate himself or herself and that there is a reasonable probability of serious self-mutilation unless adequate treatment is given pursuant to this Chapter.
Previous episodes of dangerousness to self, when applicable, may be considered when determining reasonable probability of physical debilitation, suicide, or self-mutilation.

- ALL of the following:
- **Inability to care for self** based on predicates in 3(11)a.1.I.
  - including the prima facie inference contained in section II.
- PLUS, the "Second Prong:"
- A Reasonable Probability of suffering serious physical debilitation within the "near future" (**RPSPDNF**) 3(11)a.1.II.
  - not merely "some vague notion of the future." There must be a connection between past conduct and future danger to self. In re: W.R.D., 248 N.C. App. 512 (2016) IVC reversed where R's debilitation could occur at "some future" point due to " a deadly heart condition, for which R is not compliant with medical treatment."

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In Re C.G. clarifies Danger to Self

- An inference that respondent is unable to care for themselves cannot alone satisfy the second prong of the statutory definition requiring a risk of suffering serious physical debilitation in the near future in the absence of involuntary commitment. The required finding "must actually be made by the trial court and cannot simply be inferred from the record." In Re C.G., 383 N.C. 224 (2022).
- Footnote 10 clarifies further that generalized evidence tending to show:
  - psychosis,
  - a risk of decompensation if discharged, and
  - a recent history of decompensation in the community,
  - Do not prove a reasonable probability of serious physical debilitation in the near future.
- "Firm adherence to the relevant statutory requirements in these cases [is] essential given the massive curtailment of liberty and stigmatizing consequences that accompany involuntary commitment." C.G. citing Vitek v. Jones, 445 U.S. 480, 491-92(1980).

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DANGEROUS TO OTHERS
G.S. 122C-3(11)b

Within the Relevant Past: remoteness goes to weight rather than admissibility. Analysis involves GS 8C-1: 401, 403.

Inflict or Attempt to inflict Serious Bodily Harm (SBH) on another: SBH is "bodily injury" NCGS 14-34.7, 14-32.4.

Threatened to inflict SBH: on another, Threat of which authorizes use of defensive force.

Creates a substantial risk of SBH: a probability such as creates a credible apprehension of SBH.

Engages in extreme destruction of property;

there must be…

Reasonable Probability of future dangerous conduct. (RPFDC)

An indictment for first-degree murder doesn't provide clear, cogent and convincing evidence of danger to others, see: *In re Church*, No. COA09-1058 (July 2010).

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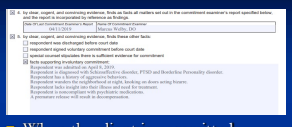
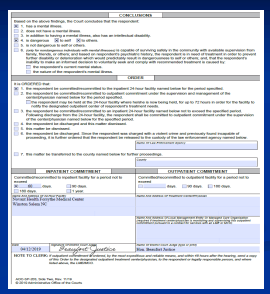
Review the Court's Order





- When the client is committed, we must review the sufficiency of the court order, if our client is demanding an appeal. DMV issue? Judge didn't order ISA commitment.
- You cannot perfect an appeal from an order that has not been entered.

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DISPOSITION 122C-271

- **Inpatient**: up to 90 days on initial commitment, 180 on second re-hearing, 365 on third and subsequent RH's;
- **Outpatient**: up to 90 days on initial commitment, 180 max on RH;
  - 122C-271(b)(4): Court must designate on the order that OP treatment is available from a provider who agrees to accept R for treatment and the name of the MCO approving service;
- **Split Commitment**: combination inpatient and outpatient equal to 90 days (e.g., "30/60" split)
- **Outpatient/Release Pending Hearing**
- **Discharge**

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COLLATERAL CONSEQUENCES
Chapter 12

Driving Privileges;	
Firearm Ownership and Possession;	• Federal Law; • State Legislation;
Restrictions on Patient Rights;	• Forced Meds/Restraint/Seclusion/Ward Routine/No social media/Internet restrictions/no cell phone use; • Visitors, Personal Property, Phone Calls, Diet.
Expunction of Minor's Record of Commitment.	

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§ 20-17.1. Revocation of license of mental incompetents, alcoholics and habitual users of narcotic drugs.

(a) The Commissioner, upon receipt of notice that any person has been legally adjudicated incompetent or has been involuntarily committed to an institution for the treatment of alcoholism or drug addiction, shall forthwith make inquiry into the facts for the purpose of determining whether such person is competent to operate a motor vehicle. If a person has been adjudicated incompetent under Chapter 35A of the General Statutes, in making an inquiry into the facts, the Commissioner shall consider the clerk of court's recommendation regarding whether the incompetent person should be allowed to retain his or her driving privilege. Unless the Commissioner is satisfied that such person is competent to operate a motor vehicle with safety to persons and property, he shall revoke such person's driving privilege. Provided that if such person requests, in writing, a hearing, he shall retain his license until after the hearing, and if the revocation is sustained after such hearing, the person whose driving privilege has been revoked under the provisions of this section, shall have the right to a review by the review board as provided in G.S. 20-9(c)(4) upon written request filed with the Division.

(b) If any person shall be adjudicated as incompetent or is involuntarily committed for the treatment of alcoholism or drug addiction, the clerk of the court in which any such adjudication is made shall forthwith send a certified copy of abstract thereof to the Commissioner.

§ 20-9.1. Physicians, psychologists, and other medical providers providing medical information on drivers with physical or mental disabilities or diseases.

(a) Notwithstanding G.S. 8-53 for physicians and G.S. 8-53.3 for psychologists, or any other law relating to confidentiality of communications between physicians, psychologists, or other medical providers and their patients, a physician, psychologist, or other medical provider duly licensed in the State of North Carolina may disclose after consultation with the patient to the Commissioner information about a patient who has a physical or mental disability or disease that the physician, psychologist, or other medical provider believes may affect the patient's ability to safely operate a motor vehicle. This information shall be limited to the patient's name, address, date of birth, and diagnosis.

(b) The information provided to the Commissioner pursuant to subsection (a) of this section shall be confidential and shall be used only for the purpose of determining the qualifications of the patient to operate a motor vehicle.

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Phil Dixon's post: Dixon@sog.unc.edu

Committed to a Mental Institution. Federal law prohibits people who have been committed to a mental institution from gun possession under 18 U.S.C. 922(g)(4). "Committed to a mental institution" in this context means a formal commitment order by a court, board, commission, or other lawful authority of a person at least 16 years old. This includes substance abuse commitments but does not include admission for observation or voluntary admission to a mental health facility. 27 CFR 478.11 ("Committed to a mental institution"). With a patient who voluntarily admits his or herself or who is discharged after involuntary admission for examination but before a formal commitment order by a district court is entered, it seems that federal firearms ban is not triggered.

North Carolina law does not specifically ban people who have been involuntarily committed from possessing a firearm. State law prohibits a person who has been committed to a mental institution from qualifying for a purchase permit under G.S. 14-404(c)(4). Our concealed carry permit law prohibits issuance of the permit to a person "adjudicated by a court or administratively determined by a governmental agency . . . to be mentally ill," which would seemingly cover people who have been involuntarily committed. G.S. 14-415.12(b)(6).

There does not appear to be any state authority in Chapter 122C or elsewhere permitting a North Carolina court to order the seizure or surrender of guns following an involuntary commitment, even when the federal ban applies (and even where the conduct leading to commitment involved firearms). A district court judge who knows that a mentally ill and dangerous person has access to firearms can seek to persuade the person to voluntarily surrender the weapons or else may ask for the assistance of federal authorities to enforce the federal law.

There is a process to restore state and federal gun rights following a commitment or other mental health disqualification pursuant to G.S. 14-409.42. For more information on this type of disqualification, see Benjamin M. Turnage, John Rubin, & Dorothy T. Whiteside, North Carolina Civil Commitment Manual § 12.3, Firearm Ownership and Possession (UNC School of Government, 2d ed. 2011).

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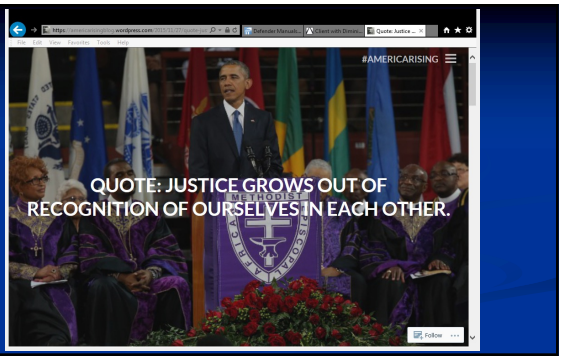

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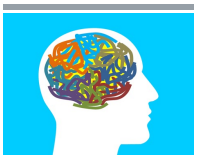
Aggie as she likes to be called says that she and Randy met at Tender Loving Care Group Home. Her guardian passed away 3-4 years ago. She and Randy fell in love, got married. Everything was going well. Aggie says: My outpatient provider said they only needed to see me every three months. A couple of months ago, Randy relapsed. He started going to the neighbor's house to use. I didn't like it, and I let him know it. I contacted my outpatient provider; they referred me and Randy to family therapy. I wasn't taking care of myself because I was too worried about him. I was anxious. I don't know what happened with my meds, but I ended up short for the 3-month supply. I started taking some Ativan that I had from a couple of years ago. A friend told me about CBD for anxiety. I got fed up with Randy being so reckless. I went down to Randy's so-called friend's house, called Randy out and told them to stay away from Randy. This Lithium they give me makes me feel terrible. I can't take it. The doctor said if I don't take it, they're going to give me a shot. I'm taking it until I can get back to my outpatient provider. I haven't needed a shot since I've been here. Two days ago, another patient came into my room and started looking through my stuff. I told them to leave my room, they got mad. We got into an argument. The other patient said I hit her. When staff responded, I was crying, yelling. Staff said I spit on them, but I think I was just so slobbery from being upset.

On review of the chart, Dr. Welby writes that Lithium was below therapeutic range on admission. Aggie tested positive for benzodiazepines and marijuana. Diagnosis: Schizoaffective Disorder, Bi-Polar type, PTSD, Borderline Personality Disorder. Since Aggie is experiencing side effects with the Lithium, Dr. Welby needs time to remove Lithium and see what happens. He may increase the Seroquel, but Aggie doesn't want to gain weight. Other anti-psychotic medications can be tried, but that will take time. Welby wants the safety of the inpatient setting for medication changes. Aggie's recent history is creating havoc with her neighbors. Aggie has made threats of suicide in the past. She has a significant history of rape and abuse. She has a history of unstable relationships. Aggie has been a patient at Novant on three prior occasions. The last admission was 2015.

Social Worker notes indicate that Aggie wouldn't give consent to talk to anyone about her admission to the hospital. Aggie has several goals for treatment, but she doesn't want to discuss them. Randy has been calling the unit, but he has not been provided information. Randy told staff that Aggie damaged a door at a neighbor's home while trying to enter. Randy says Aggie hasn't been taking Lithium for a while. Randy says Aggie will come back home with him; they've been going to marriage counselling. Aggie's mother was appointed Aggie's guardian during Aggie's last admission to Novant in 2015. In 2015, Aggie was discharged to a group home. At the time, the guardian had agreed to the discharge plan. There is no other family available currently. Aggie would have to live with Randy if discharged. Aggie has no children. Aggie is unemployed. Aggie receives $1200/mo. SSD and Medicaid. Aggie has been living with Randy in a TCL apartment since the GOP died in 2016. Aggie was compliant with outpatient services through Guiding Light Family Practice and Juanita Chancellor. Her last appointment with them was 12/4/2018. Treatment team is discussing medications, need for a guardian and possible placement in a group home.

STRATEGIES FOR WORKING EFFECTIVELY WITH CLIENTS FACING CIVIL COMMITMENT

Dr. Maggie Carraway
Forensic Psychologist
Durham, NC



1

LEARNING OBJECTIVES

- Attendees will be able to articulate common issues among the treatment and care of people facing involuntary commitment
- Attendees will be able to identify symptoms of common mental health conditions affecting people involved in civil commitment proceedings.
- Attendees will be able to utilize interviewing strategies to effectively communicate with clients displaying active symptoms of mental illness.
- Attendees will be able to identify and navigate potential personal and systemic biases in the legal representation of individuals facing civil commitment.
- Attendees will be able to recognize and address important safety considerations relevant to working with individuals facing civil commitment.

