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Criminal Defendants Deemed Incapable to Proceed to Trial: An Evaluation of North Carolina's Statutory Scheme

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COMMENTS

CRIMINAL DEFENDANTS DEEMED INCAPABLE TO PROCEED TO TRIAL: AN EVALUATION OF NORTH CAROLINA'S STATUTORY SCHEME*

Envision the following scenario: a person known for his easy-going, friendly disposition withdraws from his previous social circle and takes less joy in his favorite activities, if he even participates in them at all. His demeanor changes; within a short time-frame, his physical appearance becomes dull, and his eyes lose a once-resounding spark. He is fading away. When asked about this change, he reveals that he feels overwhelmed. A burden of anxiety and sadness weighs him down. He is drowning in life, unable to stay above the surface. The undertow pulls him down, slowly yet forcibly, until barely his head remains above water.

Now imagine this person is you. How would you combat these encompassing symptoms of a mental disorder? Would you perhaps try to get someone's attention so that you might be saved? Would you try to keep your head above water, utilizing any energy that might be left to kick and paddle in order to prevent sinking even deeper and try to swim ashore? Or would you just acquiesce to the undertow and begin to sink further beneath the surface, allowing the burden to bury you so deep even your eyes cannot see the light above the water line?

More than 22.1%, or 1 out of every 5, Americans who suffer from a diagnosable mental disorder may be forced to avail themselves of these alternatives. Of the options mentioned above, this Comment

* The author wishes to express gratitude to Dr. Mark Hazelrigg and Dr. John Wallace for their helpful insight in regard to the issues discussed herein.

1. See American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders xxii (3d ed., rev., Am. Psych. Assn. 1987). A mental disorder is a clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with present distress (a painful symptom), disability (impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability or an important loss of freedom.

2. See U.S. Dept. of Health and Human Services, National Institutes of Mental Health, NIMH Publication No. 01-4584, The Numbers Count: Mental Disorders in
focuses on those individuals who grasp someone's attention by yelling or screaming while wailing away in the water - those individuals who succeed in getting the attention of the criminal justice system - the mentally ill who engage in crime and are incapable to stand trial.

We as a nation are beginning to realize that historically there has been a strong correlation between mental illness and criminal incarceration.³ Many seriously mentally-ill individuals cannot adequately survive in their communities without the individualized help and treatment administered by hospitals and other health care facilities.⁴ However, when hospitals cannot administer treatment, as a result of such circumstances as bed shortages or strenuous statutory requirements, the mentally ill often find themselves in prison due to minor antisocial, disruptive behavior that is unrelated to their illness.⁵

The purpose of this Comment is neither to justify this link nor to encourage reduced responsibility for such criminal defendants. Rather, it advocates criminal defendants deemed incapable to proceed to trial receive efficient treatment addressing both their ability to regain capacity so they may face trial and their ability to rejoin society as a beneficial member. In order for this goal to be accomplished, the applicable commitment sections of the North Carolina General Statutes need to be revised and stated more plainly, so that in addition to the "dangerousness standard," appropriate "need-for-treatment" language may be added. Also, government funding needs to be allocated efficiently to preventative treatment programs so that the mental illness-criminal incarceration correlation may be better managed and reduced.

This Comment will first address North Carolina's statute governing incapacity to proceed to trial. Next, this Comment will turn to the purpose and need for involuntary commitment, followed by a discussion of and explanations for the correlation between mental illness and criminal incarceration. This Comment will then present some suggestions for statutory revision of the existing North Carolina statute and will conclude with a brief discussion of funding issues.

⁴ See id.
⁵ See id.
Defendant's "Incapacity to Proceed"

North Carolina General Statute § 15A-1001(a) expressly prohibits trying, convicting, sentencing or punishing a criminal defendant "for a crime when by reason of mental illness or defect he is unable 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." This statute guarantees that a criminal defendant will not be tried or punished while mentally incapacitated, thus ensuring a fair trial.

