Study on the Lack of Capacity to Proceed Process

Recommendations for Improvements to the Incapacity to Proceed (ITP) System in North Carolina

Session Law 2017-147

Final Report to the

Joint Legislative Oversight Committee

on Health and Human Services

and

Joint Legislative Oversight Committee

on Justice and Public Safety

By

North Carolina Department of Health and Human Services

March 29, 2018

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Executive Summary

Background and Overview: Session Law 2017-147, directed the NC Department of Health and Human Services (DHHS) to convene a workgroup and stakeholder group to study and develop a report that includes the following:

1. Issues within the system that impact an individual who lacks capacity to proceed to trial and the process to determine capacity;
2. Issues that create barriers within the system that negatively impact service providers including jails, courts, hospitals, and law enforcement agencies, in their efforts to serve an individual who lacks the capacity to proceed;
3. Solutions to reduce the number of persons who lack the capacity to proceed, the number of person who are referred to the State psychiatric hospitals (SPHs), and the number of stays in the hospitals that extend beyond the clinical needs of the person who lacks the capacity to proceed.

DHHS convened a workgroup including representatives from the criminal justice system and the behavioral health system. The Incapacity to Proceed (ITP) process merges these two systems in a unique way that requires identification of issues and solutions crossing both systems. System issues and challenges have been addressed in previous reports and presentations. A summary of the specific issues is provided in the three separate sections of the report under the heading "Current Status and Challenges."

Incapacity to Proceed Evaluations: To develop a greater understanding of the perception of quality and usefulness of the ITP reports generated in the current system, a survey was developed and distributed to North Carolina Court stakeholders regarding ITP evaluations performed by local evaluators and SPHs, primarily Central Regional Hospital (CRH) evaluators.[1] In general evaluations by forensic staff at the SPHs were rated with higher satisfaction compared to the satisfaction reported for the local evaluators. Across both evaluator types, primary concerns were: timeliness, biased outcomes, evaluator qualifications, and thoroughness of reports including supportive evidence for conclusion as well as consistency between evaluators. The workgroup studied ITP evaluation models in other states and reviewed recent legal actions in other states regarding the ITP process.

Overall the research supported developing ITP evaluation systems that combine timeliness of evaluations in an appropriate setting by highly qualified professionals with ongoing training and quality monitoring.[2] Furthermore a previous study on the ITP system by Thomas Grisso, PhD recommended improvements in training and certification of evaluators in NC.

Recommendation: Eliminate the local evaluator system and create pre-trial evaluation programs at Cherry Hospital and Broughton Hospital identical to the existing pre-trial evaluation center at CRH. This will regionalize the State and create access to qualified evaluators in both an outpatient and inpatient setting with the ability to also provide evaluations in the community. Recognizing that this recommendation will trigger higher transportation costs by county jails, the Department would be willing to offset this local transportation cost if sufficient funding can be secured.

[1] Please see pgs. 5-7 for more information.
[2] Please see pgs. 9-10 for more information.

Capacity Restoration Programming (CRP): In response to Session Law 2013-18, Senate Bill 45,[3] DHHS adopted guidelines for treatment of individuals involuntarily committed subsequent to a determination of incapacity to proceed by evaluation and judge's order.

All three SPHs have enhanced their CRP over the past three years by providing a broader array and more frequent individual programming to assist people to regain capacity to proceed to trials. The workgroup focused on how to ensure people have access to CRP in the most appropriate location based on their clinical needs and severity of charges. Outcome research and current models of CRP in the community are limited. The workgroup reviewed the available research, models in other states and proposals from organizations providing this type of CRP in non SPH settings.[4]

Recommendation: Conduct a pilot jail-based CRP via a Request for Information (RFI) from interested counties and/or via Request for Proposal (RFP) in which the respondents include location. Operating within a jail setting, this program will provide professional mental health services including psychiatry, psychology, case management and psychoeducation to individuals that would otherwise go to the SPH for capacity restoration. There are several models for the provision of jail-based capacity restoration services[5]. While specifics of the models vary, all models must ensure that a defendants' rights are protected by receiving an appropriate level of mental health care and treatment in a segregated area of the jail. The program award will be located in counties that have high SPH admissions of individuals who are ITP.[6]

Breaking the Recidivism/Readmission Cycle: Anecdotal information from the SPHs indicate that it is relatively common for individuals who return to jail following a reevaluation and recommendation of capacity to proceed, to decompensate clinically, lose ability to proceed, and must then return to the SPH. This pattern has been recognized by previous workgroups leading to Session Law 2013-18[7] which specifies timeframes for court hearings related to ITP. That workgroup acknowledged the timeframes are not currently met and there is no system actively tracking the interval from the time the individual transfers from the SPH to the jail to the capacity hearing and trial. Several recommendation and actions resulted from this discussion.

Recommendations:

- Administrative Office of the Courts (AOC) should implement suggested revisions to current forms. The workgroup created two new forms to improve communication between the state hospital's Assistant Attorney General (AAG) and the court. These forms also provide improved communication between the CRP provider and local court staff responsible for timely subsequent court involvement. The forms are included in the report appendix.
- Develop guidelines for patient specific communication regarding medication regime prior to return to jail.

[3] Please see pg. 12 for more information.
[4] Please see pgs. 12-14 for more information.
[5] Please see page 21 for more information.
[6] Please see pg. 15 for more information.
[7] Please see pg. 16 for more information.

- The AOC should consider their ability to enhance current technological system to track hearing and trial dates for individuals in the ITP process to create a monitoring tool to meet S.L. 2013-18, SB 45.

State Hospital Reimbursement: Currently, when an individual is unable to proceed to trial and is transferred to the SPH, the SPH absorbs the full cost of care for the individual. Similarly, the county jail system is no longer financially responsible for the care of the individual. Given that the responsibility for individuals who have been determined to be ITP is shared between the mental health and criminal justice systems, options for shared reimbursement were also a topic of discussion by the workgroup.

Recommendation: The workgroup did not reach consensus on a recommendation. DHHS proposes considering whether counties can/should share the cost with the SPH for an amount that is roughly equivalent to the cost they would have borne had the individual remained in the jail. The most applicable rate would be $106.92 per day, the average statewide close custody daily rate.

Conclusion:

Data included in the report demonstrates that the overall percentage of individuals in the SPHs with ITP status has increased significantly in the past several years. This increase is imbedded in the appropriate and much-needed movement toward decriminalization of mental illness – an effort which requires a strong public community behavioral health system that is designed to meet both the treatment and support needs (housing, food, healthcare, transportation, etc.) of people with Severe and Persistent Mental Illness (SPMI). There are clear costs associated with a system that waits to intervene until people with serious mental illness are arrested, incarcerated, and adjudicated as incapable to proceed.

Recommendations for Improvements to the Incapacity to Proceed (ITP) Process in North Carolina

I. Background

Session Law 2017-147 directed the NC Department of Health and Human Services to convene a workgroup and stakeholders group to study and develop a report that includes the following:

1. Issues within the system that impact an individual who lacks capacity to proceed to trial and the process to determine capacity;
2. Issues that create barriers within the system that negatively impact service providers including jails, courts, hospitals, and law enforcement agencies, in their efforts to serve an individual who lacks the capacity to proceed;
3. Solutions to reduce the number of persons who lack the capacity proceed; the number of persons who are referred to the State psychiatric hospitals; and the number of stays in the hospitals that extend beyond the clinical needs of the person who lacks the capacity to proceed.

The ITP process is one component of a much larger mental health service array. Along with the rise in the number of individuals with mental illness in the local jails and within state prison populations, the number of individuals involved in the ITP process has increased significantly in the State over the past few years.

The focus of this workgroup was to address areas of improvement around the ITP process. While these improvements to the ITP system would benefit individuals, who are involved with the criminal justice and behavioral health systems, changing the ITP process alone, without making improvements to the larger behavioral health delivery system, will minimize the impact of any changes recommended by the ITP workgroup.

North Carolina has a fragmented mental health service delivery system and services are not easily accessible due to limited provider networks and limited funding. Equally as important, in the current system, it is difficult for individuals to receive timely access to services especially when they are returning to the community from either the prison/jail or from a SPH. Changes to the larger behavioral health delivery system should be considered in support of the recommended changes to the ITP system included in this report.

In addition to funding an adequate community mental health service array for people with serious mental Illness (SMI), criminal justice diversion programs are widely accepted as a necessary solution. Programs such as Crisis Intervention Training (CIT) and the Stepping Up Initiative which uses Sequential Intercept Model (Munetz, M.R. & Griffin, P.A., 2006) would slow the flow of people with mental illness into jails and prisons by diverting them for treatment at their initial contact with law enforcement - and prior to trial - through interventions at other points in the criminal justice system and by appropriate interventions to address criminal justice recidivism upon their release from the criminal justice system.

The Stepping Up Initiative is a national effort with the goal of reducing the number of people with mental illness in jails. Forty-five counties in NC have endorsed the goals of the Stepping Up Initiative, and many of those counties are actively implementing programs designed to

divert people with mental illness from jail to treatment in the community. The goal of both of both CIT and the Stepping Up initiative is to decriminalize mental illness and behavioral health issues.

As directed by legislation, this report focuses on the ITP process. In developing this report, the overarching goals of the workgroup were to:

- Make the ITP process more efficient from initial evaluation to trial
- Improve the quality of initial forensic evaluations so that only those truly incapable to proceed are deemed ITP
- Increase options for individuals to receive quality behavioral health and capacity restoration programming in the setting that is most appropriate for their clinical needs and current criminal status.

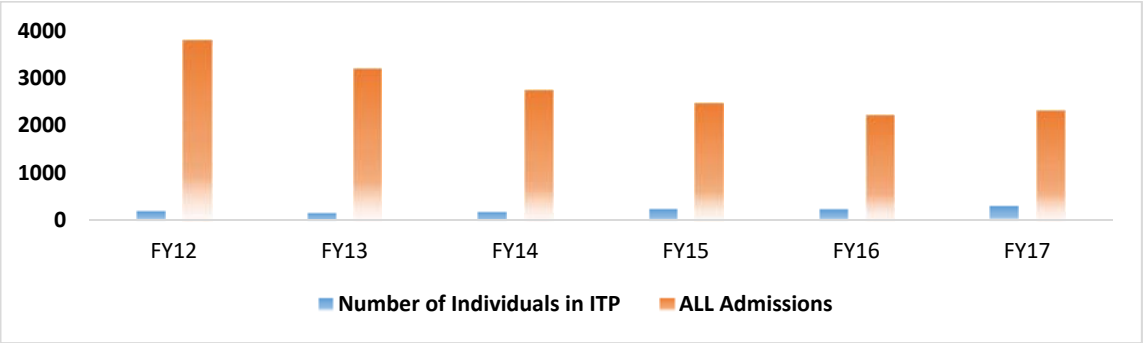
Together, these goals benefit the individuals who lack the capacity to proceed to trial, the various service providers and it also reduces the number and length of time individuals who lack capacity are hospitalized in State hospitals. Changes to the ITP system, however, should be considered from a systemic perspective to understand how modifications to one component of the mental health system impacts other components. While it is recognized that some stakeholder groups would advocate that all individuals with an ITP status be served in the State Psychiatric Hospital (SPH), the mental health system overall would be negatively impacted as it would lead to much longer wait times for individuals without an ITP status. As such, the recommendations aim to balance the need to serve individuals with an ITP status while decreasing the extensive wait times for other individuals who require the acute level of care that is provided only at the State hospital. The workgroup built upon Session Law 2013-18, Senate Bill 45, an "Act to Amend the Laws Governing Incapacity to Proceed."