2

YOU ARE HERE FOR A REASON.

You could practice any type of law, but you were drawn to representing people facing involuntary commitment. Why?

3

WHAT ARE SOME DAILY CHALLENGES YOU EXPERIENCE REPRESENTING CLIENTS FACING INVOLUNTARY COMMITMENT?

4

CRIMINALIZATION OF MENTAL HEALTH

- Transportation via law enforcement vehicle - *Is a crime being committed?*
  - **Consider putting someone who is in a psychiatrically fragile state into shackles in a police vehicle…**
    - "Taking someone's rights away and tying their wrists and ankles together in the course of mental health treatment can be an extremely traumatizing experience."
- **Impact?**
  - Person temporarily loses the right to make their own decisions while under examination
  - Forced psychiatric treatment against a person's will
  - Revolving door pattern: Mental health symptoms worsen, admission to a psychiatric facility where they're stabilized and discharged without follow-up care. Then the cycle repeats.

People you see are currently stuck against their will in a system that ultimately criminalizes mental health, they feel victimized by, and usually exacerbates extant mental health issues.

5

WHY IS THIS IMPORTANT?

- Compassion serves as a buffer against frustration and burnout that is not uncommon in working with IVC clients
- How you approach the client often makes your job easier
  - If the client feels they're being punished or being treated poorly, they may appreciate an advocate who recognizes and validates that, making for a better attorney/client relationship
  - Many clients respond best when they feel validated/understood, making information gathering less onerous
- You have an ethical duty!
- **Your role is to serve as your client's "zealous advocate," REGARDLESS OF…**
  - **Your personal desire to protect someone you feel to be disadvantaged**
  - **Your belief that you or the doctor knows what is best for them**
  - **Their mental health issues and current presentation**

6

WHAT COMES TO MIND WHEN YOU THINK OF CHARACTERISTICS OF CLIENTS FACING IVC?

7

IVC CLIENT POPULATION ("WITH DISCLAIMER")

- Adults and juveniles
- People with untreated (or undiagnosed) serious mental illness (SMI)
  - Disorders often include symptoms of psychosis (e.g., schizophrenia spectrum disorders, bipolar disorder)
- Other disorders include severe depression, PTSD, and substance use disorders
- High rates of substance use
- History of criminal justice system involvement
- High rates of poverty and homelessness
- History of trauma and past violent victimization
- Many difficulties to accessing and receiving quality treatment due to nature of the disorders and systemic issues

8

COGNITIVE BIAS

- What you already know or what you are expecting to happen will influence how you interact with and evaluate new information, and how you feel about your evaluation of that new information.
- *We **all** have bias, which includes everyone else we interact with in the context of your representation of your clients*
  - I.e., Judges, medical/mental health professionals who evaluated your client (aka me), etc.
- **Important**: Cognitive biases are **not** inherently bad.

9

THE DANGER OF BIAS

- *It is possible for you to violate your client's right to a zealous advocate if you don't consider your/others' biases in your legal representation of them.*
- Bias can impact every step of your representation of your client
  - **Stigma:** Preconceived notions about mental illness can lead attorneys to underestimate the client's needs, overestimate their dangerousness, or minimize their rights.
  - **Stereotyping:** Stereotypes about mentally ill individuals can color how we assess someone's abilities.
  - **Missed Opportunities:** Bias can cause attorneys to overlook crucial evidence, fail to investigate potential defenses, or neglect to explore less restrictive treatment options.
  - **Undermining Client Autonomy:** Attorneys may unintentionally prioritize the perceived needs of others (e.g., family members, the state) over the client's own wishes and preferences.
  - **Erosion of Client Trust:** If clients perceive their attorney as biased or unsupportive, it can damage the attorney-client relationship and hinder effective communication.

10

MITIGATING THE RISKS OF BIAS

- **Self-Reflection:** Engage in regular self-reflection to identify and address your own biases.
- **Continuing Education:** Participate in continuing education courses on cultural competency, implicit bias, and mental health issues.
- **Seek Supervision:** Consult with colleagues, supervisors, or mentors to discuss potential biases and ensure objective decision-making.
- **Client-Centered Approach:** Prioritize the client's perspective, needs, and wishes throughout your representation of them.
- **Active Listening and Empathy:** Actively listen to the client's experiences, concerns, and perspectives with empathy and understanding.

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GENERAL INTERVIEW CONSIDERATIONS

- Early on, ensure client is oriented to reality by asking basic questions regarding who/where they are and the current time frame, and **adjust expectations accordingly**
  - "What is your name?" / "What are we?"
- Establish rapport and trust through active listening, demonstrating compassion for their situation, and emphasizing the importance of confidentiality to ensure they feel safe sharing information
  - "What we talk about is private, and my goal is to help you, not to cause more problems for you."
- Be transparent when discussing allegations/evidence with client, even when client denies evidence of danger or mental illness
  - Lead with what the potential outcomes are (e.g., their preferred defense is likely to fail) based on the info you have been given
  - E.g., "While respecting your belief that God has told you to convert people, this is so far from the experience of most people that in my opinion the court is likely to agree with your doctor that this belief is a symptom of mental illness and poses a danger to other people. That would probably lead to your commitment."
- Validation goes a long way!!! ("I can't imagine how tough that must be" or "Remember, there are no right or wrong answers")

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INTERVIEW STRATEGIES: GATHERING INFORMATION

- Ask open-ended questions when possible to avoid influencing client's answers and elicit their desires for treatment
- Ask about mental health history using a trauma-informed lens
  - "It's not uncommon for people in this process to have gone through really difficult experiences. Is there anything from your past that might still be affecting you today?"
- Normalize mental health difficulties
  - "A lot of people I work with have gone through tough experiences and feel overwhelmed, stressed, or sad sometimes. These feelings are common and important to understand so I can represent you fully. Is there anything in your life that's been affecting how you feel or think?"
- Use a collaborative approach and respect client autonomy by asking for their perspective, assuring them you are working together, and informing them of their options
  - "What kind of support do you think would be helpful to you right now?"
  - "I understand this is a difficult situation. I want to work with you to understand your concerns and explore all possible options."
- Frame mental health discussions in the context of defense strategy
  - "Understanding how your mental health has been affected might help us build a stronger defense or explain certain things to the judge."

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CULTURAL CONSIDERATIONS IN INTERVIEWING

- Different cultural groups experience, understand, and communicate suffering/mental health symptoms in different ways
  - Some people may explain their problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, etc.
- Inquire about client's cultural beliefs related to mental health with questions regarding client's cultural background, their beliefs about causes of mental illness, preferred treatment methods, and the role of family and community in recovery
  - "In your community, how do people usually talk about stress or feeling down?"
  - "Is there a particular way you or your family deal with emotional struggles that may be helpful for me to know?"
- Do not neglect asking about physical symptoms
- Advocate for treatment options that are culturally appropriate and sensitive to the client's needs
  - Inquire about the client's preferences regarding family involvement in their care.
- Avoid making assumptions!!!
  - "Everyone experiences stress differently, how do you usually cope with tough situations?"

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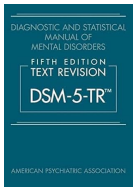
COMMON MENTAL HEALTH DISORDERS AMONG CLIENTS FACING IVC

As defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Ed., Text Revision (DSM-5-TR)



- Schizophrenia
- Major Depressive Disorder
- Bipolar Disorder
- Substance-Use Disorders

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SCHIZOPHRENIA
DEFINED BY PSYCHOTIC SYMPTOMS (I.E., LOSS OF TOUCH WITH REALITY)

- **Delusions** – Strongly held false beliefs not based in reality & not amenable to change
  - E.g., Believing that one's neighbors are constantly plotting to harm them, such as poisoning their food
- **Hallucinations** – When someone sees, hears, feels, or smells things that are not actually there
- **Disorganized Thinking/Speech** – Difficulties in organizing and expressing thoughts often resulting in incoherent speech
- **Disorganized or Abnormal Motor Behavior** – Bizarre behavior ranging from childlike silliness to unpredictable agitation
  - Catatonia: lacking ability to process and react to world around them
- **Negative Symptoms** - Diminished emotional expression, apathy, lack of motivation, inability to take care of oneself

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OTHER KEY FEATURES OF SCHIZOPHRENIA

- Anosognosia: A lack of insight into one's mental illness, which can make it difficult for them to understand their situation, their attorney's role, etc.
  - Approximately half (50-60%) of people with schizophrenia
- Cognitive symptoms, such as slowed information processing ability, inability to concentrate, memory problems, and problems with planning and organization.
- All these experiences:
  - 1) Feel completely real to the person experiencing them
  - 2) Are not under the person's control, and
  - 3) Can be very vivid and convincing.
- ***Medication is the primary treatment!***
  - ***NOTE ON IMPACT OF MEDICATION***: If someone's symptoms are managed with medication, common side effects include drowsiness and cognitive dulling, which may affect their ability to engage fully.
  - Consider scheduling around client's focus or energy levels; shorten the interview or reschedule if necessary.

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WHAT THIS ACTUALLY LOOKS LIKE

- Unprompted, inappropriate laughter
- Staring off into space/mental preoccupation
- Speech characterized by frequent derailment, jumbled words, or shifting topics abruptly
- Confusion about one's surroundings
- Paranoia/severe mistrust of others
- Poor or very intense eye contact
- Disheveled appearance
- Statements expressing unusual or distorted thoughts
  - People may even have an entire system of interconnected ideas developed that support their delusions

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COMMUNICATION STRATEGIES FOR ACTIVE PSYCHOSIS

Emphasize Trust and Rapport

Show genuine concern for their well-being

Lead with empathy

Respect boundaries if clients are reluctant to share certain details

Offer reassurances of confidentiality

Adapt Communication Style

Maintain a calm voice and demeaner, and reassuring tone, even when facing challenging or confusing statements

Use clear and simple language; avoid legal jargon

Ask specific, straightforward questions (e.g., yes/no or short-answer questions) and avoid complex sentences

Focus on concrete facts and evidence rather than abstract concepts or theories when discussing legal matters

If client exhibits speech that is hard to follow or off-topic, gently guide them back to the subject matter without being dismissive or judgmental.

Structured Meetings

Adjust interview pace or offer breaks as needed, if possible, due to potential for extreme emotional responses

If possible, implement shorter, more frequent meetings to avoid overwhelming client

Consider using visual aids such as flowcharts or diagrams to explain legal concepts

Involve mental health professionals as needed who can offer insights into how best to communicate with the client or manage symptoms during interviews

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ADDRESSING DELUSIONS/HALLUCINATIONS

Gold Standard: Walk thin line between not confronting delusions and not reinforcing them.