This objective of a fair trial supports the public policy in North Carolina (as well as the rest of the United States) that a mentally-incapable criminal defendant not be tried while in this condition, as such a situation deprives him of his due process right to a fair trial. North Carolina's test for capacity to stand trial assesses whether a defendant possesses capacity to comprehend his position, to understand the nature of the proceedings against him, to conduct his defense in a rational manner, and to cooperate with his counsel so that any available defense may be exercised. The following circumstances and factors are relevant and may be used to evaluate a defendant's capability to stand trial: evidence of irrational behavior, the defendant's demeanor at trial, and any prior medical opinion on capacity to stand trial. The issue of a defendant's capacity to stand trial may be raised at any time by the defendant himself, the prosecutor, or the court, sua sponte.

However, the decision to grant a motion for an evaluation of a defendant's incapacity to stand trial remains within the trial judge's discretion.

Once the issue of the defendant's mental capacity to proceed to trial has been raised, the court may evaluate whether the defendant meets the above incapacity criteria. The court makes this determination either by appointing a medical expert (a qualified physician) to evaluate the defendant's competency and produce a written report on his findings or holding a hearing to commit the defendant "to a state...

13. See N.C. GEN. STAT. § 15A-1002(b)(1) (2003); N.C. GEN. STAT. § 122C-263(c) (2003). The physician's examination should include at least an assessment of the defendant's current and previous mental illness and mental history, dangerousness to
mental health facility for observation and treatment for a period, not to exceed 60 days. 14

If the court opts to turn the defendant over to a qualified physician to determine capacity to proceed to trial, the physician must complete a statutorily required physical of the defendant. 15 After administering the physical, the physician must produce an examination report containing the results of the physical and his recommendations. 16 The physician has three options. 17

First, if the physician determines that the mentally ill defendant is both capable of safely surviving in the community with supervision from family or friends and needing additional treatment which he may not voluntarily seek, 19 the physician will recommend outpatient commitment. 20 In outpatient commitment, the court orders a defendant into the care of a designated provider for a maximum of 90 days in order to receive the treatment and supervision necessary to assist in controlling symptoms of mental illness. 21 The physician will provide the defendant with the contact information for the proposed outpatient setting or others, ability to survive safely without inpatient commitment, and his capacity to make an informed decision concerning treatment.

14. See N.C. GEN. STAT. § 15A-1002(b)(2) (2003). This supports the policy advanced by the United States Supreme Court in Jackson v. Indiana in 1972. The Court ruled that without a civil commitment order, a state can only hold a criminal defendant who is incapable to stand trial as long as it is necessary to determine whether he will regain competency (See Jackson v. Indiana, 406 U.S. 715, 717, (1972)).

17. See id.
18. See N.C. GEN. STAT. § 122C-3(21) (2003) (stating that a mentally ill person is one possessing an illness "which so lessens the capacity of the individual to use self-control, judgment, and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance or control").
20. See N.C. GEN. STAT. § 122C-3(27) (2003) (stating that outpatient treatment is "treatment in an outpatient setting and may include medication, individual or group therapy, day or partial day programming activities, services and training including educational and vocational activities, supervision of living arrangements and any other services prescribed either to alleviate the individual's illness or disability, to maintain semi-independent functioning, or to prevent further deterioration that may reasonably be predicted to result in the need for inpatient commitment to a 24-hour facility").
tient physician or center.\textsuperscript{22} Outpatient commitment provides a less-restrictive alternative to inpatient commitment and is often a helpful intervention technique for defendants who are not considered dangerous, but may possess the propensity to become dangerous.\textsuperscript{23}

Second, if, on the other hand, the qualified physician finds that the mentally-ill defendant is either dangerous to himself\textsuperscript{24} or dangerous to others,\textsuperscript{25} and the defendant meets the involuntary commitment requirements, the physician may recommend inpatient commitment.\textsuperscript{26} Inpatient commitment is 24-hour confinement in a facility that allows the patient to participate in a structured living environment and treatment or rehabilitation.\textsuperscript{27} In North Carolina, a finding of dangerousness means the defendant is either unable to properly care for himself, has attempted or threatened to harm another or has actually harmed another.\textsuperscript{28} Under the current statutory scheme, a defendant may only be involuntarily committed to inpatient care if he is both mentally ill and dangerous.\textsuperscript{29}

