EXHIBIT 10

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

DISABILITY RIGHTS NORTH CAROLINA, *Plaintiff*, v. THE NORTH CAROLINA DEPARTMENT OF HEALTH AND AND HUMAN SERVICES and KODY KINSLEY, in his official capacity as Secretary of the North Carolina Department of Health and Human Services, *Defendants*.	)	Civil Action No. 1:24-cv-335

EXPERT DECLARATION OF DANIEL MURRIE, PhD

I. SUMMARY OF EDUCATION AND PROFESSIONAL EXPERIENCE

I, Daniel Murrie, declare hereby as follows:

1. I have prepared a response to the questions that follow. I work as a forensic-clinical psychologist, university faculty member, and national expert in forensic mental health services, with specific areas of expertise including competence evaluation and restoration treatment. I currently serve as Director of the University of Virginia's Institute of Law, Psychiatry, and Public Policy (ILPPP) and as a Professor of Psychiatry and Neurobehavioral Sciences in the UVA School of Medicine. In these roles, I oversee a state-wide training programs in forensic evaluation, direct a forensic training clinic, perform forensic evaluations (including adjudicative competence), and consult with state

forensic mental health systems regarding forensic services. Along with my Groundswell Services, Inc. colleagues, I have provided formal consultation to many U.S. state forensic systems on matters of competence evaluation and restoration treatment. I also currently serve as a federally appointed "special master" overseeing reform of the competence system in Colorado. As a scholar, my research and teaching address topics in forensic psychology, with a focus on reliability, bias, and quality improvement in forensic evaluation. I have authored over 100 peer-reviewed scientific publications and numerous book chapters on forensic mental health evaluations and services. My full qualifications and publications are detailed in my curriculum vitae.

II. QUESTIONS ASKED OF GROUNDSWELL SERVICES, INC.

2. Groundswell Services, Inc., has been retained to answer the questions that follow. This Declaration is submitted in response to plaintiff's requests for Groundswell's input addressing the following questions that relate to people with serious mental illness awaiting capacity to proceed to trial[1] services in North Carolina jails:

a. What kinds of issues or conditions can afflict severely mentally ill people who are detained in jails for long periods of time without adequate treatment, and how does that effect their capacity for restoration?

[1] In North Carolina, the test of capacity to proceed is whether a person is able to understand the nature and object of the proceedings against him, to comprehend his own situation in reference to the proceedings, and to assist in his defense in a rational or reasonable matter (NC General Statutes: Chapter 15A, Article 56, § 15A-1001). These collective capacities are also referred to as *competence to stand trial* in the research literature and many statutes. Thus, much of the scholarship cited in this report refers to *competence to stand trial* rather than *capacity to proceed.*

b. Why is it important to have and enforce limits on the amount of time that mentally ill defendants can be detained awaiting assessment or treatment?

c. What actions could the North Carolina Department of Health and Human Services take to reduce waiting periods for evaluations for all or nearly all detainees?

d. What actions could the North Carolina Department of Health and Human Services take to reduce waiting periods for restoration for all or nearly all detainees?

3. Plaintiffs raised these questions in the context of North Carolina's challenges in providing timely mental health services related to capacity to proceed. To be clear, North Carolina is not alone in facing such challenges.

a. Across most U.S. states, the demand for capacity evaluations has grown dramatically. Two decades ago, experts estimated that approximately 60,000 capacity evaluations were ordered annually across the U.S.,[2] but current estimates suggest more than 140,000 capacity evaluations are ordered annually.[3] Rates have increased drastically in most states across the U.S.[4]

[2] Bonnie, R. J., & Grisso, T. (2000). Adjudicative competence and youthful offenders. In T. Grisso & R. G. Schwartz (Eds.), *Youth on trial: A developmental perspective on juvenile justice* (pp. 73–103). Chicago, IL: University of Chicago Press.

[3] Kois, L. E., Potts, H., Cox, J., & Zapf, P. (in press). *Law and Human Behavior.*

[4] For example, Wik, A., Hollen, V., & Fisher, W. (2020). Forensic patients in state psychiatric hospitals: 1999–2016.

b. As the number of court orders for capacity evaluations rises, so does the number of persons found incapable to proceed (ITP) and ordered to restoration. Many jurisdictions report this trend, with rates of restoration orders increasing from 100% to 250% in just a few years.[5] Perhaps more perplexing than the increase in the *number* of restoration orders is the increase in the *proportion* of defendants opined ITP. An influential meta-analysis of capacity studies published from 1960-2009 revealed a historical average ITP rate of 27.5%, which came to be considered the "typical" rate of ITP findings.[6] However, recent data from states that track capacity evaluations indicate much higher ITP rates.[7]

c. Overall, United States capacity service systems have faced rapid and dramatic increases in demand. Courts are ordering far more defendants to undergo capacity evaluations than ever before, and evaluators are opining a far greater portion—and, of course, a far

[5] For summary, see: Murrie, D.C. Gowensmith, N.G., Kois, L.E., & Packer, I. (in press). Competency Restoration and Forensic Service Systems. In P. Zapf et al. (Eds.). *The APA Handbook of Forensic Psychology—Second Edition*. Washington DC. American Psychological Association.

[6] Pirelli, G., Gottdiener, W. H., & Zapf, P. A. (2011). A meta-analytic review of comparative competency to stand trial research. *Psychology, Public Policy, and Law, 17*, 1–53.

[7] Murrie, D.C. Gowensmith, N.G., Kois, L.E., & Packer, I. (in press). Competency Restoration and Forensic Service Systems. In P. Zapf et al. (Eds.). *The APA Handbook of Forensic Psychology—Second Edition*. Washington DC. American Psychological Association.

greater number—of those defendants ITP. Inevitably, this has led to far more court orders for restoration services, which places tremendous strain on the systems that have provided capacity restoration services.

d. This demand is challenging traditional approaches to capacity restoration. This widespread and substantial increase in referrals for evaluation of capacity to proceed and restoration has been labeled a "crisis." [8, 9, 10, 11, 12] Not only have waitlists for admission to state hospitals increased, but the average wait time has also significantly increased. As a result, more people with SMI now languish in jails without adequate psychiatric treatment services, often experiencing increasingly severe and harmful symptoms. Given the harm to those who wait in jails excessively for inpatient capacity restoration services, advocacy organizations have filed lawsuits in many states to demand faster and better mental health care for criminal defendants

[8] Gowensmith, W. N. (2019).
[9] Callahan, L., & Pinals, D. A. (2020).
[10] Tullis, P. (2019, December 6). When mental illness becomes a jail sentence. *The Atlantic.*
[11] Warburton, K., McDermott, B. E., Gale, A., & Stahl, S. M. (2019). A survey of national trends in psychiatric patients found incompetent to stand trial: Reasons for the reinstitutionalization of people with serious mental illness in the United States. *CNS Spectrums, 25,* 245 - 251.
[12] Wortzel, H., Binswanger, I. A., Martinez, R., Filley, C. M., & Anderson, C. A. (2007). Incompetence to proceed to trial: Harbinger of a systemic illness. *Journal of the American Academy of Psychiatry and the Law, 35,* 357-363.

found ITP and waiting for inpatient hospitalization.[13, 14] At the same time, many states have been developing additional, and alternative strategies beyond the traditional default to inpatient restoration, and a few have drastically decreased their waitlists and wait times for restoration.