- Allow client to share their thoughts and gently redirect the conversation as needed
- Acknowledge their concerns without validating the delusion and shift focus
  - "I understand that this is important to you, but let's focus on how we can move forward with your case."
  - "I understand you believe you are married to Elvis Presley and that is important. My job right now is understanding what you want irrespective of that."
- Talk to them in a calm voice and remind them they are safe
  - "I understand you're experiencing this, and it sounds very distressing" / "I know you must feel like others are out to get you, but we will do what we can to make you feel safe."
- Use reality-based statements when appropriate, but not if it's going to turn into an argument
  - "It is (insert date)"
  - "Okay." (No matter how delusional the statement is) versus "I can't believe that happened."
- If delusions/hallucinations interfere with the interview (e.g., they get very fixated on a concept), suggest taking a short break and resuming later

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DELUSIONS/HALLUCINATIONS: WHAT **NOT** TO DO

Try to argue or provide logical explanations regarding their delusions/hallucinations

- Given how they feel very real to a person, this method is generally unhelpful, only serving to increase agitation and/or hurt the attorney/client relationship

Convince them they are wrong, challenge their delusions, or antagonize them

- "No one is out to get you"

Be dismissive or demeaning

- "Don't worry, it's not a big deal"

Assume everything they say is delusional

- Consider cases in which client is believed to be psychotic, but factors are being manipulated by petitioner
- Always seek confirmation/denial of their statements from records and other care providers before assuming it is a delusion

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MOOD DISORDERS

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MAJOR DEPRESSIVE DISORDER (MDD)

Depressed mood	• Feeling sad, empty, hopeless • Inability to experience joy that does not go away despite things going well
Poor motivation/anhedonia	• Feeling tired all the time • Feeling "numb" or indifferent
Feelings of worthlessness/guilt	• May blame themselves for things that aren't their fault • Feel like a burden to others
Concentration issues	• Difficulty focusing, making decisions, or remembering things • Slow processing speed
Thoughts of death/suicide	• May include self-harm behavior or suicide attempts • Take any mention of death/dying seriously... high rates of suicide

Combination of medication (antidepressants) and psychotherapy is primary treatment!

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WHAT SEVERE DEPRESSION LOOKS LIKE

- Limited eye contact
- Tearfulness
- Isolation/withdrawal
- Poor hygiene (malodorous, disheveled appearance)
- Low energy levels and daytime sleepiness
- Visible scars due to self-harm
- Irritability/restlessness (more common manifestation of depression in juveniles)
- Self-defeating motivation ("Why should I even care")
- Can co-occur with anxiety symptoms such as feeling anxious or on edge, restlessness, and obsessive rumination
- *****Delusions and/or hallucinations can also be present*****

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SPECIFIC CHALLENGES ASSOCIATED WITH DEPRESSION

Impaired Memory and Difficulties Thinking Clearly

- "Brain fog" can make it difficult to recall and articulate thoughts effectively during meetings
- Complex legal matters difficult to understand
- Decreased ability to make decisions quickly

Reduced Motivation and Initiative

- Poor engagement during meetings or unwillingness to discuss allegations of petition and/or participate in hearing
- May seem uninterested in working with attorney which limits ability to understand client's needs and gather information
- Feeling like a burden may make client more suggestible or unwilling to disclose important information

Decreased Problem-Solving Abilities

- Difficulty identifying and evaluating solutions
- Making poor decisions or not fully considering their options due to impaired judgment
- Getting stuck in negative thought patterns (rumination)

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COMMUNICATION STRATEGIES FOR DEPRESSION

- Be patient and understanding of the client's slow processing speed and difficulty concentrating.
- Empower client to express their needs, ask for clarification, or request accommodations if they are struggling.
  - E.g., If a client is struggling to put together a timeline of mental health treatment history due to impaired memory, ask if it would be more helpful for them to drawn out a timeline
- Maintain consistent communication to build trust and reassure the client that you are available to support them.
- Provide extra time for discussions - Allow the client to take breaks as needed to manage fatigue and improve focus.
- Focus on hope and emphasize the potential for recovery.
- Maintain professional boundaries and avoid getting personally involved in the client's emotional state.

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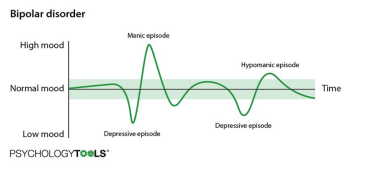
BIPOLAR DISORDER

- MANIA
  - Elevated mood
  - High energy and very talkative
  - Inflated self-esteem and overly confident
  - Impulsive decisions
  - Grandiose thinking
  - Increased risk taking



- Extreme mood swings, shifting between emotional highs (mania) and lows (depression)
- Mood changes more intense than "normal ups and downs" and can last days, weeks, or even months

Medication (mood stabilizers) are primary form of treatment!

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SPECIFIC CHALLENGES ASSOCIATED WITH MANIA

Communication Challenges – Makes it difficult to gather accurate information.

- Express ideas that seem unrealistic or disconnected from reality
- Easily distractible, hard to follow, jumping from topic to topic, etc.
- Relentless pursuit of unrelated goals make it difficult to maintain focus during meetings

Impulsivity – Makes it difficult to provide guidance or ensure they understand their options.

- Acting impulsively can lead to risky decisions such as hastily agreeing, pursuing a strategy without considering the consequences
- Increased confidence in their legal knowledge/themselves leading to disregard attorney's advice or believe they can handle things better

Unpredictability – Makes it difficult to maintain a consistent strategy or focus.

- Outlook on their case/situation can shift dramatically depending on their mood
- E.g., When manic, may feel overly optimistic and dismiss potential risks in their case due to inflated self-esteem

Emotional Outbursts/Conflicts – Puts strain on attorney/client relationship.

- Paranoia/distrust, such as feeling like attorney is working against them or doesn't have their best interests in mind
- Irritability can make client easily argumentative, leading to increased frustration and challenges to attorney's decisions
- Inappropriate courtroom behavior

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COMMUNICATION STRATEGIES FOR MANIA

Manage Emotionality/Impulsivity

Maintain calm, detached, and professional demeaner, even when faced with anger/hostility

Use de-escalation techniques, such as active listening and empathetic validation, to calm the client down

Encourage client to reflect on potential consequences before making decisions

Carefully document all agreements and ensure they understand the implications of their decisions

Adapt Communication Style

Redirect the conversation towards practical matters and facts

Acknowledge client's feelings and concerns without validating delusions or unrealistic expectations

Use simple and direct language; avoid legal jargon

Use shorter, more focused questions (rather than long, multi-part questions) and concrete examples

If client exhibits speech that is hard to follow or off-topic, gently guide them back to the subject matter without being dismissive or judgmental.

After explaining a concept, ask them to explain it back to you to confirm understanding

Structured Meetings

Minimize distractions in the environment

If possible, implement shorter, more frequent meetings to avoid overwhelming client

Utilize written communication to document conversations and decisions clearly

Involve mental health professionals as needed who can offer insights into how best to communicate with the client or manage symptoms during interviews

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SUBSTANCE USE DISORDERS

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SUBSTANCE USE WITHIN THE IVC POPULATION

- High rates of co-occurring SUDs among individuals facing IVC
- Disorders range from mild to a severe state of chronically relapsing, compulsive pattern of drug-taking despite significant drug-related social/occupational/legal problems
- Usually many unsuccessful attempts at quitting before successful
- Potential for "drug-induced psychosis," where someone presents with psychosis (seemingly has schizophrenia), but return to normal functioning after a few days once the drugs leave their system
- People vary greatly in their stance towards their substance use from complete denial to complete acknowledgement of the consequences of their use and desire to change

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ADDICTION: WHAT YOU SHOULD KNOW

By understanding the complexities of addiction, attorneys can provide more effective and compassionate representation for their clients.

Addiction is a chronic brain disease, not a matter of willpower!	• Drug use alters brain chemistry, which make it extremely difficult for individuals to stop using, even when they desperately want to • This mentality actively discourages people from seeking help, as they feel ashamed, judged, and hopeless
Addiction often develops as a way to cope with mental health symptoms	• Important for effective treatment and advocacy for client's needs, especially when in court • E.g., Using drugs to cope with reminders of childhood trauma
Dealing with denial	• To the extent possible, deal candidly with client who is in denial about their use • E.g., If someone says they don't use drugs, but toxicology screen was positive, they should be told this information and informed of the evidentiary consequences of this evidence.

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POTENTIAL ISSUES ON COURT DAY

- Client has strong wishes concerning presentation of the case and/or desires to represent themselves
  - Consider finding a compromise with client where their voice is heard on court day, without giving them free rein in a way that hurts their case
  - Consider…asking client a series of direct, specific questions? Stating the client's case for them using careful language?
    - "My client wants the court to know that…"
  - **Many clients who contest commitment and lose are satisfied if they feel that they have actually been heard and considered in court**
- Client doesn't want to appear
  - Always inquire reasons as to why a client doesn't want to appear - not uncommon for this decision to be based on misinformation or misapprehensions regarding nature or possible consequences of hearing that may be alleviated through accurate information
    - Areas of focus: Who can be present (closed hearing), possible outcomes (jail not a possibility), etc.
  - Inquire about past unpleasant experiences in legal proceedings (especially if they're reluctant to appear) and address any incorrect info

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SAFETY CONSIDERATIONS

- **Attorneys should maintain a healthy concern for their physical safety during all interactions with their clients**
- Prior to meeting with client:
  - Note allegations of dangerousness in the petition
  - Ask hospital staff about any evidence of dangerous behavior or threats to harm others while in the hospital
  - Ask staff whether there have been any incidences of use of restraints or seclusion
- Environmental considerations
  - Consider sitting so you are closest to door (in general, client should never be in between you and the only exit of a room)
  - Necessity of presence of a third person… in room? …outside of door with door open?
- Indicators of potential danger:
  - Increased volume of speech associated with increased agitation, threatening language towards self or others; rapid or pressured speech above baseline; clenched fists or jaws; standing/sitting close or looming over you, or assuming a defensive posture; sudden changes in demeanor

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IMPORTANT (MAYBE DISCOURAGING) REMINDERS

- **The nature of mental illness can create inherent challenges for attorneys, even with the best intentions.**
  - Actions aimed at helping the client, such as gathering information or presenting their case, can inadvertently cause additional distress or exacerbate symptoms due to the client's mental health condition (i.e., sometimes people are just really sick).
- Working with IVC clients can be emotionally demanding - You're human too! It's **okay** to take breaks and be frustrated.
- Prioritize self-care to avoid burnout and maintain their own mental well-being, including setting boundaries, seeking support from colleagues, and engaging in stress-reducing activities.
- Finally, adjust your expectations to their level of functioning and abilities during the interview

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THANK YOU!

QUESTIONS/COMMENTS?

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Strategies for Working Effectively with Clients Facing Civil Commitment

Criminalization of Mental Health

- Transportation via law enforcement vehicle - Consider putting someone who is in a psychiatrically fragile state into shackles in a police vehicle
- **Important context:** People you see are currently stuck against their will in a system that ultimately criminalizes mental health, that they feel victimized by, and that usually exacerbates extant mental health issues.

Why is this important?

- Compassion serves as a buffer against frustration and burnout that is not uncommon in working with IVC clients
- How you approach the client often makes your job easier (i.e., recognition of the inherent flaws in the system and validation/understanding of what they're going through)

Your role is to serve as your client's zealous advocate, REGARDLESS OF…

- Your personal desire to protect someone you feel to be disadvantaged
- Your belief that you know what is best for them
- Your belief that the doctor knows what's best for them
- Their mental health issues and current presentation

Serious mental illness (SMI): is an umbrella term that includes what is generally considered the most serious psychiatric disorders in that it puts clients at greatest risk for criminal legal system involvement, homelessness, psychiatric hospitalization, and involuntary treatment.

Bias - There will be many times you may believe your client is mentally ill or a substance abuser; however, that belief does not interfere with your duty and ability to zealously represent the client and advocate for their wishes.