The ITP process triggers a merging of the court and mental health systems in a unique way that can be both confusing and slow-paced. Once a defendant is ordered for evaluation of their capacity to proceed to trial, they enter a process that is dependent upon efficiencies and clarity in both systems. People evaluated and found to have capacity to proceed to trial are usually returned to their communities, frequently to local jails, to await the resumption of their criminal case proceedings. Individuals evaluated and found to lack the capacity to proceed to trial are often involuntarily committed to a SPH for treatment of mental disorder(s) and treatment to restore their capacity to proceed to trial. According to state law, the individuals involuntarily committed to the SPH must meet criteria for involuntary commitment (IVC) at the time of admission and throughout the hospitalization. Many of the involuntarily committed defendants will continue to meet criteria for IVC and will need continued treatment to prepare for a reevaluation of their capacity to proceed. Others may no longer meet the IVC criteria, but may still require capacity restoration services to prepare for a future reevaluation of their capacity to proceed. Upon reevaluation and if found to have capacity to proceed, the court system is informed and a capacity hearing can be scheduled. However, external factors may still delay discharge from the SPH. These factors include limited dates in the community for a trial, the jail may not have the resources to continue prescribed medication, and there can be issues with attorney schedules. Meanwhile, those found to have not gained capacity to stand trial remain a patient of the SPH. For some, restoration never occurs and they are not able to stand trial, leading to lengthy periods of hospitalization.

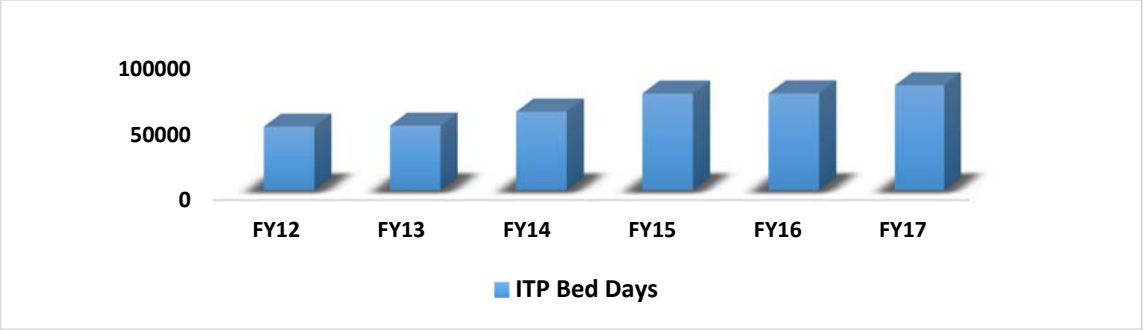
Data demonstrates that the number of individuals admitted to the state hospital with ITP status has increased slightly over the last several years. In SFY12 (State Fiscal Year), approximately

5% of all admissions were ITP. At the same time as the number of admissions on ITP have increased, the number of overall admissions to the state facilities has decreased. This leads to a greater percentage of patients in the SPH with an ITP status: SFY17 13%. This increase, coupled with the longer lengths of stay necessary for capacity resolution, results in a significant increase in the number of overall bed days for individuals with ITP status.

All SPH Admissions vs. ITP Admission FY12-FY17:



Number of ITP Bed Days FY12-FY17:



Currently only CRH operates a forensic services unit (FSU). By statute, individuals found not guilty by reason of insanity (NGRI) are admitted to the FSU and nearly all the beds are occupied by individuals found NGRI. This results in individuals determined to be ITP being admitted to the civil (non-forensic) beds in admissions units of each of the three SPH. The Adult Admissions Units at each of the three State psychiatric hospitals operate at full capacity with delays for individuals referred to the beds. People are referred from many community sources including community hospital emergency departments, community psychiatric inpatient units, community hospital medical units, community crisis centers, and the court system/jails. Referrals are authorized by the Local Management Entities/ Managed Care Organizations (LME/MCOs) and may be placed on a delay list until a bed is available. Individuals may be prioritized to the top of the list when they are extremely psychotic, aggressive and/or self-injurious. However, because of statutory requirements, individuals sent by the court system on ITP status will bypass this process and go directly to the State hospital admissions office. This extends the time other individuals on the delay list must wait for a bed even when they have been prioritized.

Historically, as many as one-third of adult beds (adult acute and adult long term) have been occupied by individuals with ITP status. As most individuals with ITP status are male, as many as 60% of adult male civil beds may be filled with patients with ITP status. In SFY17, individuals referred from EDs waited, on average, over 5 days for admission with many waiting much longer. Research from CRH suggests that once individuals with ITP status are admitted to a State psychiatric hospital, they are likely to have a length of stay double that of a civil patient. One side-effect of direct court admissions

and the resulting longer lengths of stay, is that individuals, especially males, who are in EDs or other locations, that need State psychiatric hospitalization, have restricted access to a very limited resource.

Session Law 2017-147 included a requirement that a workgroup be convened to "study the lack of capacity to proceed process." Section 2 of the session law directed the Department of Health and Human Services (DHHS) to "convene a workgroup to evaluate the laws governing the lack of capacity to proceed process, including the impact of the laws on the limited resources of the community mental health system, hospitals, state psychiatric hospitals, local law enforcement, court system, jails, crime victims, and criminal defendants." DHHS was required under the legislation to present preliminary findings of the workgroup to stakeholder organizations identified in the legislation.

The preliminary report was presented to the stakeholder group on 12/18/2017. After receiving feedback and recommendations from the stakeholder group, the workgroup completed the final report for submission to the Joint Legislative Oversight Committee for Health and Human Services and the Joint Legislative Oversight Committee on Justice and Public Safety.

II. Initial Forensic Evaluation for Capacity (Section 3 (B) (1))

1) Current Status and Challenges

In North Carolina, the question of capacity to proceed may be raised at any time by the defendant, defense counsel, the prosecutor, or the judge. Capacity evaluations are requested when there are concerns that a mental disorder and/or cognitive impairment impacts the defendant's ability to:

- understand the nature and object of the proceedings against him
- to comprehend his own situation in reference to the proceedings
- or to assist in his defense in a rational or reasonable manner

In 2013, the state laws regarding these evaluations were amended pursuant to Session Law 2013-18, Senate Bill 45, "*An Act to Amend the Laws Governing Incapacity to Proceed."* Under these changes, defendants with misdemeanor charges were not to go to a CRH for an evaluation, but were to be evaluated only by a local evaluator managed by the local management entity/managed care organization (LME/MCO). For defendants with felony charges, evaluations were to be conducted either by a local evaluator or by an evaluator at CRH. Additionally, the law required the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services to adopt rules that requires local evaluators to compete annual continuing education seminars. The Commission, as a result, amended eight existing rules to incorporate the requirements of the Session Law. At the time of this Report, the Rules Review Commission (RRC), the executive agency responsible for reviewing and approving rules adopted pursuant to G.S. 150B, has approved each of the rules as amended by the Commission. However, the RRC received 10 letters of objections to five of the eight rules which now subjects them to legislative review per G.S. 150B-21.3(b2) and has thus delayed effective date for those rules until the next legislative session per G.S. 150B-21.3(b1). Since there are three rules not being objected to, the Commission has asked all eight rules have a delayed effective date as provided by G.S. 150B-21.3(b2) noted above.

Presently, evaluations of capacity to proceed may be completed by a local evaluator in the community or at a SPH, usually CRH in Butner, North Carolina. All evaluations conducted by the local community evaluator and 90% of the evaluations conducted by the Pre-Trial Evaluation Center at CRH are done on an outpatient basis. For outpatient evaluations done by CRH, a sheriff normally transports the individual to CRH where the evaluation is conducted and the individual returns to the jail the same day. If the defendant is not in the custody of the jail at the time of evaluation, other transportation may be arranged. The remainder of the initial forensic evaluations conducted by CRH, (approximately 10% or 85 annually) are conducted on an inpatient basis. Meaning, the individual is admitted to the hospital for the length of time needed to complete the forensic evaluation. Individuals admitted for evaluation are those who are so psychiatrically acute that they need hospital level of care to conduct the evaluation, or the case is so complex that additional time is required to adequately evaluate the individual.

Anecdotally, community evaluations are thought to be of lower quality and satisfaction than evaluations completed at the SPH. Thomas Grisso, PhD, in his 2005 report for North Carolina Capacity to Proceed Evaluations for Persons with Mental Retardation, raised concerns regarding the "local screener" process. While noting these systems can expedite the completion of ITP evaluations, he makes the point that the system in NC is not equivalent to other state systems which require higher standards, training and monitoring of local evaluators. He noted that other states require higher

standards for community evaluators with training and experience like those doing evaluations in the state hospitals.

As stated previously, North Carolina requirements are minimal and will remain so until new rules requiring annual training are codified, or there is a change in statute strengthening the requirements for those doing evaluations in the community. Furthermore, the current rate of $100 for an outpatient evaluation conducted by a community evaluator is inadequate compensation for a professional, thorough evaluation. This low rate of reimbursement (which averages $12.50 per hours for an 8 hour effort) may also account for some of the lack of quality found in the evaluations. Per Gowensmith et. al. (2015), there is wide variability across states regarding payment with the 19 states reporting payment data for outpatient evaluations ranging from $170 to $3000, and an overall average of $762.11. North Carolina's rate of $100 is actually below the lowest rate reported.

Judging from the survey results (see below), local community evaluators with fewer credentials and experience are perceived to produce low-quality evaluations. As a result, courts may require a secondary evaluation from evaluators at CRH which leads to further delays in the process. Additionally, defendants with misdemeanor charges continue to be ordered to CRH for evaluations.

