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IN THE COURT OF APPEALS OF NORTH CAROLINA

No. COA20-64

Filed: 1 September 2020

Buncombe County, No. 19 SPC 1689

IN THE MATTER OF: R.H.

Appeal by respondent from order entered 15 August 2019 by Judge Ward D. Scott in Buncombe County District Court. Heard in the Court of Appeals 11 August 2020.

Attorney General Joshua H. Stein, by Assistant Attorney General Erin E. McKee, for the State.

Appellate Defender Glenn Gerding, by Assistant Appellate Defender Candace Washington, for respondent-appellant.

TYSON, Judge.

R.H. (“Respondent”) appeals from an involuntary commitment order, which committed him to twenty-one days of inpatient treatment. We affirm the trial court’s order.

I. Background

Respondent has a history of suffering from schizophrenia and refusing to comply with prescribed treatment. On 26 July 2019, Respondent voluntarily presented at the emergency room, asserted he was experiencing auditory hallucinations, and asked to be admitted. Respondent was homeless at the time of his hospital admission. After several days of treatment, Respondent requested to be discharged and stated he planned to walk approximately 300 miles to Myrtle Beach, South Carolina after release from the hospital. Staff at the hospital initiated involuntary commitment proceedings.

Dr. Sarah Volk completed the initial evaluation of Respondent. Dr. Volk noted Respondent became agitated, punched a wall in the emergency room, and called 911 to claim a nurse had molested him. Dr. Volk opined that Respondent was mentally ill, a danger to himself and others, and recommended inpatient treatment for thirty days. Dr. Elena Perra completed the second evaluation of Respondent and opined conclusions consistent with Dr. Volk's.

Dr. Eric Larsson, Respondent's treating psychiatrist at the hospital, was the sole witness at the commitment hearing. Dr. Larsson did not diagnose Respondent, but agreed with his colleagues' previous diagnosis of schizophrenia. Dr. Larsson noted Respondent had claimed people were trying to poison his food, were "out to get him," and voices were telling him "mean things."

Respondent had been treated previously with three different anti-psychotic drugs. Due to ineffective responses to those prior medications, Dr. Larsson began treating Respondent with Clozapine, a more powerful drug. Due to a high risk for potential side-effects, Respondent's dosage of Clozapine was titrated, slowly increasing the amount administered, while closely monitoring the patient. Dr. Larsson testified a potential side effect of Clozapine is a dangerous condition called aplastic anemia, when a patient stops producing a certain kind of blood cell. Dr. Larsson also testified another possible side effect of Clozapine is serious sedation, which can cause patients to fall and suffer head injuries. Dr. Larsson testified when administering Clozapine, the more titration occurs, the more therapeutic efficacy or benefit a patient receives.

Respondent was receiving a 250 mg Clozapine dosage at the time of the proceeding, with a goal of raising his dosage to at least 300 mg. Dr. Larsson's treatment plan indicated it would take four or five days to safely increase Respondent's dosage of Clozapine to 300 mg. Once Respondent reached that dosage, two weeks post-monitoring was necessary to ensure no onset of acute side effects. The treatment plan goal was for Respondent to have a positive response to the medication and be discharged at the end of this monitoring.

At the 15 August 2019 hearing, the trial court found and concluded Respondent was a danger to himself and ordered he be committed at Mission Memorial Hospital

for twenty-one days in accordance with Dr. Larsson's treatment plan. A Notice of Hearing for Involuntary Commitment was filed for 5 September 2019, but not served due to Respondent's discharge. Respondent filed a written notice of appeal on 9 September 2019.

II. Jurisdiction

An appeal of right lies with this Court from a final judgment of involuntary commitment pursuant to N.C. Gen. Stat. §§ 7A-27(b)(2) and 122C-272 (2019). "When the challenged order may form the basis for future commitment or may cause other collateral legal consequences for the respondent, an appeal of that order is not moot." *In re Webber*, 201 N.C. App. 212, 217, 689 S.E.2d 468, 472-73 (2009). This appeal is properly before this Court "notwithstanding the fact that the period of [Respondent's] involuntary commitment has ended." *In re Whatley*, 224 N.C. App. 267, 270, 736 S.E.2d 527, 529 (2012) (citation omitted).

III. Issue

The sole question presented to this Court is whether the findings of fact recorded by the trial court are sufficient to support its conclusion that Respondent satisfies the second statutory prong of being dangerous to himself. Respondent asserts the findings of fact did not demonstrate and support a conclusion he would suffer "serious physical debilitation within the near future unless adequate treatment is given." N.C. Gen. Stat. § 122C-3(11)(a)(II) (2019).