- Cognitive bias: What you already know or what you are expecting to happen will influence how you interact with and evaluate new information, and how you feel about your evaluation of that new information.
- We **all** have bias and cognitive bias is not inherently bad, but it is possible for you to violate your client's right to a zealous advocate if you don't consider your/others' biases in your legal representation of them.
    - Beware of: Stigma, stereotyping, missed opportunities, undermining client autonomy, and erosion of client trust.
    - *Remember...their poor functioning is not a choice, but often a result of their disorder! They are not TRYING to be difficult!*
- Mitigating the risks of bias occurs through self-reflection, continuing education, seeking supervision, using a client-centered approach, and implementing active listening and empathy

Common Mental Health Disorders Among IVC Population:

1. **Schizophrenia:** Group of symptoms characterized by psychosis (a loss of contact with reality)
    a. Disruptions in thought processes, perceptions, emotional responsiveness, and social interactions.
    b. Possible symptoms include delusions, hallucinations, disorganized thinking/speech, abnormal motor behavior, and diminished emotional expression

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c. 50-60% of people experience anosognosia (lack of insight into one's mental illness)
d. *Remember:* These experiences feel completely real to the person, are not under their control, and can be very vivid and convincing!
e. Primary treatment is medication, which has side effects including cognitive dulling and drowsiness

Communicating with Psychotic Clients: Do's and Don'ts

DO:

» Use clear and simple language; avoid legal jargon
» Ask specific, straightforward questions (e.g., yes/no questions) and avoid complex questions
» Talk to them in a calm voice and remind them they are safe
  - E.g., "I can imagine that is scary, but we will do what we can to make you feel safe."
» If client exhibits speech that is hard to follow or off-topic, gently guide them back to the subject matter without being dismissive or judgmental
» Allow the client to share their thoughts even if responses seem disjointed/delusional, gently redirecting the conversation as needed
» Adjust the interview pace or offer breaks as needed – Suggest taking a short break and resuming later if delusions/hallucinations interfere with the interview
» If the client shares delusional thoughts, acknowledge their concerns without validating the delusion.
  - E.g., "I understand that this is important to you, but let's focus on how we can move forward with your case."
» Adjust your expectations to their level of functioning and abilities
» Include family, caregivers, and/or mental health professionals, as they can help improve communication by offering insight into how best to communicate with the client

DON'T:

» Try to argue or provide logical explanations regarding their delusions/hallucinations, convince them they are wrong, challenge their delusions, or antagonize them
  - E.g., "There is no one out to get you," or "Don't worry, it's not a big deal."
» Be dismissive or demeaning
» Assume everything they say is delusional. Sometimes they are telling us true statements, but we dismiss them as delusions, therefore missing out on important.

2. **Major Depression Disorder (MDD):** Characterized by persistent feelings of sadness, hopelessness, or emptiness.
   a. Behavioral symptoms include poor motivation, loss of interest or pleasure in activities once enjoyed, fatigue, sleep disturbances (insomnia or sleeping too much), changes in appetite or weight, psychomotor agitation or retardation.
   b. Cognitive symptoms include difficulty concentrating, indecisiveness, feelings of worthlessness or guilt, thoughts of death or suicide.
   c. Depression can significantly impact cognitive functions, hindering clients' ability to navigate legal proceedings effectively.
      i. Thinking and Memory Issues: Difficulties concentrating, recalling information, and making decisions quickly.
      ii. Reduced Motivation: Lack of engagement, disinterest in working with the attorney, and reluctance to disclose information.

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iii. Poor Decision-Making: Difficulty evaluating options and making sound judgments due to impaired judgment and negative thinking patterns.

d. Communication strategies for depression
   i. Patience and Understanding: Acknowledge and accommodate the client's potential difficulties with concentration and processing information.
   ii. Empowerment and Collaboration: Encourage the client to actively participate and request support as needed.
   iii. Consistent Support: Maintain regular communication to build trust and reassure the client of your support.
   iv. Flexibility: Provide extra time and breaks as needed.
   v. Focus on Hope and Recovery: Emphasize the potential for recovery.
   vi. Professional Boundaries: Maintain a professional distance while showing empathy and support.

3. **Bipolar Disorder:** Extreme mood swings, shifting between emotional highs (mania) and lows (depression)
   a. Mania characterized by abnormally elevated arousal, mood, and energy level; impulsive decisions and increased risk-taking
   b. Symptoms can negatively impact communication with their attorney, including expressing unrealistic or disconnected ideas, difficulty staying focused and on topic, and acting impulsively, which can lead to poor decision-making; Their mood can fluctuate dramatically, making it hard to maintain a consistent strategy; paranoia and irritability can strain the attorney-client relationship.
   c. Communication strategies similar to those of psychosis, plus additional ways to manage impulsivity/emotionality:
      i. Maintain calm, detached, and professional demeaner, even when faced with anger/hostility
      ii. Use de-escalation techniques, such as active listening and empathetic validation, to calm the client down
      iii. Encourage client to reflect on potential consequences before making decisions
      iv. Carefully document all agreements and ensure they understand the implications of their decisions
4. **Substance Use Disorders (SUDs):** range of problems that can result from the use of a substance
   a. Disorders range from a mild to a severe state of chronically relapsing, compulsive pattern of drug-taking despite significant drug-related problems
   b. People vary greatly in their stance towards their substance use from complete denial to significant acknowledgement of the consequences of their use and desire to change
   c. By understanding the complexities of addiction, attorneys can provide more effective and compassionate representation for their clients.
      i. Addiction is a chronic brain disease, not a matter of willpower!
      ii. Addiction often develops as a way to cope with mental health symptoms

General Tips for Communicating with Clients with Potential Mental Illness

» Establish rapport and trust through active listening, demonstrating compassion for their situation, and emphasizing the importance of confidentiality to ensure they feel safe sharing information – Validation goes a long way!

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- Be transparent when discussing allegations/evidence with client, even when client denies evidence of danger or mental illness
    - Frame mental health discussions in the context of defense strategy
- Use clear and simple language
    - Break down complex legal terms into simpler language, avoid jargon, periodically check-in to confirm their understanding (e.g., after explaining a concept, ask them to explain it back to you), reiterate key points, and use shorter, more focused questions (rather than long, multi-part questions)
- Consider providing a written summary of key points discussed and frequently checking for understanding
- Consider use of alternate forms of gathering/providing information (e.g., diagram to explain legal concepts)
- Normalize mental health difficulties
- Ask about mental health history using a trauma-informed lens (i.e., understanding trauma is common and can have widespread, lasting mental health effects; creating a safe and supportive environment, and prioritizing client's safety and trust)

Cultural Considerations

- Different cultural groups experience, understand, and communicate suffering, behavioral problems, or troubling thoughts/emotions in different ways (e.g., people may express emotional distress by describing physical symptoms, such as headaches or stomachache)
- Inquire about client's cultural beliefs related to mental health, including the causes of mental health, preferred treatment methods, and the role of family and community in recovery
- Advocate for treatment options that are culturally appropriate and sensitive to the client's needs

Safety Considerations:

- Personal safety should **always** be an important consideration for attorneys working with this population due to the nature of SMI.
- Before meeting with client, note allegations of dangerousness in the petition, ask hospital staff about any evidence of dangerous behavior or whether there have been any incidences of use of restraints or seclusion
- Possible indicators of danger: Increased volume of speech associated with increased agitation, threatening language towards self or others; rapid or pressured speech above baseline; clenched fists or jaws; standing/sitting close or looming over you, or assuming a defensive posture; sudden changes in demeanor

So, You Had an IVC Hearing; What's Next?

Zachary Thayer
Special Counsel
NC Office of Special Counsel

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2

Possible Dispositions of Your Hearing

NCGS 122C-271(b)

- You Lose
  - Outpatient Treatment
  - Inpatient Treatment
- You Win (we will get to this later)

3

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Outpatient Commitment

- Appropriate when (NCGS 122C-271(b))
  - Respondent has a mental illness
  - Respondent can safely survive in community
  - In need of treatment to prevent deterioration in dangerousness
  - Due to current MH status, wouldn't seek treatment voluntarily
- What happens on outpatient commitment? (NCGS 122C-273)
  - Compliance → Termination of Commitment
    - Can be terminated by notice from provider
    - If IVC'd because of ITP, must be supplemental hearing
  - Non-compliance → Supplemental Hearing or IVC
  - Not to exceed 90 days

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Outpatient Commitment cont.

- Supplemental hearings (NCGS 122C-274)
  - Must be calendared 14 days within receipt of request
    - Respondent must be personally served with notice of hearing 72 hours prior to hearing
    - All other parties can be served in other appropriate manners
  - Outcomes
    - If probable cause to believe dangerous to self and mentally ill, request evaluation for commitment
    - Can just change terms of outpatient treatment
    - Can Discharge from commitment
- Representation of Respondent (NCGS 122C-270(e)
  - You are responsible for representation at trial level until one of three things:
    - Client's voluntary admission into facility
    - Discharge ordered by court
    - Unconditional discharge from facility

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Inpatient Commitment

- Original Inpatient commitment period may not exceed 90 days.
- If IVC originated because client was charged with a violent crime and client was found ITP, commitment order must state so.

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Right to Appeal

- NCGS 122C-272: Appeal is to the Court of Appeals
- Considerations for Appeal
  - Is it Worth It?
  - Things you Hopefully did During the Hearing
  - Ask for Office Appellate Defender

8

Rehearing

NCGS 122C-276

- Prior to 15 days of the end of the ordered period of commitment, physician must determine if more treatment is necessary. (inpatient or outpatient commitment)
- If so, they must notify the clerk to schedule a hearing
- Clerk must calendar hearing 10 days prior to end of commitment period
- Practice Point: Consider calendaring of hearing at the end of hearing you just lost

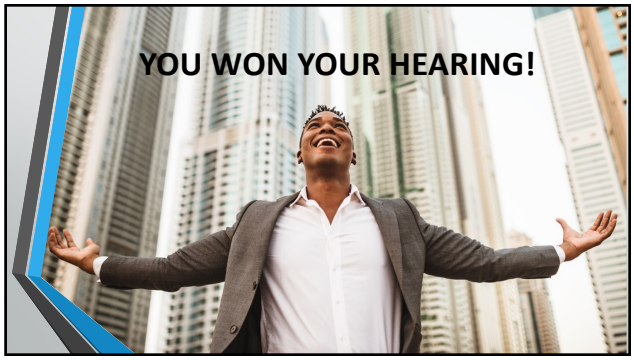
9

Rehearing cont.

- Rehearing procedure is the same as procedure for original hearing.
- If inpatient treatment is ordered again, commitment period cannot exceed 180 days.
- If second rehearing is held and more inpatient treatment needed, commitment period cannot exceed 1 year.

10

YOU WON YOUR HEARING!



11

Discharge of Your Client

- If the court finds that Respondent does not meet the criteria for outpatient or inpatient commitment, the Respondent shall be discharged and the facility in which the Respondent was last a client shall be notified. NCGS 122C- 271(b)(3).
- So that's the end, right…

12

GUARDIANS!!!!

THE REAL ENEMY

13

Guardians Rights
NCGS 35A-1241

- The guardian shall make provision for the ward's care, comfort, and maintenance, and shall, as appropriate to the ward's needs, arrange for the ward's training, education, employment, rehabilitation, or habilitation.
- The guardian of the person may establish the ward's place of abode inside or outside this State…The guardian also shall give preference to places that are not treatment facilities. If the only available and appropriate places of domicile are treatment facilities, the guardian shall give preference to community-based treatment facilities, such as group homes or nursing homes, over treatment facilities that are not community-based.
- The guardian of the person may give any consent or approval that may be necessary to enable the ward to receive medical, legal, psychological, or other professional care, counsel, treatment, or service…

14

Ways to Combat Guardians

- Involve Guardians in the original commitment hearing
- Show Cause the Guardian for Failure to Comply with Court Order
- File Petition of Habeus Corpus in Superior Court

15

Show Cause / Civil Contempt

- Elements of Civil Contempt (NCGS 5A-21)
  - The order remains in force
  - The purpose of the order may still be accomplished with compliance
  - The non-compliance by the person to whom the order is directed is willful, and
  - The person to whom the order is directed is able to comply with the order or is able to take reasonable measures that would enable the person to comply with the order.
- Process for Civil Contempt (NCGS 5A-23)
  - Aggrieved Party Files Motion, Judge Orders Party not Complying to appear, or Judge Gives party notice they must appear to show why they haven't complied
  - Must give notice of hearing 5 days ahead of hearing
  - Judge is trier of fact at hearing
  - Judge enters order
    - Order for or against party not complying on each element
    - Must make finding of facts constituting contempt
    - Order must state how noncomplying party can purge contempt
- Punishment- Up to 90 days imprisonment (fine not possible)

16

Possible Problems with Civil Contempt

- Willfulness
- Jurisdiction/ Authority of District Court Judge
  - NCGS 7A-149
    - Notwithstanding any other provision of law, a district court judge of a district court district which is in a set of districts as defined by G.S. 7A-200 has jurisdiction in the entire county or counties in which the district is located to the same extent as if the district encompassed the entire county, and has jurisdiction in the entire set of districts to the same extent as if the district encompassed the entire set of districts.
  - NCGS 7A-291 A District Court Judge has the following Powers
    - To administer Oaths
    - Punish for Contempt
    - To Compel the Attendance of Witnesses and production of evidence
    - To set bail
    - To issue arrest warrants valid throughout the State, and search warrants valid throughout the county of issue
    - To issue all process and orders necessary or proper in the exercise of his powers and authority, and to effectuate his lawful judgments and decrees

17

Petition for Writ of Habeus Corpus

NCGS 17-3

- Every person imprisoned or restrained of his liberty within this State, for any criminal or supposed criminal matter, or on any pretense whatsoever, except in cases specified in G.S. 17-4, may prosecute a writ of habeas corpus, according to the provisions of this Chapter, to inquire into the cause of such imprisonment or restraint, and, if illegal, to be delivered therefrom.

