House Select Committee on Involuntary Commitment and Public Safety: Public Comment Portal Public Comments Report - LINC

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02/24/2026 01:54 PM	Adam Austin	1 Test Str., Raleigh, NC 27601	Wake	adam.austin@ncleg.gov	Testing
02/26/2026 08:36 AM	Mrs. Sarah Lee	83 Gibbs Rd, Lillington, North Carolina 27546	Harnett	parentsagainstloss@gmail.com	Want to fix a major root issue that results in mental health crisis in both adults and their children? Stop the corruption, fraud, and gross neglect in the child welfare system of our state. Exposing children to the fostercare industry unnecessarily sets the foundation for severe mental health crisis and bodily adulthood harm with exposure to psychotropic drugs while in the system. Mere exposure to the fostercare industry is known to give mebtal health crisis to children! Then there is the abuse of children in the system that puts them at risk for abusing other people as adults. They cannot function like healthy adults can and end up in prison. Please give the people of NC a public hearing before the NC DHHS oversight committee!!!! The Federal Civil Rights Division gave us one - but our own state will not hear its own people!!!
02/26/2026 08:45 AM	IVC recommendations Tara Muller	3724 National Dr Ste 100, Raleigh , NC 27612	Wake	Tara.muller@disabilityrightsnc.org	Good afternoon. Thank you, again, for your leadership in addressing the missed opportunities in North Carolina's involuntary commitment (IVC) system that allow people with serious mental health conditions to cycle in and out of EDs, IVC holds, and jail. Like you, we are horrified by the murder of Raleigh teacher Zoe Welsh. We are glad that you are working to address the problem of a system that just spins – spending and spending with zero healing and zero return on investment. We must end the cycling. Relying on jails and EDs creates a revolving door cycle – people with mental health needs in the ED may be arrested, charged, and sent to jail because of symptoms that may manifest in difficult ways, like violence toward health care workers, and then those same people in jail will decompensate and end up back in the ED. Both the financial costs and the human costs are staggering. As we recommended in our 2025 IVC Report, mental health and competency evaluations should be done in therapeutic settings where staff is well trained to help people through behavioral health crises. Neither jails nor emergency departments are equipped to do that. We need more community-based behavioral health clinics to serve this role. During the last IVC committee hearing, nearly everyone seemed to agree that the revolving door cycle is a problem

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					that must be fixed. Building more community-based behavioral health clinics would help, but that takes time. What can we do now? We suggest that, when someone is involuntarily committed, the person should go to a DSOHF-operated psychiatric hospital. Right now, DSOHF hospitals are too short-staffed to fill that role, but we understand that they have the necessary physical plant resources and would have capacity if they were properly staffed. Since that infrastructure is already in place, immediately giving DSOHF hospitals the staffing resources they need may be the most efficient way to fill this crucial gap in the short term. Also, our report identified gross IVC overuse, for which we recommend IVC speedbumps / diversion via training for county clerks and magistrates so that they can educate petitioners and collaborate with LME/MCOs. Another way to reduce unnecessary IVCs is by adequately funding counties to strengthen their mental health emergency response through 211, 988, and non-police response teams. We recommend that each county create a "tiger team" dedicated to administering evaluations expeditiously. NC already has great models that work well – the HEART model and the ACORNS model, for example, which pair expert clinicians with EMTs – but they only work if fully staffed and immediately responsive. Handling these calls properly, by professionals familiar with the array of service options in the community, will reduce cycling -- a win-win for both the disabled person and the taxpayer. Thank you for considering these ideas. Please feel free to contact me if you would like to meet or if you would like us to present information about our IVC report to your committee.
02/26/2026 09:15 AM	Mr. Jean-Luc Duvall	8408 Neuse Rapids Rd, Raleigh, NC 27616		jlcduvall@gmail.com	The biggest step to solving this problem is passing a state budget. A portion of that step is not cutting staff vacancies to trim the budget
02/26/2026 10:40 AM	Dr. Peggy Terhune	738 N LAKE DR, Asheboro, NC 27205-1058	Randolph	peggy.terhune@monarchnc.org	I am the CEO of Monarch, a provider of MH services. We are doing a pilot with Wake Med (started 5/25) to keep frequent users (more than 12 visits/year)out of the ED and hospital. We care manage people and initiate meetings with people. We connect with them in the ED, and then work with them when they get out, with a staff on the ground that visits them, takes them to lunch, etc. We have virtual primary and psychiatric health available 24/7 via telemed. In May, 46 members had 27 hospital events. In January, this same group had 7. This is a 34% reduction in ED visits and hospital admissions for these individuals. This pilot is unfunded. We

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					are doing this to try to see what works. We would love to share more specifics.
02/26/2026 10:45 AM	Kate Whitfield	222 Holly Drive, Washington, NC 27889	Beaufort	kwhitfield@pridenc.com	As a Licensed Clinical Mental Health Counselor and Clinical Director serving children, adolescents, and families across North Carolina, I see every day how our current system is failing individuals with serious mental illness — and placing the burden on jails, emergency departments, and state psychiatric hospitals. We should be clear: incarceration is not mental health treatment. When individuals are held in jail because there is nowhere else for them to go, we are criminalizing illness. When state psychiatric beds are occupied primarily by justice-involved individuals deemed incompetent to proceed, we create a bottleneck that prevents access for those in acute crisis who have not committed crimes. The result is predictable — emergency departments boarding psychiatric patients for days or weeks, correctional facilities operating beyond capacity, and families in crisis with nowhere to turn. We cannot solve this problem by shifting people between systems. We must build capacity where it actually prevents escalation. I urge the Committee to prioritize the following solutions: Expand and adequately fund community-based crisis stabilization services, including mobile crisis teams and 24-hour walk-in crisis centers, to reduce unnecessary involuntary commitments and law enforcement involvement. Increase funding and workforce development for Intensive In-Home (IIH), Community Support Teams (CST), and trauma-focused outpatient treatment so individuals receive stabilization before behaviors escalate to criminal charges. Create dedicated forensic step-down units separate from acute psychiatric beds so justice-involved individuals do not occupy limited state hospital capacity intended for acute mental health crises. Implement statewide diversion programs that allow law enforcement and courts to route individuals with serious mental illness into structured treatment pathways instead of incarceration. Strengthen oversight and quality standards for private

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					psychiatric facilities to ensure trauma-informed, evidence-based care that meets the same standard as state-operated facilities. Address workforce shortages by investing in clinician retention incentives, supervision support, and reimbursement reform. Without a stable behavioral health workforce, bed expansion alone will not solve this crisis. Improve data transparency across DSS, Medicaid health plans, courts, and hospital systems to identify where individuals are getting stuck in the system and intervene earlier. From a child and adolescent perspective, many of the adults entering the correctional and forensic mental health systems today were youth whose trauma, developmental needs, and family instability were not addressed early enough. If we do not invest upstream — in trauma-informed assessment, early intervention, and coordinated child welfare services — we will continue to see this cycle repeat. Public safety improves when behavioral health systems function well. The current strain on jails, hospitals, and families is not a failure of public safety — it is a failure of behavioral health infrastructure. I strongly encourage the Committee to recommend structural investment in prevention, diversion, and community-based care rather than continued reliance on correctional and emergency systems as default mental health providers.
02/26/2026 10:53 AM	MD Thomas Sneed	102 Fox Run Ct, Durham, NC 27705	Durham	tsneed395@gmail.com	House Select Committee members, NC's Assisted Outpatient Treatment (AOT) needs a 72 hour option for specific severely mentally ill (SMI) individuals. I am a psychiatrist with over 20 years of experience in the not-for-profit sector. In my opinion, which is supported by research, there is a relatively small subset of under- or un-treated individuals with severe mental illness that are associated with loss of life, such as occurred with the loss of Iryna (NC), Zoe (NC), and Kendra (NY). The severely mentally ill perpetrators of these crimes had a number of similarities. The most important of which was a lack of insight into their mental illness. This is common in severe mental illness, particularly in psychotic illness, which all three of these individuals have. The loss of insight is secondary to the chronic neurotoxic effects of their untreated mental illness.

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					This is important to recognize because without insight a person will not independently seek help or allow others to help them. The environment around them can be full of compassionate caregivers, excellent mental health programming, and highly skilled clinicians but if they do not think they have a problem none of those resources will stand a chance at making a difference. I included "Kendra" in the list of victims above because, like Iryna, NY created "Kendra's Law" after Kendra was murdered by an individual with SMI on the light rail system in NY. Kendra's law added a 72 hour hold option to NY's Assisted Outpt Treatment (AOT). The 72 hour hold allows providers to hold an individual for 72 hours for observation if they are refusing care; this includes refusal of medication. Even though Kendra's Law does not explicitly allow for forced meds, it is effective because of a characteristic that most SMI individuals develop. Just like individuals with psychotic SMI's develop a lack insight due to the neurotoxic effects of their untreated illness, they also develop concrete thinking. Concrete thinking results in very simple decision making. For example, if they are offered medication they do not want, if given an option, they will not take it. If they are presented with a choice of two things they do not want, they will choose the option that gives them, what they perceive to be, the most immediate freedom. For example, if they have a choice to take a medication or stay on a 72 hour hold, they will typically take the medicine. There are two other elements that are important to keep in mind for the 72 hour hold option to be effective and appropriate: mental capacity and the availability of medications called long-acting injectables. Capacity- Just like psychotic SMI's cause permanent concrete thinking and a loss of insight, they also cause a permanent loss of the capacity to make decisions about compliance with medication. Loss of capacity to make decisions about medication compliance is clinically determined. Requiring clinical determination of loss of capacity to make decisions about medication refusals should be part of any statutory language that describes appropriateness for 72 hour holds. This would be a layer of protection to reduce the risk of misuse of 72 hour holds. Long-acting injectables (LAI's)- LAI's are antipsychotic meds that are administered by injection. These injections, depending on type, require varying intervals of administration. Some are every 2 weeks and others are every 6 months. These meds alone can treat the psychotic SMI that these individuals have. They will not cure the illness, but they will

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					greatly improve the functioning of the individuals that have psychotic SMI's. This will greatly reduce the risk that their SMI poses to them and to others. They will be much more likely to voluntarily participate in other resources when offered. They will be much less likely to hypercycle into emergency rooms, psychiatric hospitals, jails, prisons, etc. Everyone involved is safer and the cost of care goes down. One of the interesting elements of Kendra's Law is that the NY legislature included a requirement to review it and reapprove it periodically. They fact that they keep renewing it suggests that it has been beneficial. Apologies for the length of this comment. I am sure you are well aware of the option of a 72 hour hold, I wanted to make sure you were aware of why, when done correctly, it works really well. If there is anything I can do to support this option, please do not hesitate to ask. Respectfully, Tom Sneed, MD
02/26/2026 11:08 AM	Child custody/ mental heal Nathan Cartwright	1130 laurel branch road, Waynesville , North Carolina 28785	Haywood	nathanwcartwright@icloud.com	Why does the courts not recognize mental abuse as actual abuse? My son is having visible symptoms due to his mother's actions to the point that his teachers/school is seeing the fallout plain as day yet this is not grounds for my lawyer to file for emergency custody because it's not physical abuse. I dare say mental abuse is worse and last longer having far more complications to heal from.
02/26/2026 11:20 AM	Dr. Amelia Tankersley	Durham, NC			I am a clinical psychologist speaking for myself, as a private citizen. I strongly advocate that psychology trainees (practicum students, interns, and post-docs) be able to deliver reimbursable services under licensed supervision to patients with Medicaid. Washington State has done this successfully via HB 2247 Section 5 by creating a new credential, "Licensed Psychological Associate." This will significantly expand our behavioral health workforce, expand access to mental health services for low income folks, prevent escalations to our overwhelmed emergency departments, and save lives. The American Psychological Association has been advocating for these changes for years (see HR4484 ADAPT Act).
02/26/2026 11:38 AM	Dr. Arthur Kelley	293 Staffordshire	Forsyth	psyaek812@gmail.com	As a retired psychiatrist I am deeply concerned about the treatment of severely mentally ill citizens of NC. Psychosis,

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		Road, Winston Salem, NC 27104			particularly schizophrenia is a devastating illness and usual care generally does not have good outcomes. There is an evidence based, recovery oriented treatment--Coordinated Specialty Care for First Episode Psychosis-- that improves symptom control and quality of life, shows higher rates of school and employment participation, reduces psychiatric hospitalizations and emergency service use, creates greater treatment engagement and satisfaction while lowering overall system costs over time. Although there are five CSC programs in the state, they are not coming close to meeting the need. For example, the third and fourth largest metropolitan areas in the state--Greensboro and Winston-Salem have no programs. Large swaths of rural NC are also without CSC but could be served virtually. The State has not adequately funded these programs. Less than 50% of the cost of this program in NC can be funded through through reimbursable services. CSC needs a service definition that would then enable the state to fund these programs using a case rate methodology. Arthur E. Kelley, MD, DLFAPA
02/26/2026 12:04 PM	Ms Kathleen Najdek	260 Covington Drive, Advance , NC 27006	Davie	Kathienajdek@gmail.com	We lock alzheimer people in 'memory care' units. Why not lock mentally unstable street people in 'stability' units. It seems more humane than living under a viaduct. It would protect them and the citizens
02/26/2026 01:55 PM	Susan Hertz	2822 Pickett Rd. Apt. 135, Durham, NC 27705	Durham	susan@susanhertz.com	From long experience with my daughter I believe things could be done with our State Psychiatric Hospitals to significantly improve outcomes and reduce the revolving door cycle. Consumer and family input is needed and if there is a mechanism for that I have not been able to access it, even as a member of the NC Mental Health Block Grant Advisory Council and years of participating with SCFAC. A substantial number of inpatients have severe trauma in their history. There are essential evidence-based treatment approaches that are not available in our state hospitals. I suspect the mission of the hospitals is to stabilize the patient and discharge them. But in reality many stay for months and months anyway so treatment could be provided. In the case of my daughter I believe with all my being that there are treatment approaches that have a real chance of breaking the rehospitalization cycle that has been going on for many years, but they are not available to her and others like her. Another topic is that despite people staying or cycling in and

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					out for many years dental care is pretty much non-existent except pulling teeth after they start causing pain. You might be told that patients don't want dental care or aren't cooperative but I know first hand that is not accurate. Looking at the number of hours a dentist and hygienist spend at each hospital per month would make the situation become clear. The most important factor is funding. The pay is so poor for the conditions that hospitals can't get/keep enough quality staff. I'm sure you understand how shortages and high turnover negatively impact the quality of care. You have the old guard who came in back when the retirement and benefits package was enough offset. Not much has been offered for many years so they are not getting the same quality people now, and for the good ones it seems like a stepping stone for resume for a year or two, increasing training costs with diminishing returns. Thank you for considering.
02/26/2026 02:08 PM		Winston-Salem, NC 27104	Forsyth		Among the many legal and fiscal arguments, I encourage the committee to specifically address the following concerns: 1) There is a demonstrated need for additional mental health practitioners, nurses, and support staff in both public and private hospitals in NC. The problem is far more extensive for public hospitals which have behavioral health components (Broughton, Central, and Cherry). This need is current, not former or projected. Unfortunately, the State will likely have to make a "double investment" to see any meaningful result of new legislation on IVC or mental health. The State must first address the existing staffing and facility issues to meet current demand. The State then must fund additional demand projected from new legislation. By only addressing one, the State will leave these resource-starved institutions worse off by failing to meet additional workload created. The committee cannot rely alone on increasing efficiency or moving money from one line to another - it needs meaningfully increased resources and structural changes. Both increasing position salary and increasing the number of positions will likely be needed. 2) Patients with severe mental illness experience a revolving door. Because the US Supreme Court has held that the patient must show a "requisite conduct" of dangerousness before IVC can be ordered and maintained, patients who have recurring, but temporally inconsistent, illness are often