\begin{itemize}
\item \textsuperscript{22} See N.C. GEN. STAT. § 122C-263(d)(1) (2003).
\item \textsuperscript{23} See id.
\item \textsuperscript{24} See N.C. GEN. STAT. § 122C-3(11)(a) (2003) (stating that within the relevant past, the defendant has acted in such a way as to show that he would be unable, without care, supervision, and the continued assistance of others not otherwise available, to exercise self-control, judgment, and discretion in the conduct of his daily responsibilities and social relations, or to satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety; and there is a reasonable probability of his suffering serious physical debilitation within the near future unless adequate treatment is given pursuant to this Chapter; a showing of behavior that is grossly irrational, of actions that the individual is unable to control, of behavior that is grossly inappropriate to the situation, or of other evidence of severely impaired insight and judgment shall create a prima facie inference that the individual is unable to care for himself).
\item \textsuperscript{25} See N.C. GEN. STAT. § 122C-3(11)(b) (2003) (stating that within the relevant past, the individual has inflicted or attempted to inflict or threatened to inflict serious bodily harm on another, or has acted in such a way as to create a substantial risk of serious bodily harm to another or has engaged in extreme destruction of property; and that there is a reasonable probability that this conduct will be repeated. Previous episodes of dangerousness to others, when applicable, may be considered when determining reasonable probability of future dangerous conduct; clear, cogent, and convincing evidence that an individual has committed a homicide in the relevant past is prima facie evidence of dangerousness to others).
\item \textsuperscript{26} See N.C. GEN. STAT. § 15A-1003(a) (2003).
\item \textsuperscript{28} See N.C. GEN. STAT. § 122C-3(11)(a) and (b) (2003).
\item \textsuperscript{29} See N.C. GEN. STAT. § 122C-263(d)(2) (2003).
\end{itemize}
Third, if the physician finds the defendant neither mentally ill nor dangerous to himself or others, the proceedings will terminate. The defendant will then return to court to stand trial for his pending criminal charges.

At this point, the court evaluates the findings of the physician or the results of the trial capacity hearing to determine whether it believes the defendant truly mentally ill and incapable to proceed to a trial. If the court finds the defendant mentally ill and incapable to proceed to trial, it will either consider the physician’s recommendations to make a ruling on whether involuntary inpatient or outpatient treatment is most appropriate, or if the court held a hearing in lieu of a physician’s evaluation, it will order a psychiatrist to evaluate the defendant and take further action to prepare the defendant to stand trial.

**PURPOSE OF AND TEST FOR INVOLUNTARY COMMITMENT**

The primary purpose of involuntary commitment is to protect the person who, after due process, has been found to be both mentally ill and imminently dangerous by placing such a person in a more protected environment where the danger may be minimized and has treatment be facilitated. The two-fold rationale behind North Carolina’s involuntary commitment statute allows temporary withdrawal from society of those individuals deemed dangerous and provides them with appropriate treatment.

However, since involuntary inpatient commitment significantly limits an individual’s liberty interests and is the most restrictive form of treatment, public policy demands both its careful implementation and its bearing some rational relation to the purpose for which the individual is committed. Traditionally, the government maintains a two-prong obligation to the individual and society. Under the theory of *parens patriae* - literally translated as - “the parent of the country” - the government has a duty to act as a nurturing parent for anyone who cannot survive safely or properly take care of himself. However,

34. See N.C. GEN. STAT. § 122C (2003).
under the second prong, the government possesses a police power to protect the well-being of society. 38

The individual's liberty interest must be balanced against the state's interests in providing care to its citizens who are unable, because of mental illness, to care for themselves, and its police-power interest in protecting the community from persons who are mentally ill and dangerous to ensure the individual receives the least restrictive form of treatment possible. 39 Substantive due process requires that before a person may be involuntarily committed, the state's interests both in protecting society and the mentally ill individual must be shown to outweigh the individual's interest in personal liberty. 40

In O'Connor v. Donaldson, the United States Supreme Court furthered this policy notion by establishing precedent preventing the involuntary commitment of people who were simply mentally ill and neither dangerous to themselves nor others. The O'Connor Court ruled unconstitutional involuntary commitment based solely on mental illness. 41 In North Carolina, the trial court is required to find the defendant both mentally ill and either dangerous to himself or others before he may be involuntarily committed. 42

However, this raises the paramount question of whether requiring a finding of both mental illness and dangerousness to justify commitment truly signifies the best approach and really results in an unreasonable encroachment on individual liberty. Although this nation has recognized the fundamental right to freedom from governmental interference, society recognizes that circumstances may arise that require the protection of vulnerable individuals and limitation of certain rights to promote utilitarianism. 43 If an individual, due to mental illness, lacks the insight to decide whether he needs to seek treatment, what alternatives does society have to protect its members and the welfare of the mentally-ill individual?