18

Habeus Corpus cont.

- NCGS 17-5: Any person can file on behalf of someone detained
- NCGS 17-6: Made in writing to any of judges or justices in appellate division or Superior Court
- NCGS 17-7: Application for writ must contain
  - The party detained, where the are detained, the party detaining them
  - Why client is being detained
  - Copy of Process detaining them (IVC Paperwork)
  - Why the detention is Illegal
  - A sworn Affidavit stating the above

19

Other Options?

- File Civil contempt/Show Cause Motion Against Hospital
- File APS report against Guardian in the County you're in
- File motion to have guardian removed in the county where Guardianship was established

20

Removal of Guardian

NCGS 35A-1290

- The clerk has the power and authority on information or complaint made to remove any guardian appointed under the provisions of this Subchapter, to appoint successor guardians, and to make rules or enter orders for the better management of estates and the better care and maintenance of wards and their dependents.
- It is the clerk's duty to remove the Guardian or take other action to protect the ward if…
  - The guardian neglects to care for or maintain the ward or his dependents in a suitable manner…
  - The guardian has a private interest, whether direct or indirect, that might tend to hinder or be adverse to carrying out his duties as guardian…
  - The guardian refuses or fails without justification to obey any citation, notice, or process served on him in regard to the guardianship…
  - The clerk finds the guardian unsuitable to continue serving as guardian for any reason…

21

Removal of Guardian cont.

- Emergency Removal of Guardian NCGS 35A-1291
  - The clerk may remove a guardian without hearing if the clerk finds reasonable cause to believe that an emergency exists that threatens the physical well-being of the ward or constitutes a risk of substantial injury to the ward's estate.
  - In all cases where the letters of a guardian are revoked, the clerk may, pending the resolution of any controversy in respect to such removal, make such interlocutory orders and decrees as the clerk finds necessary for the protection of the ward or the ward's estate or the other party seeking relief by such revocation.
- Successor Guardian NCGS 35A-1293

22

Questions?

Contact Information

Email: Zachary.H.Thayer2@nccourts.org
Phone: 919-733-5544

23

Involuntary Commitment Appeals:

Passing the Baton from Trial to Appellate Counsel

David Andrews, Assistant Appellate Defender
January 17, 2025

1

Roadmap

- ✓ First Principles
- ✓ Issue preservation
- ✓ The mechanics of appeals

2

First Principles

3

A massive curtailment of liberty

- ✓ *Humphrey v. Cady*, 405 U.S. 504 (1972): Involuntary commitment involves a "massive curtailment of liberty."
- ✓ *O'Connor v. Donaldson*, 422 U.S. 563 (1975): "[A] State cannot constitutionally confine without more a nondangerous individual . . . ."

4

A massive curtailment of liberty

- ✓ *Addington v. Texas*, 441 U.S. 418 (1979): "Civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection."
- ✓ *Foucha v. Louisiana*, 504 U.S. 71 (1992): "[I]n certain narrow circumstances persons who pose a danger to others or to the community may be subject to limited confinement . . . ."

5

In re C.G., 383 N.C. 224 (2022)

- ✓ A "trial court's findings that an individual suffers from a mental illness, exhibits symptoms associated with that mental illness, and may not be able to take care of his or her needs are not sufficient to satisfy the second prong of the statutory test for the presence of a 'danger to self.'"

6

In re C.G., 383 N.C. 224 (2022)

- ✓ A trial court's finding that "respondent's 'active psychosis causes him to be a danger to himself' fails to explain how respondent's psychosis precludes him from attending to his physical needs or causes him to face a risk of serious physical debilitation in the near future."

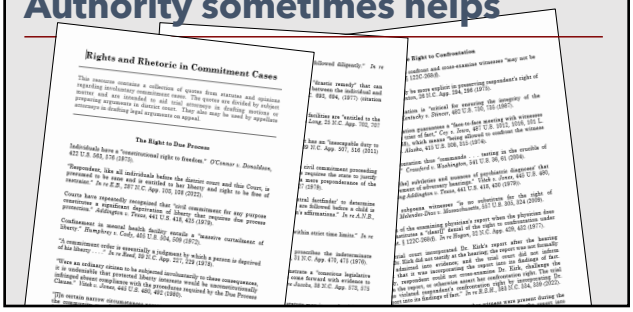
7

In re C.G., 383 N.C. 224 (2022)

- ✓ "[W]e hold that a risk that someone else might engage in unlawful conduct by assaulting respondent cannot support a determination that respondent poses a danger to himself . . . ."

8

Authority sometimes helps



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Issue preservation

10

The main idea

- ✓ If you want something, ask for it
- ✓ If you don't ask for it, it will be waived

11

The main idea

- ✓ "Constitutional issues not raised and passed upon at trial will not be considered for the first time on appeal." *State v. Lloyd*, 354 N.C. 76 (2001)

12

Object

Object

Object

Object

13

Your duty

- ✓ Be sure to assert that committing your client violates due process under the Fourteenth Amendment to the U.S. Constitution and N.C. Const. art. I, § 19

14

The right to confrontation

- ✓ The respondent's right to confront and cross-examine witnesses "may not be denied." N.C. Gen. Stat. § 122C-268(f)
- ✓ "The statute could hardly be more explicit in preserving respondent's right of confrontation." *In re Benton*, 26 N.C. App. 294 (1975)

15

The right to confrontation

- ✓ "In this case, it was not the trial judge's responsibility to intervene when Respondent's attorney failed to object to the alleged hearsay testimony." *In re B.H.*, No. COA19-411 (N.C. Ct. App. Mar. 17, 2020) (unpublished)

16

The right to confrontation

You should object when the State or facility presents:

- ✓ A report of a non-testifying doctor or psychologist
- ✓ Testimony of a substitute doctor or psychologist

17

The right to confrontation

Other grounds for objection include:

- ✓ Hearsay
- ✓ Lack of personal knowledge

18

You can also file motions

19

Would you challenge this petition?

- ✓ Patient presented to ER complaining of being abused by her boyfriend
- ✓ She demonstrates racing thoughts, pressured speech, and disorganized thoughts
- ✓ She appears acutely manic
- ✓ Patient denies SI, HI, AVH but is perseverative in joining the Air Force
- ✓ She describes how she was previously prescribed anti-psychotics

20

N.C. Gen. Stat. § 122C-261(a)

A custody order will issue if the respondent is:

Dangerous to self or others, OR "in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness"

21

N.C. Gen. Stat. § 122C-261(a)

A custody order will issue if the respondent is:

Dangerous to self or others, OR in need of treatment in order to prevent the respondent from becoming dangerous

22

Would you challenge this petition?

- ✓ Patient presented to ER complaining of being abused by her boyfriend
- ✓ She demonstrates racing thoughts, pressured speech, and disorganized thoughts
- ✓ She appears acutely manic
- ✓ Patient denies SI, HI, AVH but is perseverative in joining the Air Force
- ✓ She describes how she was previously prescribed anti-psychotics

23

In re Moore, 234 N.C. App. 37 (2014)

- ✓ "Here, respondent failed to raise the issue of the sufficiency of the affidavit during the first involuntary commitment hearing, nor did the record reflect that he raised it at any of the four recommitment hearings preceding the present appeal. Thus, we hold respondent has waived any challenge to the sufficiency of the affidavit to support the magistrate's original custody order."

24

Vagueness / overbreadth challenge

- ✓ Dissenting opinion in *In re K.B.*, No. COA17-1395:

  "I concur with the Majority but write separately to note my apprehension over involuntarily committing persons suffering from mental illness before they have truly become dangerous to themselves or others."

25

Vagueness / overbreadth challenge

- ✓ Dissenting opinion in *In re K.B.*, No. COA17-1395:

  "Respondent has not made any argument on appeal that the evidence negated the State's prima facie showing under N.C.G.S. § 122C-3(11)(a) that he 'is unable to care for himself.' Further, Respondent did not challenge this statutory presumption as unconstitutionally vague or overbroad or make any type of as applied challenge to the statute."

26

Vagueness / overbreadth challenge

- ✓ Dissenting opinion in *In re K.B.*, No. COA17-1395:

  "Respondent and others similarly situated may be caught in too large of an undefined funnel depriving them of their rights to liberty and forcing them to undertake psychoactive drug regimens at too remote a stage in their illness."

27

Vagueness / overbreadth challenge

- ✓ In re Torski, 791 N.E.2d 1308 (Ill. Ct. App. 2003):
  - Statute allowing commitment based on "threatening behavior" or "conduct that places another individual in reasonable expectation of being harmed" was vague.
  - The statute "poses a risk of arbitrary application to mentally ill individuals engaging in merely unusual or annoying behavior."

28

Vagueness / overbreadth challenge

- ✓ N.C.G.S. § 122C-3(11)(a)(1)(II):

  "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."

29

Vagueness / overbreadth challenge

- ✓ Certainty is required in statutes because "[n]o one may be required at peril of life, liberty or property to speculate as to the meaning of penal statutes." *Lanzetta v. New Jersey*, 306 U.S. 451 (1939).
- ✓ Don't forget that you can also make an as-applied vagueness challenge

30

The mechanics of appeals

31

N.C. Gen. Stat. § 122C-272

"Appeal may be had to the Court of Appeals by the State or by any party on the record as in civil cases. Appeal does not stay the commitment unless so ordered by the Court of Appeals. The Attorney General represents the State's interest on appeal."

32

Notice of appeal (Appellate Rule 3)

- ✓ Must be (1) in writing and (2) filed within 30 days
- ✓ Must be served on the State or facility
- ✓ The client does not have to sign the notice of appeal
- ✓ Oral notice of appeal is invalid

33

The problem with appeals

- ✓ They take a long time
- ✓ They do not get clients out of facilities

34

The benefits of appeals

- ✓ If successful, they can get commitment orders reversed
- ✓ They can create helpful precedent

35

Talk to your clients about appealing

36

What to consider

- ✓ If this is the client's first commitment, an appeal might be worthwhile (e.g., 18 U.S.C. 922(g)(4))
- ✓ Was the hearing unfair?

37

What to consider

- ✓ Recoupment is not allowed in IVC appeals (*See* N.C. Gen. Stat. § 7A-455)
- ✓ The client will not know the result for a long time

38

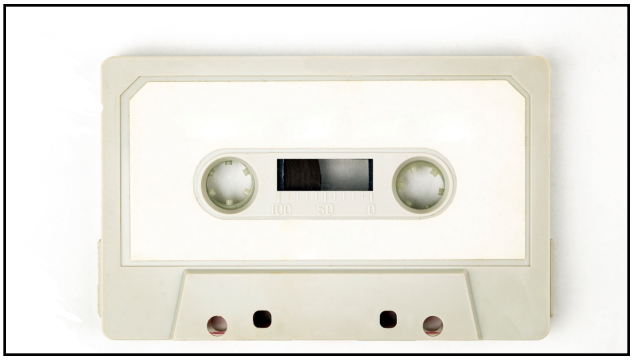
The most common argument in IVC appeals (by far)

- ✓ The trial court failed to make sufficient findings of fact to justify the IVC order

39

Why do appeals take so long?