4. Regarding North Carolina's specific challenges in providing services regarding capacity to proceed, records provided by Disability Rights North Carolina and the American Civil Liberties Union of North Carolina via public records requests paint a picture that appears similar to the national crisis. Indeed, North Carolina's forensic mental health system is marked by high demand and increasing wait times for defendants awaiting capacity services. For example, a defendant's average wait time for a capacity evaluation was approximately 33 days in 2017. By the end of 2023, a defendant could expect to wait an average of 61 days for an evaluation.

a. The number of defendants requiring capacity restoration, as well as their wait times for this service, has also increased. Capacity restoration wait times grew from approximately 121 days in 2022 to approximately 155 days in 2023.[15]

[13] Gowensmith, W. N. (2019).

[14] Heilbrun, K., Giallella, C., Wright, H. J., DeMatteo, D., Griffin, P. A., Locklair, B., & Desai, A. (2019). Treatment for restoration of competence to stand trial: Critical analysis and policy recommendations. *Psychology, Public Policy, and Law, 25*(4), 266–283.

[15] The North Carolina Department of Health and Human Services began tracking these data in March 2022.

b. Historically, the North Carolina Department of Health and Human Services offered capacity restoration solely in the state psychiatric hospital setting. In recent years, the Department has attempted to expedite and expand services for ITP defendants through the implementation of Detention Based Capacity Restoration Programs (DBCRPs) and Community Based Capacity Restoration Programs (CBCRPs). The Department now offers capacity restoration in three general settings: the state psychiatric hospital, the detention center (jail), and the community. However, despite these efforts, the number of individuals who have been recommended to and ultimately ordered to these programs is extremely low relative to the number of defendants who need services.

c. The NC RISE (Restoring Individuals Safely and Effectively) Program, established via a collaboration of the North Carolina Department of Health and Human Services, Mecklenburg County Sheriff's Office, and Wellpath Recovery Solutions, is the only DBCRP available for ITP defendants in North Carolina. Its operational plan indicates the program adopts an evidence-informed framework for providing restoration and treatment for ITP defendants detained in the Mecklenburg County Jail.[16] Detention-based restoration can be a suitable approach for a portion of ITP defendants, such as those with lower clinical acuity. However, many ITP defendants have

[16] NC RISE Program at Mecklenburg County Operational Plan. (2022).

significant needs that would exclude them from participating in NC RISE. Indeed, there are many "rule out" criteria that would exclude many ITP defendants with serious mental illness from receiving restoration services while detained in jail. Additionally, defendants with significant physical disabilities or needing assistive medical devices—situations that are not uncommon in jail[17]—are mostly excluded from the program. While NC RISE can be an important contribution to North Carolina's capacity services spectrum, NC RISE eligibility criteria demonstrate that it is not an appropriate or available solution for the many ITP defendants who require a higher level of care. Further, only eligible Mecklenburg defendants may be granted access to the program, which significantly limits North Carolina's DBCRP capacity and reach.

d. CBCRPs have been implemented in Wake, Mecklenburg, and Cumberland Counties. As of March 2024, local evaluators have made 21 referrals for the Cumberland County CBCRP, which resulted in three court orders for defendant participation. In Wake County, evaluators have made 20 referrals to its CBCRP, but no defendants have been court-ordered to participate. In Mecklenburg County, nine defendants have been referred to its CBCRP, and five have been court-ordered to participate. These data demonstrate that in North Carolina, CBCRP access and enrollment are insufficient for meeting

[17] Tomoko, U. (2019). Chronic medical conditions in U.S. adults with incarceration history. *Health Psychology, 38*(3), 217-225.

the needs of the many ITP defendants who are likely well-suited for this treatment context.

5. In light of the North Carolina's struggle to provide timely capacity-related services, and drawing on emerging research and best practices amid the broader national crisis, I respond to the questions the plaintiffs raised:

III. WHAT KINDS OF ISSUES OR CONDITIONS CAN AFFLICT SEVERELY MENTALLY ILL PEOPLE WHO ARE DETAILED IN JAILS FOR LONG PERIODS OF TIME WITHOUT ADEQUATE TRETAMENT, AND HOW DOES THAT INFLUENCE THEIR CAPACITY FOR RESTORATION?

6. My response to this question is informed by national organizational standards including the National Commission on Correctional Health Care's *Standards for Mental Health Services in Correctional Facilities*[18] and *Standards for Health Services in Jails,*[19] the American Psychiatric Association's *Guidelines on Psychiatric Services in Correctional Facilities,*[20] the American Academy of Psychiatry and the Law's *Practice Resource for Prescribing in Corrections*[21] and the American Correctional Association's *Performance-*

[18] National Commission on Correctional Health Care. (2015). *Standards for mental health services in correctional facilities*.

[19] National Commission on Correctional Health Care. (2018). *Standards for health services in jails*.

[20] American Psychiatric Association. (2016). *Psychiatric services in correctional facilities* (3rd ed.). Author.

[21] Tamburello, A., Penn, J., Ford, E., Champion, M., Glancy, G., Metzner, J., Fergusen, E., Tomita, T., Ourada, J. (2022). The American Academy of Psychiatry and the Law practice resource in prescribing in corrections. *Journal of the American Academy of Psychiatry and the Law, 50*(4), 636-637.