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38. See id.
39. See id.
WHAT HAPPENS TO CRIMINAL CHARGES WHEN AN INDIVIDUAL IS DEEMED INCAPABLE TO PROCEED TO TRIAL

If the court orders the defendant into involuntary inpatient commitment, the defendant's criminal charges may be dismissed with leave by the district attorney. If the court orders the defendant into involuntary inpatient commitment, the defendant's criminal charges may be dismissed with leave by the district attorney. A dismissal with leave results in the defendant's case being removed from the docket of the court until either the defendant becomes capable of proceeding or the prosecutor believes the defendant will soon be able to proceed. In the interim, the defendant is committed to a psychiatric facility for involuntary inpatient treatment.

COURT-ORDERED INVOLUNTARY INPATIENT COMMITMENT

The initial reason for the defendant's hospitalization is his lack of capacity to proceed. As such, the main purpose of the psychological treatment sessions as articulated under the law is to determine the extent of the defendant's mental illness so he may be treated and made ready to stand trial. Unfortunately, the main focus of these sessions is alleviating the symptoms and not curing the disease - truly dealing with the defendant's mental illness and helping him become a contributing, functioning member of society instead of a repeat-criminal offender.

As a result, these incapable defendants never truly receive long-term, enduring help for their mental illness and enter a revolving door, bouncing from short stays at mental hospitals, to prisons, back into the community to commit another crime and then return to the same cycle. Hospitals medicate and stabilize defendants, who are then found capable to proceed. However, when the defendants return to prison to await trial, they rapidly destabilize and lose capacity again.

44. See N.C. Gen. Stat. § 15A-1009 (2003) (stating that although the prosecutor has removed the defendant's case from the docket, he may bring the charges again when he determines that the defendant is competent to stand trial; North Carolina General Statute § 15A-1009 provides that a prosecutor may enter a dismissal with leave if a defendant is found by the court to be incapable to proceed to trial).

45. See id.


49. See id.

50. See id.
Correlation Between Mental Illness and Criminal Incarceration

Numerous severe mental disorders appear to predominate among the incarcerated mentally ill. Schizophrenia, affective disorders, and bipolar disorder constitute examples of such serious illnesses. Studies indicate that the prevalence of severe mental disorders among inmates is significantly higher than the general population. According to a study conducted by the National Alliance for the Mentally Ill and the Public Citizen's Health Group, more than 1 out of every 14 inmates, or 7.2% of the prison population, suffers from a form of serious mental illness.

As no permanent cure for severe mental disorders exists, the best form of treatment is symptom control. Common forms of effective treatment for symptom control include the use of pharmacologic agents and psychotherapy. Pharmacologic agents include antipsychotic and antidepressant drugs. Antipsychotic drugs are used to reduce hallucinations and delusions in patients with schizophrenia and acute mania. Approximately 70% of patients diagnosed with

52. See American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders 188 (3d ed., rev., Am. Psych. Assn. 1987). Schizophrenia is a disorder in which there are characteristic disturbances in several of the following areas: content and form of thought, perception, sense of self, and relationship to the external world.
53. Id. at 213. Affective disorders are also called mood disorders. They cause a disturbance of mood, accompanied by a full or partial Manic or Depressive Syndrome that is not due to any other physical or mental disorder.
55. Stone, supra note 51, at 283.
56. Id.
57. Id. (citing E. Fuller Torrey, et. al., Criminalizing The Seriously Mentally Ill: The Abuse of Jails and Mental Hospitals, 13 (1992)).
60. Id.
61. Id.
schizophrenia experience clear improvement from the use of antipsychotic drugs.\textsuperscript{62}