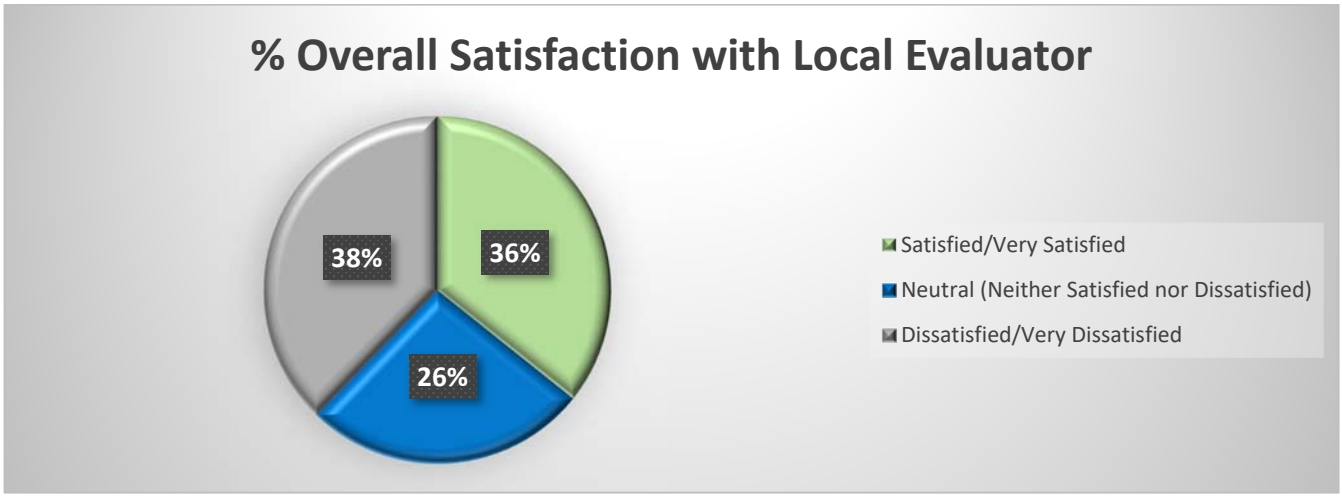
Survey: Methods and Results

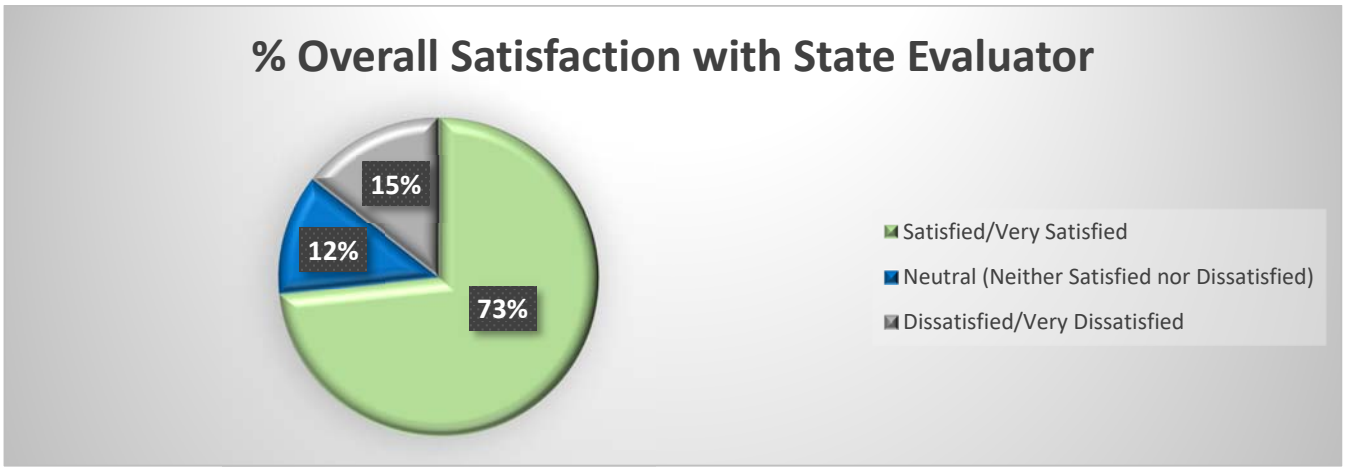
A survey (See Appendix A) was developed by members of the ITP workgroup and was distributed to relevant North Carolina court stakeholders regarding forensic evaluation performed by local evaluators and SPH evaluators, to determine:

- The satisfaction with the current system
- Satisfactory and unsatisfactory elements of the current evaluation system
- Frequency of evaluation duplication, in which the defendant is evaluated by both a local evaluator and by a state hospital evaluator
- Common concerns and barriers

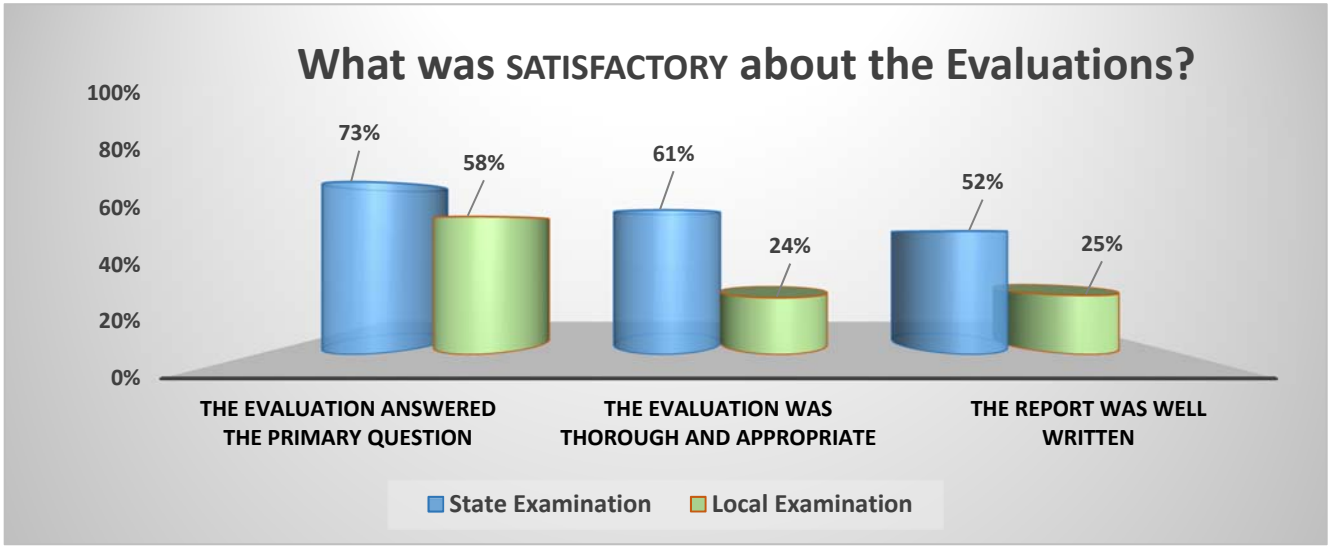
The survey was distributed via North Carolina Advocates for Justice Criminal Listserv, statewide Judicial Branch employee emails and was posted for response on JUNO (AOC's intranet platform). The survey, open from August 1-August 15, 2017, was accessed 408 times and finished by 120 individuals. While remaining anonymous, respondents were given the options of 1) Judge 2) DA/Prosecutor 3) Defense Attorney and 4) Other, and were asked to self-identify their current role in the judicial system. Those self-identifying as "Other" were thanked for their participation and were exited out of the survey. Of those that identified as a Judge, DA/Prosecutor or Defense Attorney, respondents were asked to select their level of direct experience with ITP cases in North Carolina. As the intent was to focus on the perspective of those using the current system, survey responses were narrowed to include only those with direct ITP experience in NC, resulting in 120 completed surveys (N=120).

Respondents were asked about their experience with both state and local evaluations and responded only to the types of evaluations with which they had experience. Results were rounded-up or down when appropriate, and as such, resulting percentages may range from 99-101%. The questions were not comparative in nature; rather experience-based with the specific evaluation types. Using a 5-point Likert scale, survey results demonstrate that 36% of respondents were Satisfied/Very Satisfied with the quality of local evaluations while 38% were Dissatisfied/Very Dissatisfied. 26% identified as "neutral." 73% of respondents identified as Satisfied/Very Satisfied with the quality of state evaluations, with 15% indicating they were Dissatisfied/Very Dissatisfied and the remaining 12% self-identifying as "neutral."



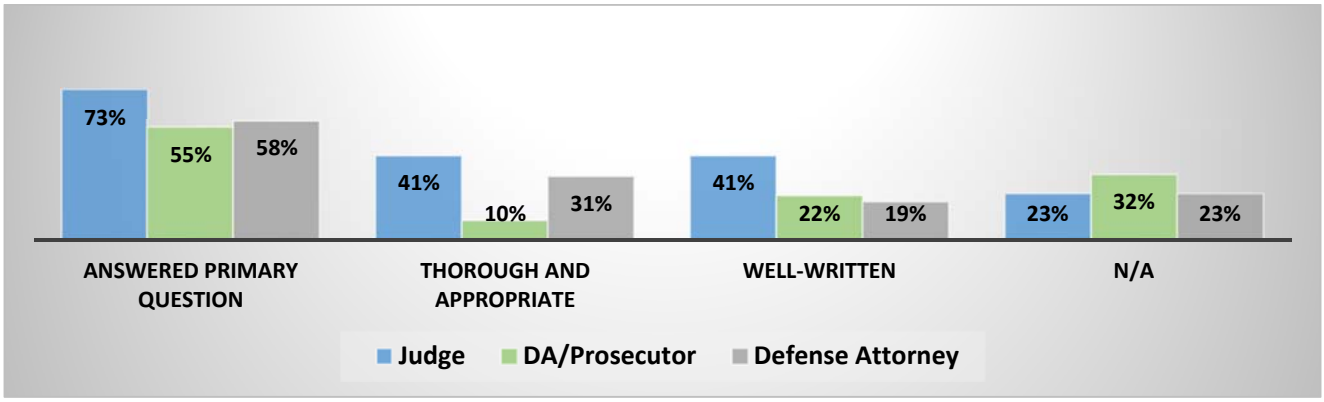


The "quality" of evaluations was explored to better understand that 58% of respondents perceive that the local evaluations answer the primary question, 24% indicate the reports are thorough and appropriate and 25% believe the reports are well-written. Comparably, 73% of respondents believe the state evaluations answered the primary question, 61% believe the evaluations are thorough and appropriate and 52% indicate the reports are well-written (see visual representation).

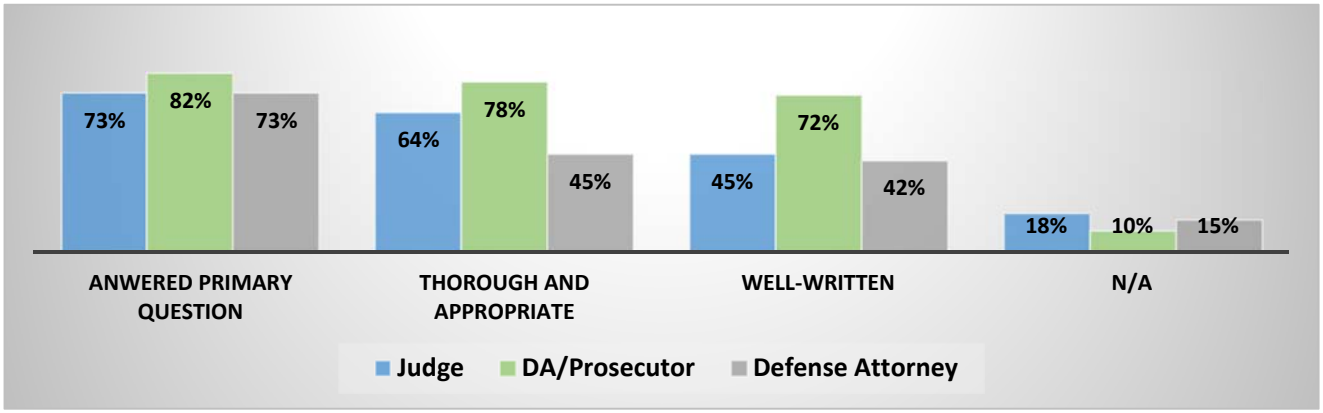


This data, broken down by respondent-type, demonstrates that overall, judges perceive the evaluations as having answered the primary questions 73% of the time, regardless of the evaluator type. There appears to be considerable variances between the perceived thoroughness and appropriateness of the two reports with state evaluations resulting in a considerable higher satisfaction rate.

Local Examiner:

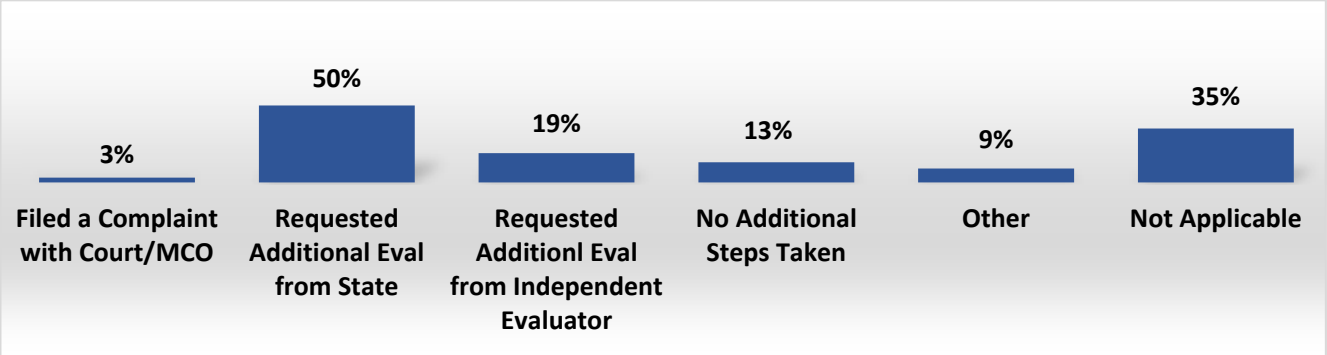


State Examiner:



Given the anecdotal concerns surrounding dissatisfaction with some evaluations, court respondents were asked to identify what their response had historically been when they were dissatisfied with the quality of a completed evaluation. Data from the survey indicated that, when not satisfied with the quality of local evaluator's examinations, 50% of respondents request an additional (or duplicate) evaluation from the state psychiatric hospital and an additional 19% have requested a second evaluation from an independent evaluator. Duplication of effort results in lost time, is costly and leads to misdirected resources.