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					released and re-committed. To illustrate, consider the following common cycle: a person experiences a severe mental illness; the person commits a crime or is otherwise flagged for being a danger to themselves or others; a court orders their commitment or the person voluntarily self-commits; the illness subsides; the person is released. This cycle then continues. The reasons behind this are vast: perhaps the person has an illness that is intermittent, or perhaps they need assistance obtaining or taking their medication, or perhaps they are exposed to an environment which exacerbates an otherwise mild illness. Many other reasons exist. The impact, however, is extraordinary. The cost on State personnel and resources increases at each re-admittance. The person experiences tumult and trauma from inconsistent care and restraint. Those around the person experience fear, worry, violence, or any combination of these and more. The current treatment environment provides that these patients either receive full inpatient care or nothing, unless they voluntarily desire otherwise which is strikingly rare. The committee must address how the intermittently or inconsistently ill can be treated in a scaffolded manner rather than the "on/off" approach currently utilized. The committee should look at how part time inpatient, monitored intensive outpatient, and other environments can be created and structured. 3) States have over-corrected from US Supreme Court jurisprudence finding that "mere public intolerance" of those with severe mental illness is insufficient to find that a patient is "dangerous to others" and other findings that "being unable to perform some activities of daily living" is "not severe enough to warrant commitment for a danger to self." These two pieces are connected. First, North Carolina law (NCGS 122C-3.11) in this area is commonly cited as being a model for the nation since we specifically delineate what constitutes "danger to self." Our execution of this law is not as positively cited. There may need to be more situations listed or a broader definition of danger. The committee must reckon with both providing an expansive list to address common situations without being unconstitutionally vague or so expansive as to improperly confine those who are not actually a danger to self. On the second area of dangerous to others, to speak plainly, the law is not sufficient to protect the public from those who are experiencing severe mental illness. The "mere public intolerance" standard has been interpreted to mean that a patient must manifest violence AND a reasonable probability

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					they will continue to act in a violent manner before they are dangerous to others, anything less would be impermissible "mere public intolerance" of the mentally ill. This interpretation is far too stringent. Situations common in this area also implicate the issues I mention above. For illustration, consider this scenario: a person experiencing a mental health episode is shouting and waving at people on a sidewalk; people walking are scared and spill into the street; the people now in the street are at risk of being hit by a car. The actions of the person shouting and waving creates the situation which places others in danger. No matter what is written in the law on this situation or how our prosecutors may interpret this, in reality this situation will never be sufficient for intervention, despite the underlying illness and the actions having a proximate cause of placing others in reasonable danger. This person then does not receive treatment or the option of treatment, and the public remain at risk. This is not just "mere public intolerance" of the person experiencing illness - it constitutes infringement on the rights of others and has a reasonable probability to place them in danger. The committee must address these and similar scenarios in their assessment of state law, and ensure proper guidance to police, prosecutors, and judicial officials to abate these concerns.
02/26/2026 02:13 PM	Honor Moor	604 Old Toll Road, Asheville, NC 28804	Buncombe	honormoor@gmail.com	I am the founder and Chairman of the Asheville Coalition for Public Safety and represent 265 members of the community who stood up for the Asheville Police Department (after we lost nearly 1/2 of them.) All cities should be required to do a 72 hour hold in their jails for minor infractions. That gives people time to sober up and or go be sent to a medical detox. An assessment of mental health and ability to stabilize would then be made for next best steps. We should instate two new mental health campuses in our state. These would be full time living campuses, with farms with animal therapy, ability to make things to be sold that are needed in our state, a place for recovery but with an effort towards graduating with peer led levels. Our local ABCCM led by Rev Scott Rogers is an amazing resource for guidance. We need to rethink how involuntary institutions look. They should be a sanctuary of relief, a place for recovery, a place to live peacefully with natural beauty around a campus (just like a college/farm setting.) Volunteers could be involved. Places for families to stay nearby could be developed by the private

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					sector. Whole villages in two sides of our state would be amazing and we could lead the effort for the entire country as a model. Where would you want your family member to stay if they had a serious mental health crisis? Where would you want them to live if they could not function and work? We should not have anyone living in our streets, addicted to drugs and struggling to exist. the Housing First model was a fail. It has no recovery model, no expectations to stay sober and becomes unsafe for those who mind the rules and live amongst neighbors who continue to do drugs. That type of housing should be for people who are able to function and graduate or qualify to be in that type of free setting. We also need easy to access step-down stations open 24-7 that give out prescribed drugs for those trying to stop using.
02/26/2026 02:39 PM	Pat Jackson	165 Elkwood Dr, Asheville, NC 28804	Buncombe	itspj@charter.net	Asheville has many homeless and sheltered people with mental disorders that often create repeated dangerous incidents for both strangers and family members. There needs to be help for the families and be able to identify repeated dangerous incidents that should lead to more facilities and in-voluntary care for these individuals and for the safety for all citizens. We once had these facilities and need to return to have this available. Cut the fraud and wasteful use of our tax dollars and take care of Americans.
02/26/2026 03:08 PM	Talk to families Lynn Killgore	402 Shoreline Dr, Cedar Point, NC 28584	Carteret	Lynnkillgore@hotmail.com	Talk to families about their personal stories. Too much to put here but extremely important. Substance abuse is a large part of the problem that makes it worse to manage.
02/26/2026 03:08 PM	Mrs Miranda Frisbee	110 N Bear Creek Rd, Asheville, NC 28806		cherrygrl333@gmail.com	Public safety of our families is at stake. We must do what we have to with repeat offenders.
02/26/2026 03:30 PM	Mary Beth Rehm	2304 Coley Forest Place, Raleigh, NC 27612	Wake		When the psychiatric hospitals were closed, money was not appropriated for community programs and so here we are. The pendulum has swung too far the other way. Perhaps we need a range, a continuum of different services for individuals with mental illness. It seems more humane to have some folks live in a good in patient facility than untreated medically , starving and homeless on the street. Huge mistake to close Dix, in my opinion. It could have been inpatient services, outpatient services, and there would still be room for a park.

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02/26/2026 04:05 PM	Mr. Robert Carbo	314 Sandy Bottom Ct, Clayton, NC 27520	Johnston	captonager@gmail.com	As a former state employee who worked for many years in the NC prison system as a mental health professional, I urge you to consider taking some serious steps to deal with the Mental Health crisis in North Carolina. 1. The first step is to hire and pay appropriately qualified mental health professionals. You can't skimp here. If you want to deal with these serious mental health issues, you need skilled, qualified professionals who are experts. That's not going to be cheap, but it will be effective. 2. There must be specialized mental health treatment facilities - not jails, not prisons, not emergency rooms - but facilities specifically for treating the mentally ill, staffed by qualified mental health professionals. 3. When an individual is placed in a treatment setting, it will take some time to be sure that the person is treated effectively, not rushed back out to the street to save money. They must be given the time to allow treatment to be effective. 4. There must be transition services for those about to be released from prison, as well as those about to be released from mental health treatment. There needs to be a gradual process of allowing these individuals to adjust to society, and to develop support systems so they can be successful members of our communities and not return in a revolving door fashion. As I stated, this will not be cheap - we must commit to taking these needed steps. These people are part of our community - they are part of our family. We cannot let them be ignored, neglected, or thrown in prison, hoping the problem will go away. It's time for compassion and long-term strategies to help our communities heal.
02/26/2026 04:38 PM	ms Barbara Mezo	35 Citation Dr, Durham, NC 27713	Durham	msmezo@hotmail.com	As a Clinical Social Worker the two major problems I see with Mental Health system is Homelessness and lack of continuity in out patient care. Central Regional Hospital is currently under utilizing it's capacity because of lack of staffing, while using only 150 of it's 343 beds.
02/26/2026 04:51 PM	Debate With Patients				We own a business, have a mansion in a low crime neighborhood, and went to UNC Chapel Hill. Supreme Court ruled in Olmstead that patients should live in the least restrictive community setting. Any chemical torture is unconstitutional cruel punishment, except to wake someone from a catatonia coma. I've seen patients be violent while on heavy antipsychotics. Virginia, Idaho, etc. allow patients to be sober under the talk

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					therapy of a priest. Every 6 months there should be a jury trial to determine whether to release (with GPS tracker) someone from a ward.
02/26/2026 06:58 PM	Ms. Sherrie McGimsey	104 Terrace Pl, Morganton, NC 28655	Burke	sherrimcgimsey@gmail.com	A 24 hour hold or a 72 hour hold is not enough time to stabilize a loved one in a major psychosis. Having a mental illness is not a crime not getting the treatment and care is. You can't pass a bill without funding it to back it up.
02/26/2026 09:38 PM	PMHNP-BC, Founder. CEO Crystal Parker	2920 Forestville Rd Ste 100-1082, Raleigh, NC 27616	Wake	RAIN@restorativeinstitute.org	Public Comment – Crystal Parker, PMHNP-BC Founder & CEO, Rural Access Integrative Network (RAIN by RMBI) Thank you for the opportunity to provide input on North Carolina’s involuntary commitment and public safety challenges. As a psychiatric provider and founder working across rural and underserved communities, I see daily how gaps in early behavioral-health access contribute to the escalating pressures on emergency departments, law enforcement, and state psychiatric hospitals. Individuals who ultimately enter the involuntary commitment process often begin with treatable symptoms that go unaddressed due to the absence of timely psychiatric evaluation, medication management, and ongoing behavioral-health support. In rural areas, these gaps are even more pronounced. When primary care providers lack access to psychiatric consultation or integrated behavioral-health resources, patients are more likely to deteriorate until crisis intervention becomes the only available pathway. From a clinical perspective, earlier access to psychiatric care reduces symptom escalation, improves treatment adherence, and prevents the cycles of decompensation that lead to ED boarding, repeated hospitalizations, and avoidable criminal-justice involvement. From an operational and systems perspective, strengthening upstream access is one of the most effective ways to reduce strain on the state’s crisis infrastructure. While crisis-level reforms are essential, I encourage the committee to also prioritize community-based, upstream access solutions that prevent crises before they occur. Expanding integrated behavioral-health services in rural and medically underserved communities can: • Reduce emergency department utilization • Decrease involuntary commitment petitions

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					• Improve continuity of care • Reduce jail cycling for individuals with untreated mental illness • Strengthen collaboration between primary care, behavioral health, and community supports Through RAIN by RMBI, my work focuses on improving psychiatric access in these communities by supporting primary care practices and rural health systems in delivering timely, coordinated behavioral-health care. While our model is not a crisis or criminal-justice program, it directly addresses the upstream factors that feed the crisis pipeline. I appreciate the committee's attention to these issues and the Governor's recent emphasis on behavioral-health and public safety. As the state continues to explore solutions, I would welcome the opportunity to contribute to future stakeholder discussions or working groups focused on strengthening early access, improving care coordination, and reducing the burden on emergency departments, jails, and state hospitals. Thank you for your commitment to improving North Carolina's behavioral-health system and for inviting public input on these critical issues.
02/27/2026 06:59 AM	Mentally Ill / addiction Mary Whisenant	628 N Oak St, Lincolnton, NC 28092	Lincoln		As a mom of a mentally ill and an addict son .. we need to find a better system. He is 26 and began using marijuana at age 15. His brain is not that of a 26 year old. He has been in/ out psychiatric hospitals, rehabs up and down the east coast with only running or AMA. He has gotten kicked out of all the sober houses because failed drug tests. Lately he has spent more time in and out of jail. Everything he has done including 2 felonies lately a quick dismissal of the court system. He is currently in WS adult corrections because of not following the probation rules. He was just approached by 2 top criminal attys giving him options of treatment because they have lived this with their family members. He denies he has done anything wrong. Something has to be done. I have spent 130k of hard earned money over the last 8 years for it to be washed away . Surely there is something that can be done. He is definitely non medicine compliant. I am begging for help for him along with the multitude of many more humans in this cycle that somehow it needs to be broken to give them some sort of chance at living a decent life. Feel free to call me for more details..
02/27/2026 07:04 AM	IVC Mary Sifford	628 N Oak St, Lincolnton, NC	Lincoln	Mightymary21@gmail.com	My son has had at least 6 IVC's in the last 8 years only to get stable then released back to the street and or a sober house

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		28092			to go right back to the old patterns.. in out of work, getting high , back to jail, released and then it begins again.. his behavior has gotten worse. He is a pathological liar so a really good diagnosis can not be made unless he had someone who knows the truth sitting there with him.
02/27/2026 07:20 AM	Bailey Vaughn	263 School Rd E, Asheville, NC 28803		baileysellswnc@gmail.com	To Our North Carolina Legislative Leaders, I am writing to express my full support for meaningful reform to our state's mental health system. What we are doing right now is not working. Families are overwhelmed. Law enforcement is overwhelmed. Emergency rooms are overwhelmed. And most importantly, individuals suffering from severe mental illness are being cycled through ERs, jails, and short-term holds without ever receiving the sustained care they truly need. That is not treatment. That is containment without resolution. Across our communities, homelessness tied to untreated mental illness and addiction is visibly out of control. There is tremendous human suffering on our streets. At the same time, local leadership and nonprofits often say their hands are tied — that we cannot require someone to accept treatment unless they are an immediate danger. So people spiral publicly. They deteriorate in plain sight. Needles, human waste, trash, and unsafe conditions become normalized. Business owners struggle. Families feel unsafe. And the individuals themselves continue to suffer without meaningful intervention. This cannot be the best we can do. Compassion should not mean abandoning people to self-destruction. True compassion sometimes requires structured intervention. We need facilities where individuals experiencing severe mental health crises can be safely held, stabilized, and treated until they are genuinely well enough to reenter the community. Not overnight observation. Not temporary fixes. Real care. Supervised care. Long enough to break the cycle. This is not about punishment. It is about protection — for the individual, for families, and for the public. The current system leaves everyone frustrated and heartbroken.

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					Please prioritize expanded inpatient treatment capacity, clearer evaluation standards, coordination between hospitals and law enforcement, and sustained funding that matches the scale of this crisis. We need the ability to intervene before tragedy happens — and before people lose years of their lives on the streets. North Carolina deserves a system that is both compassionate and effective. You have my full support in pursuing reforms that move us toward real solutions. Respectfully, Bailey Vaughn
02/27/2026 09:17 AM	Ashlie West	412 Devlin Place, Durham, NC 27707	Durham	ashliewest@gmail.com	1. Adjust State Employee salaries to address pay discrepancy with the private sector. Return BCBS as the provider of our insurance benefits and reduce premium costs. State benefits should exceed the private sector if you want to hire and retain employees for State facilities. It is extremely unsafe at CRH now that the primary patients are coming from detention centers. There are no supports for staff to feel safe with violent offenders and their visitors, who have been known to bring in drugs and drug paraphernalia (leading to the death of a patient by overdosing on fentanyl brought in by family). Without strong staff, we will not be able to open the closed beds at State Hospitals, which account for nearly 1/2 of the closed beds. If you cannot open these beds, more people will die. It has been clearly documented from multiple sources that the horrible pay discrepancy and safety issues are preventing retaining and hiring new staff. Without staff, there will be no way to have the hospitals at full capacity. 2. Prevent new Social Work graduates (LCSWAs who are in training for full licensure) from working in private practice. The NC Social Work Board used to require LCSWAs to work in the community (non-profits, State services, etc.) which filled the needed Clinical staff in the community. ACT Teams and CST Teams had the Clinical staff that are critical to keeping people with mental illness safe in the community. 3. Revamp the Outpatient Commitment order to require medication adherence or risk forced medications. Without forced medications in the community, there will continue to have high risks of aggression. Otherwise, the current way Outpatient Commitments are written, they are useless. 4. The state NEEDS more housing options. There are dramatically fewer group homes since the inception of TCL housing. Group Homes need to be fully funded to allow for