Antidepressant drugs are used by patients with depression or mood disorders to influence mood.\textsuperscript{63} Approximately 70\% to 80\% of patients with depression or mood disorders who are given antidepressant drugs experience recovery.\textsuperscript{64} Psychotherapy is used to relieve distress and help promote readjustment and modification of long-standing patterns of maladaptive behavior.\textsuperscript{65}

According to a November 6, 2001, article in \textit{The News and Observer}, an estimated 80\% of North Carolina inmates are either mentally ill, have substance-abuse problems, or struggle with both difficulties.\textsuperscript{66} Further, a Common Sense Foundation special report on North Carolina's mental health system states that, in 2001 alone, the state spent an estimated $117 million incarcerating people with mental illness.\textsuperscript{67}

A 1998 study estimates approximately 43.7\% of mentally ill inmates housed in federal prisons have previously been convicted of a violent crime, as compared to 21.6\% of the general population among federal prisons.\textsuperscript{68} In addition, approximately 50\% of mentally ill federal inmates report taking prescribed medication.\textsuperscript{69} However, once the prisoners are released, only approximately 36\% continue to take their medications.\textsuperscript{70}

As can readily be seen from the above-mentioned statistics, psychotherapy and antipsychotic and antidepressant drugs help control symptoms of a substantial portion of the mentally-ill population.\textsuperscript{71} As a result, providing such preventative treatment as medication and psychotherapy with current government funding may reduce the mental illness-criminal incarceration correlation.

\textsuperscript{62} Stone, supra note 51 at 283. (citing Torrey, supra note 58, 192). However, 25\% percent of patients experience little to no improvement and five percent claim to get worse.

\textsuperscript{63} Id. at 305 (citing Gelder, supra note 59, at 337).

\textsuperscript{64} Id. (citing Robert Michels & Peter M. Marzuk, \textit{Progress in Psychiatry}, 329 \textsc{New Eng. J. Med.} 628, 628-29 (1993)).

\textsuperscript{65} Id. (citing Gelder, supra note 59, at 353-54).


\textsuperscript{67} See id.

\textsuperscript{68} Stavis, supra note 3, at 182. (citing Theodore Milton, et al., \textit{Psychopathy: Antisocial, Criminal & Violent Behavior} (1998)).

\textsuperscript{69} Id. at 183.

\textsuperscript{70} Id.

\textsuperscript{71} Stone, supra note 51, at 305 (citing Gelder, supra note 59, at 353-54).
Proposed Explanations For This Mental Illness-Criminal Incarceration Correlation

Several theories explain the correlation between mental disorders and criminal incarceration. One theory suggests the funding reduction for state-run psychiatric facilities and the large spending increases for correctional facilities have made the transfer of mental health treatment from the civil to the criminal justice setting more common.\(^7\) As a result of decreased funding, state mental health facilities have been unable to maintain the level of close supervision of the mentally ill and the administration of their medications that would be desired in order to promote patients' success in re-adapting to community living.\(^7\)

In addition, another theory purports the correlation’s increase to have originated because of the failure to establish efficient community mental health programs to replace the waning institutions.\(^4\) One of the main reasons attributed to the cause of community programs' failure is the cessation of medications due to a patient’s loss of insight as a result of his mental illness and need for treatments.\(^5\) A patient’s condition may worsen, and he may engage in erratic behaviors, including violence.\(^6\) As a result of inefficient community assistance for the mentally ill, the criminal justice system may intervene upon the community treatment system’s failure.\(^7\)

An additional noteworthy theory is that of commitment statutes’ focus on “dangerousness” rather than “need-for-treatment.”\(^8\) At present, under the dangerousness standard requirement of involuntary commitment, the trial court must find the following three elements present in order to find the defendant dangerous to others: (1) within the recent past (2) defendant has (a) inflicted serious bodily harm on another, or (b) attempted to inflict serious bodily harm on another, or (c) threatened to inflict serious bodily harm on another, or (d) has acted in such a manner as to create a substantial risk of seriously bod-

\(^7\) Id. at 305 (citing Robert D. Miller, Economic Factors Leading to Diversion of the Mentally Disordered Offender from the Civil to the Criminal Commitment Systems, 15 INT'L J. L. PSYCHIATRY 1, 1 (1992)).