Based Health Care Standards for Adult Local Detention Facilities,[22] as well as the empirical literature, and my professional experience.

a. People with mental illness are overrepresented in correctional institutions around the country, according to vast research on the topic. Of course, identifying "the" exact prevalence of mental illness in jails is difficult because the vast research base uses varied definitions of mental illness and varied assessment methods to arrive at diagnoses.[23-24] Nevertheless, even by the strictest definitions, the prevalence of mental illness in correctional settings is several times higher than in the general population. People admitted to jails are roughly five times more likely to have a mental illness than those in the community.[25] Indeed, authorities often comment that jails are the largest providers of mental health treatment in the United States.[26]

---

[22] American Correctional Association (2004). *Performance-based health care standards for adult local detention facilities* (4th edition). https://www.aca.org/ACA_Member/ACA/ACA_Member/Standards_and_Accreditation/StandardsInfo_Home.aspx?New_ContentCollectionOrganizerCommon=2

[23] Kolodziejczak, O., & Sinclair, S. J. (2018). Barriers and facilitators to effective mental health care in correctional settings. *Journal of Correctional Health Care*, *24*(3), 253-263.

[24] Maloney, M. P., Dvoskin, J., & Metzner, J. L. (2015). Mental health screening and brief assessments. In R. L. Trestman, K. L. Appelbaum, & J. L. Metzner (Eds.), *Oxford Textbook of Correctional Psychiatry* (pp. 57–61). Oxford University Press.

[25] Kubiak, S., Comartin, E.B., Hanna, J. & Swanson, L. (2020). Identification, referral, and services for individuals with serious mental illness across multiple jails. *Journal of Correctional Health Care*, 26(2), 168-182.

[26] Roth, A. (2018). *Insane: America's criminal treatment of mental illness*. Hachette UK.

7. The term Serious Mental Illness (SMI) is used to describe a subgroup of people with any mental illness who experience mental, behavioral, or emotional disorders resulting in serious functional impairment, which substantially interfere with one or more major life activities.[27] The American Correctional Association provides a standard definition of SMI in correctional facilities as,

> "psychotic disorders, bipolar disorders, and major depressive disorder, and any other diagnosed mental disorder (excluding substance use disorder) currently associated with serious impairment in psychological, cognitive, or behavioral functioning that substantially interferes with the person's ability to meet the ordinary demands of living."[28]

The prevalence of SMI in jails is estimated around 14.5% among men and 31% among women.[29] This is significantly higher than in the general population, where the prevalence of SMI is estimated around 5%.[30]

8. Even outside of jails and prisons, individuals with SMI, particularly those diagnosed with schizophrenia spectrum disorders, are at increased risk for suicide and early

---

[27] National Institute of Mental Health (2023). *Mental illness*. https://www.nimh.nih.gov/health/statistics/mentalillness#:~:text=Serious%20mental%20illness%20(SMI)%20is,or%20more%20major%20life%20activities.

[28] American Correctional Association (2016). *Restrictive Housing Standards*. https://www.wsj.com/public/resources/documents/Restrictive_housing.pdf

[29] Steadman, H. J., Osher, F. C., Robbins, P. C., Case, B., & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services*, *60*(6), 761-765.

[30] National Institute of Mental Health (2023).

mortality.[31, 32] Under stressful environmental conditions and in the absence of appropriate treatment, individuals with SMI are at risk of psychiatric decompensation (i.e., re-emergence or worsening of symptoms, such as delusions, hallucinations, manic episodes, severe depression, suicidal ideation or attempts).[33] To prevent psychiatric decompensation, individuals with SMI typically require more intense psychiatric services than those with any mental illness, including timely administration of psychotropic medication, counseling/therapy, or inpatient care *particularly when medications need to be administered involuntarily*.

A. The stress and challenges of jail.

9. The jail environment poses many challenges to providing mental healthcare, even compared to prisons. Unlike prisons, people in jails are directly admitted from the community. Many have been without treatment and thus experience active psychiatric symptoms, the effects of intoxication, or life-threatening withdrawal from substances. Indeed, individuals in jails experience more acute mental health symptoms and treatment needs than people in prisons.[34] Furthermore, jails were built as transitional places to

[31] Ilyas, A., Chesney, E., & Patel, R. (2017). Improving life expectancy in people with serious mental illness: should we place more emphasis on primary prevention? *The British Journal of Psychiatry*, *211*(4), 194-197

[32] Yeh, H. H., Westphal, J., Hu, Y., Peterson, E. L., Williams, L. K., Prabhakar, D., ... & Ahmedani, B. K. (2019). Diagnosed mental health conditions and risk of suicide mortality. *Psychiatric Services*, *70*(9), 750-757.

[33] Ilyas, A., Chesney, E., & Patel, R. (2017).

[34] Dvoskin, J. and Brown, M. C. (2015). Jails and prisons. In R. L. Trestman, K. L. Appelbaum., & J. L. Metzner (Eds.), *Oxford textbook of correctional psychiatry* (pp. 31-34). Oxford Press.

temporarily house those waiting for their dispositions. Thus, they tend to have poorer physical conditions. Jails are often noisy and crowded.[35] Jails typically have small holding or intake spaces, lack natural light, and little or no outdoor spaces.[36, 37] This makes it difficult for clinicians to conduct screening, assessment, and treatment in confidential and safe spaces. Furthermore, the pre-trial status of people in jails is related to uncertainty about the legal case, which adds to the stress of incarceration. Lastly, mental health resources and funding are often limited in jails, including access to qualified mental health professionals (e.g., due to low salaries, high caseloads, and high turn-over).[38] Even for jails with appropriate staffing, the rapid turnover and unpredictable numbers of admissions and discharges make it difficult for mental health departments to allocate staffing and provide continuity of care. The high turnover also means that incarcerated people are commonly moved to different housing areas, often without warning, making it difficult to establish a sense of stability or safety. All these factors make the jail environment exceptionally

---

[35] Scheyett, A., Vaughn, J., & Taylor, M. F. (2009). Screening and access to services for individuals with serious mental illnesses in jails. *Community Mental Health Journal*, *45*, 439-446.

[36] Barber-Rioja, V., Roth, L., Subedi, B., & Chen, M. (2023). Mental health treatment in jails. In V. Barber-Rioja, A. Garcia-Mansilla, B. Subedi, and A. Batastini (Eds.). *Handbook of mental health assessment and treatment in jails* (pp. 38-56). Oxford Press.

[37] Mai, C., Belaineh, M., Subramanian, R., & Kang-Brown, J. (2019). *Broken ground: Why America keeps building more jails and what it can do instead.* Vera Institute of Justice.https://www.vera.org/downloads/publications/broken-ground-jail-construction.pdf

[38] Kolodziejczak, O., & Sinclair, S. J. (2018). Barriers and facilitators to effective mental health care in correctional settings. *Journal of Correctional Health Care*, *24*(3), 253-263.

stressful for any person, and likely to exacerbate pre-existing mental health symptoms for those with SMI. These are likely some of the reasons that the national rate of suicide in jails is three times as high as in the general population, making suicide the leading cause of death in jails around the country.[39, 40]

10. There is general agreement that jails are ill equipped to treat mental illness.[41, 42, 43] A nationwide survey of county jails found that on average, 36% of incarcerated individuals with mental illness did not receive *any* psychiatric treatment or mental health services.[44] A smaller study of just a few counties found that in one jail, 69% of individuals identified as needing mental health care and referred for services never received an assessment or service.[45] Black and Hispanic individuals are even less likely to receive mental health services than White individuals.[46] To be clear, some jails have implemented

---

[39] Carson, A. E., & Cowhig, M. P. (2020). *Mortality in Local Jails, 2000-2016 - Statistical Tables*. Bureau of Justice Statistics.