IV. Standard of Review

In order to involuntarily commit an individual, the trial court must find clear, cogent, and convincing evidence to support a conclusion the individual is (1) mentally ill; and, (2) dangerous to himself or others. N.C. Gen. Stat. § 122C-268(j) (2019). This Court reviews an involuntary commitment order for “clear, cogent, and convincing evidence” to support “the ‘facts’ recorded in the commitment order and whether the trial court’s ultimate findings of mental illness and dangerousness to self or others were supported by the ‘facts’ recorded in the order.” *In re Whatley*, 224 N.C. App. at 270-71, 736 S.E.2d at 530 (citation omitted).

V. Analysis

Respondent argues the trial court erred by involuntarily committing him. He asserts the conclusion that he was dangerous to himself is not supported by sufficient written findings of fact. The statute provides a respondent is dangerous to himself if, “within the relevant past,” he has acted in a way to show:

I. [Respondent] would be unable, without care, supervision, and the continued assistance of others not otherwise available, to exercise self-control, judgment, and discretion in the conduct of the individual’s daily responsibilities and social relations, or to satisfy the individual’s need for nourishment, personal or medical care, shelter, or self-protection and safety; and

II. There is a reasonable probability of the individual’s *suffering serious physical debilitation within the near future* unless adequate treatment is given pursuant to this Chapter. A showing of *behavior that is grossly irrational*,

of actions that the individual is unable to control, of behavior that is grossly inappropriate to the situation, or of *other evidence of severely impaired insight and judgment shall create a prima facie inference that the individual is unable to care for himself or herself.*

N.C. Gen. Stat. § 122C-3(11)(a) (emphasis supplied).

Respondent does not challenge the trial court's findings with respect to the statute's first prong of mental illness. Clear, cogent, and convincing evidence to support "ultimate findings of mental illness and danger[] to self or others [must be] supported by the 'facts' recorded in the order." *In re Collins*, 49 N.C. App. 243, 246, 271 S.E.2d 72, 74 (1980) (citation omitted). A trial court's failure to comply with the statutory fact-finding mandate constitutes reversible error. *In re Whatley*, 224 N.C. App. at 274, 736 S.E.2d at 532.

The second prong of "dangerousness to self" has both: (1) a behavioral component; and, (2) a time component. *See* N.C. Gen. Stat. § 122C-3(11)(a)(II). The behavioral component places the burden upon the petitioner to make "[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." *Id.* The time component requires the petitioner carrying the burden of proof above to show a "reasonable probability of the individual's suffering serious physical debilitation within the near future unless adequate treatment is given." *Id.*

This Court has held that the behavioral component of “dangerousness to self” is not satisfied by a trial court’s findings, which merely cites past acts. *See In re Whatley*, 224 N.C. App. at 273, 736 S.E.2d at 531. In the case of *In re Whatley*, the trial court found the respondent was “exhibiting psychotic behavior that endangered her, remained paranoid, exhibited disorganized thinking, and demonstrated very poor insight and judgment.” *Id* (internal quotations omitted). The “trial court’s findings pertain[ed] to the respondent’s history of mental illness [and] behavior leading up to the commitment hearing, but [did] not indicate that [the symptoms would persist or] the circumstances rendered [the patient] a danger to herself in the future.” *Id*.

Our statutes mandate the petitioner to prove by clear, cogent, and convincing evidence to show “behavior that is grossly irrational” or “other evidence of severely impaired insight and judgment” to show a “prima facie inference that [Respondent] is unable to care for himself.” N.C. Gen. Stat. § 122C-3(11)(a)(II).

The trial court found Respondent “has exhibited impaired judgment as evidenced by his stated desire to walk [300 miles] to Myrtle Beach upon discharge”; “has a low capacity to use self-control, judgment and discretion”; and “has been experiencing auditory hallucinations, paranoid beliefs that staff and other patients on the unit are talking about him,[and] has threatened a staff member and another

patient.” The trial court also found that Respondent has “a history of medication noncompliance.”

Dr. Larsson testified and opined that if released, Respondent would not take his medication, resulting in him “probably get[ting] in some sort of trouble.” The evidence supporting the findings of fact support a conclusion that if released, Respondent’s future likelihood of medication non-compliance, “grossly irrational” behavior, and “severely impaired insight [and] judgment” would continue. *See id.*

The statute requires a reasonable probability the individual will suffer a serious physical debilitation within the near future. N.C. Gen. Stat. § 122C-3(11)(a)(1)(II) (emphasis supplied); *see In re W.R.D.*, 248 N.C. App. 512, 516, 790 S.E.2d 344, 348 (2016) (emphasis supplied) (Where a schizophrenic patient was not compliant with prescribed medical treatment for a heart condition and this Court reversed the commitment).

In the case of *In re W.R.D.*, the treating doctor testified that the patient’s refusal to take his heart medication “could be deadly,” but did not testify that ceasing medication would create a serious risk “within the near future.” *Id.*

Here, *inter alia*, the trial court made the following relevant findings of fact:

3. Respondent has a history of medication noncompliance. Respondent has been experiencing auditory hallucinations, paranoid beliefs that staff and other patients on the unit are talking about him, has threatened a staff member and another patient, and has exhibited impaired judgment as evidenced by his stated desire to walk to Myrtle Beach

upon discharge.