Next Action When Not Satisfied with Quality of Local Evaluation:



Areas of Concern from Survey

The purpose of the survey was to gain an understanding of user confidence and satisfaction with the current evaluations. While it was generally a quantitative review, respondents were given the opportunity to provide additional feedback by way of comments, allowing for a surface-level qualitative review as well. Comments were categorically grouped between local and state evaluation types and the themes were then extrapolated.

The following themes were identified consistent regardless of evaluation type:

- Poor Timeliness;
- Biased Outcomes;
- Qualifications of the Evaluator;
- Lack of Supporting evidence (evaluations not perceived to be sufficiently thorough enough to decide) and;
- Consistency between evaluators: overall quality is dependent on the specific evaluator assigned.

State Hospital Data:

To better understand the total numbers of evaluations, who is doing them and how often they are duplicated, data was gathered directly from the state facilities. The results indicate the following

- For the calendar year January 1, 2016-December 31, 2016, the SPHs (primarily CRH) managed 835 "encounters." Encounters include individuals that may have been referred or seen by hospital staff, but not all required an evaluation or, in some cases, charges were dropped before the report could be completed

- Of the 835 encounters, 94% (789) resulted in completed evaluations.

- Approximately 35-40% of evaluations completed by the state facilities are duplicates (individual had previously received an assessment from a community-based evaluator).

Local Community Evaluator Data:

- From 2013-2016, an average of 820 community-based evaluations were completed annually;
- 44% of community-based forensic evaluations were identified as a felony charge;
- More than 35% of community-based evaluations were subsequently referred to CRH for an additional (or duplicate) evaluation.

The demand for ITP evaluations as well as other components of the broader ITP system have continued to present challenges to the mental health and criminal justice systems. Nationwide, questions regarding the criteria for who may do these evaluations have arisen as states work to maintain a system that provides high quality evaluations in a timely manner. The highest standard for evaluations requires they be done by doctorate-level professionals in a setting where the individual can be observed by a team of behavioral health professionals in an inpatient psychiatric hospital. While this is ideal, the high demand for doctorate-level professionals can create unreasonably long waits for evaluations, which can be argued to be a violation of an individual's right to a speedy trial. On the other hand, a system that includes professionals with fewer credentials and less experience may result in a lack of confidence in the evaluator's opinion or lower quality evaluations, but can improve the system's efficiency.

Improvements to the local evaluator system were attempted by the legislature in the Session Law 2013-18, Senate Bill 45, "*An Act to Amend the Laws Governing Incapacity to Proceed."* That law required the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services to adopt rules which would require local evaluators to complete all training requirements necessary to be credentialed as 'certified forensic evaluators' and would require all local evaluators to compete annual continuing education seminars. As stated previously in this report, because of objections to some of the rules, none of the eight rules have been implemented as of the preparation and submission of this report.

2) Alternative Models for Initial Forensic Evaluations

In their 2015 article, *States' Standards for Training and Certifying Evaluators of Competency to Stand Trial*, Gowensmith, Pinals and Karas reviewed the standards that states use to train, certify and retain evaluators of capacity to stand trial, and found wide variation across the United States. Their study focused on the state-appointed evaluators who perform most capacity to proceed evaluations. They found that 19 States had mandatory capacity to proceed evaluator certification requirements. This workgroup acknowledged that evaluator professional standards and training are important to ensure quality in capacity to stand trial evaluation reports. The following is a summary of a few of the training and qualifications standards for various states:

- Virginia: requires clinicians complete a 5-day training course by the University of Virginia's Institute of Law, Psychiatry and Public Policy (ILPPP), culminating in an exam. The staff of ILPPP remain a resource to those trained. In addition, these evaluations must be performed by a psychiatrist or doctoral-level psychologist. The required training is recognized by the Virginia Commissioner of Behavioral Health and Developmental Services and the Commissioner maintains the list of approved evaluators for the State. Furthermore, evaluations

must be outpatient except when the court finds that outpatient evaluation services are unavailable or unless the results of outpatient evaluation indicate that hospitalization for the evaluation is necessary (§ Virginia G.S. 19.2-169.1).

- Colorado: Like Virginia, requires the psychiatrist or psychologist evaluators who have completed a six-hour training program and a four-hour program annually. They also are required to have one evaluation reviewed by a mentor program annually. The evaluations are typically done in a state hospital. And due to the extended wait times for defendants to be admitted into state hospitals for evaluations, Colorado is currently being sued by the Department of Disability Law.
- Oregon: In their article, Gowensmith et. al., (2015) reviewed a program in Oregon in which there are three types of certification, full, temporary and conditional. Evaluators with full certification can perform all evaluations, while evaluators with temporary certification may only evaluate defendants with misdemeanor or non-violent felony charges. Conditional certificates are provided under unusual circumstances, such as for an out-of-state expert or when unusual expertise is required, and expires when the legal matter for which the certification was issued is resolved. Oregon specifies that only psychiatrists and psychologists can be certified, with one exception; they allow licensed clinical social workers to complete evaluations for juveniles. All potential evaluators must attend a two-day training at the Oregon Forensic Training Program (OFETP) and pass a test. They must renew by attending a 1 day training every 24 months.
- Multiple States: Gowensmith et. al. noted, in general, several states allow both psychiatrists and psychologists to perform evaluations. In 15 states, other masters-level clinicians may be trained and certified. Because these masters-level clinicians may have vastly different training in basic mental health assessment and in court experience, the authors recommended, to ensure high quality from these evaluators, states must require targeted and sophisticated training to foster skills across disciplines (Gowensmith, et al, 2015).

In their 2014 report prepared for the State of Washington's Department of Social and Health Services, Groundswell Services, Inc. did a review of the forensic services system. The review was done in part due to the concerns about the quality and timeliness of mental health services to individuals involved in the criminal justice system. Recommendations from the report included establishing a centralized Office of Forensic Mental Health Services with adequate authority and data management capacity to oversee all forensic evaluation services, assist hospitals and community agencies, and serves as a liaison across systems. The report also suggested establishing state-wide procedures to facilitate forensic evaluations, train forensic evaluators, and monitor quality of forensic evaluation reports. The report did identify the need for additional evaluators, the need for satellite sites for evaluations, and the need to address low salaries. Many of these issues are common to the system in North Carolina.

3) Recommendations and Analysis

Recommendation 1

The workgroup recommends eliminating the local community evaluator system and replacing it with a regional model based at each of the three state hospitals, (Central Regional, Cherry and Broughton). The workgroup recommends creating pre-trial forensic evaluation programs at Cherry and Broughton Hospitals which, along with the existing program at CRH, will be responsible for the court-ordered forensic evaluations in their respective region. Most of the evaluations done at CRH are outpatient

and we expect this same pattern when Broughton and Cherry become the regional evaluation centers. The primary costs will be tied to hiring additional forensic evaluators and support staff at both Cherry and Broughton.

There are multiple benefits that the workgroup attributed to this proposed regional evaluation center model:

- Duplications in the current local and SPH evaluator system will be eliminated.
- Reduction in the time and cost of transportation for individuals needing an evaluation as they will have availability at the SPH in their region instead of all being transported to CRH.
- Increased control over the qualifications, training and supervision of evaluators will improve the quality of the evaluations.
- Higher quality reports will increase the court system confidence in the evaluator's expertise and opinions.
- Incarceration and necessary psychiatric treatment within the jail setting will decrease in frequency and duration.
- The risk that incarcerated individuals with SPMI might accumulate additional charges secondary to psychiatric symptoms while in jail will decrease with access to a regional pretrial evaluation center.
- The risk of a lawsuit against NC will be decreased with improved efficiency and quality in the evaluation system.

Costs:

Cost projections for regionalizing the forensic evaluation system which would include creating pre-trial evaluation centers at Cherry and Broughton Hospital in addition to the existing one at CRH are based on several basic assumptions:

1. It is anticipated that there will need to be 12 additional positions to fully staff all 3 pre-trial centers.
2. Most evaluations will occur at the State facilities on an outpatient basis consistent with the current pattern at CRH (90%)
3. To offset some of the additional costs of law enforcement who will transport more defendants to the regional SPH rather than have a local evaluator in the community conduct the evaluation, evaluators at the SPH will travel within their catchment areas to provide some services. This additional cost for SPH evaluators has been built into the projections.
4. The SPH may outstation forensic evaluators in counties that have a high volume of individuals referred for capacity evaluations.

Estimated Annual Costs[8]				
Personnel	**Mileage - Evaluations**	**Mileage - Court**	**Subsistence**	**Total**
$1,725,000	**$52,000**	**$10,000**	**$11,000**	**$1,798,000**

[8] Details available upon request.

It can be assumed some of these costs will be offset by the elimination of community evaluations. The cost offset in the elimination of community evaluations based on the average of 800 evaluations in the community each year would be $80,000. As mentioned earlier in the report, consideration must also be given to the duplication of evaluations due to concern over quality and time spent on evaluations.

Recommendation 2

If the legislature does not adopt recommendation #1 in its entirety and chooses not to eliminate the local evaluator system, the workgroup recommends strengthening the local evaluator system. The forensic rules meant to improve oversight and quality of the community evaluators, are still subject to the legislative review process and will continue to be delayed (and possibly never approved as permanent rules). The workgroup therefore recommends improving the local forensic evaluator system by:

- Codifying in statute the major component of the rules as approved by the RRC following Session Law 2013-18, Senate Bill 45, "*An Act to Amend the Laws Governing Incapacity to Proceed"*:
    - Require local forensic evaluators to be licensed clinicians with verified experience with the population they propose to evaluate and employed or contracted (individually or through a provider) with the LME/MCO,
    - Require local forensic evaluators to successfully complete initial and annual training in forensic evaluation topics, to be provided by the DHHS pre-trial evaluation program at CRH,
    - Require each LME/MCO to monitor and ensure that adequate local forensic evaluators are available for the volume of court ordered community forensic evaluations,
    - Require the LME/MCO to develop a quality monitoring mechanism for the community forensic evaluations that, at a minimum includes a local forensic evaluator that meets the first two conditions above to review evaluation reports, provide feedback to evaluators and respond to questions and concerns about the forensic reports.
- Increasing the reimbursement rate for forensic evaluations completed by local community evaluators from $100 per evaluation to $800 per evaluation.

III. **Capacity Restoration Programming (Section 3. (B) (3))**

1) Current Status and Challenges

If a judge has reasonable grounds to determine that an individual determined to lack capacity to proceed also meets the criteria for involuntary commitment under Part 7 of Article 5 of Chapter 122C of the General Statutes, he or she may issue a custody order to transport the defendant to a 24-hour facility designated to accept individuals who are involuntarily committed, almost always to a SPH. Once admitted, individuals who have been determined to be ITP receive the same clinical care and treatment as civil patients. In addition, defendants participate in Capacity Restoration Programming (CRP) to assist them to understand their criminal charges and court proceedings, thus restoring their capacity to proceed.