[40] Carson, A. E., & Cowhig, M. P. (2020). *Mortality in State and Federal Prisons, 2001-2016 - Statistical Tables*. Bureau of Justice Statistics. Retrieved October 29, 2020, from http://www.bjs.gov/index.cfm?ty=pbdetail&iid=6766

[41] Kapoor, R. (2020). A continuum of competency restoration services need not include jail. *The Journal of the American Academy of Psychiatry and the Law, 48,* 52–55

[42] Martin, D. A., Bailey, C. A., & Gowensmith, W. N. (2023). Ethical considerations of competency restoration: The risk of decompensation in correctional settings. *Psychology, Public Policy, and Law*, *29*(1), 62.

[43] Pinals, D. A., & Callahan, L. (2020). Evaluation and restoration of competence to stand trial: Intercepting the forensic system using the sequential intercept model. *Psychiatric Services, 71*(7), 698–705.

[44] Sung, H. E., Mellow, J., & Mahoney, A. M. (2010). Jail inmates with co-occurring mental health and substance use problems: Correlates and service needs. *Journal of Offender Rehabilitation*, *49*(2), 126-145.

[45] Kubiak, S., Comartin, E. B., Hanna, J., & Swanson, L. (2020).

[46] Kaba, F., Solimo, A., Graves, J., Glowa-Kollisch, S., Vise, A., MacDonald, R., ... & Venters, H. (2015). Disparities in mental health referral and diagnosis in the New

therapeutic units or programs that provide effective treatment for people with SMI, as demonstrated by improved clinical outcomes for this group.[47] Unfortunately, these programs require significant resources and are not available in most jails.

B. The risk of harm to people with SMI in jails.

11. The combination of a stressful jail environment and the inadequate mental health treatment leave people with SMI particularly vulnerable to negative outcomes in jail. Symptoms that are more common in jails than prisons include: acute depression, suicidality, intoxication or substance-related symptoms, mania, and psychosis.[48, 49] The chaotic and anti-therapeutic environment of the jail setting, paired with the lack of appropriate resources and obstacles to health care (e.g., security, segregation) cause many people with pre-existing SMI to experience psychiatric decompensation, which results in re-emergence of symptoms such as psychotic disorganization, hallucinations, delusions, poor self-care (e.g., not showering or eating), aggression in the context of paranoid beliefs, and self-injury or suicide attempts. People with SMI in jails are also more likely to be

---

York City jail mental health service. *American Journal of Public Health*, *105*(9), 1911-1916.

[47] Ford, E. B., Silverman, K. D., Solimo, A., Leung, Y. J., Smith, A. M., Bell, C. J., & Katyal, M. (2020). Clinical outcomes of specialized treatment units for patients with serious mental illness in the New York City jail system. *Psychiatric Services*, *71*(6), 547-554.

[48] Dvoskin, J., & Brown, M. C. (2015).

[49] James, D. J., & Glaze, L. E. (2006). *Mental health problems of prison and jail inmates*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. https://www.bjs.gov/content/pub/pdf/mhppji.pdf

victimized by other incarcerated persons,[50] more likely to have difficulty following rules resulting in disciplinary action and segregation,[51] more likely to be subjected to uses of force by correctional staff,[52] and more likely to engage in self-harming behaviors and die by suicide.[53]

12. *Timely psychiatric assessment and treatment are thus crucial to prevent harm among people with SMI in jails*. The National Commission on Correctional Health Care[54] and the American Psychiatric Association[55] have established standards for early identification and ongoing assessment, and mechanisms through which incarcerated people can be referred for a mental health assessment at any point during their incarceration. These guidelines have also established that people evaluated during the jail intake screening or at any point during their incarceration, who require acute mental health services beyond those offered in the facility, including psychiatric hospitalization, should be transferred promptly to an appropriate facility. Access to emergency psychiatric care is critical in jails. Some jails have specific policies that delineate the criteria and procedures for transferring people

[50] Blitz, C. L., Wolff, N., & Shi, J. (2008). Physical victimization in prison: The role of mental illness. *International Journal of Law and Psychiatry*, *31*(5), 385-393.

[51] Scheyett, A., Vaughn, J., & Taylor, M. F. (2009).

[52] Fellner, J. (2015). *Callous and cruel: Use of force against inmates with mental disabilities in US jails and prisons*. Human Rights Watch.

[53] Mitchell, S. M., Fineran, V., Cary, J., Sparks, S., & La Rosa, N. L. (2023). Managing suicide risk and non-suicidal self-injury in jails. In V Barber-Rioja, A. Garcia-Mansilla, B. Subedi, and A. Batastini (Eds.). *Handbook of mental health assessment and treatment in jails.* Oxford Press.

[54] National Commission on Correctional Health Care. (2018).

[55] American Psychiatric Association. (2016).

with SMI in need of inpatient care. However, the reality is that many jails lack the resources to identify everyone in need of inpatient care and/or to provide access to psychiatric beds.

13. A critical challenge for people with SMI in jails is access to medications. The first line of treatment for people with schizophrenia-spectrum disorders is psychotropic medications, which attenuate acute psychiatric symptoms in most patients.[56] But jails can rarely implement self-medication programs (i.e., programs that allow responsible incarcerated individuals to collect and self-administer medications) due to the risk of medication misuse or diversion to non-patients. Consequently, facilities rely on nurses, who often must be able to access housing areas to administer medication. This process can be interrupted for many reasons, including lockdowns, housing transfers, or competing jail interests such as commissary or visitation, which causes lapses in medication administration.[57, 58] Challenges with medication administration make it difficult for people with SMI to take their medications as prescribed, even for those who are willing to adhere to their medication regime voluntarily. Of course, people in jails have the right to refuse treatment, including medications, and the jail setting provides many reasons that might discourage those with SMI from medication. For example, some experience medications

---

[56] American Psychiatric Association (2021). *Practice guideline for the treatment of patients with schizophrenia* (3rd ed.). American Psychiatric Association.