4. Respondent has a low capacity to use self-control, judgment and discretion in the conduct of his affairs and social relations such that it is advisable for him to be under treatment.

. . . .

6. Due to the associated health risks with Clozapine, the dosage of the medication that Respondent receives must be titrated and Respondent must undergo monitoring. Currently Respondent is receiving 250 mg of Clozapine. Dr. Larsson's treatment plan is to ultimately increase Respondent's dosage of Clozapine to 300 mg.

7. Dr. Larsson anticipates that it will take an additional 4-5 days to safely increase Respondent's dosage of Clozapine to 300 mg. Once Respondent is receiving that dose, additional monitoring for two weeks is necessary.

8. It is unlikely that Respondent would be able to satisfy his need for medical care, namely the titration of Clozapine and the need for monitoring to protect against risks associated with Clozapine, absent the care of the 24-hour facility given Respondent's impaired judgment, paranoia, history of medication noncompliance, and auditory hallucinations.

These findings were based upon Dr. Larsson's testimony and opinion that he "[does not] trust [Respondent's] judgment to make sound decisions for himself." Dr. Larsson also testified and opined Respondent would not be able to satisfy his need for self-protection and safety, and Respondent would not take his medication. Dr. Larsson opined Respondent's failure to take his medication would result in "his paranoia [getting] worse and he would probably get into some sort of trouble."

The trial court concluded “it is unlikely that Respondent would be able to satisfy his need for medical care, namely the titration of Clozapine and need for monitoring to protect against the risks associated with Clozapine.” Respondent’s history of medication noncompliance and the continuation of his irrational behaviors and impaired judgment at the time of the hearing indicate that if released, he would not comply and receive the treatment and monitoring prescribed. Without treatment, auditory hallucinations, irrational behavior, and impaired judgment would likely continue. There was a reasonable probability Respondent would stop taking medication, his psychiatric symptoms would get “much worse quite quickly,” and he would suffer from “physical debilitation within the near future” to support the conclusions in the order.

Dr. Larsson’s plan, as evidenced by his testimony, was to complete an effective administration and post-monitoring of Clozapine. Respondent should achieve a more rational state with improved judgment. Dr. Larsson would monitor Respondent for two weeks after raising to, and while receiving, his 300 mg dosage to ensure no acute onset of side effects. After this period, the goal was for Respondent to be in a condition where he could make prudent decisions and comply with his prescribed treatment.

Unlike the case *In re Whatley*, the evidence presented and findings of fact here are sufficiently forward looking to support a finding that Respondent was dangerous to himself. *See* N.C. Gen. Stat. § 122C-3(11)(a). The trial court’s findings that

Respondent “exhibited impaired judgment as evidenced by his stated desire to walk [300 miles] to Myrtle Beach upon discharge,” “has been experiencing auditory hallucinations, paranoid beliefs that staff and other patients on the unit are talking about him, [and] has threatened a staff member and another patient” exhibit that Respondent’s “behavior [] is grossly irrational” and “[he suffers from] severely impaired insight and judgment.” N.C. Gen. Stat. § 122C-3(11)(a)(II). These findings “create a prima facie inference [the Respondent] cannot care for himself.” *Id.* Respondent’s “history of medication noncompliance,” together with the “near future” probability of continued non-compliance, shows that Respondent was dangerous to himself and there was a reasonable probability he would suffer from debilitation absent commitment and treatment.

Here, the trial court’s finding “it is unlikely that Respondent would be able to satisfy his need for medical care, namely the titration of Clozapine and need for monitoring to protect against the potential risks associated with Clozapine” supports the determination that Respondent will suffer physical debilitation within the near future. *See In re W.R.D.*, 248 N.C. App. at 516, 790 S.E.2d at 348 (overruling the trial court’s involuntary commitment of a schizophrenic patient who was not compliant with her prescribed heart medication). Without involuntary commitment and administration and post-monitoring of Clozapine, Respondent was likely to suffer physical debilitation as a result of the inability to monitor his side-effects, and “get

into trouble” as consequence of his irrational behaviors and impaired judgment. The trial court’s findings of fact support the conclusion Respondent is dangerous to himself. *See* N.C. Gen. Stat. § 122C-3(11)(a)(1)(II). The court’s order limited Respondent’s confinement only to the period of time the evidence showed was needed to achieve the target dosage level and to monitor potential side effects. Respondent’s argument is overruled.

V. Conclusion

The trial court’s findings of fact are sufficient to support a reasonable probability Respondent would suffer serious debilitation in the near future if immediately released from the hospital. The trial court’s order for involuntary commitment is affirmed. *It is so ordered.*

AFFIRMED.

Chief Judge McGEE and Judge COLLINS concur.

Report per Rule 30(e).