Session Law 2013-18, Senate Bill 45, "An Act to Amend the Laws Governing Incapacity to Proceed", required the Commission for Mental Health, Developmental Disabilities and Substance Abuse Services to adopt guidelines for treatment of individuals involuntarily committed subsequent to a determination of incapacity to proceed. Those guidelines were formalized on December 1, 2013. The guidelines were written to apply to any location where CRP is provided, even though currently CRP is only provided in the SPHs. The guidelines require legal barriers to be included in the individual's treatment plan:

- understand the nature and object of the proceedings against him
- to comprehend his own situation in reference to the proceedings or to assist in his defense in a rational or reasonable manner

The guidelines also require best practice multi-modal interventions which are tailored to the needs of the individuals and may include the following:

- Prescription of psychotropic medication
- Psycho-education that focuses on charges, courtroom proceedings, sentencing, plea bargaining, role of court personnel and assisting with one's defense.
- Group treatment that includes discussion, readings, videos, role-playing and mock trials. This may include additional educational supports with defendants with learning disabilities, communication disorders, traumatic brain injury and/or intellectual/developmental disabilities.
- Individual treatment which includes addressing specific deficits and discussion of the individual's understanding of his/her specific criminal case.
- Peer support from individuals who have had similar experiences.

The three SPHs have all enhanced their capacity for CRP over the past three years with an added focus on providing a broader array of and more frequent groups and individuals programming geared at assisting individuals to regain capacity. Rather than relying solely on CRP at the SPHs, however, expanded opportunities for CRP in alternate locations that better match the individual's clinical needs and severity of charges would be beneficial to individuals determined to be ITP, the SPHs and to the larger mental health and criminal justice systems. Additionally, certain populations are not best served in the SPHs. For example, individuals with an Intellectual/Developmental Disability who need CRP may benefit from a setting that serves that population rather than a psychiatric setting.

2) Alternative Models for Capacity Restoration Programming

To address the expanding needs of individuals identified as needing forensic services from the State hospitals and the limited resources currently available, North Carolina must develop a system that ensures individuals with the greatest psychiatric need are admitted to SPH beds as soon as possible, while ensuring those in jails who have a mental disorder also receive appropriate mental health care. The system needs to be responsive and ensure that when the court designates the need for ITP evaluations and restoration, individuals have access to evaluation and treatment in the most appropriate location based on their clinical need and current criminal status. This includes capacity restoration in the following locations:

- State psychiatric hospital: for individuals with significant mental illness that meets the hospital commitment criteria and any level of criminal charges;
- Local/County Jail: for individuals who have mental illness but do not meet hospital commitment criteria and any level of criminal charges;
- Outpatient/Community: for individuals who have satisfied conditions of release and who do not meet psychiatric hospital commitment criteria

To work the most effectively, a community must have access to a full continuum of CRP and must have clear guidelines for who would be best served in each location, with the ability to transfer between the settings as necessary depending on the individual's evolving clinical and legal status.

While much research has been done regarding capacity evaluations, the research around community-based competency restoration programs is relatively new. In their 2016 report, Gowensmith, N.E., Frost, L.E., Speelman, D.W., & Therson, D.E. (2016) studied the 16 existing OCRP and determined "OCRPs show generally positive results, including financial savings, increased inpatient bed capacity, maintenance of public safety, and high rates of restoration."

Community Based Restoration Programs

Outpatient Capacity Restoration Programs (OCRP) are typically designed and implemented by local community mental health authorities and/or contract providers. Participants must meet certain eligibility requirements often based on risk of violence, level of current and past charges, history of hospitalization and housing stability. Some OCRPs require a period of hospitalization prior to referral to the outpatient program. According to Gowensmith et al, (2016) the number of participants ranged from <20 to 100+ per year, an overall average of 70% capacity restored, 20% non-restorable and the remaining had charges dropped. The most conservative average number of days to restoration was 149 days. Gowensmith reported an average savings per day of $388 for States with OCRPs. In their 2016 report, Gowensmith et. al. also stated "The current study indicates that OCRPs, as a rule, show promising and positive outcomes. However, data for some outcome variables were missing from some states." Careful consideration must be given to such issues as:

- The volume of demand for OCRP for individuals who have been determined to be ITP, but are still able to participate in and benefit from an outpatient setting.
- Public safety must be considered so only those defendants with low level charges would be candidates for the program.
- Access to these programs may be hindered by low economic status as access to bail, living arrangements and transportation are often limited for people who have a SPMI.

One specific cohort of individuals who would benefit from OCRP are defendants who have satisfied their pretrial release conditions and who do not meet commitment standards. These individuals cannot

be served either in jail (because they are eligible for pretrial release) or in an inpatient setting (because they do not meet criteria for hospitalization). Individuals with low level charges who have been determined to be ITP and who also have an Intellectual/Developmentally Disability would likely benefit from OCRP.

Jail-Based Restoration Programs

Jail-based programs and capacity restoration programs within the jail setting are like state hospital inpatient programs with professional services including psychiatry, psychology, case management and psychoeducation. There are several different models for jail-based capacity restoration programs: programs that provide capacity restoration while individuals are awaiting transfer to a state hospital or community restoration program, standalone capacity restoration programs within a jail setting that function independently from other general population units in the jail, as well as programs that are staffed by state hospital personnel and run as a satellite of a traditional SPH forensic unit. Regardless of the model, a jail based program must ensure that defendants' civil rights are protected by receiving an appropriate level of mental health care and treatment in a segregated area of the facility.

The North Carolina Department of Health and Human Services (NC DHHS) previously received information from two companies that currently provide standalone competency restoration programs that are imbedded within a jail setting:

- Liberty HealthCare Corporation, Inc. approached the Department to pilot a jail based capacity restoration program in the counties that are the highest utilizers of restoration services in the SPHs. Liberty stated in the presentation to DHHS that their program Restoration of Competency (ROC) "offers a unique jail-based program for restoring competency that can significantly cut the demand for state hospital forensic beds and directly assist local jails and law enforcement to better manage a high-risk population – yielding major cost savings and improved services." They highlighted the program in current operation in California at the West Valley Detention Center in San Bernardino County.
- DHHS met with representatives from CorrectCare, Inc. regarding their jail-based capacity restoration model, Restoring Individuals Safely and Effectively (R.I.S.E) currently operating in several states with varying scope and service models. CorrectCare, Inc. highlighted the R.I.S.E. program in Colorado at the Arapahoe County Detention Center. The program opened in November 2013 and expanded in August 2016.

Both models had a great deal in common including a multidisciplinary or interdisciplinary team approach to jail-based capacity restoration. According to the companies running the program, they are showing promising outcomes. Liberty reported their program in San Bernardino restored about 58% of the participants in an average of 56 days. CorrectCare reported the Colorado R.I.S.E program served 256 patients over three years and the average length of time for restoration of capacity to stand trial was 51 days.

Jail-based capacity restoration is not indicated as the most appropriate setting for all individuals to receive capacity restoration, but some data does indicate that jail-based capacity programs may restore appropriately referred individuals to capacity quicker than inpatient capacity restoration programs. Other settings within the Department of Public Safety system, such as Central Prison's Safe Keeping, might be appropriate for individuals who are ITP and transferred to Safe Keeping.

As the result of a June 2017 settlement with the Disability Law Center, the Utah Department of Health and Human Services[9] agreed to significant changes to the ITP process in the state. The

[9] Disability Law Center v. State of Utah, U.S.D.C. (D. Utah), Case No. 2:15-cv-00645-RJS.

settlement established timeframes for SPH to complete initial screenings as well as additional options for individuals to receive capacity restoration including:

- Outreach Program- Individuals who are deemed likely to show meaningful progress towards restoration within 30 days and likely to be referred for reevaluation within 60 days may receive capacity restoration through the SPH Outreach program within the county jails.
- Alternative Therapeutic Unit- Consistent with the option discussed above, these units are established and operated by SPH or under contract with the department on or off the SPH campus for persons who do not require hospitalization level of care.
- Jail Based/ SPH off-site Program- Forensic facility (usually jail-based or other secure setting) administered by SPH staff or similarly qualified employed by a department contractor at a location other than the SPH campus where individual receive capacity restoration.

3) Recommendations and Analysis

- The workgroup recommends conducting a pilot of a jail-based capacity restoration program. The following conditions would apply:
    - Release a Request for Information (RFI) to solicit interest from counties that may be interested in providing space for the Jail-based CRP. The RFI would assist the State with the future RFP process by determining whether there was enough interest in a CRP. This would increase the State's relationship with the county/jail and authority over the CRP. If there is not sufficient initial interest solicited via the RFI, finding a location for the CRP would be included in the actual RFP.
    - A small group of representatives from the SPH, Sheriff's Offices and DHHS should develop the RFP. The RFP should ensure that services meet quality standards and that there is strong collaboration between the CRP, the jail, and the local SPH
    - To initiate the pilot in the most time efficient manner, the program should be competitively bid with a start date set within 6 months of contract award date,
    - The pilot should be conducted in a county jail that sends a high number of individuals with ITP status to the SPH (Please see Appendix B). This could include the highest utilizer counties or counties that respond during the RFI process that can work collaboratively with these counties to address the need.
    - Additional "points" should be awarded to providers who will provide the program in the county jails in the SPH catchment areas that have the longest waiting period for admission,
    - Establish and monitor metrics that determine whether the program is successful; this might include but would in no way be limited to readmissions to the hospital,
    - After 18 months of operation, the program should be evaluated according to metrics identified in the RFP and a determination should be made to expand the CRP to other jails, continue with the existing CRP, modify the existing CRP for additional assessment or terminate the CRP.

Cost and Savings Estimate- There are different models for contracting with a vendor to provide CRP services in a jail-based setting for example:

- Vendor contracts directly with the State and sub-contracts with the Sheriff/county to utilize space and other jail resources such as security, nutrition, etc.
- The State contracts with the vendor who is a subcontractor of the Sheriff/county. In this model, all services are usually negotiated and included in the contract.

Utilizing these models which are currently in place in other states, as a comparison NC, suggest the startup costs for a CRP could be approximately $130,000-$300,000, and the daily cost per bed approximately $308 -$418. Using this same cost range, a 20-bed pilot would cost approximately $ 2,057,440 to $ 2,795,246 presuming full occupancy which is 334 days of treatment per bed/per year. Comparing this to the cost of treatment in the State Hospital, which Medicaid Cost Rate from SFY 17/18 averages $1216.00 per bed per day, the cost savings would be substantial, as demonstrated in the provided chart. In addition to these estimated cost savings, by implementing a jail-based restoration pilot for individuals whose clinical needs and criminal charges could be supported inside the jail setting, other individuals whose clinical needs exceed the level of care they are currently receiving could be more quickly served in an appropriate setting -

	Cost Per Day	x20 Beds	x 334 Days
Jail-Based CRP	$308-$418	$6,160-$8,360	$2,057,440-$2,795,246
Hospital Stay	$1,216	$24,320	$8,122,880
Cost Savings:	**- ($5,327,634 - $6,065,440)**		

*Medicaid Cost Rate using the average of 3 state hospital rates SFY 17/18

- The workgroup recommends that consideration be given to providing capacity restoration programing in Central Prison, Safe-Keeping, as provided by the Department of Public Safety,
- The workgroup recommends further investigation into the emerging practice of using an Alternative Therapeutic Unit. This unit would be separate from the SPH for individuals that do not meet criteria for Inpatient level of care and whose needs could be better met in a setting outside of the hospital. As this is a relatively new model, it would be important to further explore tracked outcomes as well as successes and barriers to implementation.
- The workgroup recommends DHHS direct DSOHF, DMH/DD/SAS and DMA to examine how outpatient CRP services could be built or added into existing community service definitions and billing mechanisms. If billing permits, establish a community-based pilot for individuals whose clinical needs and current criminal status allows for CRP in an outpatient setting.

IV. Breaking the Recidivism/Readmission Cycle (Section 3. (B) (2))

1) Current Status and Challenges

Anecdotal information from the SPH indicates that it is relatively common for individuals who return to jail following a re-evaluation and a recommendation of capacity to proceed to decompensate clinically, lose their capacity to proceed and must then return to the SPH for further competency treatment Individuals can return to the SPH prior to the capacity hearing or after the capacity hearing, but prior to the criminal trial. One hospital described an individual with ITP status who repeatedly has been evaluated as restored to capacity and returned to the county jail, but prior to the capacity hearing decompensates and returns to the SPH. The hospital finally decided he should remain admitted until the capacity hearing to ensure that he did not decompensate clinically and lose capacity prior to the hearing again. When an individual alternates between the SPH and jail, not only does it result in disjointed services to the individual limiting progress to trial, but it is also detrimental to the hospital and jails who use their limited resources to serve the individual on a repeated basis. In the case of the hospitals, the cycle significantly delays the admission of others who need inpatient psychiatric care.