40



41

Clerks have to figure out how to digitize cassette recordings

42

Clerks have to find a court reporter

43

Appellate Rule 7(c)(2)

- ✓ "The clerk must serve the appellate entries on each party and on each transcriptionist no later than fourteen days after a judge signs the form."

44

Appellate Rule 7(e)

- ✓ The court reporter has sixty days to deliver the transcript after receiving the appellate entries

45

AOC Court Reporting Manager

- ✓ Jennifer LLoyd
  jennifer.w.lloyd@nccourts.org

46

Recordings from cassette players are difficult to hear

47

"And then she tried to (inaudible), parking get out of the car. 'Come on (inaudible) get out.' And then she started talking, 'Come on, what's there?' (Inaudible), 'Sir, please tell him (inaudible) tell him what (inaudible). And at that time got out of the car and, 'Mom, there's no one here.' (Inaudible). And he (inaudible) two or three times, and I didn't know what to do, so I (inaudible), and 'Get in the car.'"

In re Hedrick, No. COA16-256, slip op. (2016)

48

"Accordingly, we conclude that Respondent has demonstrated that he was prejudiced by the lack of a verbatim transcript from the 14 May 2015 hearing and, as a result, is unable to obtain meaningful appellate review of his involuntary commitment. Therefore, he is entitled to a new hearing."

In re Shackleford, 248 N.C. App. 357 (2016)

49

"Accordingly, we conclude that because Respondent has been able to obtain an adequate alternative to a verbatim transcript of his involuntary commitment hearing, he cannot show he was prejudiced by the absence of an actual transcript. Consequently, he was not deprived of the opportunity for meaningful appellate review of his involuntary commitment hearing."

In re Derrick Woodard, 249 N.C. App. 64 (2016)

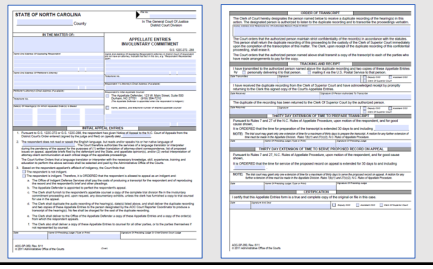
50

I WANT YOU

to help get rid of cassette recorders

51

The Appellate Entries


STATE OF NORTH CAROLINA

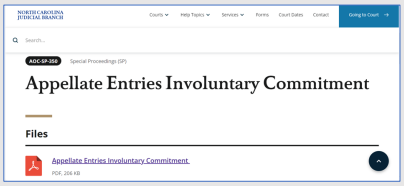
APPELLATE ENTRIES
INVOLUNTARY COMMITMENT

52

The Appellate Entries

www.nccourts.gov/documents/forms

AOC-SP-350



53

Here's How You Can Help

54

What you can do

- ✓ Determine before the IVC hearing whether the client will want to appeal
- ✓ Make sure the clerk turns on the recording device
- ✓ File written notice of appeal the same day the client is committed

55

What you can do

- ✓ Fill out the first page of an appellate entries and ask the judge to sign it
- ✓ Ask the clerk to identify the court reporter
- ✓ If the clerk doesn't know which court reporter to assign, send an email to Jennifer Lloyd and copy the clerk on it

56

What you can do

- ✓ Make sure the clerk emails the digital recording to the court reporter
- ✓ Send me an email with the name of the case, the file number, and county
- ✓ If you have questions about this process, send an email to the commitment listserv

57

Thank you

David Andrews
Assistant Appellate Defender
David.W.Andrews@nccourts.org

58

Rights and Rhetoric in Commitment Cases

This resource contains a collection of quotes from statutes and opinions regarding involuntary commitment cases. The quotes are divided by subject matter and are intended to aid trial attorneys in drafting motions or preparing arguments in district court. They also may be used by appellate attorneys in drafting legal arguments on appeal.

The Right to Due Process

Individuals have a "constitutional right to freedom." *O'Connor v. Donaldson*, 422 U.S. 563, 576 (1975).

"Respondent, like all individuals before the district court and this Court, is presumed to be sane and is entitled to her liberty and right to be free of restraint." *In re E.B.*, 287 N.C. App. 103, 108 (2022).

Courts have repeatedly recognized that "civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection." *Addington v. Texas*, 441 U.S. 418, 425 (1979).

Confinement in mental health facility entails a "massive curtailment of liberty." *Humphrey v. Cady*, 405 U.S. 504, 509 (1972).

"A commitment order is essentially a judgment by which a person is deprived of his liberty . . . ." *In re Reed*, 39 N.C. App. 227, 229 (1978).

"Were an ordinary citizen to be subjected involuntarily to these consequences, it is undeniable that protected liberty interests would be unconstitutionally infringed absent compliance with the procedures required by the Due Process Clause." *Vitek v. Jones*, 445 U.S. 480, 492 (1980).

"[I]n certain narrow circumstances persons who pose a danger to others or to the community may be subject to limited confinement . . . ." *Foucha v. Louisiana*, 504 U.S. 71, 80 (1992).

The procedures under Chapter 122C "must be followed diligently." *In re Barnhill*, 72 N.C. App. 530, 532 (1985).

Commitment to a mental health facility is a "drastic remedy" that can become an "ominous presence in any interaction between the individual and the legal system . . . ." *In re Hatley*, 291 N.C. 693, 694, (1977) (citation omitted).

Minors subject to confinement in mental health facilities are "entitled to the protection of due process procedures . . . ." *In re Long*, 25 N.C. App. 702, 707 (1975).

In hearings under Chapter 122C, the trial court has an "inescapable duty to vouchsafe due process . . . ." *In re Watson*, 209 N.C. App. 507, 516 (2011) (citation omitted).

"[T]he individual's interest in the outcome of a civil commitment proceeding is of such weight and gravity that due process requires the state to justify confinement by proof more substantial than a mere preponderance of the evidence." *Addington v. Texas*, 441 U.S. 418, 427 (1979).

"Due process requires an inquiry by a 'neutral factfinder' to determine whether constitutionally adequate procedures are followed before a child is voluntarily committed based upon his guardian's affirmations." *In re A.N.B.*, 232 N.C. App. 406, 412 (2014).

Hearings under Chapter 122C "must be held within strict time limits." *In re Mikels*, 31 N.C. App. 470, 475 (1976).

The 15-day deadline for hearings "clearly proscribes the indeterminate commitment of any patient . . . ." *In re Mikels*, 31 N.C. App. 470, 475 (1976).

The procedures under Chapter 122C demonstrate a "conscious legislative decision to place the burden on the State to come forward with evidence to justify the commitment within 10 days." *In re Jacobs*, 38 N.C. App. 573, 575 (1978).

While "the lack of flexibility provided in the statute may impose hardship on the State, the plain language of the statute, until amended, must control." *In re Jacobs*, 38 N.C. App. 573, 576 (1978).

The statutes under Chapter 122C are "designed to protect against arbitrary or ill-considered involuntary commitment." *Gregory v. Kilbride*, 150 N.C. App. 601, 611 (2002).

The State has a "great interest in preventing unwarranted admission of juveniles into . . . treatment facilities . . . ." *In re A.N.B.*, 232 N.C. App. 406, 408 (2014).

Even though it may be "impractical," it is "encumbent" upon all who employ involuntary commitment procedures to do so with "care and exactness." *Samons v. Meymandi*, 9 N.C. App. 490, 497 (1970).

Involuntary commitment must occur "in ways consistent with the dignity, rights, and responsibilities of all North Carolina citizens." N.C. Gen. Stat. § 122C-2.

Involuntary commitment can only occur "under conditions that protect the dignity and constitutional rights of the individual." N.C. Gen. Stat. § 122C-201.

"The policy of this State as declared by our Legislature is to encourage voluntary admissions to treatment facilities . . . and to favor a less restrictive mode of treatment than involuntary commitment whenever appropriate." *In re Farrow*, 41 N.C. App. 680, 686 (1979).

"North Carolina's policy on the mentally ill promotes less restrictive methods of treatment and more patient autonomy." *Williamson v. Liptzin*, 141 N.C. App. 1, 18 (2000).

"Despite public perceptions to the contrary, the vast majority of the mentally ill are not violent or are no more violent than the general population and thus, such rigid measures as involuntary commitment are rarely a necessity." *Williamson v. Liptzin*, 141 N.C. App. 1, 17 (2000).

"This Court does not take lightly the violation or deprivation of any juvenile's constitutionally protected liberty interest. We therefore strongly admonish DSS and Michael's legal guardian Autry for their lackluster performance here, and we also specifically caution DSS not to interpret our holding in this case as an excuse for future failures to take timely action in securing post-discharge placements." *In re M.B.*, 240 N.C. App. 140, 157 (2015).

The Right to Confrontation

The respondent's right to confront and cross-examine witnesses "may not be denied." N.C. Gen. Stat. § 122C-268(f).

"The statute could hardly be more explicit in preserving respondent's right of confrontation." *In re Benton*, 26 N.C. App. 294, 296 (1975).

The right to confrontation is "critical for ensuring the integrity of the factfinding process." *Kentucky v. Stincer*, 482 U.S. 730, 735 (1987).

The right to confrontation guarantees a "face-to-face meeting with witnesses appearing before the trier of fact," *Coy v. Iowa*, 487 U.S. 1012, 1016, 101 L. Ed. 2d 857, 864 (1988), which means "being allowed to confront the witness physically." *Davis v. Alaska*, 415 U.S. 308, 315 (1974).

The right to confrontation thus "commands . . . testing in the crucible of cross-examination." *Crawford v. Washington*, 541 U.S. 36, 61 (2004).

"It is precisely '[the] subtleties and nuances of psychiatric diagnoses' that justify the requirement of adversary hearings." *Vitek v. Jones*, 445 U.S. 480, 495 (1980) (*quoting Addington v. Texas*, 441 U.S. 418, 430 (1979)).

The power to subpoena witnesses "is no substitute for the right of confrontation." *Melendez-Diaz v. Massachusetts*, 557 U.S. 305, 324 (2009).

The admission of the examining physician's report when the physician does not testify constitutes a "clear[]" denial of the right to confrontation under N.C. Gen. Stat. § 122C-268(f). *In re Hogan*, 32 N.C. App. 429, 432 (1977).

"Here the trial court incorporated Dr. Kirk's report after the hearing concluded. Dr. Kirk did not testify at the hearing; the report was not formally offered or admitted into evidence; and the trial court did not inform respondent that it was incorporating the report into its findings of fact. Accordingly, respondent could not cross-examine Dr. Kirk, challenge the findings in the report, or otherwise assert her confrontation right. The trial court thus violated respondent's confrontation right by incorporating Dr. Kirk's report into its findings of fact." *In re R.S.H.*, 383 N.C. 334, 339 (2022).

"[B]ecause neither Dr. Thrall nor any other witness were present during the hearing to authenticate the report, any attempt to admit the report into

evidence or otherwise incorporate it as findings would have been error." *In re A.S.*, 280 N.C. App. 149, 158 (2021)

Danger to Self

There is "no route to bypass the statute's requirement of a finding '[t]hat there is a reasonable probability of [Respondent's] suffering serious physical debilitation within the near future.'" *In re McCray*, No. COA09-1623, 2010 N.C. App. LEXIS 1086 at *13 (N.C. Ct. App. Jul 6, 2010) (unpublished) (*quoting* N.C. Gen. Stat. § 122C-3(11)(a)(1)).

Evidence that the respondent's persistence in preaching on the street might cause people to "resist" and "become physically aggressive toward her" did not mean that the respondent was dangerous to herself. Instead, "it would seem more appropriate to commit her aggressor rather than the respondent." *In re Hogan*, 32 N.C. App. 429, 431 (1977).

Findings describing the respondent's history of mental illness and her behavior leading up to the commitment hearing did not establish that the "circumstances rendered Respondent a danger to herself in the future. *In re Whatley*, 224 N.C. App. 267, 271 (2012).