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					single occupancy rooms and staff who are trained to support mentally ill patients. There are so few group homes for women with mental illness, that the only options for housing are TCL and that does not provide enough support for patients with complex needs. 5. TCL Housing needs to add a service that will provide daily in-home support to ensure medication adherence and treatment engagement. The amount of money wasted on patients being evicted due to medication nonadherence and relapsing is extensive. Then, if a person has a legal history or multiple prior evictions, it takes longer to rehouse them and their stays in State Psychiatric hospitals are incredibly lengthy, causing a back log in bed availability but also high costs from them remaining inpatient.
02/27/2026 09:26 AM	Mental Health Crisis Gwen Bayyan	4328 Candle Court, Raleigh, North Carolina 27616	Wake	bayyang@aol.com	We need more financial resources bring invested in mental health. There are not enough hospitals and clinics to support the need. Prisons should not be used to house the mentally ill. We are failing that population.
02/27/2026 10:53 AM	Mrs. Aysha McKenna	4725 Pennoak Rd, Greensboro, NC 27407	Guilford		In August 2024, I was involuntarily committed based on words. No actual threat to my life, no actual violence, no self harm inflicted and my risk assessment put my risk at a zero. The first night, I was told I was pregnant and that I had a panic attack brought on by pregnancy hormones. I was transferred to a mental hospital anyways. Overnight I lost everything because the stigma of being sent to a mental hospital preceded my absence and when I was in the hospital there were two other people in the hospital not because they attempted suicide but because they said “if you are going to control my life then why do I bother living” and “if that is how you are going to treat me then kill me now”… my crime was “my brain hurts so bad, I could die”. I was finally able to leave the hospital a week later because I was a very compliant pregnant woman who just wanted to go home not because panic attacks are actually dangerous and I did not have one in the hospital despite almost miscarrying in my bed. Once I finally was able to leave, I was told that my elevated pregnancy hormones were so high three OB-GYNs thought I had cancer. My paperwork reflected the whole time that my hormone levels were abnormal, yet I was kept anyways. I ended up having a healthy baby. Involuntarily committing people because of words is what is overburdening the system right now. Involuntary commitment went up 91% since North Carolina started allowing people to be involuntarily committed over hyperbole and the overreaction is taking services and beds away from people who actually need it and putting the mentally ill who are actually

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					dangerous out onto the street. I’m grateful for my baby and my anti-anxiety medication, but there were other ways to resolve it and if this provision was removed, it would have been resolved the right way instead of locking me up for being pregnant and having anxiety.
02/27/2026 10:57 AM	Mental Health Crisis in C Shannon Roberson	6400 Loyola Court, Mint Hill, NC 28227	Mecklenburg		If you look at the patients who have gone through Partial Hospitalization Programs at Atrium’s Behavioral health office of Billingsley rd. The patients learn the skills to cope. What if you took a plan like this and made it instead of a 4 week program, but a year round program. You would have to implement the giving of medications daily. You could have varying lengths of this program. 4, 8,12,20 weeks etc. It would help a lot of people to get the help they can get. Then you can graduate to the next level which would be intense outpatient program. Instead of going daily, you go 3 days out of the week. A lot of people will not goto Billingsley Rd. Because of the neighborhood it is in. There’s only 1 psychiatric ER for all of Charlotte. Why can’t we expand this to 2-3? I was a patient at the partial Hospitalization Program. I came out with a lot of skills to help me when a family member wanted to start an argument. I learned how to not engage in it. I learned how to cope with my SI thoughts. The 6 hours Monday-Friday truly helped me. I learned how to express my feelings. I never had to go in patients because of this program. My therapist wanted me to be admitted, I didn’t want to be admitted. So she worked with me and got into the Partial Hospitalization Programs. I think if people going through the drug court system should be going a through stint of partial hospitalization program. I know a friend who has been in and out of drug court, but they aren’t addressing the mental health part of why this person keeps going back to the drugs. It should be like this for mental health: 1: How severe is this person’s depression? 2: which would be the best benefit: inpatient, partial hospitalization, or intensive outpatient program?

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					If they can still function then it's PHP, IOP, and after that you still get to meet with your counselor from the program once a month to make sure you are doing well. That your meds are going well. Even though you have your outpatient therapist. Sometimes you might have a harder issue going on that the php counselor can help you with and work with you on it. After you graduate these programs we have zero support from the people we met in the program. We need a support group lead by a professional. When were released from this php program. We went from supportive people back to environments that are causing problems for us. We can't talk to these people from the program who we learned a lot from during that time.
02/27/2026 11:57 AM	Susan Hertz	2822 Pickett Rd. Apt 135, Durham, NC 27705	Durham	susan@susanhertz.com	There is ample peer-reviewed evidence that the Clubhouse model community based treatment programs for adults with severe and persistent mental illness significantly reduces the need for Involuntary Commitments. Increased funding for expansion of existing Clubhouse programs and opening new ones is an important part of the solutions. A Medicaid definition for Clubhouse model and recurring funding from General Assembly are important priorities.
02/27/2026 12:10 PM	Cynthia Wiford	55 hamlet grovr dr, Pittsboro, NC 27312	Chatham	cwiford@act-llc.org	I have worked in the public MH/DD.SAS system since 1998. One critical service area that is missing from the state NCDHHS design is emergency crisis system design and response. Where this becomes apparent is especially in the rural counties; rural hospitals are typically not staff by any psychiatrists, mobile crisis does not accommodate the transsport of crisis cases to facility based crisis centers or state hospitals and more times that not, at the state hospitals there is no crisis stabilization beds available. When you look into the bed census at the state facilities, the daily census is low because of waiting lists which do not work for crisis services. Individuals in a MH/SUD crisis cannot wait for help..the system has to be immediately responsive to their crisis and simply put..NC does not have a crisis service that is immediately available or accessible. The NC Division MHDDSAS does not plan for crisis, does not fund crisis intervention or crisis transportation adequately and consequently has limited providers serving people in crisis. A robust crisis system is the bedrock of any good MHDDSAS system. Robust is defined by having services and beds immediately available, transportation to those services immediately available and then follow up in the community once the crisis has been resolved. The research is very clear;

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					a MH/SUD crisis lasts between 7 and 10 days. We do not adequately fund our system to provide this level of service or responsiveness. When crisis services do not exist, jails, IVC determiniations and hospital EDs become overwhelmed with cases that are too serious for any of these systems to deal with. The Department needs to Lead the development of an adequate policy, funding and plan for an effective crisis system.
02/27/2026 12:18 PM	Dr Natalie Conner	1417 LaRochelle Lane, Charlotte, NC 28226	Mecklenburg	nataliewhisenant@gmail.com	My nephew (26 yo) is a casualty of schizoaffective disorder believed to be driven by early (age 13-present) cannabis use and exacerbated by family tragedy. He has been in 21 dual diagnoses treatment centers (his mother had excellent BCBS insurance), IVC'd 9 times, and in jail for increasingly violent crimes in Forsyth and Mecklenburg in NC and York county in SC: 9 times in an 18- month period. Sober living doesn't work-- he is noncompliant with taking his meds. He has a legal guardian in Forsyth who has failed to secure Medicaid for him among the many things she has failed to even attempt. I would be happy to testify before the committee as a non-partisan appellant-- public safety should not be a political football. My nephew needs help AND public safety should be a priority. Thank you, Natalie Whisenant Conner
02/27/2026 01:28 PM	Judy Aanstad	221 Harmon Court, Winston Salem , NC 27106	Forsyth	Jaanstad@triad.rr.com	We are past due for more resources for the mentally ill. Not only do we need more facilities and professionals available but better education about mental illness. Certainly the headlines of mentally ill individuals killing innocent citizens and family members is a wake up call. We need action!
02/27/2026 02:02 PM	Ms Janet Thew	6 Ridgebourne Way , flat Rock , NC 28731	Henderson	gavelgoddess@gmail.com	Build more public mental hospitals! It's a necessary investment in the future. No other bandaid approaches will come even close to stemming the tide. You all know this. Stop kicking the can down the road and invest in new infrastructure. Raise taxes for infrastructure. That's what government is for. People are suffering!
02/27/2026 03:40 PM	Ms Jenny Tilford	105 Kit Court, Mebane, North Carolina 27302	Alamance	jennytilford@gmail.com	I don’t feel like involuntary outpatient commitments are helpful. There are not enough mental health resources either in communities to make this feasible. Having more preventative and helpful resources like people having better and easier access to mental health services and addiction services is what I think would be best.
02/27/2026 05:32 PM					You can't expect a system you don't fund to work. Mental health providers have to feed families and pay mortgages. Medicaid and Medicare aren't priority so jails, police, and other state agencies pick up the slack as best they can. If you don't increase access, and pay mental health providers what they are worth dealing with the poorest and most burdened

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					part of society, it's not going to be fixed
02/27/2026 09:17 PM	Mrs. Audrey Leggett	74 Antioch Lane , Lumberton , NC 28358	Robeson	Lovetta1957.al@gmail.com	I am a Retired Social Worker Supervisor with Adult Protective Services in Robeson County. This little space is not large enough for me to commit on the brokenness of the Mental Health System. The 1st Problem is DEI and the 2nd is the lack of caring and knowledge of the individuals being trained in the universities today. This issue started back in the 1980's and therefore has no quick fix. So if you have a group that is ready for a challenge, then start with changes to the laws that allows a person with Severe Mental Illness to refuse their medications. When they are a danger to others or themselves the Mental Health Providers should be able to treat them without so many roadblocks/this should be a mandatory obligation by the Providers.
02/27/2026 10:57 PM	Ms Jenny Tilford	105 Kit Court, Mebane, North Carolina 27302	Alamance	jennytilford@gmail.com	I have worked in the mental health system as a social worker in North Carolina since 2001. That has included time as a social worker at a non-profit agency affiliated with the criminal justice system, in community mental health agencies and in hospital behavioral health clinics. The chipping away of the mental health system in NC that started with efforts to privatize mental health services instead of having county clinics (like OPC or the Durham Center, for example) has been a disaster for our state. Not only have some of the state psychiatric facilities closed, but the systems of care have been decimated. Individuals (child and adult) could once access wraparound services through one agency, including crisis services and case management. There was more continuity of care and stronger support for individuals who had mental health and addiction needs. Medicaid being privatized has only worsened the problem. For the current issues to improve, returning to such a wraparound system would be ideal, but it was destroyed by privatization in my opinion. Working with what is currently possible, I believe having more community services like clubhouses, employment and housing support services for people with disabilities, and easier access to outpatient treatment, including access to psychiatry and funds to cover psychiatric medications for those without insurance. This difficulty with access is a huge problem. If people cannot access mental health care, including their medications, they may not remain healthy enough to work and function, which jeopardizes their housing and other stabilizing factors in their lives. I currently work as a clinical social worker and serve on the board of directors for Threshold Clubhouse in Durham. Thank you
02/28/2026	Mr T Sonta	2608 Lytham	Mecklenburg	sontafranklin@yahoo.com	For public comment. This actually weighs on my mind and

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07:32 PM	Franklin	Dr, Charlotte, NC 28210			when I ran across this forum, I decided to share my idea. I see people repeating their offenses as adults with pass traumatization. I also seen children raised in these environments. Often the mental health is shadowed by drugs, alcohol, sex dependencies along with the mental breakdowns, anger, trust issues, bad ideas, etc. It would be most effective to start at the beginning. Carefully screening children who are at risk; be it genetics or repeat learned behaviours. An individual once told me his sisters would hang him out the second story window by his feet which was very scary and affected his mental condition along with his father mental illness which went undiagnosed in that generation. I have witness wonderfully children whose parents have knock down drag outs, physical and verbal violence, every night using drugs and alcohol. It would be most beneficial in society to intervene at the earliest ages of childhood and have a continuum through a person's life. Connecting at the early age can be life altering versus the older child or young adult has already established patterns, habitual downfall, mental disorders and who are harder to reach and reverse behaviours. They have already conditioned and learned to deal with matters on their own; and it is their normal. These adults need lot more "hands on". From my own experience there seems to be a shortage of mental health workers. Mental health workers need to be part of a network for young people to help and change the outcomes before they become adults. Also, the adults going in and out of the system need ongoing support, need an ongoing supply of their medications; especially after incarceration. Mental health contact would need to be long term and daily. Not one day a week or month, but daily for at least a year to ensure individuals have the time to establish new patterns, new behaviors; ensure mental stabilization and new patterns become established for the long term. It is too easy to fall back to the familiar. Especially if you are released right back into the same environment which one came from. Save the young, save a generation. It is the long term solution.
02/28/2026 10:36 PM	Dr. Jamie Vaske	256 Leatherwood	Haywood		Good evening, I work with behavioral health agencies both in the community

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		Cove Rd , Waynesville, NC 28785			and at the VA. I see the vast differences in the frequency, breadth, and continuum of care between these two systems on a daily basis. The VA has a connected and coordinated set of records and regulations; community behavioral health is disjointed. A veteran with severe substance use or mental health needs will attend 7-15 hours of outpatient treatment weekly for 9-20 months. That same person may get 1-9 hours of treatment for maybe 6 months in the community. This level of care for the highest need of our communities is insufficient, driven by reimbursement rates, and ultimately wasteful of time and money--it is a bandaid on a hemorrhage. In my work with veterans, I see non-VHA eligible individuals have their probation revoked and be sent to prison at a higher rate than the VHA eligible counterparts due to these differences. I would encourage lawmakers to look to the VA system as a model for community behavioral health. Thank you for your consideration, Jamie Vaske
02/28/2026 11:12 PM	Ms Michelle Lanier	2601 Valley Haven Drive, Raleigh, NC 27603		michelle.lanier@gmail.com	As a friend and loved one to several people who navigate mental illness, I am beseeching our legislators for the state of North Carolina to fund more resources for mental health crises intervention, prevention, and care. We need more funding for mental health first aid training for every sector of our state government systems, as well as our educational and private sectors. We need more awareness raising and education around mental health. We need stronger training for first responders. Lastly, we need more crisis centers for those who are navigating mental health issues, regardless of criminal activity. In terms of violent criminals with mental illness: These cases should be handled in a distinct way by trained specialists.
03/01/2026 08:30 AM	Mrs Kristi French	625 Redford Place Drive, Rolesville , NC 27571	Wake	Kristimfrench@hotmail.com	Stop UHS from participating in the mental health process in NC please. They target clients with insurance to hold for unnecessary IVC’s, clogging up the system for those that truly need them and also give substandard and dangerous care. UHS is a danger to the mental health of NC and making the system worse. I’ve seen this as a parent and as a clinician (I’m a LCMHC/QS), they are helping to break our system.
03/01/2026 06:11 PM	Mentally ill				Mentally ill should not be held in the jails. They need medication and they don’t get it this way
03/01/2026 06:59 PM	Dr Rebecca Love	201 S Washington St #401, Shelby, NC 28150	Cleveland	rjlove520@gmail.com	Idea for Public Comment on Mental Health, Involuntary Commitment and Public Safety As a family physician working with many other people and agencies to fill gaps in care in a county ranking in the bottom

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					25 on health measures, I have had personal experiences with reducing risks and improving outcomes in complex situations. Here's an idea from my work and from other evidence-based models of care and research. Allow NC Medicaid to offer an alternative to commercial insurer managed care plans with a state direct shared-service reimbursement plan, as allowed by the ACA, that pays chronic care management codes (CCM) and resumes Healthy Opportunity Pilot codes, as well as CoCM codes and E&M codes to providers in communities who organize with existing local healthcare business, municipal and non-profit partners to integrate mental, behavioral, preventative, and social health services with primary care, and coordinate treatment plans on high-complexity, high risk cases through community-wide multidisciplinary teams (MDTs) with communications on a common software platform. All IVC and guardianship decisions could be informed as a best practice by this easily accessible collective of knowledge. Run these direct pay shared service collaborative plans parallel to the Medicaid commercial managed care plans and let consumers eligible for Medicaid insurance choose which option they prefer. Then let the data prove our future. The MDTs should be comprised of our best local clinical expertise, connected virtually to state or regional clinical expert advisors to cover any gaps in local expertise, for the purpose of assisting primary care providers to develop, oversee, and communicate on a common software platform about progress on individualized treatment plans for these most difficult cases that require intense attention over a prolonged time. Separate specialized MDTs could be geared for cases involving chronic pain management, OUD/SUD, homelessness, or food insecurity and geared to function with and report to the larger community-wide MDT. Direct reimbursement to the practices and agencies doing the work in communities will reduce burdens, foster integration and allow us to provide payer agnostic care equally and efficiently to everyone. These professionals paid through different employers receiving their portion of shared reimbursement based on work done, are accountable to one another, and all are accountable to the people and families served. The costs and burdens created by commercial managed care need for profits could be avoided in this option. We simply pay for the cost of our own citizens doing the work for one another. Our many years' investment in the Healthy Opportunities Pilot,

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					that proved supporting social determinants of health improves health, saves lives and saves money, would not be lost. We could continue to reap the benefits of that investment and knowledge we gained. Set the current Medicaid “Tailored Plan” contractors and CCPN the task of helping communities and primary care practices organize the community wide collaboratives to serve all people who choose this option, not just SMI, SUD, I/DD and TBI cases, and to earn the direct payments from Medicaid with support of the Tailored Plan contractors. Instead of those contractors, sub-contracting with a medley of outside corporations to run a “managed care” set of prior authorizations and remote services, the Tailored Plan contractors should be supporting all partners who do the work together to apply extra attention and special expertise to anyone, whenever they need it. We waste huge amounts of time just trying to figure out where we can send people for help—searching for who is in network with any of the multiple plans to get paid by whichever plan a person has. Often there is only one vendor in network and when they are not available to provide service, the need is never met. People get sicker, have higher costs, and sometimes die. Or plans magically change without anyone having chosen to change, and we must start over with all the burdensome referrals and prior authorizations. It is a rat race on a gerbil wheel. Run these direct pay shared service plans parallel to the commercial managed care rat races and let consumers choose which they prefer. Collect the data. I can guarantee from my work, and from evidence in studies on informatics and shared services by Dr Samual Cykert at UNC, that you will find that having consistent relationships with professionals who show they care, organized through community health workers and MDTs, providing the SDOH supports, (some legislators think this cost should not be borne by taxpayers, but we will pay for such deficits, one way or another), mental health will improve, risks of avoidable deaths and murders will be lower, all people will be more satisfied and costs will be lower. Or you can go on thumping your heads, and wringing your hands over deaths and despair, looking the other way while using our tax dollars to plump up corporate profits, but you will be finding yourself out of office, twiddling your thumbs at home.