Presently, DHHS is not able to easily able access data that quantifies how frequently this occurs, but each hospital provided numerous examples of this hospital-jail-hospital cycle. As discussed in the previous section related to alternative models to competency restoration, the addition of enhanced jail-based services might help reduce the number of these readmissions if individuals are able to receive enhanced support inside the jail in lieu of being readmitted to the State hospital. As a result, if fewer individuals are being readmitted because of decompensation while awaiting trial, the hospitals would then be able to serve others needing care.

The Legislative Research Commission's Committee on Incapacity to Proceed that met in 2011 through 2012 also recognized the problem of individuals cycling between the jails and the hospitals. As a result, Session Law 2013-18, Senate Bill 45 established timelines for completion of forensic evaluations and reports to reduce the hospital-jail-hospital cycle. N.C.G.S. §15A-1007(a) requires that "Upon receiving the notification [that the defendant has gained capacity to proceed], the district attorney shall calendar the matter for hearing at the next available term of court but no later than 30 days after receiving the notification." Subsection (d) of the same statute states, "If the court determines in a supplemental hearing that a defendant has gained the capacity to proceed, the case shall be calendared for trial at the earliest practicable time." The workgroup acknowledged that the time frames do not seem to be met but there is no tracking system to quantify and study this. The following were determined to be primary issues contributing to the hospital-jail-hospital cycle:

- Communication breakdowns between the criminal justice system which is tasked with resolving legal charges, and the mental health system which is tasked with treating mental illness. Individuals in the intersection of these systems can get lost due to the disparate missions and legal requirements of each system.
- No clearly prescribed format for notifying the county clerk of court when an individual in a SPH has been re-evaluated and found to be capable to proceed. This results in various

methods, typically a letter, sent from the SPH or the representing Assistant Attorney General to the clerk of court.

- Medication issues including differing formularies used by hospitals and jails
- Anecdotal reports that the 30-day timeframe for calendaring the capacity hearing are not met were shared by numerous members of the workgroup.
- Questions about how quickly trials calendared at the *earliest practicable time* are calendared

2) Recommendations and Analysis

- Improve communication between mental health system and criminal justice system so as:
    - Identify opportunities for collaboration between the system including extending invitations to county court personnel to visit hospitals and hospital forensic staff presenting at conferences provided for court personnel. Topics could include such things as the ITP admission process at the hospitals, what is included in CRP, legislative updates relevant to the ITP process, etc.
    - Improve communication, clarity, and efficiency between these two systems, the workgroup redesigned several forms commonly used in the ITP process. The redesigned forms as well as one new form are currently being reviewed by the Administrative Office of the Courts (AOC) forms committee. Please see the attached draft forms (Please see Appendix C).
    - Adopt the recommended changes to the "Dismissal Notice of Reinstatement" form, AOC-CR-307B, to eliminate the vehicle which allowed prosecutors to dismiss charges with leave for patients found incapable to proceed (a practice which is no longer allowed under North Carolina law, after the repeal of General Statute 15A-1009).
    - Adopt the recommended changes to the "Involuntary Commitment Custody Order Defendant Found Incapable to Proceed" form, AOC-SP-304B/A, to ensure that forensic evaluation reports are submitted to the state hospital tasked with admitting and restoring the incapable defendants.
    - Approve two new forms, AOC-SP-310 and AOC-CR-430, which were created to improve communication between the state hospital Assistant Attorney General (AAG) and the court. With AOC-SP-310, the AAG notifies the court of the results of forensic re-evaluation, notifies the court if any criteria for dismissal may have been met, and notifies the court when and if the defendant will return to the custody of the local sheriff. With the companion form, AOC-CR-430, the clerk of court notifies the district attorney, defendant's attorney, and sheriff of the change in status so the court may schedule the defendant's legal proceedings in a timely fashion.
    - Develop medication communication guidelines. The Division of State-Operated Healthcare Facilities (DSOHF) should work with representatives from SPHs and Sheriff's Offices to develop guidelines for patient-specific communication hospital and jail personnel regarding the individual's medication regime prior to return to jail with the goal of reducing decompensation prior to the capacity hearing and trial. Issues to include in the communication include defendant's medication regime, availability of medication on the jail formulary, exceptions to formularies in critical situations, etc.

- Pursue technological solutions for improved tracking hearing and trial dates. The AOC should enhance their current system to track hearing and trial dates for individuals found incapable to proceed. This would allow for improved tracking to ensure the 30-day timeline is met for capacity hearings providing data about the length of time between capacity hearings and criminal trials. The workgroup considered recommending changes to the statutory language establishing a defined time for calendaring the trial. However, no resolution was reached by the workgroup due to the wide variations in both case complexity and court resources across the counties.

V. Reimbursement for ITP Hospital Bed Days (Section 3. (B) (3))

1) Current Status and Challenges

As stated earlier in this report, individuals who have ITP status and have been determined to meet IVC criteria are court-ordered to the SPHs and are generally admitted immediately or as soon as a bed is available. , Individuals referred from other locations, such as emergency departments, must wait until a bed is available to which an individual with ITP status is not admitted.

Historically as many as 90% of individuals with ITP status are males. This significantly extends the wait times for civilly committed males. This undoubtedly and negatively impacts individuals with mental health needs who may decompensate while waiting without needed intensive psychiatric care. Emergency departments or other locations are also financially burdened because of these delays.

Billing for inpatient services for individuals who have ITP status is challenging. Individuals who are ITP rarely have private insurance and most are adult males, so the population the least likely to be eligible for Medicaid. And our current understanding is that it is impermissible to bill Medicaid for patients who have forensic status.

The SPHs are also impacted financially by the volume of admissions of individuals with ITP status. In SFY16-17, the Division of State Operated Healthcare Facilities (DSOHF) reviewed reimbursement trends. Their analysis found that the SPHs collectively lost over $9,000,000 in reimbursement during the previous fiscal year from what would likely have been collected had the bed days been used by civilly committed patients. Due to structural budgeting issues and increases in patient acuity resulting in changes to staffing to address the higher clinical needs, the hospitals operate with a budget deficit. The increase in percentage of bed days used by individuals with ITP status has exacerbated this issue.

As discussed throughout this report, the mental health and the criminal justice systems have shared responsibility for individuals who have been determined to be ITP. General Statute 153A-225.2– states in part, that counties shall reimburse those providers and facilities providing requested or emergency medical care outside of the local confinement for “Requested or emergency medical care." This includes all medically necessary and appropriate care provided to an individual from the time that individual presents to the provider or facility in the custody of law enforcement officers until the time that the individual is safely transferred back to the care of county law enforcement officers or medically discharged to another community setting, as appropriate. The SPHs provide the clinical and medical care associated with an individual who is ITP, but his/her legal status continues to be integral to the person’s needs while in the hospital. Given the responsibility for individuals who have been determined to be ITP is shared between the mental health and criminal justice systems, options for shared reimbursement were also a topic of discussion by the workgroup.

2) Analysis and Considerations

The workgroup recognized the issue as described above, but did not have a consensus on how to address it. The Department of Health and Human Services recognizes that this is a shared responsibility of both the mental health and criminal justice systems. We propose considering whether counties can or should share in the costs for services provided by the SPH while individuals are still involved in the criminal justice system. These costs would be shared among state and local government agencies. One option for consideration is the ‘sending’ county reimburses the SPH for

each bed day used by an individual with ITP status at a rate equal to the average state-wide, close custody daily rate. That rate is currently $106.92 per inmate per day (NCDPS website). The remainder of the daily hospital rate, approximately $1100.00 would be absorbed or covered by the SPH.

VI. Conclusion

In recognition of the challenges faced in N.C. the workgroup submits this report summarizing the recommendations developed by a cross-system workgroup convened to address issues and barriers that impact individuals involved in the ITP system, reduce barriers to efficiency, and decrease the number of people in the ITP system. The report outlines very specific recommendations for the ITP system and the issues impacting people once they are involved in the ITP evaluation and capacity restoration process. The primary recommendations are:

1. Eliminating the local community evaluator system and replacing it with a regional model based at each of the three state hospitals, (Central Regional, Cherry and Broughton).
2. Pilot a continuum of capacity restoration programs within the same community; one in a jail setting and, assuming billing permits, one in a community outpatient setting.

In addition, improvements to facilitate clear communication between the behavioral health and criminal justice systems included form creation and revision, improved trial date monitoring, and reimbursement to the SPHs for people hospitalized for capacity restoration or due to inability to restore capacity are also recommended. The form revisions are in process and under consideration by the court system's form committee. With these revisions, court date and calendaring can be tracked and monitored.

In our state and nationwide, decreased treatment options for the severely and persistently mentally ill caused by decreased state hospital beds and decreased community resources has contributed to the criminalization of the mentally ill. We must move in the opposite direction, toward decriminalization of mental illness. Decriminalization of the mentally ill requires a strong public community behavioral health system designed to meet both the treatment and support needs (housing, food, healthcare, transportation, etc.) of people with severe and persistent mental illness. Systems including the SPHs, criminal justice system, community behavioral system, as well as the General Assembly must work together to implement changes to achieve the goal of decriminalization.

In this report, we address but a small part of treatment of the mentally ill, the incapable to proceed process in North Carolina, as it exists and how it should be improved. We wish to recognize that if we wait to intervene until people with serious mental illness are arrested, incarcerated, and adjudicated as incapable to proceed, we will be doing a disservice to those individuals, our state, our community, and our criminal justice system.

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APPENDIX A: Survey to NC Court Stakeholders

1. **Please indicate your current role in the judicial system:**

☐Judge

☐District Attorney/Prosecutor

☐Defense Attorney

☐Public Defender

☐Other *(Please Specify)*

2. **Do you have direct experience as an attorney or judge with North Carolina's Capacity to Proceed process?**

☐Yes, I have direct experience working on multiple cases in which capacity to proceed evaluations were ordered
☐Yes, I have direct experience working on one or two cases in which a capacity to proceed evaluation was ordered
☐No, I have no direct experience with the Capacity to Proceed Process (please skip to question 4)

3. **If yes, which of the following evaluation types have you experienced?** *(check all that apply)*

☐Examination by Local Examiner

☐Examination by State Facility

☐The Examination Types that I have experience with are not listed

3a. For the last evaluation by a <u>Local Examiner</u>, in general, how satisfied were you with the quality of the completed examination?

☐	Extremely Satisfied with the Quality of the Completed Examination
☐	Somewhat Satisfied with the Quality of the Completed Examination
☐	Neither Satisfied nor Unsatisfied with the Quality of the Completed Examination
☐	Somewhat Unsatisfied with the Quality of the Completed Examination
☐	Extremely Unsatisfied with the Quality of the Completed Examination

i. What about the evaluation(s) by a Local Examiner was satisfactory? *(check all that apply)*

☐The evaluation answered the primary question
☐The evaluation was thorough and appropriate
☐The report was well-written
☐Other *(please explain)*

ii. What about the evaluation(s) by a Local Examiner was not satisfactory? *(check all that apply)*

☐The evaluation did not answer the primary question
☐The evaluation was incomplete or inappropriate
☐The report was poorly written
☐Other *(please explain)*

iii. If the evaluation by a Local Examiner was not satisfactory, what, if any additional steps did you take to obtain a satisfactory evaluation? *(check all that apply)*

☐None
☐Filed a complaint with the court or the MCO about the evaluator
☐Requested an additional evaluation from a state facility (such as Cherry Hospital or Central Regional Hospital)
☐Requested or obtained an evaluation from an independent evaluator or other evaluator
☐Other *(please explain)*

3b. For the last evaluation by a <u>State Psychiatric Hospital</u>, in general, how satisfied were you with the quality of the completed evaluation?