"[T]he fact that a respondent had significant mental health difficulties in the past and currently exhibits symptoms of mental illness, standing alone, does not tend to establish that these symptoms will necessarily occur or persist in the future or that he or she will suffer serious physical debilitation in the near future in the absence of additional inpatient treatment." *In re C.G.*, 2022-NCSC-123, ¶ 39.

Findings indicating that the respondent had been committed two times within the previous year "[did] nothing more than demonstrate respondent's mental illness." *In re Richardson*, No. COA12-119, 2012 N.C. App. LEXIS 856 at *7 (N.C. Ct. App. Jul. 17, 2012) (unpublished).

Evidence that the respondent refused to take medication, "started to go down" once he stopped taking medication, disturbed neighbors, called out "inappropriately" to anyone passing by his house, and was "ready to fight" if he was told he did something wrong, while "indicative of some danger," did not support the conclusion that there was a reasonable probability of serious

physical debilitation within the near future. *In re Monroe*, 49 N.C. App. 23, 29 (1980).

Evidence that the 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 a risk of serious physical debilitation within the near future. *In re W.R.D.*, 248 N.C. App. 512, 516, 790 S.E.2d 344, 348 (2016). Although the 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.'" *Id.*

Danger to Others

Evidence that the 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).

Evidence that the respondent entered a neighbor's house and was later found there by a deputy sheriff did not "support a reasonable inference that [the respondent] was imminently dangerous to herself or others." *In re Hatley*, 291 N.C. 693, 699 (1977).

Findings that the respondent exhibited "psychotic behavior" that endangered her infant and that she had been "admitted [with] psychosis" while taking care of her two month old son were "clearly inadequate" to demonstrate a reasonable probability that her conduct would be repeated because the findings only involved past conduct and did not draw any "nexus between that conduct and future danger to others." *In re Whatley*, 224 N.C. App. 267, 274 (2012).

"[T]he fact that someone has been charged with a crime does not suffice to support a finding of the type required to sustain an involuntary commitment order." *In re Church*, No. COA09-1058, 2010 N.C. App. LEXIS 1282 at *22 (N.C. Ct. App. Jul. 20, 2010) (unpublished).

STATE OF NORTH CAROLINA
COUNTY OF ORANGE

IN THE GENERAL COURT OF JUSTICE
DISTRICT COURT DIVISION
11 SPC 001

****

IN THE MATTER OF:)
)
RON RESPONDENT)

****

MOTION TO DISMISS

****

NOW COMES Ron Respondent, by and through counsel, and moves this Court to dismiss the above-captioned case. In support of this motion, Mr. Respondent shows the following:

1. On January 1, 2011, a petition and affidavit were presented to an Orange County magistrate alleging that Mr. Respondent suffered from schizoaffective disorder and that he yelled at the petitioner, his roommate, during an argument over the amount that they owed in rent to their landlord. The petition and affidavit were not confirmed by oath or affirmation. The petition and affidavit are attached to this motion.

2. On the same day, an Orange County magistrate entered a custody order for Mr. Respondent stating that the petition provided reasonable grounds to believe that Mr. Respondent was mentally ill and dangerous to himself or others, or in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness. The custody order is attached to this motion.

3. This case must be dismissed because the petition and affidavit are not sufficient to confer subject matter jurisdiction on this court. The facts presented in the affidavit and petition were not presented under oath as required by N.C. Gen. Stat. § 122C-261(a). Thus, they are not sufficient to support an involuntary commitment case against Mr. Respondent. *See In re Ingram*, 74 N.C. App. 579, 581, 328 S.E.2d 588, 589 (1985) (holding that a petition and affidavit not sworn under oath cannot support a commitment order). In addition, there are no facts in the petition and affidavit that indicate that Mr. Respondent is dangerous to himself or others, or in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness.

4. Finally, committing Mr. Respondent to a mental institution based on the petition and affidavit in this case would violate Mr. Respondent's right to due process under N.C. Const.

art. I, § 19, and U.S. Const. amend. XIV, because the petition and affidavit do not provide reasonable grounds to believe that Mr. Respondent satisfies the criteria for involuntary commitment. *See In re Reed*, 39 N.C. App. 227, 229, 249 S.E.2d 864, 866 (1978) (holding that proceeding on a petition that fails to establish reasonable grounds for the issuance of a custody order constitutes a deprivation of due process).

WHEREFORE, for the above reasons, Mr. Respondent respectfully requests that this Court dismiss this case with prejudice and order such other relief as is just and proper.

Respectfully submitted, this the 15th day of January, 2011.

_____

Ann Attorney
Attorney at Law
123 Main Street
Chapel Hill, NC 27516

CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing motion was served on Ms. Jane Doe, 123 Main Street, Chapel Hill, North Carolina 27516, by deposit in the United States mail, first-class and postage prepaid.

This the 15th day of January, 2011.

_____

Ann Attorney
Attorney at Law

STATE OF NORTH CAROLINA
COUNTY OF ORANGE

IN THE GENERAL COURT OF JUSTICE
DISTRICT COURT DIVISION
11 SPC 001

****

IN THE MATTER OF:)
)
RON RESPONDENT)

****

NOTICE OF APPEAL

****

Now comes the respondent, Ron Respondent, by and through counsel, and hereby gives notice of appeal from the district court judgment in the above-captioned case involuntarily committing him to a mental health facility on January 15, 2011. Mr. Respondent hereby appeals to the North Carolina Court of Appeals.

This the 15th day of January, 2011.

_____

Ann Attorney
Attorney at Law
123 Main Street
Chapel Hill, NC 27516

CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing notice of appeal was served on Ms. Jane Doe, 123 Main Street, Chapel Hill, North Carolina 27516, by deposit in the United States mail, first-class and postage prepaid.

This the 15th day of January, 2011.

_____

Ann Attorney
Attorney at Law

eCourts & IVC

eCourts: An Historical (Anecdotal) Overview

Chad Perry,
Chief Special Counsel

eCourts & IVC

February 13th, 2023, eCourts launched in the 4 pilot counties of Harnett, Johnston, Lee, and Wake.

“The modernization of our courts from paper to digital will help us better serve North Carolinians who have business with the court and help us continue to ensure that justice is administered without favor, denial, delay.” - Former NCAOC Director Judge Andrew T. Heath

Impact on Involuntary Commitments

The Office of Special Counsel was heavily involved in the eCourts rollout as it pertains to Involuntary Commitments (IVC).

Prior to my appointment in 2022, there were a series of meetings in Wake County involving local judges, clerks, Special Counsel, AOC representatives, and attorneys representing hospitals and various stakeholders.

Early Meetings

Initially, these meetings assured everyone that IVC courts would not be significantly impacted by the eCourts system.

Meetings continued in Fall 2022.

A shift. AOC representatives stated that eFiling would initiate the IVC process, and that magistrates would start the paperwork, with the first filings being done by magistrates and the clerk’s office.

Later Meetings That I Attended

In January 2023, an AOC meeting revealed that clerks would not initiate the filing process and that hospitals would become the primary filers.

Hospital attorneys were strongly opposed to this change, citing concerns about:

- o Lack of resources for eFiling within hospitals.
- o Insufficient training and preparation for eFiling procedures.
- o Concerns about liability for eFiling errors by hospital employees.

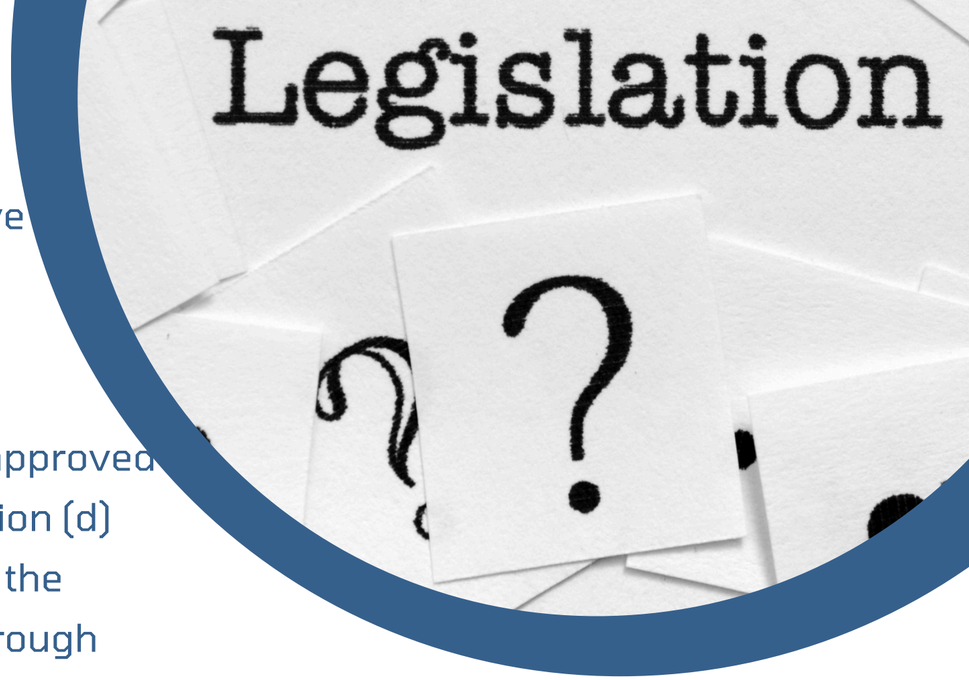
The early version of eFile allowed any hospital employee to eFile under their hospital's attorneys name, potentially putting their license at risk for filings they did not directly oversee.

In early February 2023, a few hospital attorneys pointed out a critical flaw: no legal basis existed to compel hospitals to comply with eFiling for IVCs.

On February 8th, a hospital attorney provided me a memo from former Director Andrew Heath (not readily accessible elsewhere) that exempted hospitals from eFiling while strongly encouraging them to do so.

Legislative Correction

To address this issue, a bill was passed that became 122c-261(d1) effective April 1, 2024.



(d1) If the affiant is a commitment examiner filing a petition and affidavit for an Involuntary commitment in a county that has implemented an electronic filing system approved by the Director of the Administrative Office of the Courts, the same provisions of subsection (d) of this section apply except that (i) the commitment examiner or their designee shall file the affidavit and petition, as well as any other supporting documentation required by law, through the electronic filing system, and (ii) the original affidavit and original custody order are not required to be mailed to the clerk or magistrate. In such counties, commitment examiners shall also file any subsequent documentation and notifications prescribed by statute to the clerk of superior court through the electronic filing system.

This legislation explicitly requires commitment examiners or their designees to file IVC petitions and supporting documentation through the electronic filing system.

The legislation removes the requirement to mail original documents to the clerk or magistrate.

Common eFile Problems for Involuntary Commitments

- Hospitals cannot file all documents simultaneously, leading to separate filings and potential errors.
- AOC representatives initially stated that judges would reject filings with incomplete paperwork, delaying the generation of file numbers. This has not always been the case.
- Filing documents separately can lead to human error and multiple file numbers for the same case, creating confusion.
- Attorneys often lack access to see what documents have been eFiled, hindering their ability to effectively represent their clients.
- Elevated access (the ability to see what is e-filed in a confidential case) issues and delays in IVC orders are common, with some cases not receiving contemporaneous file numbers. Example: December 2024 cases receiving January 2025 file numbers.
- Uncertainties arise when attorneys are aware of a patient but have not received confirmation of eFiling from the clerks' office. Ex. Some clerks' offices believe there is not a case until they receive the paperwork via e-file. Causing potential Due Process violations.

Thank You!

Children in DSS Custody Who Need Treatment in a PRTF: There's a Disconnect

I recently finished a 2-day course for district court judges that focused on children with significant mental health needs. There were lots of questions about the admission and discharge process for a child who is in a county department's (DSS) custody and who needs treatment in a psychiatric residential treatment facility (PRTF). It's complicated because there are **two separate but simultaneously occurring court actions:**

1. the abuse, neglect, or dependency (A/N/D) action that addresses a child's custody, placement, and services; and
2. the judicial review of a child's voluntary admission to a secure psychiatric treatment facility that was made with the consent of the child's legally responsible person.