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					I can provide some example cases that demonstrate the power of MDTs. One of those could have ended as Iryna's life did. Note that this work, effective as it is, is not sustainable without a shared system of reimbursements to the collaborative partners from different agencies and practices. Reimbursements for work done by citizens employed in health care entities, that addresses and resolves major social and health problems, ultimately reduces our tax burden while simultaneously improving our lives. That's money well spent by our governments serving citizens of our state and counties. For any questions, further explanations, or examples, I can be reached at 980-295-9862 Rebecca J. Love, MD Medicine with Mercy and Grace, PA Shelby NC 28150
03/02/2026 10:44 AM	Audrey Harville	332 Haven Dr R6, Greenville, NC 27834	Pitt	avharville@msn.com	Subject: Reform Needed for NC Mental Health Funding – The Crisis of ER Boarding and Patient Safety Dear Members of the House Health Committee, I am writing to you as a dedicated parent and a constituent to share a perspective on mental health funding that is often overlooked in budget discussions: the high cost of reactive care versus the efficiency of proactive support. A family member, who has several mental health diagnoses and who was not diagnosed with Autism until age 19 despite our advocacy since infancy, currently resides in a 5600-A Adult Care Home in North Carolina. While we are grateful for the high-quality care received there, our recent experiences with the state's crisis system have revealed a terrifying gap in patient safety and resource availability. I urge you to consider the following areas where policy shifts could save both state funds and vulnerable lives. ____ 1. The Failure of the IVC System: ER Boarding vs. Unsafe Placement Recently, the family member experienced a mental health "dip." Because the facility they resides lacked flexible funding to hire temporary, one-on-one support to stabilize the individual in their familiar environment, the situation escalated. This led to a placement under an Involuntary Commitment (IVC), which resulted in an eight-day stay in an Emergency Room because no psychiatric beds were available in the placement request system. During those eight days:

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					• Zero Clinical Care: They received no psychotherapy, no psychiatric treatment, and not even a medication adjustment. • Counterproductive Environment: On the eighth day, a psychiatric professional confirmed via telehealth that the stay was "counterproductive" to their health. The most harrowing part of this experience was being terrified about where they might be placed, and the "relief" I felt that they remained in the ER. Under an IVC, neither the patient nor their advocates have a say in where they are placed. As a family member and their Healthcare Power of Attorney, I found myself grateful that a placement in facilities like Holly Hill in Raleigh or Brynn Marr in Jacksonville was never available. Behavioral health professionals explicitly warned me to advocate against these locations. My own research into their history of systemic failures, negligent care, and regulatory non-compliance was astounding. No patient or family member should have to feel thrilled that they are being denied psychiatric care in an ER simply because the available state-sanctioned facilities are known to be traumatizing or unsafe. This current system is perpetually fostering more trauma. Families facing IVC are often trapped between two frightening realities: the neglect of ER boarding and the danger of facilities with known safety violations. 2. The Financial Impossibility of Dual Eligibility My family member is dually eligible for Medicare and Medicaid. All their SSDI is used to cover room and board, and Special Assistance covers the rest. They are allotted a $90-per-month Special Assistance allowance. As of January 1, 2026, new requirements force them to pay copays for Tier 2 and higher medications. Since 90% of their life-saving medications fall into these tiers, it is now mathematically impossible for them to afford their prescriptions, basic hygiene products, and clothing on $90 a month. This policy effectively forces vulnerable citizens to choose between medicine and basic dignity. 3. Combatting Stigma through Proactive Solutions The current "crisis-only" model fosters a culture of low expectations. When we underfund the front lines (Adult Care Homes) and overfund the back end (ERs and Acute Units), we tell patients their stability isn't worth the investment—only their crises are. ________________________________ Policy Recommendations • Establish "In-Home Stabilization" Funds: Allow 5600-A facilities to request temporary 1-on-1 support funding to stabilize residents in place, avoiding the $1,000+-per-day cost

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					of ER boarding. • Increase Oversight and Accountability for Psychiatric Facilities: Strengthen the criteria for facilities to maintain licensure. Patients under IVC are in crisis; they must not be subjected to "malfeasance" or "mishandling" that produces further trauma. • Review Medication Copay Structures: Ensure dual-eligible residents in adult care homes are not priced out of life-saving medications by the $90-per-month limit. Thank you for your commitment to public service. It is my hope that you see the human cost and the need for policy change. I look forward to hearing how the Committee plans to make North Carolina's mental health system more fiscally responsible and humanely effective. Sincerely, Audrey Harville
03/02/2026 11:30 AM	Glenn Simpson	2556 Lance DriveGreenville NC 27858, Greenville, NC 27858	Pitt	Gms2556@gmail.com	Revising 122-C would be a vital step in improving the NC behavioral health care delivery system. Professional transportation options for patients who consent to inpatient care would reduce the volume of IVC's initiated for "safe transportation". 122-C should reflect that an IVC order can not be used only for transportation. Developing a "consent to treat" form for patients to sign when at a sending facility (ex: ED) that lists all psychiatric facilities who opt to participate in this option. This would allow a 24-hour facility to still admit a voluntary patient who upon arrival to the 24 hour facility decides they no longer want treatment (the facility would be able to hold up to 72 hours as per statute for voluntary requests to discharge). (There would need to be statute changes likely to make this provision possible). Educate magistrates and healthcare that if someone has a legal guardian (such as a child), IVC is not necessary unless the guardian disagrees (there has been several stories in the media where a parent took a child for a "first exam"; the child was IVC'd; and the parents felt they were no longer involved in the decision process. Certified commitment examiners should only be used when the place of first exam is capable of boarding a patient until a 24-hour facility accepts (today, community-based fist examiners will often send a respondent by LEO to an ED. This defeats the purpose of having alternate first examiners). Use the e-Courts system to develop reports to track IVC's by magistrates, physicians, other commitment examiners (Affidavit and Petitions), transportation to first exam (Findings and Custody Orders), "overturned" first exams, second exams at 24-hour facilities, second exams indicating respondent does not need hospitalization, second exams indicating respondent does need hospitalization,

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					number of respondents that convert to voluntary after second exam and before court hearing (which is within 10 days), etc. Also, utilize the reports submitted to DMH via the State IVC Portal regarding IVC's at each facility (this data would not reflect any respondent that did not arrive at a 24-hour facility. Revise statute allowing facilities requesting IVC designation to meet criteria (even if temporary) within 30 (or X) days of licensure (vs Accreditation). Revise statute to change "24 - hour facility" to "Behavioral Health 24 - hour facility (many interpret 24-hour facility as an ED or acute medical unit). NOTE: The comments in this message represent ONLY my personal comments and do not represent anyone else or any organization.
03/02/2026 01:48 PM	Ms. Susan Trabka	1906 Sunset Avenue, Durham, NC 27705	Durham		I have a close family member in another state who had a pattern of DWI arrests, only during manic episodes. He was never able to acknowledge having a mental illness (bipolar disorder) and wouldn't accept treatment or medication after brief hospitalizations. Eventually he had a life threatening episode that resulted in involuntary long term inpatient psychiatric hospital stay followed by a residential day treatment program. At one point when he faced a DWI charge, I called the prosecutor and explained that this only happened during manic episodes but that he would refuse treatment and medication. I hoped that court ordered treatment would be part of the outcome, but that didn't happen. Years later after the long hospital stay, he is on Social Security & Medicaid and has subsidized housing contingent on regular treatment & medication. He also has regular social worker support. This service is provided through an organization that helps fund housing for people with a history of of substance abuse, long term hospitalization, or homelessness. I'm not sure if this story is directly relevant to the House Select Committee's recommendations, but maybe it will help generate some ideas.
03/02/2026 07:07 PM	Mrs. K Anderson	451 North Prince Henry Way, Cameron, NC 28326	Moore	kimurq12345@gmail.com	My concern is the lack of transparency and the manner in which providers can abuse this process. We recently had a child experience a mental health crisis, we agreed to a treatment plan proposed by the hospital. The following day we were told that they had obtained an IVC. There was no need for it, we were more than willing to get care for him and actually could have gotten him to a treatment facility faster had they not gone the route of IVC. We were not clearly informed about the legal implications, the loss of parental authority, or the long-term consequences of an involuntary commitment order. We now will have to spend

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					money on an attorney in an attempt to have their medical records sealed and they IVC expunged.
03/03/2026 11:51 AM	Debra Rhodus	439 First Avenue NW, Hickory, NC 28601		ccc.drhodus@gmail.com	I am a LIcensed Clinical Mental Health Counselor for people in NC of all ages. I constantly find a lack of inpatient beds for my clients when they are suicidal or homicidal. We need to add more inpatient beds and more residential treatment beds for NC residents.
03/03/2026 11:57 AM	Former NC CHHS employee Mary Eldridge	113 Essex Drive, CHAPEL HILL, NC 27514-1501	Orange	stu.rosenfeld@gmail.com	Studies of states that have have reduced the hospitalization, incarceration, and entry into homeless shelters of people with severe and persistent mental illness show the following. These people have significant wrap-around services initially to gain stable housing and daytime activities that they value (employment, volunteer work, continuing education, etc.). As result, they have an incentive to take needed medication and accept services in order to keep what they value. They want to remain in the community. Case management, with reasonable caseloads, stable housing, and meaningful daytime activities are key components to making these results possible.
03/03/2026 02:04 PM	Mary Grant	1145 S Hawthorne Road, Winston Salem, NC 27103	Forsyth	mcgrant@carolinapsychologygroup.com	As a licensed clinical mental health counselor supervisor and licensed clinical addictions specialist in the state of North Carolina, I have navigated the IVC process numerous times to assist clients navigating symptoms clearly contributing to danger to self or others and unable/unwilling to seek stabilization voluntarily. Unfortunately I have also witnessed first hand how the process often fails to address underlying concerns or to connect individuals with needed services/ supports prior to discharge, often leading to resumed symptoms within hours to days with no recourse or alternative prevention/treatment. North Carolina has certainly made strides in improving our crisis resources; however, most of the community-based crisis response options require the individual to engage voluntarily which is often challenging with someone may or may not be under the influence of substances and/or navigating severe or persistent mental illness contributing to alterations in awareness/ability to access logic/reason.
03/03/2026 02:48 PM	Psychotherapist Julie Ingram	1301 Durlain Dr. Ste 204, Raleigh, NC 27614-6426	Wake	juliekristeningram@gmail.com	I have been a psychotherapist in Raleigh for 36 years. Inpatient clinicians often do not provide a discharge plan that patients need before leaving facilities. They often try to "dump them" on clinicians in private practice (like myself) without making sure the clinician accepts the health insurance of the patient. They may also offer them resources that they clearly can't afford after discharge. This practice would probably reduce the revolving door in facilities. When I get a discharged patient, I have to make multiple phone calls

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					to mental health facilities in NC to acquire a discharge plan. I can no longer accept these folks if I don't have a plan outlined by the facility. This is for continued care and professional liability issues. Facilities need to be mandated to provide discharge plans to both the patient and the provider who will be continuing care on an outpatient basis.
03/03/2026 08:19 PM	Ms. Deana Flynn	4904 Fayetteville Rd A, Lumberton, NC 28358	Robeson		Dear Members of the North Carolina General Assembly, My name is Deana Flynn, and I am a Psychiatric Mental Health Nurse Practitioner and the owner of Fortis Behavioral Health in Robeson County, North Carolina. Over the course of my career, I have worked in community mental health systems, including locked inpatient psychiatric units serving individuals with serious mental illness. Today, in my private practice, I treat both adults and children across southeastern North Carolina. From these experiences, I have witnessed firsthand the revolving door between untreated mental illness, emergency departments, and incarceration. This cycle is often framed as a problem of medication noncompliance or insufficient inpatient beds. While medication adherence and programs such as Assertive Community Treatment (ACT) teams are important components of care, they do not address the root cause of the problem. The true driver of the mental health–to–ER–to–prison pipeline is the failure to identify and treat psychiatric illness early, particularly among children living in socioeconomically disadvantaged communities. Many of the adults cycling through emergency departments, jails, and state psychiatric facilities began experiencing symptoms of mental illness years earlier. Conditions such as ADHD, anxiety disorders, trauma-related disorders, mood disorders, and early substance misuse often go undiagnosed and untreated throughout childhood and adolescence. In many cases, individuals later develop substance use disorders as a form of self-medication. When these underlying conditions remain untreated, the behavioral consequences—impulsivity, poor decision making, emotional dysregulation, and risk-taking—can ultimately lead to school failure, addiction, and involvement with the criminal justice system. Research has repeatedly demonstrated the high prevalence of untreated mental illness in incarcerated populations. For example, studies have found significantly elevated rates of undiagnosed ADHD and other neurodevelopmental disorders

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					among incarcerated individuals. When these conditions are not identified early, affected individuals often engage in “dopamine-seeking” behaviors, including substance use and high-risk activities, which can contribute to criminal involvement. If North Carolina is serious about reducing the burden on emergency departments and correctional facilities, we must shift our focus upstream. The most effective intervention is early identification and treatment of mental health conditions in elementary school, middle school, and high school. Routine mental health screening, early psychiatric evaluation, and timely treatment can significantly reduce the likelihood that children will later enter crisis systems. However, early intervention requires adequate access to qualified mental health providers. Many rural counties, including Robeson County, face severe shortages of psychiatric physicians. Psychiatric nurse practitioners are highly trained clinicians who are already providing a large portion of mental health care in underserved communities. Expanding full practice authority for psychiatric nurse practitioners would significantly improve access to early diagnosis and treatment, particularly in rural and high-poverty regions where the mental health workforce is limited. Allowing nurse practitioners to practice independently would enable them to work in schools, community health centers, and primary care settings where early identification of mental illness can occur. By increasing the availability of psychiatric evaluation and treatment for children and adolescents, North Carolina can intervene before mental health conditions evolve into crises that require emergency department visits or result in incarceration. The current system is primarily designed to respond to psychiatric emergencies after they occur. A more effective approach is to invest in early detection, early treatment, and expanded access to care. If we address mental illness when children first begin to struggle, we can dramatically reduce the number of individuals who later cycle through emergency rooms, jails, and state hospitals. Thank you for the opportunity to provide input on this critical issue affecting communities across North Carolina. Sincerely,