[57] Tamburello, A., Penn, J., Ford, E., Champion, M., Glancy, G., Metzner, J., Fergusen, E., Tomita, T., Ourada, J. (2022). The American Academy of Psychiatry and the Law Practice Resource in Prescribing in Corrections. *Journal of the American Academy of Psychiatry and the Law, 50*(4), 636-637.

[58] Kushner, D. B., Stossel, L. M., & Khan, M. A. (2023). Psychopharmacology in the jail setting. In V. Barber-Rioja, A. Garcia-Mansilla, B. Subedi, and A. Batastini (Eds.). *Handbook of mental health assessment and treatment in jails* (pp. 137-155). Oxford Press.

as sedating and believe that this would prevent them from defending themselves in an environment that they consider dangerous. Others believe that being perceived as mentally ill can place them at risk of assault or exploitation. Medication may carry a stigma or sense of embarrassment. Absent appropriate medication treatment, some people might become so severely and acutely ill that their symptoms interfere with their capacity to refuse treatment. Managing these refusals in jail is complex and requires a thorough evaluation and collaboration among clinical and legal professionals.[59] Procedures for how to intervene when people who lack capacity are refusing medications vary across jurisdictions. Even though there is legal precedent for using involuntary medications on an emergency basis in jails, administering involuntary medications in jails raises ethical and security concerns, and many jails lack the resources to implement these practices appropriately.[60] Thus, many jails decline to administer involuntary medication, even when someone is gravely ill.

14. People with SMI face additional harms if placed in segregation, particularly when they are actively experiencing symptoms. Segregation is sometimes a way for security departments to observe or manage mentally ill individuals who engage in institutional misconduct as a result of acute psychiatric symptoms.[61, 62] Research has found

[59] National Commission on Correctional Health Care. (2015).

[60] Kushner, D. B., Stossel, L. M., & Khan, M. A. (2023).

[61] O'Keefe, M. L. (2013). Administrative segregation for mentally ill inmates. In D. W. Phillips III (Ed). *Mental health issues in the criminal justice system* (pp. 149-165). Routledge.

[62] Walters, G. D., & Crawford, G. (2014). Major mental illness and violence history as predictors of institutional misconduct and recidivism: Main and interaction effects. *Law and Human Behavior*, *38*(3), 238-47.

that people with mental illness are disproportionately represented in segregation housing, are more likely to be placed in segregation rather than to receive lesser disciplinary action, and are held in segregation housing much longer than people without mental illness.[63, 64, 65] Professional organizations warn that people experiencing active symptoms of mental illness (e.g., auditory hallucinations, delusional beliefs, manic symptoms, suicidal ideation) should not be placed in segregation and should instead be transferred to an acute psychiatric treatment setting.[66] Yet in the absence of appropriate resources and treatment for individuals experiencing psychotic or manic agitation, security departments can resort to isolating people with mental illness as a management strategy. I have observed people in jails experiencing active, severe symptoms placed in isolation under poor conditions of confinement, including dirty cells, and limited access to natural light, showers, or mental health treatment. Even when Sheriffs and correctional staff perceive this situation as alarming, they may see no other way to manage the population. This is particularly true in jails with acutely ill detainees and inadequate staffing.

---

[63] Clark, K. (2018). The effect of mental illness on segregation following institutional misconduct. *Criminal Justice and Behavior*, *45*(9), 1363-1382.

[64] Kaba, F., Solimo, A., Graves, J., Glowa-Kollisch, S., Vise, A., MacDonald, R., ... & Venters, H. (2015). Disparities in mental health referral and diagnosis in the New York City jail mental health service. *American Journal of Public Health*, *105*(9), 1911-1916.

[65] Maszak-Prato, S., & Graham, L. (2022). Reducing the use of segregation for people with serious mental illness. *The Prison Journal*, *102*(3), 283-303.

[66] American Psychiatric Association. (2016). *Psychiatric services in correctional facilities* (3rd ed.).

C. Delayed (or lacking) access to appropriate care for people experiencing acute psychiatric symptoms in jails can result in harm (see question #2).

15. Harms include not only psychological distress and suffering (e.g., hearing harsh voices, paranoia, ruminative thoughts about suicide) but also long-term negative consequences. Although not specific to the jail environment, the psychiatric literature has identified Duration of Untreated Psychosis (DUP), which is typically defined as the period between the onset of psychosis and the start of treatment, as a significant predictor of poor prognosis. For example, an umbrella review on prognostic outcomes identified a relationship between longer duration of untreated psychosis and more severe psychiatric symptoms, lower chances of remission, poor overall functioning, and more severe global psychopathology.[67] There is not yet research that directly investigates the relationship between DUP and capacity restoration outcomes. However, severe psychopathology and cognitive deficits *are* clearly associated with poorer capacity restoration prognosis.[68, 69, 70]

---

[67] Howes, O., Whitehurst, T., Shatalina, E., Townsend, L., Onwordi, E., TL. AM.,… Osugo, M. (2021). The clinical significance of duration of untreated psychosis: An umbrella review and random-effects meta-analysis. *World Psychiatry, 20,* 75–95.

[68] Roye, S., Coffey, C. A., Nitch, S. R., Glassmire, D. M., & Kinney, D. I. (2022). The clinical utility of the NAB Judgment subtest among individuals diagnosed with schizophrenia spectrum disorder within a forensic inpatient setting. *Assessment*, *29*(8), 1686-1699.

[69] Staats, M. L. P., Kivisto, A. J., & Connell, R. E. (2021). The role of cognitive functioning in predicting restoration among criminal defendants committed for inpatient restoration of competence to stand trial. *International Journal of Law and Psychiatry*, *74*, 101654.

[70] Toofanian Ross, P., Padula, C. B., Nitch, S. R., & Kinney, D. I. (2015). Cognition and competency restoration: Using the RBANS to predict length of stay for patients deemed incompetent to stand trial. *The Clinical Neuropsychologist*, *29*(1), 150-165.

Thus, it is reasonable to assume that defendants with increasing DUP have lower likelihood of restoration success.

D. Risks are significant for those found Incapable to Proceed.

16. SMI is much more prevalent among incarcerated people found ITP. Indeed, severe psychotic illness is the primary reason for an ITP finding.[71] An ITP finding is often a proxy for *acute* SMI, meaning that symptoms are active and severe. Therefore, people found ITP represent those in the jail population who likely have the most acute, severe, and chronic mental illnesses. In the absence of appropriate psychiatric care, most individuals found ITP are at increased risk for further psychiatric decompensation, as is true for all people with SMI. The research also suggests that delays in treatment access can result in long term consequences, such as decreasing chances of full recovery. In short, the available literature, along with clinical experience, gives strong reason to expect that the longer the wait, the higher the likelihood of substantial harms (i.e., psychiatric decompensation, victimization, segregation, self-harm/suicide, and severe human suffering), and a longer period of treatment necessary to restore stability.