\(^8\) See Cameron Quanbeck, Mark Frye, & Lori Altshuler, Mania and the Law in California: Understanding the Criminalization of the Mentally Ill, 160 AM. J. PSYCHIATRY 1245 (July 2003).
ily harm to another, and (3) there is a reasonable probability that such conduct will be repeated.79

**Problems with the Existing Statutory Scheme**

Problems arise as a result of the dangerousness standard. Proving all of the elements of dangerousness can be difficult, if not impossible. It involves qualified physicians to estimate, in their expert opinions, whether the defendant is likely to engage in future behavior that may result in the infliction of harm upon himself or upon others.80 A second relevant difficulty is that an individual’s dangerousness must be proven by a “clear and convincing standard.”81

As to the difficulty of proving dangerousness, no concrete, specifically identifiable standards can be implemented by physicians which can accurately predict such behavior. As a result, failure to predict future dangerousness can lead to tragic results. The 2002 North Carolina Court of Appeals case, *Gregory v. Kilbride*, provides an illustrative example.82

During the 36 hours leading to his evaluation by Dr. Kilbride, Mark Gregory made numerous threats to kill his wife, Kathryn, and himself.83 Mark’s father Lloyd Gregory feared for the safety of his son and daughter-in-law and petitioned the magistrate for Mark’s involuntary commitment. Mark was taken into custody and transported to the Cabarrus County Memorial Hospital where he was evaluated by a psychiatric social worker and an emergency room physician with training in psychology. Both found Mark met the criteria for involuntary commitment. However, in order to satisfy the statutorily required “two-physician certification,” Mark was taken to Broughton Hospital to be evaluated by Dr. Kilbride. Dr. Kilbride found that although Mark was mentally ill, he did not meet the statutorily required definition of dangerousness, subsequently refused to involuntarily commit Mark, and released him. That same afternoon, Mark fired seven point-blank range shots, using two different weapons, to kill his wife Kathryn and then himself.

The North Carolina Court of Appeals instructed in the *Gregory* case that a psychiatrist must use “accepted professional judgment, professional practice and professional standards of practice exercised by psychiatrists with similar training and experience situated in the same

81. *Id.*
83. *Id.*
or similar communities.”

Nowhere in either this opinion or the North Carolina General Statutes does it define appropriate standards of professionalism or give relevant examples. This leads to an enormous ambiguity that, as witnessed by the Gregory case, can easily lead to tragic consequences.

Another difficulty arising with the dangerousness standard is the requirement that the “clear and convincing” evidentiary standard be used. The United States Supreme Court ruled that in order to comport with the Due Process guarantees under the Fourteenth Amendment, the clear and convincing evidence standard of proof is required to be met in civil proceedings brought under state law to involuntarily commit an individual in a state mental hospital. Likewise, North Carolina follows this example by requiring the court to find by clear, cogent, and convincing evidence that the defendant is mentally ill and dangerous to himself or others according to N.C. Gen. Stat. § 122C-3(11)(a) and (b) (2003) to issue an inpatient commitment order.

The “clear, cogent, and convincing” evidentiary standard presents a greater burden to satisfy than “preponderance of the evidence” but is not quite as high a threshold as the criminal burden requiring proof “beyond a reasonable doubt.” The “clear, cogent and convincing” evidentiary standard “should fully convince.”

Furthermore, another difficulty arising under the current statutory scheme of dangerousness is that once the defendant no longer meets either of the two statutory requirements for involuntary commitment, he must be released from the mental care facility in accord with his Due Process right to receive the least restrictive form of treatment necessary. As a result, the person no longer receives much-needed treatment in order to help him readjust to society and stand trial for his criminal charges. However, by providing a “need-for-treatment” approach as an alternative to the dangerousness requirement of the statute, mental health professionals would be able to provide medical care to patients who cannot make rational decisions for

84. Id. at 608, 565 S.E.2d at 691.
86. See N. C. GEN. STAT. § 122C-268(j) (2003).
89. N. C. GEN. STAT. § 122C-263(d)(2) (2003) (defining mental illness and dangerousness to self or others).
90. Landis, supra note 85, at 781.
91. Id.
themselves because of their inability to recognize their mental illness. A focus on the need for treatment would help put an end to this hospital recidivism.92 Hospital recidivism results in substantial human suffering and demoralization, as well as a significant fiscal burden to the public and private mental hospitals.93