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					Deana Flynn, PMHNP Owner, Fortis Behavioral Health Robeson County, North Carolina
03/04/2026 07:56 AM	Chelsea Ralston	113 Sycamore Street, Cary, NC 27513	Wake	chelseairalston@gmail.com	I'm writing to express my concerns about the new policies and processes being proposed for Involuntary Commitment. As a trained IVC examiner, I am very familiar with the existing issues related to the IVC process, as well as with placing individuals for treatment, whether voluntary or not. When I worked at WakeMed, we often had people who were petitioned without appropriate evidence and even if they could have benefited from mental health care, the entire process of being apprehended and transported by police was often traumatic and made them understandably resistant to further treatment. Additionally, the process for transporting people under IVC, including with police, in handcuffs, and in paper scrubs is traumatic and inhumane. The wait times for placement, and lack of choice and ability to match based on patient needs, leads to ineffective care, more burden on hospital staff, and multiple admissions. The state of inpatient care in the state is abysmal, as evident by the recent report from Disability Rights NC (https://disabilityrightsnc.org/news/press-release/ncs-involuntary-commitment-process-overused-misused-harmful/), which leads to further traumatization, lack of actual therapeutic care, sometimes worsening symptoms (most are just changing meds or dosage and discharging folks without appropriate follow up care), and leading folks stranded in other cities or counties when they are signed in voluntarily. IVC is a band-aid solution proposed by those with no real interest in or education on the needs of individuals experiencing crisis or diagnosed with a serious mental illness. Trauma and genetics play a large role, and until we address social conditions that contribute to development, and expand access to healthcare (including expand intensive outpatient or partial hospitalization programs, create more affordable housing, fund rural hospitals and mental health facilities, hold state institutions accountable for inexcusable treatment/behaviors, expand Medicaid eligibility and reimbursement rates for practitioners, hire more school social workers, defund police and increase funding for trauma-informed emergency responders) we will continue to see multiple re-admissions, decompensation in individuals who have been through the IVC process, and more hospitals becoming overwhelmed and understaffed by behavioral health patients.
03/05/2026 08:22 AM	Roxanne Saucier	556 E EDENTON ST,	Wake	saucier.roxanne@gmail.com	The legislature should avoid enacting laws that would increase involuntary treatment for people with substance use

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		RALEIGH, NC 27601			disorder. Forced treatment can increase risk of overdose, remove people from their support systems, and retraumatize people. Importantly, it does not improve treatment outcomes. We need to increase access to voluntary, evidence-based treatment for substance use disorders in the community. Too many people who want drug treatment can't access the treatments that are proven to work. Rather than forcing people into often-ineffective treatments, we should be working to strengthen voluntary pathways. More information and data about the drawbacks of involuntary commitment for SUD is available in this report: https://drugpolicy.org/wp-content/uploads/2024/09/TheDrugTreatmentDebate_10.30.24-Interactive.pdf.
03/05/2026 09:54 AM	Ms Tara Muller	801 Corporate Center Dr 100, Raleigh, NC 27612	Wake	tara.muller@disabilityrightsnc.org	(Sent via email in January 2026) Dear Speaker Hall, Committee Chairs, and Committee Members, On behalf of Disability Rights NC (DRNC), thank you very much for establishing and serving on the House Select Committee on Public Safety and Involuntary Commitment. We share your interest in addressing violent crime driven by mental illness in a way that works – by addressing the many weaknesses in our broken involuntary commitment (IVC) and justice systems that allow for people with mental illness to cycle in and out, sometimes for years, while getting worse instead of better. As you begin this work, we invite you to review our recent IVC report, https://disabilityrightsnc.org/news/involuntary-commitment-in-nc-overused-misused-and-harmful/, which includes related policy recommendations. In short, after an in-depth investigation, we found tremendous waste and misuse in a system that nearly always does more harm than good, financially disincentives the appropriate use of beds, and uses our scarce mental health resources to make people sicker. Please reach out to us if you have any questions about our data and recommendations on ways to improve our IVC system. Best, Tara Muller Policy Attorney
03/05/2026 10:05 AM	rebecca taylor		Durham		Having patients who are on involuntary commitment be required to be transported by the sheriff is not only

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					demoralizing and dehumanizing, it is unnecessary use of law enforcement resources. This should be addressed and safe non-law enforcement transportation should be allowed across the state.
03/05/2026 02:54 PM	Mrs. Mary Jernigan				As clinician serving NC population for almost 20 years clinical impression is that legislation to shift telehealth into permanency, providing a rented tablet to each child for academic purposes, increasing equal statewide access to farm fresh foods, creating CPT codes that provide parity to mental health clinicians for integrative mental health sessions, and supporting research towards non-traditional neuro health interventions would get us back on track. Thanks for asking!
03/07/2026 10:05 AM	Mental Hospitals Again				This issue is deeply personal to our family, as we have a loved one living with severe mental illness, including schizophrenia, PTSD, traumatic brain injury, and anosognosia. At the same time, we know that millions of families across the country are facing the same difficult realities. I support several aspects of the law, including clearer expectations for magistrates, stronger pretrial release rules, and requirements for mental health evaluations in appropriate situations. These are important steps toward addressing gaps that can allow dangerous situations to escalate. However, I believe the larger issue that deserves continued attention is how our system responds to severe mental illness before violence occurs. In many areas of medicine we use implied consent or surrogate decision-making when someone cannot safely make decisions for themselves. Yet with severe mental illness—particularly conditions where a person may lack insight into their illness—the system often cannot intervene until someone becomes an immediate danger to themselves or others. A major factor in many severe mental illnesses is **Anosognosia, which means the individual is often unable to recognize that they are ill or that they need treatment. Because of this, families frequently recognize when a loved one is deteriorating long before a crisis escalates, while the individual themselves may firmly believe nothing is wrong. Unfortunately, many families report that when they call for help, they are told that little can be done unless the individual has already committed a crime or is making a clear and

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					immediate threat. Law enforcement officers are often placed in the difficult position of responding to a mental health crisis but lacking the authority or resources to ensure the individual receives meaningful treatment. Even when individuals are taken for evaluation, the result is often a very short-term hold followed by release without long-term stabilization or treatment. This cycle can repeat many times, leaving families and communities feeling powerless while the individual continues to deteriorate. Because of this, prevention should be a major focus. We need stronger systems that allow earlier intervention, expanded mental health treatment options, and more long-term treatment facilities for individuals who are clearly unable to manage their illness but have not yet committed a crime. Families who are trying to get help for a loved one in crisis should have meaningful options available before a tragedy occurs. Preventing tragedies should be the goal. Strengthening early intervention systems, improving access to meaningful treatment, and creating options for longer-term stabilization when families and professionals recognize a serious mental health crisis may help address the deeper systemic issues that cases like this reveal. Thank you for considering these perspectives.
03/07/2026 12:54 PM	LCMHC Steven Allman	75 highmeadow lane, clayton, nc 27520	Johnston	stevenallman384@gmail.com	As a NC Licensed Clinical Mental Health Counselor with 16+ years of experience with NC DHHS working in the Division of Vocational Rehabilitation Services, I have had many contacts with our NC Assertive Community Treatment Team(ACT Team), without exception all very positive contacts. When I retired from DHHS in January 2021, the ACT Team was the "leading edge" of our effort to "Deinstitutionalize" our friends & neighbors with a chronic, persistent mental health disorder. So far as I know, the ACT Team continues in this capacity. IF a judge cannot rule to IVC a person charged with a crime when recommended by a District Attorney, and that defendant also has been assessed by a NC Licensed Mental Health Professional to have a chronic mental health disorder, why can't that defendant be referred to the ACT Team to be monitored until his or her trial? It may require some modification of the ACT Team mission by the General Assembly but that could be done, even to include requiring an "ankle monitor" to follow his or her location. It may also require resources to house that defendant if they are currently

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					"unhoused." It may be that the defendant has already "fallen through the cracks" in our mental health system and has not been offered ACT Team services or has made an unwise decision to refuse ACT Team Services. Seems like a possible solution worth considering. We've been struggling to provide treatment for folks with chronic, persistent mental health disorders for 250 years and working to "deinstitutionalize" since the Community Mental Health Act in 1963. We have made great progress but have a ways to go yet. Good luck with all your efforts to solve this problem!
03/08/2026 10:02 AM	Mrs Azure Kimbrel	202 Stonehill Rd, Chapel Hill, NC 27516		Azkimbrel@gmail.com	I am a nurse at UNC Chapel Hill and have the experience of working with or supervising staff that are providing direct patient care to mental ill patients with criminal backgrounds that have been brought in to the hospital for evaluation and treatment. These patients are housed on general medicine units with other patients. Often young nursing assistants or college students are required to sit with these patients around the clock to make sure they do not harm themselves or others. These patients are often very difficult to deal with and staff supervising them are not trained to deal with psych patients. The patients often sit in the hospital for weeks waiting for safe placement at discharge. This current arrangement places staff and other patients at risks. It is also not helpful for the psych patient because they are not getting the treatment they need. A psychiatrist only rounds on them once a day for 15-20 minutes . The lengthy stay of this patient also takes a bed away from another patient waiting for medical treatment. I personally think these folks need to be housed in a psych facility to begin with or a psych floor at the least. Then they will have nurses and doctors with psych training rounding on them regularly. Real treatment could begin inpatient while outpatient arrangements are being made. I encourage you as a committee to send a representative to follow one of these individuals through the hospital so you can see first hand the challenges that are faced by staff and the hospital in managing this unique patient population.
03/09/2026 03:35 PM	Dr. Ellyn Mullis	Children's Hope Alliance, 194 Barium Springs Drive, Statesville, NC 28677	Iredell	epmullis@childrenshopealliance.org	Substance misuse plays a large role in the lives of most of the children and youth we see at Children's Hope Alliance, especially in higher level services, like IIH, ACTT, foster care, and Day Treatment. Often both the child/youth in treatment AND adults/other youth in the household have substance use issues. For all ages, involuntary commitment for purposes

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					of detoxing and starting SA treatment would be extremely helpful. For persons with multiple rounds of unsuccessful detox/treatment initiation, closely monitored stepdown programs (residential or outpatient) would help. Other actions that could help are: closing vape shops, close monitoring of any facility that sells alcohol/TBD products/ etc. to be sure sales are not made to minors, eliminating cell phone use in school (and any other actions that would reduce access to easy dopamine' hits'). We are seeing more and more children with histories of in utero exposures and identifying more children with Fetal Alcohol Spectrum Disorder. These children often have significant behavioral/intellectual challenges that make home and school life challenging. Their multiple cognitive issues make 'independent' adulthood problematic. Education campaigns on avoiding alcohol (and other drugs) during preconception and pregnancy would be helpful. In addition, some of the empty cottages at Murdoch Center could be dedicated to providing care to these children (who often end up in foster care with several disrupted placements due to behavior challenges)--both respite care for kinship placements and longer-term care for the most challenging children/youth. For some adults with FASD, longterm/respite care for adults could keep them from ending up homeless and/or in jail.
03/09/2026 09:49 PM	Mrs Alison Moeller	108 sun oaks court, Benson , Nc 27504	Johnston	dougalisonlacey@yahoo.com	IVC NEEDS TO BE CHANGED. Not just anyone should be able to IVC SOMEONE, only immediate families should have this right. RN OVER 40 years
03/10/2026 10:02 AM	NC's default response Alicia Brunelli	232 Spencer st, High point, Nc 27265	Guilford	Alimarbru@gmail.com	Good afternoon, Thank you for the opportunity to provide comment today. My name is Alicia Brunelli, and my work focuses on behavioral health systems, crisis response, and supporting communities across the state in implementing evidence-based strategies that improve health and safety. I want to speak briefly about the role of involuntary commitment in North Carolina's behavioral health system. Involuntary commitment was designed as a critical safety mechanism for situations involving imminent danger, but over time it has increasingly become a default response to a wide range of behavioral health and substance use crises. This shift reflects broader gaps in our system rather than the intent of the law.

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					Across North Carolina, we routinely see individuals transported long distances under involuntary commitment orders, held for extended periods in emergency departments while awaiting placement, and then discharged without meaningful connection to ongoing care. This process is difficult for individuals in crisis, places significant strain on hospitals and law enforcement, and often fails to create long-term stability. For individuals who use drugs, the use of involuntary commitment is particularly complex. Short-term detention without access to sustained, voluntary, evidence-based treatment rarely leads to improved outcomes. In some cases, it can increase trauma and further distance people from the healthcare system. If the goal of this body is to improve safety, stabilization, and long-term recovery, policy solutions should focus on strengthening the parts of the system that prevent crises from escalating in the first place. This includes expanding access to community-based behavioral health services, mobile crisis response teams, peer support, voluntary treatment options, and harm reduction services that keep people alive and connected to care. Involuntary commitment should remain available when absolutely necessary, but it should function as a last resort within a broader continuum of care, not as a substitute for services that our communities currently lack. North Carolina has an opportunity to build a system that prioritizes dignity, effectiveness, and long-term outcomes. I encourage the Commission to focus on policies that strengthen voluntary care, reduce unnecessary system strain, and ensure that individuals experiencing behavioral health crises receive the support they actually need. Thank you for your time and consideration.
03/10/2026 03:28 PM	Dr Joshua Pagano	619 Sullivan Rd, Statesville, NC 28677	Iredell	joshpagano@gmail.com	Here is an article from 2024 which describes our situation well: https://ncnewsline.com/2024/04/03/nc-mental-health-facilities-plagued-by-big-and-chronic-staffing-shortages/ ECU just opened a new facility with 144 beds in 2025. And WakeMed is building a behavioral health hospital in Garner.

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					All while hundreds of beds sit empty in our state hospitals. Therefore, if our lawmakers wants to help solve our mental health crisis, they must prioritize really paying and empowering our nurses and HCTs - to use the beds we already have instead of building all new facilities which will very likely only worsen the staffing shortages across North Carolina. Spreading an already thin workforce across more hospitals means more beds will sit empty, and fewer patients will get care. There is no fixing mental health care without paying nurses and HCTs.
03/12/2026 09:26 PM	Melanie Adkins	7702 McAllen Drive, Greensboro , NC 27409	Guilford	Madkinsrn@gmail.com	I’m an ER RN concerned about the safety of my coworkers and patients.
03/12/2026 09:29 PM	Mrs. Faye Holcombe	4618 Country Meadows Dr., Gastonia, North Carolina 28056	Gaston	Holcombefaye@gmail.com	Jails are absolutely no place for a person with a mental illness. They put them in what they call protective custody but it really seems to be solitary confinement. The rooms are very small and they are allowed out of lockup for only one hour about three times per week. It is during that time that they are allowed to take a shower and use the kiosk to read mail and order snacks if they are lucky enough to have money to pay for them. Evidence shows that solitary confinement worsens mental illness especially for those who suffer with symptoms of psychosis. It is cruel and inhumane to do that to a person whose only crime is having a mental illness that he or she did not choose. Why would this society not treat a person who has a serious mental illness with the same love and respect in a hospital as they treat people who have other serious illnesses such as cancer, kidney failure, heart disease or others? The insurance and funding is there for them.....why is it not there for those who have a mental illness? The IVC is not a treatment regardless of what many people think. IVC is approximately 5 days which is not near enough time to stabilize a person experiencing symptoms of psychosis. The jails offer medication but do not insist the mentally ill take it so most often they do not. The jails are not equipped with skilled mental health care givers who can successfully treat those with mental illness. Those who have a mental illness with symptoms of psychosis should always get the first available beds in mental hospitals. Many of the expensive mental health institutions will not even accept mentally ill patients who are experiencing psychosis. What a shame when those are the ones who need it most! Psychosis is when the mentally ill person hears voices that are not real and most often they are very frightening . They see scary things or people that are not

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					there. They are paranoid and sense things that are not true. The list goes on. Educate yourselves about it in order to better understand the seriousness of symptoms of psychosis. Sadly, people who have a mental illness with these symptoms live a very challenging and disturbing life that they did not choose. The lack of medical treatment in the jail's solitary confinement worsens those horrifying symptoms. Why are the mentally ill in our society treated that way? Their lives are valuable and they have done nothing wrong that they could prevent to deserve that treatment. The state should quit wasting money that could build more mental hospitals and staff them with highly skilled professionals to care for the most vulnerable and forgotten in our society. Build several small affordable hospitals that accepts all insurance and scatter them across the state in order to better staff them with highly trained mental health experts who would not have to relocate away from the town where they reside. It is a known fact to those of us who have direct or indirect experience with mental illness that the long wait time for the mentally ill to get evaluations and treatment is an absolute disgrace. Both should be done in a hospital rather than virtually and they should never be done in a jail. So much can be said about the stigma surrounding the mentally ill in our society. It should not exit because mental illness has no boundaries. It can happen to anyone whether good or bad, rich or poor, famous or unknown, black white or any others. Just remember that underneath that mental illness is most likely very kind and loving human beings who are depending on us to do the right things to help them. What would you do if it were your child, grandchild or any other loved one whose life was taken from them by a mental illness? Would you rather he or she be in the jail's solitary confinement without treatment or in a mental hospital getting the best treatment possible? Please keep our most vulnerable and forgotten ones in your hearts and minds as you strive to reach a solution to this most important situation. Hoping and praying for a great outcome.
03/14/2026 11:03 AM	Dr. Lynda Bialobrzeski	129 Wentworth Drive, Wiston Salem, NC 27107	Davidson	lmb1121@gmail.com	To Whom It May Concern, I am writing regarding the implementation of Iryna’s Law in North Carolina. I fully support the intent of the law, which is to ensure that individuals with mental illness receive appropriate evaluation and treatment rather than being managed solely through the criminal justice system. However, I am concerned that the law was enacted without sufficient planning or