☐	Extremely Satisfied with the Quality of the Completed Examination
☐	Somewhat Satisfied with the Quality of the Completed Examination
☐	Neither Satisfied nor Unsatisfied with the Quality of the Completed Examination
☐	Somewhat Unsatisfied with the Quality of the Completed Examination
☐	Extremely Unsatisfied with the Quality of the Completed Examination

Appendix A. (Cont.)

i. What about the evaluation(s) by the State Psychiatric Hospital was satisfactory? *(check all that apply)*

☐The evaluation answered the primary question
☐The evaluation was thorough and appropriate
☐The report was well-written
☐Other *(please explain)*

ii. What about the evaluation(s) by the State Psychiatric Hospital was not satisfactory? *(check all that apply)*

☐The evaluation did not answer the primary question
☐The evaluation was incomplete or inappropriate
☐The report was poorly written
☐Other *(please explain)*

iii. If the evaluation by the State Psychiatric Hospital was not satisfactory, what, if any additional steps did you take to obtain a satisfactory evaluation? *(check all that apply)*

☐None
☐Filed a complaint with the court or the MCO about the evaluator
☐Requested an additional evaluation from a state facility (such as Cherry Hospital or Central Regional Hospital)
☐Requested or obtained an evaluation from an independent evaluator or other evaluator
☐Other *(please explain)*

When complete, please skip to question 5

4. **Do you believe you understand the process well enough to navigate the Capacity to Proceed process if necessary?**

   ☐Yes, I believe I have the knowledge and/or capacity to navigate the Capacity to Proceed if needed.

   ☐No, I am not familiar with the process and would need support and/or training to navigate the Capacity to Proceed process.

5. **Do you have any additional comments related to the questions above?**

APPENDIX B: ITP Admissions by County

Individuals Admitted to the three State Psychiatric Hospitals (SPH) for Incapacity to Proceed (ITP) and Pre-Trial ITP Evaluations During State Fiscal Year 2017

ITP Admissions and Pre-Trial Evaluation Admissions FY 2017 Highest Utilizing Counties			
County	**ITP Admissions**	**Pre-Trial Evaluation Admissions**	**Total**
Cumberland	56	2	58
Guilford	30	4	34
Mecklenburg	20	5	25
Wake	18	4	22
Pitt	13		13
Durham	7	4	11
New Hanover	9	2	11
Nash	8	1	9
Buncombe	6	2	8
Henderson	7	1	8
Wayne	8		8
Alamance	5	2	7
Davidson	3	3	6
Macon	6		6
Pender	4	2	6
Forsyth	4	1	5
Hoke	4	1	5
Johnston	5		5
Onslow	5		5
Rockingham	5		5
Rowan	3	2	5
Vance	4	1	5
Caldwell	2	2	4
Columbus	4		4
Harnett	3	1	4
McDowell	3	1	4
Richmond	2	2	4
Union	4		4

APPENDIX B: ITP Admissions by County *(Cont.)*

Counties with a total of 3 SPH ITP Admissions in SFY 2017			
County	**ITP Admissions**	**Pre-Trial Evaluation Admissions**	**Total**
Cleveland	3		3
Gaston	3		3
Haywood	1	2	3
Iredell	3		3
Moore	3		3
Northampton	3		3
Person	3		3
Robeson	2	1	3
Rutherford	3		3
Surry	3		3
Wilkes	3		3

Counties with a total of 2 SPH ITP Admissions in SFY 2017			
County	**ITP Admissions**	**Pre-Trial Evaluation Admissions**	**Total**
Anson	1	1	2
Brunswick	2		2
Carteret	2		2
Caswell	2		2
Catawba	2		2
Chowan	1	1	2
Craven	2		2
Hertford	1	1	2
Jackson	1	1	2
Lincoln	2		2
Madison	2		2
Martin	2		2
Pasquotank	2		2
Sampson	1	1	2
Swain	2		2
Wilson	2		2
Yadkin	2		2

APPENDIX B: ITP Admissions by County *(Cont.)*

Counties with a total of 1 SPH ITP Admission in SFY 2017			
County	**ITP Admissions**	**Pre-Trial Evaluation Admissions**	**Total**
Alexander	1		1
Bertie	1		1
Cherokee	1		1
Duplin	1		1
Franklin		1	1
Gates	1		1
Granville		1	1
Greene	1		1
Jones	1		1
Mitchell		1	1
Randolph	1		1
Scotland	1		1
Stokes		1	1
Warren	1		1
Watauga	1		1
Yancey	1		1

APPENDIX C: FORMS UPDATED AND/OR CREATED BY WORKGROUP

STATE OF NORTH CAROLINA

_____ County

Special Proceeding File No.

In The General Court Of Justice
District Court Division

IN THE MATTER OF

Name Of Defendant/Respondent

State Mental Health Facility Where Defendant/Respondent Is Committed

Criminal File No.

NOTIFICATION OF CHANGE IN STATUS FOR DEFENDANT PREVIOUSLY FOUND INCAPABLE TO PROCEED AND INVOLUNTARILY COMMITTED TO A STATE MENTAL HEALTH FACILITY

G.S. 15A-1002 to -1008; Chapter 122C

INSTRUCTIONS: *The Assistant Attorney General at a State Mental Health facility completes the NOTIFICATION section below to notify the court:*
*- that the defendant/respondent has been re-evaluated and is thought to be capable to proceed or to be non-restorable to capacity; **and/or***
*- that the defendant/respondent's charges may be eligible for dismissal under G.S. 15A-1008(a); **and/or***
- of the current status of the defendant/respondent's involuntary commitment.

*After receiving the notification, the clerk of superior court must complete, place in the criminal case file, and distribute copies of form AOC-CR-430, "Notification By Clerk For Defendant Previously Found Incapable To Proceed." The clerk should **not** place this form AOC-SP-310 in the defendant/respondent's criminal case file. Form AOC-SP-310 should appear only in the defendant/respondent's special proceeding file.*

NOTIFICATION BY ASSISTANT ATTORNEY GENERAL

This is to notify the court of a change in status for the above-named defendant/respondent, who is charged in the above-named county with *(specify offense(s))* _____

_____

_____,

who was previously found by the court to be incapable to proceed to trial pursuant to G.S. 15A-1002, and who was involuntarily committed pursuant to Chapter 122C of the General Statutes of North Carolina.

1. Pursuant to G.S. 122C-278, the defendant/respondent has been re-evaluated by _____ *(forensic examiner)* on _____ *(date)*. A copy of the examiner's report is attached. The examiner is of the opinion that the defendant/respondent is
   - ☐ **CAPABLE** to proceed.
   - ☐ **NON-RESTORABLE** to capacity to proceed.

☐ 2. It appears to the Assistant Attorney General that one or more criteria for dismissal may have been met, pursuant to G.S. 15A-1008(a), which states that the court shall dismiss the defendant/respondent's charges upon the **earliest** of the following conditions:
   - ☐ when it appears to the satisfaction of the court that the defendant/respondent will not gain capacity to proceed.
   - ☐ when as a result of incarceration, involuntary commitment to an inpatient facility, or other court-ordered confinement, the defendant has been substantially deprived of his/her liberty for a period of time equal to or in excess of the maximum term of imprisonment permissible for prior record Level VI for felonies or prior conviction Level III for misdemeanors for the most serious offense charged.
   - ☐ upon the expiration of a period of five years from the date of determination of incapacity to proceed in the case of misdemeanor charges or ten years have elapsed from the date of determination of incapacity to proceed in the case of felony charges.

3. The defendant is currently involuntarily committed to the State Mental Health Facility named above. Treating clinicians at that facility recommend that the defendant/respondent's involuntary commitment be
   - ☐ Continued. The commitment currently expires on _____ *(date)*. If the defendant is required to appear in court while he/she remains committed, the court may contact the Assistant Attorney General named below to make arrangements for the defendant to attend court hearings.
   - ☐ Discontinued. A hearing to discharge the defendant/respondent from the State Mental Health Facility to custody of the _____ County Sheriff is currently scheduled in the _____ County Court on _____ *(date)*.

Date	*Name Of Assistant Attorney General (type or print)*	*Signature Of Assistant Attorney General*

AOC-SP-310, New X/18

STATE OF NORTH CAROLINA

_____ County

File No.

In The General Court Of Justice
District Court Division

IN THE MATTER OF

Name And Address Of Respondent

INVOLUNTARY COMMITMENT
CUSTODY ORDER
DEFENDANT FOUND
INCAPABLE TO PROCEED
(For Offenses Committed On Or Before Nov. 30, 2013)

G.S. 15A-1003, -1004; 122C-261, -262, -263

I. FINDINGS

The respondent has been charged in File No._____with a criminal offense in the above named county and has been found incapable of proceeding to trial under G.S. 15A-1002. The Court considered the opinion of _____ *(name of forensic evaluator)* in the report dated _____ *(list date of report)* as evidence of incapacity to proceed. A copy of the evaluator's report shall be provided to the clinicians at the facility where the respondent is receiving treatment pursuant to G.S. 15A-1002, and is attached.

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

In addition, the Court finds that the respondent

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

☐ 2. is charged with a violent crime in violation of G.S._____, in that *(insert appropriate findings)*

ORDER

To The Sheriff Of _____ County:

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

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

The Court ORDERS you to deliver a copy of the forensic evaluation report referenced above to the Assistant Attorney General and the Special Counsel at the program where the respondent is to receive capacity restoration and that report, and any information previously-ordered released pursuant to G.S. 15A-1002(b)(4), is ordered released as to them.

Notice To Hospital, Institution, 24-Hour Facility:
Criminal charges still are pending against the respondent. You must report to the Clerk in the above named county the condition of the defendant-respondent and the likelihood of the defendant's gaining capacity to proceed at the time of each commitment rehearing. You must also report if the defendant-respondent regains capacity to proceed or if the defendant-respondent is released. If the defendant-respondent is released, he/she must be released to the law enforcement agency named below.

Name Of Law Enforcement Agency

Name And Address Of 24-Hour Facility

Or Following Facility Designated By Area Authority:

Date

Signature Of Judge

Name Of Judge (type or print)

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

AOC-SP-304A, Rev. X/18 (Over)

II. RETURN OF SERVICE

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

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

A. FOR USE WHEN RESPONDENT NOT CHARGED WITH VIOLENT CRIME

☐ 1. The respondent was presented to an authorized examiner locally available as shown below.

☐ 2. The respondent was temporarily detained at the facility named below until the respondent could be examined by an authorized examiner locally available.

Date Presented	*Time* ☐ AM ☐ PM	*Name Of Examiner*
Name Of Local Facility		

☐ 1. Upon examination, the examiner named above found that the respondent did meet the criteria for outpatient commitment. I returned the respondent to his/her regular residence or to the home of a consenting person.

☐ 2. Upon examination, the examiner named above found that the respondent did meet the criteria for inpatient commitment.

- ☐ I transported the respondent and placed the respondent in the temporary custody of the 24-hour facility named below for observation and treatment.
- ☐ I placed the respondent in the custody of the agency named below for transportation to the 24-hour facility.

☐ 3. Upon examination, the examiner named above found that the respondent did not meet the criteria for inpatient or outpatient commitment.

The examiner's written statement ☐ is attached. ☐ will be forwarded.