17. Of course, beyond the risk for significant harms (described above), delays in treatment for people found ITP create other practical complications. Defendants found ITP must ultimately undergo psychiatric treatment to "restore" capacity. That is, treatment must reduce the symptoms that interfere with capacity to the extent that the defendant can meaningfully participate in legal proceedings. Yet lengthy delays in treatment, while ITP

[71] Pirelli, G., Gottdiener, W. H., & Zapf, P. A. (2011). A meta-analytic review of competency to stand trial research. *Psychology, Public Policy, and Law*, *17*(1), 1.

defendants wait in jail, make restoration more difficult. Specifically, symptoms become more severe, generally requiring more time and treatment before they stabilize. Although people and symptoms vary greatly, it is generally true that longer periods of untreated psychosis—resulting in increasingly severe symptoms—will require longer periods of treatment to restore capacity.

IV. WHY IS IT IMPORTANT TO HAVE AND ENFORCE LIMITS ON THE AMOUNT OF TIME THAT MENTALLY ILL DEFENDANTS CAN BE DETAINED AWAITING ASSESSMENT OR TREATMENT?

A. Limiting the amount of time that people are detained awaiting capacity services will limit the amount of harm they experience.

18. As reviewed above, lengthy waits inevitably invite further clinical decompensation—that is, worsening psychiatric symptoms—a form of human suffering that also increases the risk of other harms: i.e., cognitive damage due to untreated psychosis, poorer response to eventual treatment once it is provided, self-harm, failure to provide basic self-care (sometimes leading to medical problems), aggression to others, victimization by others, or additional institutional or criminal charges due to behaviors that are symptoms of the illness. As one review summarizes,

> "A steadily growing body of literature shows that delaying treatment in persons with acute mental illness may lead to a host of negative consequences. When treatment is delayed for acute episodes of mental illness, several problems arise, including the increased use of coercive methods in treatment, higher medical comorbidity, increased systemic costs,

> and the development of refractory mental illness with poorer prognoses in the long run…
>
> …Evidence from multiple meta-analyses of clinical trials shows that the longer patients with schizophrenia wait to be treated, the poorer their response to antipsychotic medication and the more severe their mood and cognitive symptoms. In addition, their relapses and hospitalizations increase, as does their risk of suicide. Increasing clinical evidence also reveals that affective disorders like depressive and bipolar disorders have poorer outcomes when left untreated, including a worse response to pharmacological treatment, release, chronicity, and higher rates of suicide and medical comorbidities."[72]

To be clear, the most robust research addressing the harms of untreated psychiatric illness addresses first-episode psychosis, or the initial emergence of SMI. Whereas some ITP defendants are in this earliest phase of illness, most are beyond the early phase. The field has less research addressing the consequences of delaying treatment in these later stages of illness. Certainly, I can identify no peer-reviewed literature *specific* to the types of lengthy delays (e.g., delays for a matter of months) in treatment common to ITP defendants. *But the available literature gives strong reason to expect substantial clinical harm to those waiting months for psychiatric treatment, with longer waits associated with greater harms, and greater difficulty attaining their capacity to proceed upon eventual treatment*.

[72] Biswas, J., Drogin, E. Y., & Gutheil, T. G. (2018). Treatment delayed is treatment denied. *Journal of the American Academy of Psychiatry and the Law*, *46*(4), 447-453.

19. Of course, beyond any long-term clinical or medical consequences of delayed treatment, the most obvious consequence is a longer period of *suffering the symptoms of serious psychiatric illness.* Most psychiatric illness are characterized by the extreme distress (e.g., fear, paranoia, disorganized thinking, depression, suicidality, etc.); this is one reason that these illnesses are associated with much higher incidence of suicide. Delaying psychiatric treatment inevitably lengthens the time people experience the severe distress attributable to their psychiatric symptoms.

20. Thus, for ITP defendants with serious psychiatric illness facing lengthy waits in jail before inpatient restoration treatment, time limits (deadlines) to begin restoration services are a means to limit the degree and duration of clinical harm and human suffering.

B. Strategies to reduce wait times are available.

21. The North Carolina Department of Health and Human Services is not alone in facing a challenging demand for capacity services. Criminal defendants in many states experience lengthy delays, often in jails with insufficient mental health treatment, awaiting evaluation or restoration services. Addressing these challenges requires a multifaceted approach that involves not only allocating sufficient resources but also improving coordination and collaboration across mental health and criminal legal systems. By identifying and addressing the root causes of delays, state systems can reduce their forensic waitlists and ensure that criminal defendants receive timely access to essential services in the least restrictive settings possible.

22. The good news is that no state system needs to start from scratch. Many innovative and emerging best practices have been implemented successfully in other

jurisdictions. Examples in subsequent sections of this report, though not comprehensive, highlight some of the steps taken elsewhere to reduce backlogs and wait times for those needing capacity evaluations or restoration services. None of these measures are "the" solution to the national crisis. *But when multiple strategies are implemented properly, they can meaningfully reduce the number of people waiting for capacity services, the length of time they wait, and the harm they experience while they wait.*

23. These strategies are promising elements that comprise a larger, comprehensive, problem-solving approach; some strategies are more straightforward, and require fewer resources to implement. Of course, many of the larger changes (e.g., legislation and organizational overhauls) will have the largest impact, but also take more time and effort. "Upstream" deflection and diversion away from the criminal legal system are the best strategies for linking individuals with care immediately, and avoiding the slower process that is focused on capacity to proceed. Foundational practice and policy changes such as these reduce the number or people requiring evaluation, which also reduces the number of people referred for restoration.

24. I begin with simpler, targeted strategies to reduce waits for evaluation and restoration. I progress towards strategies with broader impact. I report strategies on a rough continuum of complexity, and highlight those that are more immediately actionable.

V. WHAT ACTIONS COULD THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES TAKE TO REDUCE WAITING PERIODS FOR EVALUATIONS FOR ALL OR NEARLY ALL DETAINEES?

A. Maximize video telehealth evaluation services where appropriate.

25. To the extent that a few evaluations in rural areas may require extra time and transportation resources that slow the broader evaluation system, it may be reasonable to implement video telehealth services for CTP evaluations (particularly in more remote areas), to reduce the need for in-person appointments and more promptly accommodate defendants in remote areas. These must follow best practices for telehealth evaluations, of course.[73] But when performed appropriately, research suggests telehealth evaluations do not systematically yield different results from the in-person alternative.