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					infrastructure to support its practical implementation. I work in an emergency department in North Carolina and see firsthand the consequences of our state’s limited mental health resources. Even under current conditions, patients in need of psychiatric admission frequently remain in the emergency department for days or even weeks awaiting placement, due to a shortage of inpatient psychiatric beds. This situation is particularly difficult for patients with a history of violence or severe psychosis, who often require higher levels of supervision and are more difficult to place. Caring for these patients in an emergency department setting places staff at risk of harm and limits our ability to provide timely care to other medical emergencies, as treatment rooms must be held for extended periods. There is concern among emergency physicians and hospital staff that, without a clearly defined system for psychiatric evaluation within the correctional system, individuals detained under Iryna’s Law will be transported to emergency departments for evaluation by default. Emergency departments are not equipped to serve as the primary entry point for large numbers of forensic psychiatric evaluations, and doing so would significantly worsen crowding, increase wait times, and compromise patient and staff safety. In addition, many of the individuals affected by this law are part of a population that has been struggling for years with the downstream effects of the closure of long-term psychiatric facilities in North Carolina. Patients with severe and persistent mental illness, such as chronic schizophrenia, often require structured environments and supervised medication administration to remain stable. Without access to long-term care options, these individuals frequently cycle between homelessness, psychiatric decompensation, hospitalization, incarceration, and release back to the community without adequate support. For Iryna’s Law to function as intended, the state will need to establish a coordinated system that includes: -Access to psychiatrists or qualified mental health professionals who can evaluate individuals within the jail or correctional setting -Increased inpatient psychiatric capacity, including beds appropriate for patients with violent or high-risk behavior

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					-Consideration of long-term or supervised treatment options for individuals who are unable to maintain stability independently -Clear guidelines for law enforcement and correctional agencies that do not rely on emergency departments as the default location for psychiatric evaluation Without these supports in place, implementation of the law risks overwhelming already strained emergency departments while failing to provide the level of mental health care that the law was intended to ensure. Thank you for your time and for your work on this important issue. Sincerely, Lynda Bialobrzeski, MD Winston Salem, NC
03/14/2026 12:30 PM	udwivuesgx rkwmvsnwen qzijgyowik	terzyjifyi uxorzrwjsg, tuxtjgtqow, sjilljhizn ythhgtjvze	Option2	uqptqlws@checkyourform.xyz	hexflgfewigsthtwrigrkmixtimupe
03/14/2026 12:46 PM	Dr. Brian Hiestand	Winston-Salem, NC 27106	Forsyth	Brian.Hiestand@advocatehealth.org	I understand the good intentions behind Iryna's Law. There is a small segment of severely mentally ill individuals who have not been well served by the discontinuation of long term custodial psychiatric beds in North Carolina, which in fact has one of the lowest inpatient bed per capita in the United States. We do have a substantial problem with access to psychiatric care in NC. As a practicing emergency physician, I see the consequences of the lack of support from the state for psychiatric care every single shift. However, mental illness is actually a greater risk factor for being a victim of violent crime, as opposed to a perpetrator. Law enforcement already routinely brings patients suffering acute psychiatric illness directly to the ED for stabilization and care. Iryna's law requires that suspects with a history of involuntary commitment undergo a commitment evaluation as part of the pre-trial release process. Unfortunately, the remedy in the law is to bring these violent offenders to already overcrowded and under-resourced emergency departments, without any thought as to the safe transport, logistics, impact on local court resources, or impact on other patients needing emergency care. Almost by definition, these offenders are

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					not suffering from an emergency - if that was the case, the initial arresting officer would have already taken them to the ED prior to processing. We are now many years in to establishing telehealth as a mode of delivering care, and one that is well suited for psychiatric evaluation. It is my fervent wish that the state removes the requirement for physical transport of these violent offenders to the Emergency Department, and instead establishes a solution whereby these offenders are maintained in the secure environment of the jail with telepsychiatric evaluation via contracted services with the state. There is no value-add to the offender by being brought to the ED for a non-emergency, and substantial cost to the legal system, the medical system, and patients actually requiring emergency care.
03/14/2026 05:16 PM	Involuntary ckmmitment sa Charles Wagoner	3129 Millstone Dr , Gastonia, N.C			It's a shame that Mentally ill are being held in county jails without medical treatment and left for their health to decline !! Put money into building hospitals to treat those precious souls ! Thank you !!
03/16/2026 10:08 AM	Executive Director Fran Charlton	199 Larch Ln, Greensboro , NC 27406	Guilford	fcharlton08@yahoo.com	Emergency Departments across North Carolina are consistently dealing with overcrowding, long waits, high acuity, and workplace violence from existing patients. Our goal is to care for patients as timely as possible. Iryna’s Law as currently written will exacerbate our issues causing patients who need our care to wait even longer. Violent offenders should not be in our EDs just because unless they truly need emergency care. Please find another way-our EDs are already in crisis. We often have Behavioral Health patients waiting weeks and months in our EDs for placement because there aren’t enough facilities across the state. Please tour local EDs to understand our issues before passing this bill.
03/16/2026 10:58 AM	Dr. Jessica Auslander	3820 Litchfield Dr, Waxhaw, NC 28173	Union	Jessica@pwmnc.com	I am a licensed clinical mental health counselor (LCMHC) and licensed clinical addiction specialist (LCAS). I would like to make two brief comments regarding involuntary committment: 1. Those with my license type are not allowed to engage in this process. When I have someone indicating self-harm I either have to hope they or their family members will take them to an emergency room, or I have to involve another party (HS, law enforcement, etc...). I treat gambling disorder, which has the highest rate of suicidality of any other diagnosis. 2. We do not have the resources to handle all of the crises we are seeing. There are not enough providers/facilities where people can get help safely, and NC still allows for lower reimbursement for mental health care as compared to

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					physical health. We would have more providers if we were paid a sustainable wage comparable to our education and training. I have a PhD but can only be paid on a Master's level... just because the insurance companies can. All hospitals, ERs and Urgent Cares should have mental health resources. I should not have to send my patients hours away when they could be better supported close to home. Thank you, Dr. Auslander
03/16/2026 04:06 PM	Mrs Jennifer Kennedy	72 South Vista Drive, Hendersonville, NC 28739	Henderson	wizardesslyn@gmail.com	I have been a PMH (Psychiatric Mental Health) RN since 2001. I have an MSN in nursing education. In that time, I have seen funding for mental health decrease year by year. We are currently in a mental health crisis in this state. We do not have enough educated staff that are PMH nurses. We do not have enough beds for patient's that are older or those that are younger. Patients are sitting in the ERs for days at a time, weeks, some even months, waiting for a bed to be opened. We need more trained personnel that understand the complexities of mental health nursing. We need more beds to take care of our mentally unwell children and elderly. Why is this not a priority? Now with the Federal government changed nursing to state that it's not a profession, how will students get funding to go to become a nurse? We are already short of staff, we need more nurses, not less. Patients become restless sitting in an ER room for days on end and become violent with nothing to do. This is not good treatment, as they are not getting any mental health treatment in the ER. Please find the funding to help our PMH patients and for us to train more PMH nurses. Thank you, Jenn H. Kennedy MSN, BSN, RN, PMH-BC
03/17/2026 02:56 PM	Mary Ann Williams	4012 Martins Point Road, KItty Hawk, NC 27949	Dare	info@threedogink.com	Thank you for the opportunity to share my family’s experience with North Carolina's mental health system. I understand the challenges many face, including frequent hospitalizations, a lack of providers, and the high cost of necessary treatments. It appears the current focus remains on the "endgame"—where individuals with mental health issues unfortunately transition into the justice system. My husband and I are 75 years old and are currently raising our 14-year-old grandson under a Chapter 50 custody order. He has autism and comorbid diagnoses resulting from being born addicted, which required an extended NICU stay. While we sought every possible service during his early years, we found that even the most economical solution—early

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					intervention—is a lost opportunity when service providers are unavailable. Our experience with the school district has been equally difficult. Despite having an IEP since age four, my grandson was eventually excluded from public school after the third grade and has missed three years of education. We faced delays, denials of testing, and a lack of support in Eastern North Carolina. It became clear that the district prioritized legal fees over creating necessary programs, often leaving families to move away or seeing children enter the juvenile justice system. While my grandson has had encounters with the police, he has not yet been arrested. Based on our journey, I offer the following recommendations: - Early Identification: Identify children who need help early and establish a comprehensive history of their needs. - Integrated Services: Combine Health and Human Services with educational delivery to ensure a holistic approach. Medicaid and funding opportunities for treatment. Community support for children with disabilities. - Adherence to IDEA: Ensure school districts follow the Individuals with Disabilities Education Act. If a district has an attorney then someone from the Dept. of Ed should supervise the process. An outside agency or individual will support and help families through the IEP process and knowing their rights. - Fund more schools that specialize in Children with disabilities including housing. - Provider Support: Pay service providers appropriate fees to ensure availability. - Family Support: Provide resources to help entire families, including siblings, cope with these challenges. Families should not have to hire an attorney to receive the help that their children need. The ultimate goal should be to keep individuals with disabilities and mental health needs out of the justice system. This is the most expensive and ineffective treatment. Jail is the last place they should be. If you desire further, in-depth information of our experience with the school district, social services , mediation and legal encounters, and navigation of mental health services please feel free to contact us.
03/18/2026	LCSW Cameron	319	Orange	Equineassisted@yahoo.com	My current understanding is that mobile crisis is not available

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10:33 AM	Burleson	SHAMBLEY Rd., Mebane, North Carolina 27302			to every county and the limitation to individuals not covered under Medicaid . Also, you have to contact mobile crisis directly. It is not accessible through 911 unless a responder informs mobile crisis themselves. There are also questions about mole, crisis, access, and rural communities
03/19/2026 12:26 PM	Disability Rights NC Corye Dunn	801 Corporate Center Drive suite 118, Raleigh, NC 27607	Wake	CORYEDUNN@GMAIL.COM	Disability Rights NC respectfully submits the following: Dear Committee Members and Chairmen, Thank you, again, for your willingness to investigate and work to repair our flawed IVC and public safety systems. As you know from our prior communications to this committee and from years of working together on this and other issues, Disability Rights NC is here to partner with you in your work as it affects people with disabilities. Today's committee meeting included opinions about the role of Disability Rights NC in the mental health space that require clarification. We are your federally mandated advocacy group – here to support people with disabilities, including mental illness, but also developmental disabilities, sensory disabilities, mobility impairments, traumatic brain injury, and every other type of disability you can name. Our mandate requires us to ensure NC complies with federal laws – in this case, allowing people with disabilities to get their services in the least restrictive setting appropriate for their needs instead of forcing them into a facility like a nursing home or hospital simply because nothing is available in the community. This does not mean we think everyone can and should live in the community. Like you, we want more mental health services, not fewer. We do not close treatment options – we advocate for more, because we know firsthand that we do not have enough services. That is one reason that we advocated to delay closure of Dix Hospital – we knew there were not enough community services available, and the new hospital was not yet safe. Almost two decades later we still lack adequate community-based services. That's also why we fought to open schools during the COVID pandemic – students with disabilities need to attend school to access the services they need. The only times we have advocated for the closure of mental health services is when they were not meeting their legal obligations, notably private facilities that engaged in significant abuse and neglect of people in their care while billing our state's Medicaid program. This advocacy saves lives, and we will continue to monitor and report to state agencies on these facilities. We have never advocated for closure of state operated facilities. In fact, we

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					have noted repeatedly that unstaffed beds in state hospitals are a critical under-utilized resource, and beds that are filled with people who are ready for discharge but lack adequate community resources to be discharged safely are a drain on our mental health service system. We fight for cost-effective measures and look hard at the numbers. Why is it that 70% of people discharged from EDs following a suicide attempt do not access treatment after discharge? Why is it that 83% of people with mental illness do not receive any mental health care after admission to jail? We need data collection to determine which programs actually help to prevent crisis and hospitalization, and to determine how many costly inpatient admissions could be avoided if the right services were available. And we do not need to reinvent the wheel; we want reproduction of proven, effective interventions such as the HEART program (funded as a pilot by NCGA), LME/MCO flexibilities for enhanced rates, and peer-run crisis programs such as Promise Resource Network (PRN) respite homes and peer-run warm line to divert people from more expensive interventions and save the scarce, intensive mental health resources for those who need it. We are here to help you find common sense solutions, and that is exactly why we have a dedicated policy team willing to partner with you. We greatly appreciated the presentations today, especially from UNC and from Cicero. The UNC speakers underscored what we have seen in issues of competency, capacity, and commitment. Also, we agree with Dr. Sharp from Cicero that, like other states, we should continue to leverage our 1115 waiver programs through Medicaid Managed Care to support the mental health crisis. However, contrary to Dr. Sharp's point on youth, we have found that NC's youth do have serious mental illness. We monitor in juvenile facilities regularly and see children with serious mental illness, both in carceral settings and in treatment facilities. In fact, from 2011 to 2020, youth suicide rates in NC increased 103%. We are happy to provide the publicly-available parts of our monitoring in youth facilities if you would like examples. Again, we hope that this letter clears up our role and our position on these complex issues. Please feel free to use our team as a resource at any time. In partnership,

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					Corye Dunn Director of Public Policy Tara Muller Policy Attorney
03/22/2026 06:13 PM	David Cook	1812 Hunting Ridge Road, Raleigh, NC 27615-5512		davidacooknc@gmail.com	The Clubhouse model community-based treatment programs for adults with severe and persistent mental illness has been shown to significantly reduce the need for Involuntary Commitments. Increased funding through a Medicaid definition for the Clubhouse model and recurring funding from the General Assembly are important steps toward that goal.
03/25/2026 11:28 AM	Katy Kranze	222 N Person Street, Suite 012, Raleigh, NC 27601	Wake	kkranze@ncpsychiatry.org	The North Carolina Psychiatric Association (NCPA) appreciates the opportunity to provide comments, we have emailed a copy of our full comments. We represent nearly 1,000 psychiatrists who provide care in hospitals, community clinics, private practices, emergency departments (EDs), jails, and state facilities. Recent events highlight gaps in the behavioral health (BH) system and underscore the need for reforms that protect public safety while preserving clinical judgment and patient rights. It is critical to recognize that increasing front-end demand for IVC—without investment in treatment capacity and community services—will exacerbate existing system strain. EDs already experience significant psychiatric boarding; additional demand may delay access to care, worsen outcomes, and undermine patient and public safety. We offer the following recommendations: Reevaluate the 3-Year Lookback Period for Violent Offenses Serious violence is difficult to predict, and IVC is designed to assess current risk of harm based on recent behavior and clinical presentation. Iryna's Law includes a 3-year lookback for violent offenses when determining need for IVC evaluations. This timeframe is overly broad and could lead to unnecessary evals that strain limited emergency psychiatric resources. Research suggests risk of violence is highest immediately following hospitalization or acute crisis, rather than years later. Policymakers may consider whether a 1-year lookback would better target those at highest risk while minimizing unnecessary evals for those who do not meet clinical or legal criteria at assessment. Expand Telepsychiatry Options for Initial Evaluations Iryna's Law requires evaluations to occur in EDs or crisis facilities. EDs are already experiencing significant psychiatric boarding. Allowing telepsychiatry evals will reduce strain on