Likewise, jails and prisons are not prepared to provide the mental health services for the large numbers of mentally ill who have come under their care. Many correctional facilities lack adequate mental health resources to effectively provide the treatment needed by persons with severe mental disorders.94 As a result of the inadequate treatment resources, the mental conditions of many inmates worsen and lead to increased destabilization in mental and physical health.95 Criminal justice administrators indicate jail programs are not properly equipped to respond effectively to the needs of mentally ill offenders.96

STATUTORY REVISION SUGGESTIONS

In order to effectively help the mentally ill receive necessary treatment and reduce the mental illness-criminal incarceration correlation, the North Carolina General Statutes should include a need-for-treatment approach in addition to the current dangerousness requirement. This would enable physicians to commit individuals who are mentally ill and EITHER dangerous to themselves or others OR in need of treatment. Five possible additions to N.C. Gen. Stat. § 122C-263(2) (2003) are suggested as follows, with the proposed language in italics:

1. If the physician or eligible psychologist finds that the respondent is mentally ill and dangerous to self, as defined in G.S. 122C-3(11)(a), or others, as defined in G.S. 122C-3(11)(b), OR unable or refuses to make responsible decisions with respect to voluntary placement for treatment, the physician or eligible psychologist shall recommend

93. See Marvin S. Swartz, Jeffrey W. Swanson, H. Ryan Wagner, Barbara J. Burns, Virginia A. Hiday, & Randy Borum, Can Involuntary Outpatient Commitment Reduce Hospital Recidivism?: Findings From a Randomized Trial with Severely Mentally Ill Individuals, 156 AM. J. PSYCHIATRY 12 (1999).
94. Stone, supra note 5, at 285 (citing Linda A. Teplin, Psychiatric and Substance Abuse Disorders Among Male Urban Jail Detainees, 84 AM. J. PUB. HEALTH 290, 292 (1994)).
95. Id.
96. Quanbeck, et. al., supra note 78, at 1245.
inpatient commitment, and shall explain his findings on the examination report.97

2. If the physician or eligible psychologist finds that the respondent is mentally ill and dangerous to self, as defined in G.S. 122C-3(11)(a), or others, as defined in G.S. 122C-3(11)(b), OR unable to make or communicate rational decisions concerning personal welfare and lacking the capacity to understand that this is so, the physician or eligible psychologist shall recommend inpatient commitment, and shall explain his findings on the examination report.98

3. If the physician or eligible psychologist finds that the respondent is mentally ill and dangerous to self, as defined in G.S. 122C-3(11)(a), or others, as defined in G.S. 122C-3(11)(b), OR unable to make or communicate rational decisions concerning personal welfare and lacking the capacity to understand that this is so, the physician or eligible psychologist shall recommend inpatient commitment, and shall explain his findings on the examination report.99

4. If the physician or eligible psychologist finds that the respondent is mentally ill and dangerous to self, as defined in G.S. 122C-3(11)(a), or others, as defined in G.S. 122C-3(11)(b), OR substantially unable to make an informed treatment choice and needs treatment to prevent further deterioration, the physician or eligible psychologist shall recommend inpatient commitment, and shall explain his findings on the examination report.100

5. If the physician or eligible psychologist finds that the respondent is mentally ill and dangerous to self, as defined in G.S. 122C-3(11)(a), or others, as defined in G.S. 122C-3(11)(b), OR faces a substantial risk of further destabilization from lack of or refusal to take pre-

97. See Fla. Stat. Ann. § 394.467(1)(a)(1)(b) (2002). The Florida statute provides that a person may be involuntarily committed for treatment if the court finds by clear and convincing evidence that he is mentally ill and is unable to determine for himself, because of his mental illness, whether commitment is necessary.

98. See Haw. Rev. Stat. § 334-60.2(3) (2003). The Hawaii statute provides that a person may be committed to a psychiatric facility for involuntary hospitalization if the court finds that the person is in need of care, treatment or both.

99. See Miss. Code. Ann. § 41-21-61(e) (2003). The Mississippi statute provides that a person is mentally ill if he is in need of treatment in order to prevent further disability or deterioration.