B. Hire a court-based clinician or clinic.

26. Using this approach, clinical staff can quickly advise the judiciary about arrestees' clinical condition, viability of civil (versus forensic) pathways to more rapid treatment, admissions criteria for various programs, and so on. Court-based clinicians can advise on which defendants likely require an evaluation of capacity to proceed. Clinicians can encourage appropriate (versus unnecessary) referrals for evaluation. But more broadly, clinician availability to quickly advise on clinical matters can help with diversion efforts, even when more formal diversion programs (described later) are not yet available. Put simply, the country has a national crisis partly because capacity services usually appear to be the only path to clinical services for defendants with mental illness; court-based clinicians can help the court understand clinical needs and identify other (non-capacity) paths to clinical treatment or services.

[73] Batastini, A. B., Guyton, M. R., Bernhard, P. A., Folk, J. B., Knuth, S. B., Kohutis, E. A., ... & Tussey, C. M. (2023). Recommendations for the use of telepsychology in psychology-law practice and research: A statement by American Psychology-Law Society (APA Division 41). *Psychology, Public Policy, and Law*, *29*(3), 255.

C. Enhance training and education for mental health professionals and legal stakeholders.

27. Providing comprehensive training programs on best practices for conducting capacity evaluations is crucial for any forensic system. Strong evaluator training programs (e.g., Massachusetts and Virginia) tend to improve reliability and accuracy, in ways that reduce erroneous conclusions and poor practices (which ultimately delay services for those who most need services). Likewise, educating courts and attorneys about capacity tends to increase appropriate orders for evaluations, decrease inappropriate orders for evaluations, and generally helps promote other evaluation efficiencies (e.g., knowing which records to share and how to share them promptly).

D. Pursue and devote increased funding and staffing in the context of a strategic plan.

28. Put simply, most states facing an overwhelming demand for capacity evaluation and restoration seek and allocate additional resources to hire more evaluators and support staff. Of course, any new evaluators should be adequately trained and qualified. "Lowering the bar" to enlist unqualified evaluators may lead to poor evaluations, and less appropriate conclusions, which causes other problems that far outweigh any advantages of increased speed.

VI. WHAT ACTIONS COULD THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES TAKE TO REDUCE WAITING PERIODS FOR RESTORATION FOR ALL OR NEARLY ALL DETAINEES?

A. Focus on reducing waiting periods for restoration.

29. **Consider a standardized re-evaluation mechanism.**

a. Some states implement a standardized re-evaluation mechanism, such as Washington state's "21 Day Competence Check." This initiative allows courts, jails, prosecutors, or defense attorneys to trigger a capacity screening for defendants awaiting inpatient forensic services from Washington's Department of Social and Health Services (DSHS). This process may lead to a full re-evaluation of capacity based on psychiatric symptom improvements, medication adjustments, or apparent stability. Once the re-evaluation mechanism is triggered, the capacity evaluation must be conducted within 21 days. States that have implemented re-evaluation services notice that a meaningful portion of defendants are already capable; when they are removed from the waitlist, the remaining ITP defendants, with more severe symptoms, receive treatment sooner.[74]

[74] Again, re-evaluation is *not* a substitute for treatment. It is only a mechanism to identify those ITP defendants on a waitlist who have stabilized and become capable (often due to taking medication in jail, or the resolution of "symptoms" that were more attributable to substances or temporary distress). These defendants can proceed with adjudication, leaving the treatment resources for the ITP defendants who need them most.

30. **Establish a restoration triage placement system.**

a. Colorado implemented a triage system for inpatient capacity restoration treatment that prioritizes defendants based on the urgency of their clinical need. Evaluators categorize incapable defendants into Tier 1 (urgent need for inpatient care due to imminent danger, grave disability, or severe progressing symptoms) who must be admitted within 7 days, or Tier 2 (requiring inpatient services but less urgently) who must be admitted within 28 days. This replaces the previous "first come, first served" approach, which tends to leave severely ill defendants waiting in line "behind" defendants who may be much more stable. Much like triage services in hospital emergency departments, triage strategies for capacity restoration reduce human suffering by prioritizing treatment for those who need it most urgently.

31. **Streamline and expedite referral, admission, and discharge processes.**

a. Targeting administrative bottlenecks will expedite enrollment in services and treatment progress. Strategies will depend on state-specific inefficiencies, of course. But most states who thoroughly investigate delays find many ways to improve efficiencies in the exchange of information and records, transportation of defendants, communication around intake and discharge, etc.

32. **Develop restoration treatment "on ramps."**

a. Defendants awaiting restoration can begin psychiatric treatment, such as medication, in the jail. A California program of this sort has greatly

accelerated defendants' improvements, and played a key role in drastically decreasing their waitlist. Although such interventions do not *replace* inpatient capacity restoration, they are critical for promptly addressing severe symptoms that may impede restoration efforts or diversion eligibility. In short, the sooner *some* form of psychiatric treatment begins, the sooner defendants stabilize enough for restoration or diversion. When defendants stabilize sooner, they complete restoration sooner, which frees capacity for the next defendants ordered to restoration services.

33. **Develop, scale up, and spread a Continuum of Care for capacity restoration services.**

a. The traditional model of providing all restoration services in an inpatient facility is no longer feasible, or even appropriate. Many ITP defendants can be better served in the community. So, a continuum of care must prioritize CBCRPs for all defendants who are suitable, and provide DBCRPs for the portion of defendants not appropriate for the community or the hospital.

34. **Offer state-wide Community Based Capacity Restoration Programs.**

a. *Wide-scale CBCRP programs are a crucial step in resolving the crisis.* Indeed, CBCRP is quickly emerging as standard practice. Some states (Virginia and Colorado) even identify, in statute, CBCRP as the *default setting* for capacity restoration, and they offer CBCRP state-wide in every jurisdiction. Even if inpatient services were widely available, they are inappropriate for certain defendants, such as those with intellectual disability,

or those whose clinical condition does not warrant inpatient treatment and thus could be treated in the community if released on bond. Consistent with the longstanding principle of providing treatment in the "least restrictive alternative," CBCRP allows participants to remain closer to their homes, communities, and other resources. CBCRP programs, when designed well, can also strengthen a defendant's ties to community treatment services, so that even post-restoration, the defendant is less likely to decompensate and face arrest for behaviors related to symptoms (which, of course, would return them to the capacity system). Put simply, robust CBCRP, when delivered in ways that foster long-term treatment engagement, is one of the best strategies to reduce the "revolving door" of capacity restoration services.