Name Of 24-Hour Facility	*Date Delivered*	*Time Delivered* ☐ AM ☐ PM	*Date Of Return*
Name Of Transporting Agency	*Signature Of Law Enforcement Official*		

B. FOR USE WHEN RESPONDENT CHARGED WITH VIOLENT CRIME

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

Name Of 24-Hour Facility	*Date Delivered*	*Time Delivered* ☐ AM ☐ PM	*Date Of Return*
Name Of Transporting Agency	*Signature Of Law Enforcement Official*		

C. FOR USE WHEN ANOTHER AGENCY TRANSPORTS THE RESPONDENT

☐ I took custody of the respondent from the officer named above, transported the respondent and placed him/her in the temporary custody of the facility named below for observation and treatment.

Name Of 24-Hour Facility	*Date Delivered*	*Time Delivered* ☐ AM ☐ PM	*Date Of Return*
Name Of Transporting Agency	*Signature And Rank Of Law Enforcement Official*		

D. FOR USE WHEN STATE FACILITY TRANSFERS WITHOUT ADMISSION

☐ Pursuant to G.S. 122C-261(f), I took custody of the respondent from the State 24-hour facility named above, where he/she was not admitted, and transported the respondent and placed him/her in the temporary custody of the facility named below for observation and treatment.

Name Of Facility To Which Transferred	*Date Delivered*	*Time Delivered* ☐ AM ☐ PM	*Date Of Return*
Name Of Transporting Agency	*Signature Of Law Enforcement Or State Facility Official*		

AOC-SP-304A, Side Two, Rev. X/18

STATE OF NORTH CAROLINA

_____ County

File No.

In The General Court Of Justice
District Court Division

IN THE MATTER OF

Name And Address Of Respondent

INVOLUNTARY COMMITMENT
CUSTODY ORDER
DEFENDANT FOUND
INCAPABLE TO PROCEED
(For Offenses Committed On Or After Dec. 1, 2013)

G.S. 15A-1003, -1004; 122C-261, -262, -263

I. FINDINGS

The respondent has been charged in File No._____with a criminal offense in the above named county and has been found incapable of proceeding to trial under G.S. 15A-1002. The Court considered the opinion of _____ *(name of forensic evaluator)* in the report dated _____ *(list date of report)* as evidence of incapacity to proceed. A copy of the evaluator's report shall be provided to the clinicians at the facility where the respondent is receiving treatment pursuant to G.S. 15A-1002, and is attached.

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

In addition, the Court finds that the respondent

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

☐ 2. is charged with a violent crime in violation of G.S._____, in that *(insert appropriate findings)*

ORDER

To The Sheriff Of _____ County:

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

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

The Court ORDERS you to deliver a copy of the forensic evaluation report referenced above to the Assistant Attorney General and the Special Counsel at the program where the respondent is to receive capacity restoration and that report, and any information previously-ordered released pursuant to G.S. 15A-1002(b)(4), is ordered released as to them.

Notice To Hospital, Institution, 24-Hour Facility:
Criminal charges are still pending against the respondent. If defendant-respondent is released he/she must be released to the law enforcement agency named below. If the defendant-respondent is not charged with a violent crime and no law enforcement agency is specified, you may release him/her to whomever you think appropriate. You must examine the defendant-respondent to determine whether he/she has gained the capacity to proceed to trial prior to releasing him/her from custody. A report of the examination must be provided to the court pursuant to G.S. 15A-1002.

Name Of Law Enforcement Agency

Name And Address Of 24-Hour Facility

Or Following Facility Designated By Area Authority:

Date

Signature Of Judge

Name Of Judge (type or print)

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

AOC-SP-304B, Rev. X/18 (Over)

II. RETURN OF SERVICE

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

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

A. FOR USE WHEN RESPONDENT NOT CHARGED WITH VIOLENT CRIME

☐ 1. The respondent was presented to an authorized examiner locally available as shown below.

☐ 2. The respondent was temporarily detained at the facility named below until the respondent could be examined by an authorized examiner locally available.

Date Presented	*Time* ☐ AM ☐ PM	*Name Of Examiner*
Name Of Local Facility		

☐ 1. Upon examination, the examiner named above found that the respondent did meet the criteria for outpatient commitment. I returned the respondent to his/her regular residence or to the home of a consenting person.

☐ 2. Upon examination, the examiner named above found that the respondent did meet the criteria for inpatient commitment.

- ☐ I transported the respondent and placed the respondent in the temporary custody of the 24-hour facility named below for observation and treatment.
- ☐ I placed the respondent in the custody of the agency named below for transportation to the 24-hour facility.

☐ 3. Upon examination, the examiner named above found that the respondent did not meet the criteria for inpatient or outpatient commitment.

- ☐ I examined the respondent for capacity to proceed to trial and returned him/her to his/her regular residence or the home of a consenting person. *(Use for offenses occurring on or after December 1, 2013.)* (**NOTE:** *Submit report of capacity examination to Clerk of Superior Court in accordance with G.S. 15A-1002.*)

☐ 4. The examiner's written statement ☐ is attached. ☐ will be forwarded.

Name Of 24-Hour Facility	*Date Delivered*	*Time Delivered* ☐ AM ☐ PM	*Date Of Return*
Name Of Transporting Agency	*Signature Of Law Enforcement Official*		

B. FOR USE WHEN RESPONDENT CHARGED WITH VIOLENT CRIME

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

Name Of 24-Hour Facility	*Date Delivered*	*Time Delivered* ☐ AM ☐ PM	*Date Of Return*
Name Of Transporting Agency	*Signature Of Law Enforcement Official*		

C. FOR USE WHEN ANOTHER AGENCY TRANSPORTS THE RESPONDENT

☐ I took custody of the respondent from the officer named above, transported the respondent and placed him/her in the temporary custody of the facility named below for observation and treatment.

Name Of 24-Hour Facility	*Date Delivered*	*Time Delivered* ☐ AM ☐ PM	*Date Of Return*
Name Of Transporting Agency	*Signature And Rank Of Law Enforcement Official*		

D. FOR USE WHEN STATE FACILITY TRANSFERS WITHOUT ADMISSION

☐ Pursuant to G.S. 122C-261(f), I took custody of the respondent from the State 24-hour facility named above, where he/she was not admitted, and transported the respondent and placed him/her in the temporary custody of the facility named below for observation and treatment.

Name Of Facility To Which Transferred	*Date Delivered*	*Time Delivered* ☐ AM ☐ PM	*Date Of Return*
Name Of Transporting Agency	*Signature Of Law Enforcement Or State Facility Official*		

AOC-SP-304B, Side Two, Rev. X/18

STATE OF NORTH CAROLINA

File No.

_____ County

In The General Court Of Justice
☐ District ☐ Superior Court Division

NOTE: *Do not use this form for cases covered by G.S. 20-138.4. Use form AOC-CR-339 instead.*

STATE VERSUS	DISMISSAL NOTICE OF REINSTATEMENT (For Offenses Committed On Or After Dec. 1, 2013) G.S. 15A-302(e), -931, -932
Defendant Name	

File Number	Count No.(s)	Offense(s)

☐ **DISMISSAL**

NOTE: *Recall all outstanding Orders For Arrest in a dismissed case.*

The undersigned prosecutor enters a dismissal to the above charge(s) and assigns the following reasons:

☐ 1. No crime is charged.

☐ 2. There is insufficient evidence to warrant prosecution for the following reasons:

☐ 3. Defendant has agreed to plead guilty to the following charges:

in exchange for a dismissal of the following charges:

☐ 4. The defendant was charged as the result of ☐ defendant's identity being used without permission. ☐ mistaken identity.
(**NOTE TO PROSECUTOR:** *You must notify the Court of this dismissal. The Court should use AOC-CR-283, Order Of Expunction Under G.S. 15A-147(a1) (Identity Theft Or Mistaken Identification) to expunge charges.*)

☐ 5. Other: *(specify)* ☐ See additional information on reverse.

A jury has not been impaneled nor has evidence been introduced. *(If a jury has been impaneled, or if evidence has been introduced, modify this sentence accordingly.)* _____

☐ **DISMISSAL WITH LEAVE**

The undersigned prosecutor enters a dismissal with leave to the above charge(s) and assigns the following reasons:

☐ 1. The defendant failed to appear for a criminal proceeding at which the defendant's attendance was required and the prosecutor believes that the defendant cannot readily be found.

☐ 2. The defendant has been indicted and cannot readily be found to be served with an Order For Arrest.

☐ 3. The defendant has entered into a deferred prosecution agreement with the prosecutor in accordance with the provisions of Article 82 of G.S. Chapter 15A.

☐ 4. Other: *(specify)* ☐ See additional information on reverse.

NOTE: *Pursuant to the repeal of G.S. 15A-1009, the prosecutor can no longer dismiss charges with leave for defendants found incapable to proceed.*

NOTE: *This form must be completed and signed by the prosecutor when the dismissal occurs out of court. The better practice is for the prosecutor to complete and sign the form when the charges are orally dismissed in open court.*

Also, in accordance with G.S. 15A-931(a1), unless the defendant or the defendant's attorney has been otherwise notified by the prosecutor, a written dismissal of the charges against the defendant must be served in the same manner prescribed for motions under G.S. 15A-951. If the record reflects that the defendant is in custody, the written dismissal shall also be served ***by the prosecutor*** *on the chief officer of the custodial facility where the defendant is in custody.*

Date	*Name Of Prosecutor (type or print)*	*Signature Of Prosecutor*

☐ **REINSTATEMENT**

This case, having previously been dismissed with leave as indicated above, is now reinstated for trial.

Date	*Name Of Prosecutor (type or print)*	*Signature Of Prosecutor*

AOC-CR-307B, Rev. X/18 (Over)

STATE OF NORTH CAROLINA

_____ County

Criminal File No.

Special Proceeding File No.

In The General Court Of Justice
☐ District ☐ Superior Court Division

STATE VERSUS

Name Of Defendant/Respondent

NOTIFICATION BY CLERK FOR DEFENDANT PREVIOUSLY FOUND INCAPABLE TO PROCEED

G.S. 15A-1002 to -1008; Chapter 122C

NOTIFICATION BY CLERK OF SUPERIOR COURT

The clerk of superior court has received notice via AOC-SP-310 that the above-named defendant, who previously was found by the court to be incapable to proceed to trial pursuant to G.S. 15A-1002, requires review by the court under G.S. 15A-1007 because *(check one)*

☐ the defendant may be capable to stand trial under G.S. 15A-1006 and G.S. 15A-1007.

☐ the defendant's case may be eligible for dismissal under G.S. 15A-1007(c) and G.S. 15A-1008.

Pursuant to G.S. 15A-1006 and G.S. 15A-1007, the undersigned clerk has provided a copy of this completed form to the district attorney of the district that includes the county named above, the sheriff of the county named above, and the defendant's attorney, on the date shown below.

NOTE TO THE DISTRICT ATTORNEY: *Pursuant to G.S. 15A-1007, the court shall hold a supplemental hearing if it has been reported to the court that the defendant/respondent has gained capacity to proceed OR if it appears that any of the criteria for dismissal have been met. If it has been reported that the defendant/respondent has gained capacity to proceed, the district attorney shall calendar the matter for hearing at the next available term of court but no later than 30 days from receipt of this notification.*

NOTE TO THE SHERIFF: *Pursuant to G.S. 15A-1004, when a defendant/respondent accused of a violent crime is placed in the custody of a hospital or other institution in a proceeding for involuntary commitment, the trial court must order that if the defendant is released from that hospital or institution, that he is to be released only to the custody of a specified law enforcement agency. If such a defendant/respondent is to be released from a state mental health facility, that facility will notify the specified law enforcement agency so that it may take custody of the defendant/respondent.*

NOTE TO THE CLERK: *Place the original of this form in the defendant/respondent's criminal case file. Place a certified copy in the defendant/respondent's special proceedings case file.*

Date	*Name Of Clerk (type or print)*	*Signature Of Clerk*	☐ *Deputy CSC* ☐ *Assistant CSC* ☐ *Clerk Of Superior Court*

AOC-CR-430, New X/18