100. See Wis. Stat. Ann. § 51.20(1)(a)(2)(e) (2002). The Wisconsin statute provides that because of mental illness, an individual evidences an incapability to express an understanding of the advantages, disadvantages and alternatives to treatment, and thus is unable to make an informed decision.
scribed psychotropic medications for a diagnosed condition, the physician or eligible psychologist shall recommend inpatient commitment, and shall explain his findings on the examination report. 101

Statutory Proposals One and Two focus on an individual's inability to make a rational, informed decision concerning the need for treatment for his mental illness. The overwhelming advantage of these proposals is they allow intervention before an individual reaches the point of dangerousness and comes into contact with the criminal justice system. However, a visible problem exists with these proposals. They require society as a whole to agree to protect an individual's liberty interest by intervening to assist him in receiving treatment. As a result, a mentally-ill individual may not be left to make a treatment decision on his own.

Statutory Proposals Three, Four and Five focus on preventing an individual's further deterioration by allowing intervention to maintain the status quo. The primary focus of these proposals is on outward manifestations of the mental illness rather than the individual's decision-making capability for treatment. A potential problem with these statutory proposals exists in that intervention comes too late, once outward signs of inner disturbances already appear.

The best statutory scheme for incorporating a need-for-treatment approach would be to add language regarding inability to make appropriate treatment decisions AND preventing further deterioration in order to encompass a more thorough statute.

**Commitment Funding Issues**

Since one of this Comment's proposals focuses on helping to decrease and more manageably control the mental illness-criminal incarceration correlation through more efficient allocation of government funding, the necessity arises to briefly discuss important funding issues. The North Carolina General Statutes command state and local governments to use available resources to provide such core services as consultation, prevention, education, and emergency services. 102 “Available resources” are statutorily defined as state funds, non-state funds, and other resources that are “appropriated, allocated

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101. See Wyo. Stat. Ann. § 25-10-101(a)(ii)(C) (2003). The Wyoming statute provides that due to mental illness, there is a substantial probability that serious mental debilitation or destabilization will result from lack of or refusal to take prescribed psychotropic medications for a diagnosed condition.

or otherwise made available for mental health."

In addition, local funds are allocated to fund these core services. "Local funds" constitute fees from client payments, Medicare and Medicaid, and fees from agencies under contract and gifts and donations.

According to N.C. Gen. Stat. § 143-117, all persons admitted to regional psychiatric hospitals and special care centers are required to pay the actual cost of their care, treatment, and maintenance. This statutory provision applies to all persons confined within a state institution, regardless of whether deemed criminally insane or civilly committed. However, no individual may be refused services because of his inability to pay.

The state Secretary of Health and Human Services possesses the discretion and authority to determine and fix the actual cost of care to be paid by and for each person admitted to an institution. The person admitted to the facility or the person legally responsible for paying the cost of the admittance is notified of the amount due as soon as the amount is determined and is further notified via statement on a monthly basis. If this person is unable to pay the cost by the due date, the Secretary may arrange for the payment of a portion of the cost monthly and extend payments until the costs are paid. In addition, insurance and third-party payment methods are also accepted to satisfy the cost.

Although the North Carolina General Statutes detail the commitment payment policies, the failure to conduct transitional planning and treatment, as well as establish community linkages with defendants who have been found incapable to proceed to trial, not only risks undermining any mental health treatment that these persons have received, but almost ensures the defendant with severe mental disorders will decompensate after release, re-offend, and subsequently revisit the criminal justice system.
Taking into consideration the high costs of caring for the mentally ill in the criminal justice system, it is essential to consider routing existing funds to prevention and other helpful alternatives. When mental illness goes untreated, violence and other criminal activities occur which lead to a person's entering, or re-entering, the criminal justice system.\footnote{Id.}

**Conclusion**

Mentally-ill criminal defendants in North Carolina who are deemed incapable to proceed to trial currently face a substantial risk of falling through the cracks, not receiving necessary treatment, and returning to their communities to re-offend. In order to decrease this risk, North Carolina desperately needs to expand its involuntary commitment statutes to include a need-for-treatment approach. Further, to reduce the mental illness-criminal incarceration correlation and to ensure that mentally-ill defendants receive the help they need, government funding must be more efficiently, and effectively, allocated to the establishment and maintenance of preventative treatment programs.

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