35. **Offer clinically robust Detention Based Capacity Restoration Programs.**

a. DBCRP is a reasonable option for the subset of defendants who both: a) do not warrant inpatient restoration and b) are not eligible for community-based restoration (usually due to the severity of their charges). To be clear, DBCRP services require far more than legal education delivered in the jail. Good DBCRPs closely approximate inpatient services (as much as possible in a jail). But when implemented appropriately, these are a narrow-but-important point on the capacity restoration continuum of care because they allow systems to prioritize inpatient restoration services for those who need them most (due to the severity of their symptoms, not simply the severity of their charges). Again, even DBCRPs must provide robust clinical services.

36. **Require capacity evaluators to comment on restoration placement.**

a. Some states (Colorado and Virginia) have explicitly articulated in statute that community-based restoration is the default location for restoration. These statutes then require evaluators to opine on whether the defendant's clinical condition requires inpatient treatment, which is necessary to deviate from the default placement into community restoration (or DBCRP, for those whose charges would preclude restoration in the community). This strategy may be necessary to counter the strong historic tendency for courts to default to ordering inpatient restoration, even for defendants who do not require inpatient treatment.

37. **Increase housing to accommodate community-based restoration.**

a. Develop specialized housing and group homes for those undergoing community restoration and persons diverted from the capacity system. Defendants should never be ordered to inpatient restoration solely because they have no other viable housing. Housing, though expensive, remains much less expensive than inpatient restoration, and tends to encourage longer-term treatment adherence and stability in the community.

38. **Pursue increased funding and staffing as part of a strategic plan.**

a. Allocate additional resources to hire more support staff, including treatment providers and correctional staff with specialized training and experience working in forensic settings. This can take many forms, depending on needs. Some states (e.g., California and Colorado) have hired psychiatry staff to

travel to jails and begin medication treatment for defendants awaiting restoration services. Some (e.g., Colorado) hired "Forensic Support Team" staff to visit defendants awaiting restoration in jails, monitor their clinical condition, pursue release on bond to community restoration services, etc.

B. Strategies that reduce both evaluation and restoration waitlists

39. **Implement specialized dockets to streamline capacity-related matters, allowing for better resource allocation and coordination.**

a. Establish centralized calendars and frequent reviews to ensure timely and accountable progress. Many states find that "capacity courts" or "capacity dockets" develop greater expertise and efficiency among legal professionals, facilitating much faster, and much better, resolution of capacity matters.

40. **Create positions for forensic liaisons.**

a. Forensic liaisons can monitor the clinical status and case status of all capacity-involved individuals, regardless of setting, and advise on capacity progress, clinical need, and placement settings. Form court case management teams to ensure proficiency and prevent individuals from languishing in the system.

41. **Leverage centralized forensic data infrastructure.**

a. Maintain a strong data management system that tracks data regarding persons found incapable (length of stay, restoration outcomes, diagnoses, etc.), evaluators (rates of findings, length of time to complete evaluations, etc.), and variables that affect forensic capacity (number of orders by county,

impact of various forensic programs and initiatives, etc.). Use rigorous data to identify system inefficiencies or problem areas and target interventions for improvement. Establish performance metrics and benchmarks to monitor the efficiency of capacity evaluation processes. Conduct regular audits or evaluations to identify bottlenecks and areas for improvement.

42. **Put sufficient time and resources into identifying, recruiting, training, and retaining forensic mental health and correctional service staff who are involved in the capacity-related programs.**

43. **More broadly, develop and use crisis hotlines, response teams, crisis stabilization centers, and other strategies to avoid or reduce arrests among those with SMI.**

a. Generally, robust community services that rely less on law enforcement officers, and more on clinicians, tend to fast-track people with severe psychiatric symptoms into the treatment services they need. For many reasons, this is far preferable to the slow and winding path to treatment via raising, evaluating, and adjudicating capacity.

44. **Increase the availability and scope of Assisted Outpatient Treatment (AOT).**

a. AOT is a strong part of any robust community mental health system that seeks to divert or deflect individuals away from the capacity system.

C. Potential legislative and policy change

45. **Reserve capacity evaluations for defendants charged with serious crimes, while diverting those charged with misdemeanors to treatment programs.**

a. Some states, such as Alabama, Florida, and New York, do not pursue charges once an individual charged solely with a misdemeanor offense is adjudicated ITP. Misdemeanor offenses are often committed by low-risk individuals with more severe psychiatric symptoms, whose needs are better addressed by diversion and other services.[75]

46. **Change statutes to prioritize civil commitment or mandated community treatment over capacity restoration for appropriate arrestees.**

47. **Change statutes to better facilitate involuntary medication orders (IMO) for those adjudicated ITP, which begins the restoration process more rapidly.**

a. IMOs should be considered and approved (where appropriate) at the hearing finding the defendant ITP, and the IMO should be able to be implemented and continued, regardless of treatment setting, if the defendant remains in the capacity system. For example, California and Minnesota developed statutes authorizing involuntary medication at the time of ITP adjudication, and these orders "follow" defendants through the adjudication process. Of course, IMOs should always be implemented in the context of rigorous and caring

[75] Murrie, D.C., Gardner, B.O., & Torres, A.N. (2022). The impact of misdemeanor arrests in forensic mental health services: A state-wide review of Virginia Competence to Stand Trial evaluations. *Psychology, Public Policy, and Law, 28(1),* 53-66.

clinical services (with good clinical services, the use of force is almost never necessary).

48. **Assertively reduce the length of inpatient restoration, often by hiring specialized staff to monitor patient progress, identify those approaching capacity, and encourage treatment changes or enhancement.**

49. **Adhere to reasonable timelines for restoration, per *Jackson v. Indiana.***

50. **Consider, like California, a "growth cap" that levies financial penalties and incentivizes diversion for counties that continue to order more people to inpatient restoration each year rather than creating or utilizing diversion and deflection options.**

VII. CONCLUSION

51. The preceding strategies vary greatly, and include some that can be implemented rapidly, and others that will take more time and formal legislative changes. Many require collaboration across systems and stakeholders to do well. All will require careful consideration of North Carolina's system strengths, vulnerabilities, and idiosyncrasies. Even strategies that have been clearly successful in other states may require adjustments specific to North Carolina. Nevertheless, there is reason for optimism, because *there are many steps North Carolina can begin promptly to make meaningful system changes and improve conditions for people with SMI ordered to receive capacity-related services.*

Pursuant to 28 U.S.C. § 1746, I declare the foregoing is true and correct.

Daniel Murrie, PhD May 13, 2024