The two actions involve different parties, courts, purposes, and laws, and they are often not coordinated even though they directly impact each other.

Placement in a PRTF

North Carolina requires a judicial review when a child is admitted to a 24-hour mental health or substance abuse facility that has the same or similar restrictions on the child's freedom of movement as a state-operated psychiatric hospital. G.S. 122C-224. A "24-hour facility" provides a structured living environment and services to a patient for at least 24 consecutive hours and includes state psychiatric hospitals, public or private facilities providing acute inpatient care, and PRTFs. G.S. 122C-3(14)g. PRTFs provide treatment to children who are mentally ill or substance abusers in need of care in a non-acute inpatient setting and whose removal from home or a community based residential setting is essential for treatment. 10A NCAC 27G.1901. Round the clock supervision and therapeutic interventions are provided with the goal of facilitating the child's transition to a less intensive and structured community setting. *Id.* For children insured by Medicaid, **prior approval** that the child's treatment in a PRTF is **medically necessary** must be obtained from the local management entity/managed care organization (**LME/MCO**). NC Div. of Medical Assistance, PRTF, Clinical Coverage Policy 8-D-1, 5.0; *see* G.S. 122C-3(20c).

When a child needs treatment in a PRTF, the placement is made by the child's **legally responsible person:** a parent, guardian, person standing in loco parentis, or legal custodian other than a parent who is specifically authorized by law or a court order to consent to medical care, including psychiatric treatment. G.S. 122C-3(20)(ii); -221(a).

The Role of the A/N/D Court and DSS in a Child's Admission

When a child has been adjudicated abused, neglected, or dependent, DSS recommends a

treatment plan that addresses the child's needs. G.S. 7B-808(b). The court may order that the child receive a mental health evaluation by a qualified professional. G.S. 7B-903(d). When the court finds the child is mentally ill, it may order DSS to coordinate with the LME/MCO to develop the child's treatment plan. G.S. 7B-903(e). The court does not have authority to order the child's placement in a PRTF. *See* G.S. 7B-903(a), (e). If the child needs treatment in a 24-hour facility, the admission must be made by the child's legally responsible person. When the court orders a child into DSS custody, DSS is the child's legally responsible person if the court also authorizes DSS to consent to the child's mental health care or treatment pursuant to G.S. 7B-505.1(c). *See* G.S. 7B-903.1(e). Otherwise, the child's parent, guardian, or person acting in loco parentis is the child's legally responsible person for admission purposes. G.S. 122C-3(20)(ii).

Judicial Review of a Voluntary Admission

Although a child's admission to a PRTF is voluntarily made with the consent of the minor's legally responsible person, NC law requires judicial review of the minor's "voluntary admission." G.S. 122C, Article 5, Part 2. The purpose of the judicial review is to protect the child's liberty interest by ensuring that the child is not improperly admitted or improperly remains in the facility. G.S. 122-221(b); *In re* A.N.B., 232 N.C. App. 406 (2014).

The judicial review is heard by the **district court in the county where the facility is located**. G.S. 122C-224(a). If the PRTF is in a different county from where the A/N/D case is pending, a different court will conduct the judicial review.

The judicial review **process begins within 24 hours** of when the child is admitted to the PRTF when the facility notifies the clerk of court of the child's admission and need for a hearing. G.S. 122C-224(c). The facility also notifies the clerk of the names and addresses of the child's legally responsible person and responsible professional (the person in the facility who is designated to be responsible for and is qualified to provide the child's care and treatment). *Id*.; G.S. 122C-3(32).

Within 48 hours of receiving the notice from the facility, the clerk must **appoint an attorney for the child,** who is presumed indigent. G.S. 122C-224.1(a); AOC-SP-912M. This attorney is not the GAL/attorney advocate appointed to represent the child in the A/N/D proceeding. *See* G.S. 7B-601. This newly appointed attorney represents the child in the judicial review proceeding and continues to represent the child until the judge relieves him or her of the appointment. G.S. 122C-224.2(c). The attorney meets with the child within 10 days of the appointment and at least 48 hours before the hearing. G.S. 122C-224.2(a).

The **hearing must be held within 15 days** of the child's admission to the facility. G.S. 122C-224(a), -224.1(b). At least 72 hours before the hearing, **notice of the hearing** is sent to the child's attorney, the child's legally responsible person, and the responsible professional. G.S. 122C-224.1(b). The hearing is closed to the public unless the child's attorney requests otherwise. G.S. 122C-224.3(d). The hearing is **held at the facility** unless the judge determines the

court calendar will be disrupted by holding the hearing there. G.S. 122C-224.3(a). In that case, the hearing may be held in a different location, such as the judge's chambers, but it should not be conducted in a courtroom if the child's attorney objects and there is a more suitable place available. *Id*. The child has a right to be present at the hearing and to testify, but he or she may waive that right or limit his or her appearance to when testifying. G.S. 122C-224.2(b), -224.3(b). Certified copies of medical records, including a psychologist's or other professional's findings and reports, are admissible in evidence so long as the child's right to confront and cross-examine witnesses is not denied. G.S. 122C-224.3(c); *In re* C.W.F., 232 N.C. App. 213 (2014).

It is unclear if a legally responsible person who receives notice of the hearing is a **party** to the proceeding. *In re* M.B., 771 S.E.2d 615 (2015). Unlike the Juvenile Code, which explicitly states that a person who has a right to notice and to be heard in certain A/N/D hearings is not a party, the statutes authorizing the judicial review of a voluntary admission are silent about the legally responsible person's role in the judicial review. *Compare* G.S. 7B-906.1(b), -908(b)(1), -1112.1 *to* 122C-224.1(b). Because a judicial review hearing is a civil proceeding, the court may look to the Rules of Civil Procedure to determine if a party should be joined or allowed to intervene if a motion is filed. *See* G.S. 1A-1, Rules 19, 20, 24; *In re* A.N.B.

The Order

There are **three possible dispositional orders.**

1. The court **concurs** in the child's continued admission and **authorizes a treatment period for up to 90 days** if the court finds by **clear, cogent, and convincing evidence**
    - the child is mentally ill or a substance abuser,
    - the child is in need of further treatment at the 24-hour facility, and
    - less restrictive measures will be insufficient. When the court is determining if less restrictive measures will be insufficient, it may look at whether those lesser measures are actually available (e.g., is there an available bed in a less restrictive facility). G.S. 122C-2; *In re* M.B.

2. The court orders a **one-time 15-day additional stay** when the court believes there are reasonable grounds to believe the child is mentally ill or a substance abuser and is in need of treatment at the facility but additional diagnoses and evaluations are needed for the court to make a determination, or

3. The court orders the **child's release**.

G.S. 122C-224.3(f), (g); AOC-SP-913M.

Additional Judicial Reviews

If the court concurs and orders continued admission for up to 90 days, the child is entitled to another judicial review before that additional treatment period ends. G.S. 122C-224.4(b). At subsequent judicial reviews, the court may order the **child's release or continued admission for up to 180 days**. *Id.* Judicial reviews will be held prior to the expiration of each subsequently authorized admission period when the responsible professional recommends a continued stay. G.S. 122C-224.4(b), (c). The responsible professional notifies the clerk at least 15 days before the admission period expires that an additional stay is recommended. G.S. 122C-224.4(c).

Discharge

Discharge planning to a less restrictive treatment setting starts at the child's admission and is part of a child's treatment plan. 10A NCAC 27G.1903(c). Legally responsible persons (e.g., parent or DSS social worker) and/or family members must be involved in the development and implementation of the child's treatment plans. 10A NCAC 27G.1903(e). Before a child is discharged, the facility should meet with the child and family team, including the DSS social worker, and make service planning decisions. 10A NCAC 27G.1904.

A child is discharged when

- the court orders the child's release,
- the responsible professional determines the child is no longer mentally ill or a substance abuser or in need of treatment at the facility,
- the legally responsible person files a written request for the child's discharge with the facility (however, the facility may hold the child for 72 hours and seek an involuntary commitment if appropriate), or
- the child turns 18 and does not consent to the treatment.

G.S. 122C-224.7; -224.3(g)(3).

What About the A/N/D Court?

The A/N/D court does not hear the judicial review of a child's voluntary admission and will not be aware of what was decided at that judicial review unless evidence of what was ordered is introduced in the A/N/D proceeding. If the A/N/D court wants to timely coordinate its hearings with the judicial review of the child's voluntary admission or with the child's discharge, it may consider ordering

- the legally responsible person (e.g., parent or DSS) notify the clerk of the date for the judicial review of voluntary admission so that the clerk may schedule a review hearing in the A/N/D proceeding shortly afterwards. *See* G.S. 7B-906.1(a); -1000.
- the legally responsible person make efforts to obtain the permission of the court deciding the voluntary admission to release information from that court file, such as the court order,

for the purpose of admitting a copy in the A/N/D proceeding. *See* G.S. 122C-54(d).

- DSS to participate in the child's treatment and discharge planning and to work with the PRTF to make timely efforts to secure a child's post-discharge placement. *See In re* M.B.
- the legally responsible person notify the clerk of a need for a review hearing if that person files a written request with the PRTF for the child's discharge.

Juveniles in DSS Custody Presenting at Hospital ED for Mental Health Treatment: New Laws and New Court Hearing Possible

Perhaps it is not surprising that juveniles who experience abuse, neglect, or dependency have a higher risk of suffering from mental health issues. These children have experienced trauma, and when they are removed from their homes and families, they further experience loss, separation, and disruption. **The National Conference of State Legislatures reports that "[u[p to** 80 percent **of children in foster care have significant mental health issues, compared to approximately** 18-22 percent **of the general population."* According to the American Academy of Pediatrics, "[m]ental and behavioral health is the largest unmet health need for children and teens in foster care."****

Some North Carolina laws set forth in the Juvenile Code address the issue of children in DSS custody who experience mental health issues. For example, G.S. 7B-505.1(c) addresses the need for DSS to obtain a court order to consent to non-routine and non-emergency medical treatment for a juvenile in its custody – such treatment includes mental health treatment requiring informed consent. And, G.S. 7B-903(d) authorizes the court to order a juvenile to receive a psychological or other necessary examination to determine the juvenile's needs. Other laws, such as those in G.S. Chapter 122C, address mental health treatment generally and include provisions specific to juveniles. **Laws specifically addressing treatment and the coordination of services between a DSS with a juvenile in its custody and managed care organization (MCO) or prepaid health plans (PHP) were lacking, until the enactment of S.L. 2021-132.**

This post focuses on two new laws that were included in S.L. 2021-132 that specifically address situations where a juvenile who is in DSS custody presents to a hospital emergency department for mental health treatment. **Effective October 1, 2021**, a new statute in G.S. Chapter 122C was enacted to address care coordination for the juvenile by DSS, the LME/MCO or prepaid health plan (PHP), the hospital, and the North Carolina Department of Human Services (DHHS): **G.S. 122C-142.2. Effective January 1, 2022**, a new statute in the Juvenile Code, **G.S. 7B-903.2**, was enacted to authorize an emergency motion and hearing to address compliance with the requirements of G.S. 122C-142.2.

Juvenile presenting at hospital for mental health treatment. When a juvenile who is in DSS custody presents to a hospital emergency department for mental health treatment and it is determined that the juvenile should not remain at the hospital and there is no immediately available appropriate placement for the juvenile, the DSS director must contact the appropriate LME/MCO or PHP within twenty-four hours of that determination. The director requests an assessment of the juvenile. G.S. 122C-142.2(b). Within five business days of the director's request, the LME/MCO or PHP must, when applicable or required by their contract with DHHS, arrange for an assessment of the juvenile by the juvenile's clinical home provider, the hospital (if able or willing), or another

qualified clinician. G.S. 122C-142.2(c). Depending on the level of care recommended by the assessment, DSS and the LME/MCO or PHP must act as provided for in the following table. G.S. 122C-142.2(d).

Recommendation	DSS	LME/MCO or PHP

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)