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					EDs and shorten the time gap between court order and assessment, thereby reducing risk to the public. Telepsychiatry has proven effective in other forensic and competency eval settings within the state hospital system. IVC examiners should be assured they have all relevant information to make assessments while still complying with confidentiality. Establish Uniform Standards for MH Screening and Treatment in Jails NC law requires MH screening at jail intake (Session Law 2007-323, HB1473), but implementation varies across counties. Standardization would help ensure individuals with SMI are identified early and connected to care regardless of location. NCPA recommends statewide standards for: MH intake screening, access to psychiatric treatment, and coordination of care upon release. Improve Coordination Between Jails and Community BH Services. A frequent concern is the "revolving door" between jails, hospitals, and the community, driven by gaps in coordination between BH and the criminal justice system. Strengthening these connections is essential to improve outcomes for justice-involved individuals with mental illness. NCPA recommends strengthening processes to ensure transfer of care at release, including connection to outpatient providers, access to case management, and coordination with community treatment teams. Improved coordination can also support diversion by connecting individuals to treatment earlier and reducing unnecessary justice involvement. Session Law 2007-323 identified LMEs as responsible for coordinating with county public health departments and sheriffs to support individuals with MH needs. However, it is unclear to what degree these requirements have been consistently implemented. NCPA recommends lawmakers review implementation of Section 10.49.(f) of Session Law 2007-323 to assess compliance and develop enforcement protocols to ensure consistent coordination between LMEs, local health departments, and law enforcement. Continue Diversion, Deflection, and Capacity Restoration Programs Strengthening diversion and deflection programs is critical to ensuring individuals with SMI receive timely treatment while improving public safety and reducing strain on EDs, hospitals, and correctional systems. Expanding access to BH treatment

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					and supports can stabilize individuals earlier, reduce repeat crises, and decrease likelihood of justice involvement. The state should continue expanding capacity restoration programs for individuals found incapable to proceed, building on pilot programs. Historically, restoration services have been provided primarily in state hospitals, contributing to long wait times and system strain. Increase Access to Psychiatric Beds NC continues to face shortages of staffed inpatient psychiatric beds and intensive community services. Expanding access to beds—while addressing workforce, staffing, and community services—is critical to strengthening the MH system. NCPA supports efforts in EO 33 to expand recruitment, improve hiring/retention, and address workforce shortages impacting BH and public safety. NCPA supports meaningful investment in the state hospital workforce, including substantial increases in nursing compensation (=15%) to improve recruitment and retention. Without competitive salaries, hospitals cannot staff existing beds. Strengthen and Enforce Outpatient Commitment NC has a statutory framework for involuntary outpatient commitment allowing courts to order structured community-based treatment. However, outpatient commitment is rarely used, in part due to unclear accountability following the transition to the LME/MCO system. While IVC is a tool for managing acute psychiatric dangerousness; outpatient commitment is a tool for individuals with SMI who have a history of treatment nonadherence, repeated relapse, hospitalization or deterioration when not engaged in care. Experience in other states shows that it is only effective when carefully implemented, combined with appropriate, intensive community services and extended for 6+ months. NCPA recommends outpatient commitment implementation aligned with APA guidance: • Outpatient Commitment should be available in a preventative form for patients who may not be currently dangerous to themselves or others but whose relapse will likely lead to severe deterioration and/or dangerousness. • Available to those who as a result of their mental illness are unlikely to seek or voluntarily adhere to needed treatment. • Include an initial commitment period of 180 days, permitting extensions based on criteria determined at regularly scheduled hearings. Expand Community Mental Health Services

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					Strengthening community MH services is essential to reducing crises and justice system involvement. Many individuals have co-occurring MH and SUD requiring integrated care. These services stabilize individuals and prevent deterioration leading to hospitalization or incarceration. NCPA supports expansion of the BH crisis continuum, including mobile crisis, BH urgent care, and 988-aligned services, to ensure psychiatric crises are managed as health conditions rather than law enforcement events. We recommend continued expansion of: Assertive Community Treatment (ACT) teams, Forensic Assertive Community Treatment programs, Formerly Incarcerated Transition Program, case management, first episode psychosis programs, supportive housing services, and dual diagnosis services. Ensure Continuity of Medicaid Coverage Maintaining Medicaid coverage is essential for individuals with SMI to access treatment. Medicaid is the primary payer for BH services in NC, including outpatient psychiatric care, therapy. ACT, an SUD treatment that help stabilize individuals and prevent crisis. Ensuring continuity of coverage improves engagement and stability, reduces systems strain, and prevents avoidable crises. Strengthening NC's BH system requires a balanced approach that addresses public safety while ensuring individuals with serious BH disorders receive appropriate, timely care. NCPA appreciates the Committee's attention and stands ready to serve as a clinical resource.
03/25/2026 03:13 PM	Dr. Kathy Hotelling	271 Fearrington Post, Pittsboro, North Carolina 27312-8556	Chatham	kathyhotelling@gmail.com	Missing piece of consideration for those cycling in and out of emergency departments, mental health treatment facilities, and jails: Prenatal Alcohol Exposure (PAE) Estimates suggest roughly 1 in 7 women drink at some point during pregnancy. Many stop once they know they are pregnant, but any PAE, even early in a pregnancy, can have effects potentially resulting in Fetal Alcohol Spectrum Disorder (FASD). The conservative prevalence of FASD is 1 in 20 (2018, May et al.). This means an estimated 524,400 of 10.49 million of the North Carolinian population could be impacted by FASD and of 118,700 babies born annually, over 5,900 have FASD. The visible manifestation of FASD is behavioral symptoms. These symptoms lead to the assignment of many mental health diagnoses and ineffective treatment approaches. FASD is a brain-based developmental disability, not a mental health condition. Only 10% of those with an FASD are properly diagnosed, leading to cyclic involvement of

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					these individuals in our systems of care. We know that those with FASD have higher rates of placement in foster care (1 in 5). Secondary characteristics of FASD are mental health problems (90%); dependent living (80%); problems with employment (80%); victims of physical/sexual abuse or domestic violence (72%); disrupted school experience (60%); inappropriate sexual behaviors (50%); confinement in jails/ prisons (50%); alcohol & drug problems (30%). The estimated annual cost to NC is over $6.49 billion in special education, residential care, correction costs, health care, and productivity costs. North Carolina must recognize this public health crisis and move proactively. The time is right. This committee has an opportunity to address this issue in deliberations. It also has the opportunity to support the establishment of an NCFASD Advisory Council, which would be responsible for administering the funds which will be forthcoming as a result of the passage of the Reauthorization Act passed at the end of 2025 by Congress and signed by the President. This Act included language pertaining to FASD. NC will receive NO dollars if we do not have this Council. Respectfully, I ask you to carefully consider what I have presented. The time is clearly now. Kathy Hotelling, Ph.D., ABPP Retired Clinical Psychologist Co-Founder and Board Chair of NCFASD Informed, Inc.
03/25/2026 04:20 PM		Durham, NC 27705	Durham		I work directly with North Carolinians living with serious mental illness, and I want to highlight several urgent needs that directly affect safety, treatment outcomes, and the long-term sustainability of our behavioral health system. 1. Address housing instability as a core mental health issue: Housing is not separate from treatment—it is treatment. Many individuals cycle through hospitals, jails, and homelessness because they have nowhere stable to go. North Carolina needs more affordable units, supportive housing, and bridge housing options so people can safely transition out of crisis settings. 2. Fully fund Medicaid and increase provider reimbursement rates: Medicaid is the backbone of our behavioral health system. Providers cannot sustain services when reimbursement rates do not match the actual cost of care. Rate increases are essential to keep clinics open, retain qualified staff, and expand access to community-based services that prevent

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					hospitalization and incarceration. 3. Invest in the direct care workforce: Our system cannot function without the people who provide hands-on support every day—nursing assistants, techs, peer support specialists, case managers, and frontline behavioral health staff. These workers need competitive wages, ongoing training, and safe staffing ratios. Without this investment, we will continue to see turnover that destabilizes care, increases safety risks, and undermines treatment. 4. Expand whole-person, community-based supports. Medication alone is not enough. People need: Case management Peer support and social opportunities Psychosocial rehabilitation Employment and education supports Transportation Skills training Family and caregiver support 5. We need a structured, statewide effort to identify where people fall through the cracks. This should include: Reviewing transitions from inpatient to community settings Identifying service deserts Evaluating workforce shortages Recommending sustainable funding models. and more I also encourage the legislature to explore a structured, court-ordered process for individuals who have engaged in violent behavior related to untreated mental illness, ensuring they receive mandated treatment and monitoring in the community. When designed carefully and paired with strong community supports, this type of outpatient commitment can improve safety, reduce repeated crises, and help individuals maintain stability outside of the hospital. These services keep people stable, connected, and safe in their communities. When they are missing, the entire system—from emergency departments to law enforcement—absorbs the consequences. North Carolina has an opportunity to strengthen public safety and improve outcomes by investing in the full continuum of care—not just crisis response. With adequate funding, a trained workforce, stable housing options, and a coordinated system of community supports, we can reduce

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					hospitalizations, prevent avoidable murders (and subsequent life institutionalization for the perpetrator), and help people live safely and successfully in their communities. Thank you for your attention to these critical issues.
03/26/2026 01:37 PM	Melissa Martin	220 Wimbish Rd, Eden, NC 27288-7670	Rockingham	Martinm49@mail.com	Help people! Not your pockets
03/28/2026 05:01 AM	D S	405 NC Hwy 210 Apt 102, Smithfield, NC 27577	Johnston	jodecie2@gmail.com	I think we need Behavioral Health Urgent Cares (BHUC) in each county to hopefully try to catch those in mental health crisis before they harm themselves or others. We also need to build long term psychiatric hospitals similar to Cherry Hospital for those who can't live in the community. Those should have never been closed. More group homes for those with mental health conditions could also be part of the solution. And of course the pay for those who work at mental health facilities needs to be higher so any of these ideas could work. Pay is currently severely too low.
03/28/2026 11:05 AM	Michele Daniels	683 Mr Henry Road, Mocksville , North Carolina 27028	Davie	Mchelyd1@gmail.com	I support any law that protects our citizens from mental health individuals harming citizens BUT these IVC pts do NOT belong in EDs. I am a NM of a Peds ED and we are already overrun with BH pts to the point we cannot provide adequate care for emergent medical conditions. Please build IVC facilities or support multiple Psych EDs across North Carolina. I am Ashamed at how poorly NC has responded to the mental health crisis. YOU as lawmakers should be ASHAMED of the inadequate resources for children in NC. YOU MUST do better NC
03/29/2026 03:31 PM	David Westmeyer	107 Oak Tree Dr, Chapel Hill, NC 27517	Orange	daowest@gmail.com	I left psychiatric nursing in 2024 after working on a psychotic disorders unit at UNC Medical Center and then as a case manager for an ACT Team in Durham. I also saw parts of the system from the 'other side of the glass' as a dual-diagnosed adolescent/young adult in and around 2001. I left psychiatric nursing to work in hospice after finding the system to be broken. I was witness to the tragically unfortunate revolving door and subsequent poor outcomes that lead patients to lose all faith in themselves and in the system. There are major shortcomings in the nursing curriculum. To be licensed as an RN, one only takes half a semester to brush over psychiatric nursing which is relevant in any nursing unit while being mandated to spend an entire semester in labor and delivery which affects patients on L&D units almost exclusively. In other words, I use psychiatric nursing skills during every shift as a hospice nurse and have never once needed to rely on what I learned in L&D.

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					The psychiatric RNs at UNC were not trauma-informed and would often make fun of patients (sometimes in front of them) for exhibiting symptoms of trauma such a somatization or constriction. Substance abuse and addiction were almost entirely ignored with there only being a single one-hour voluntary group on relapse prevention per week, a topic usually reserved primarily for the last phase of inpatient treatment for drug addiction. Patients were too easily involuntarily committed for long durations and forced to take harsh first-generation antipsychotics without proper monitoring and treatment of extrapyramidal symptoms like akathisia. I ultimately left UNC because I personally faced retaliation for reporting emotional abuse claimed by two patients against an employee with a pattern of aggressive behavior. That employee did not face consequences while I became professionally isolated in a toxic work environment. The patient support team also seemed to not respond effectively to complaints by the patients because of contempt prior to investigation. Patients on our hospital unit and those served by my ACTT did not have access to psychotherapy although the psychiatrists and social workers might claim that is not the case. CBT is within the scope of the RN but no one was trained to do it. The occupational therapists did the most to meet the patients where they were. They were the only staff that could consistently build rapport. Improving outcomes and reducing the stigma for this population is going to take years or decades of reform. Even if we offered unlimited access to resources, it will not matter so much if that includes HCW's who lack fundamental education about trauma and addiction. I hope these new efforts by the government can help end some of the complacency and bring about lasting change.
03/30/2026 10:37 AM	Dr Jeremiah Gaddy	1 Medical Center Blvd, Winston Salem, NC 27103	Forsyth	jeremiahgaddy@gmail.com	I support the goals of improving public safety and preventing tragedies. I commend the NC House of Representatives for tackling the significant mental healthcare gap in our state. That being said, using the emergency department because of its 24/7 access for a non-emergent, court ordered mental health evaluation carries a significant cost to the patients needing emergency care, the healthcare staff, and the North Carolina public. There is a significant difference in the spirit of the law between an IVC and what Iryna's law is requesting. Traditionally, an IVC involves bringing a patient (often by law enforcement) for an evaluation because of the imminent

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					concerns for the safety of the patient or others. It restricts the rights to move about society because of this imminent concern of threat. There is by definition a time sensitivity to this concern. Iryna's law is different in that a patient who is already in police custody and charged with a violent crime and has a history of IVC is to go to the emergency department. This person is in police custody and therefore does not represent the same threat to society or themselves. Already, emergency departments across North Carolina are overwhelmed by behavioral health boarding, with patients—often including children—waiting days or weeks for appropriate placement. Expanding the use of EDs for judicial evaluations of medically stable individuals with a history of violence will worsen overcrowding, increase risks to patients and healthcare workers, and divert critical resources from true emergencies. It will also place additional strain on law enforcement, keeping officers out of their communities for extended periods. Judicial evaluations should instead be conducted through telepsychiatry or in appropriate behavioral health settings. North Carolina's existing telepsychiatry infrastructure provides a proven, scalable solution that can deliver timely evaluations while improving safety and efficiency. The vast majority of the psychiatry consultations in NC emergency departments are from a telepsychiatrist so this would not degrade the evaluation they would receive in an emergency department. By expanding telepsychiatry, investing in crisis and behavioral health alternatives, and strengthening coordination across systems, North Carolina can implement Iryna's Law in a way that protects both public safety and patient care. Emergency physicians and elected representatives share a common thread of upholding an oath to serve our communities. We believe there is a way to do this together and respectfully request your collaboration on this issue by considering the proposed solutions. Thank you.
03/30/2026 11:27 AM	Ms. Martha Turner-Quest	9660 Falls of Neuse Road, Ste. 138,PMB176, Raleigh, North	Wake	martha@ncpsychology.org	Submitted on behalf of the NC Psychological Association. The full document will be emailed to Ms. Boney. The North Carolina Psychological Association ? Supports a more robust and sophisticated system of

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		Carolina 27615			intervention for people with severe mental illness, ? including those who are involved with the criminal justice system. ? Iryna's Law is a step in that direction, but since it places additional demands on systems that are already overloaded, ? those systems should be funded fully and thoughtfully. ? This includes not just hospital-based care, but also expansion of pilot programs to restore defendants' capacity that are based in local detention centers.
03/30/2026 02:16 PM	BJ Millen	PO Box 604, LOWELL, NC 28098	Gaston	bj3jmiln@hotmail.com	I have an acquaintance who was brought to the hospital on an IVC hold after a meltdown and placed in a hospital room. They are functioning well, friendly and courteous to staff, handling their bills, and demonstrating capabilities showing they can life well at home, but unable to leave. Because they went from the ER to a hospital room (thus a civil IVC hold) their due process rights are non-existent. They committed no crime and have fewer rights than those in criminal custody. There are virtually no safeguards to their deprivation of their liberty. This equates to Constructive Incarceration in a hospital setting. It's De facto Custody without prompt judicial checks. This hospital functions as if the person is incarcerated and mirrors prison conditions but is labeled medical. They need to be provided with an attorney, a hearing date, and paperwork. Thus far, they have been held over 7 weeks with no answers. Had they committed a criminal act, they would have had their due process rights and faced a District Court judge. When IVC due process is deferred for weeks, the hospital becomes a site of CONSTRUCTIVE INCARCERATION: state-mandated loss of liberty under medical guise without the prompt judicial protections the Constitution demands. Rights MUST be restored to those rotting in hospitals under civil IVC holds. The hospital facility just shrugs off any concerns. I never realized how toxic medical facilities could be. Due Process rights MUST be granted to ALL IVC HOLDS, not just those charged with a crime. Fix this. Our NC laws and statutes shouldn't allow this. The US Constitution doesn't.
03/30/2026 03:39 PM	Ms. Ashley Snyder Miller	2012 Winding Ridge Court, Winston-Salem, NC 27127	Forsyth	ASnyderMiller@gmail.com	When I was a sophomore in my Spring semester of college, I began experiencing textbook symptoms of what I assumed at that time was Major Depression. I saw a school counselor and was prescribed an antidepressant, but I struggled extensively with cognitive distortions, crippling low self-esteem, suicidal ideation, and insomnia among other serious

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					symptoms. Over the next few years, I tried a host of psychotropic medications along with Cognitive Behavioral Therapy, but my moods would often fluctuate and my attention span would vacillate between hyperfocus and absent-mindedness. I experienced heightened episodes of anxiety along with several panic attacks. During this time period, I often felt hopeless and alone despite having the privilege of a strong support system. I frequently convinced myself that the world would be better off without me, that I was devoid of a purpose and was little more than a burden to my family. In my late 20's, a thorough and compassionate psychiatrist ordered testing for me and together with that team of clinicians, I received accurate diagnoses of Bipolar Disorder II, Generalized Anxiety Disorder, and Attention Deficit Disorder, Inattentive Type. While having accurate names for what was going on with me is helpful, my journey continues. I've experienced many psychotropic medication changes and therapeutic pursuits all in an attempt to manage my disorders in a healthier manner. One of the most grueling and devastatingly unsuccessful treatments that I tried was electroconvulsive therapy. While mainstream statistics state this is an effective therapy, my personal experience with it caused me to permanently lose a good portion of my long term memories, memories of my early 20's, memories I will never regain. The loss of the memories served to exacerbate feelings of inadequacy and I believed that I had lost some of my mental acuity. Fast forward to today and I can attest that I have learned an extensive amount about my disorders and how to manage them. I know that I will always need psychotropic medications, a therapist who I connect with, and community resources like support groups. Having a mental illness is not really that different than if I suffered from a malady such as heart disease or diabetes. I also consider myself highly fortunate because I have support in my life, especially my "will-not-take-no-for-an-answer" mother. Many people with similar lived experience to my own do not have advocates on their behalf. Someone has to be a voice for the voiceless. In regard to the House Select Committee on Involuntary Commitment and Public Safety's purpose, I want to emphasize the great need for incentivizing more Medicaid providers across the state. I live in Winston-Salem, but as a recipient of the Tailored Plan, I was only able to find an ophthalmologist in Chapel Hill, a dentist in Mebane, and a psychiatrist in Greensboro. That is less than ideal, but I have to work within the confines of my health insurance. The

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					providers that Partners helped me identify in my own geographic area were no longer accepting Medicaid patients. Thus, the need to travel to other areas for care. Secondly, the need for more Crisis Centers in North Carolina is paramount. There have to be more options than emergency rooms for those in psychiatric crisis. Crisis Centers have provided me with assistance on several occasions and have been a godsend to me on my management journey, but there are not enough of them. Further, it is essential that law enforcement responding to mental health crises via 911 calls have ideally been trained in Crisis Intervention Team Training at the very least. Forsyth County has the good fortune of having the BEAR team (Behavioral and Evaluation Response Team) and it consists of a director and six crisis counselors who typically respond to Mental Health and Substance Use 911 calls within half an hour. This is a pilot program in the county. Further, the length of stay of some individuals stuck in an Emergency Room who need acute Mental Health care in a hospital setting is an urgent need in North Carolina. I am appreciative that Governor Stein is aware as evidenced by Executive Order 33 that the wait times for appropriate, symptom addressing hospitalization is too long currently due to lack of beds, lack of staff, etc. Hospitalization times are often ineffective for many patients with long term Mental Health care needs. These individuals need more than a three-five day stay to address their needs. I have been hospitalized over weekends before only to see the same individuals discharged on Friday return to being inpatients on Monday simply because their needs were not properly addressed during their initial hospital stay. In addition, how we transport individuals in crisis from an Emergency Room to a hospital in another county/city (for example) is a major issue of concern. Fifteen years ago, I was transported from the ER at Forsyth Medical Center to Frye in Hickory by a sheriff's deputy and not only was I handcuffed in the back of a police car for the transport, I was shackled. That was inhumane and I know I'm not the only individual who has experienced such treatment. (I've never even seen mass shooters apprehended with shackles before!). We as a state have to understand that how we treat the "least of these" matters. In summation, I hope that my comments have helped to shed light on what someone with Serious and Persistent Mental Illness may have to endure to get diagnosed and receive appropriate care. When others find out some of my story, I often hear: "well you don't look like you have any of those issues." To that I ask, 'what is a person with a mental illness

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					supposed to look like?" I think maybe the answer is a little like me. I leave you with profound words from French writer Albert Camus: "In the depths of winter I finally learned that within me there lay an invincible summer. And that makes me happy. For it says that no matter how hard the world pushes against me, within me, there's something stronger - something better, pushing right back." Thank you.
03/31/2026 09:12 PM	Mrs Michelle Viccaro	4105 Kincaid Dr, Raleigh, North Carolina 27604	Wake	dmrviccaro@gmail.com	Dear House Select Committee on Involuntary Commitment and Public Safety, thank you for the important bipartisan work you are doing. I have been watching closely. I was the parent and caregiver to a young adult son with SMI. We tried so hard to help him get real treatment but ran into one barrier after another. Days after Iryna Zarutska was killed, my son died in accident while he was under an IVC that I petitioned. He was 21. I understand the committee's charge and it is not small. I am advocating in support of all the individuals and families suffering from untreated/undertreated severe mental illness. An increase in IVCs under Iryna's Law will be useless until they result in appropriate care. The specialized and intensive level of in- and outpatient treatment that individuals with SMI require is unattainable to most North Carolinian's that are in need. We must rebuild the foundations of care. Until then, IVC processes will remain a road to nowhere. Recommendations that I support: • Urgently fill staff vacancies to open the closed state psychiatric beds. And add new beds. • Implement a robust statewide AOT program. "Dismiss Upon Civil Commitment" with AOT is one alternative to the competency restoration crisis. Treatment Advocacy Center has detailed information about this. Florida, Ohio and Texas have it in practice. • Do not continue to allow the symptom of anosognosia (lack of insight) to be a barrier to treatment. It amounts to inhumane, institutional neglect. "People living with schizophrenia can thrive with proper treatment and care.." -Gordon Lavigne, CEO of the Schizophrenia & Psychosis Action Alliance. • IVC processes must leverage "in need of treatment in order to prevent further disability or deterioration" without the additional qualification that states "that would predictably

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					result in dangerousness.” By requiring an individual to decompensate to the point of dangerousness at any point (past, present or future), the situation is almost guaranteed to become a public safety risk. • Improve HIPAA training for providers. “Healthcare providers rarely use allowable HIPAA exceptions for people with schizophrenia, leading to disastrous consequences. Misinterpretations of HIPAA and/or fear of lawsuits can lead to an overcautious approach in which healthcare providers refuse to share information with caregivers, even when it could be critical for optimal patient care. In some cases, this results in terrible consequences for both patients and their families, including lower-quality treatment, deteriorating physical health, increased risk of harm to the patient or others, emotional distress and in the most harrowing cases, homelessness and suicide. The intention behind HIPAA was not to obstruct care coordination and endanger patients, or to prevent families from getting information they need to care for their loved ones. When refusal to provide (or accept) critical health information about a patient results in worsening illness, homelessness or even death, HIPAA has been used inappropriately and has harmed those it is meant to protect. In certain circumstances, the most medically beneficial and compassionate move may be to share information with family members/caregivers, even without consent from the person with schizophrenia.” - Treatment Advocacy Center • Many things must change with NC’s 24-hr facilities. They are failing our citizens with SMI and profiting from the revolving door that our systems and policies have installed for them. • End discharges to homeless shelters. The legislative work you are doing is important and the need for change is dire. So many people are suffering and we must do better. Thank you for your help. I look forward to change. Sincerely, Michelle Viccaro Raleigh, NC
03/31/2026 10:02 PM	Robert Ward	4728 Saxonbury Way, Charlotte, NC 28269-9402	Mecklenburg	robert.ward.nc@gmail.com	My name is Robert Ward. Thank you for the opportunity to provide a statement to this Committee on how to better understand and improve the involuntary commitment (IVC) process in North Carolina. I began the practice of law in 1982 and in 1986 joined the Mecklenburg Public Defender’s Office

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					where I remained until I retired in 2023. My professional career has provided me with a wide range of experience in both civil and criminal law. I can provide more information upon request. In addition to working in traditional areas of the practice of law, I've had substantial experience in the legislature with reform efforts such as Structured Sentencing and Drug Treatment Courts. I was part of the team that implemented the first Drug Treatment Court in North Carolina in 1995. I was a member of the Administrative Office of the Courts' State Guidelines Committee for Drug Treatment Courts (1995-2005) that helped to implement courts throughout the state. Continuing my efforts to advocate for people and to help with systemic reform, I became the IVC attorney full time in 2012 at the Mecklenburg Public Defender's Office until I retired. In 2016 I was part of the group that implemented the Crisis Navigation Project, which sought to empower people statewide with Psychiatric Advance Directives and Psychiatric Health Care Powers of Attorney as a means to avoid IVCs if possible. A famous quote that I believe applies to IVCs and Mental Health in NC and elsewhere is "every system is perfectly designed for the results that it gets." The IVC system is not based on an integrated design. It needs a better data and management system, leadership, and institutional commitment towards developing and maintaining a meaningful systemic strategic plan. There is no entity responsible for overseeing the IVC process that is charged with managing it the way the Sentencing Commission helps with understanding and managing the criminal justice incarceration process. There are various sectors that are entities unto themselves, like the Legislature, the Agencies, the MCOs, the Hospitals, the Providers, the Counties, the Cities and Towns, the Non-Profit Providers, the Courts, and so on. The only constant is the patient who meets this invisible web and is expected to navigate it while the "system" does little to provide integrated pathways for the necessary holistic recovery or preventative care. The IVC process is based on a fifty-year-old model that lacks a reliable connection to necessary support services. Holding people in custody and ordering them into treatment where too many of the services are insufficient makes no sense. We have inadequate psychiatric emergency and treatment facilities (as evidenced by extensive hospital boarding). Another problem is how the system separates families. A mother of an eighteen-year-old called me seeking a lawyer help with the medical bills for her son. He went to a hospital in Iredell County and refused to give permission for the doctors to talk with her. This is a frequent problem but in

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					my experience is more a function of our health care system not having a mechanism like Psychiatric Advance Directives in place. Because of the lack of communication, he was there for two months then moved to a state hospital for another two months. She had no idea his location or what was happening. She found out where he'd been after he was discharged. She became his Guardian and then received a bill for his treatment for over $100,000. North Carolina is one of the top five states for involuntary commitment despite the fact that Chapter 122C states that the policy is to promote voluntary treatment. One doctor who worked with my clients told me that he was amazed at how many of his patients were involuntary committed even though they came to the emergency department voluntarily. He said that in Philadelphia, where he previously worked, they had peer support in the hospitals who were able to come alongside patients and help them to voluntarily participate in treatment. He said he only saw a few people on any given week who were involuntarily committed. One contributing factor to the high volume of involuntary commitments is the requirement that a patient be under a court order and law enforcement custody before they can be transported between hospitals. Almost every week I had clients who had no idea they were under an involuntary commitment because they came to the Emergency Room voluntarily. This was very distressing and even traumatizing for them. Another problem is the continued dependence on families and lay people to initiate the IVC. One nurse told me that when she worked in Pittsburgh, professionals were the ones who received the information and filed the paperwork. Diagnosing a mental illness and initiating a coercive legal process for a loved one is highly problematic. It creates trust issues that can cause unnecessary conflict for years. This is clearly short sighted. Why weaken the very family that you'll be asking to support the patient upon discharge? Another problem has been a steep increase in commitments since 2009. One nationally known psychiatrist told me that such a rise indicates a breakdown of community services. Another psychiatrist I know from one of our hospitals told me that it was much easier to commit and individual in North Carolina than where he previously practiced in Pittsburgh. He also said that the patients coming into the NC system, at least in his experience, were significantly more ill than those he saw in Pennsylvania. I started at the Public Defender's Office when the State still had the Willie M system. It wasn't perfect but it worked. They had case managers with specialized training for the program. I wish we had something like it now.

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					Mecklenburg County also had the Continuing Care Division from about 1989 to 2000. The program hired Social Workers to carry a case load of about twenty-five clients to support those with SPMI diagnosis and who needed more supportive care in the community to keep them out of the hospitals and the justice system. People we used to see on a regular basis in the Courts were no longer there. That program was very successful. In 2015 I was at the public meeting in Mecklenburg when the State came and announced that Cardinal Innovations was taking over for Mecklenburg's management service, MeckLink. Officials from the state said that they were now fully in charge of the delivery of mental health services and pretty much shut down what remained of the County's efforts to provide more in depth and wrap around services. Within months I saw a decline in care for my clients, particularly those with SPMI diagnosis. Our families, friends, and neighbors with an SPMI diagnosis need housing, case management, employment assistance (vocational rehab, etc.), counseling and supportive services including the reluctant ones. I have experience working with such clients, particularly in my treatment court work, and it's rewarding to see what the right people and program can do to reach them. We don't need to bring back institutionalization and coercion like some are saying. We need an adequately trained and supported work force for a voluntary system of care with a supportive infrastructure for those who need our help and for those who deliver the services. We need to turn away from an overly coercive and criminalized process towards a continuum of care of the kind that the Bazelon Center, NAMI, and Mental Health Association recommend. I recommend checking out the Disability Rights IVCs Report, NC Health News on Mental Health, Fractured on WFAE, and IVCs on Charlotte Talks as well. I hope there are policies and practices that can help genuinely reform the vision, mission, objectives, and goals of our health care and justice systems. Only then will we have healthier people, the highest and best use of public and private resources, and safer communities.
03/31/2026 10:07 PM	G.R. Wallace	9099 Mail Service Center #ACP 2603, Raleigh, NC 27699	Wake	gwallace22996@gmail.com	As you consider Iryna's Law in North Carolina, I ask that you look closely at what is happening with Severe Mental Illness in our state. What I am seeing is a system that waits. We wait until someone is in crisis. We wait until there is danger. We wait until it is too late. That is not how we handle any other serious medical

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					condition. When a person is in psychosis and cannot recognize they are ill, that is not a choice. That is a medical failure of the brain. Yet our laws treat it as if the person is fully capable of making rational decisions. Families are left to manage situations that are escalating, unpredictable, and at times dangerous, with no real path to intervene early. Law enforcement becomes the default response, which puts everyone at risk, including the person who needs care. I am a veteran. I understand duty, responsibility, and what it means to act before a situation becomes dangerous. We can do better than this. Intervention should happen when psychosis is present, not after harm has occurred. That is where recovery is still possible. That means creating a clear, legal pathway for early intervention, before someone meets a “dangerous” threshold, and ensuring continuity of care so treatment is not stopped the moment symptoms begin to improve. Please act. Waiting for danger is not care. It is abandonment.
03/31/2026 10:34 PM	Ms. Leslie Ewald	48 GREENWOOD FIELDS DR, Asheville, NC 28804	Buncombe	templetonalways@aol.com	The criminal justice system should be the exception instead of the norm for our mentally ill population to be filtered through. I strongly believe we should repurpose an existing closed prison or build state facilities to safely house and treat our mentally ill population who are not safe to be on our streets. What kind of a society are we and what value of human life do we show when we do absolutely nothing to address those who cannot safely receive treatment in our communities and as a result pose a threat to themselves and others? Our jails nor our hospitals are equipped to address long term care that is required for certain illnesses. I know our hospitals are set up to address acute care and we could keep that process to “stabilize” someone to be transferred to a state facility for treatment to be determined. That could include determining length of treatment and gradual reintroduction to society to include families if possible or other stable housing and services with an assigned community counselor. I realize there would be many details in

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					between but when public safety is at stake I strongly believe any hurdle can be addressed.
04/01/2026 02:17 AM	Alisha Fox	335 n center street , Statesville , Nc 28677	Iredell	alishafoxbene@gmail.com	ForLoveNotMoney, Alisha Fox, ADM peace*love*lite
04/01/2026 10:41 AM	Ms. Lisette Nimmons	600 East 4th St, Charlotte, NC 28202	Mecklenburg	lisette.nimmons@mecklenburgcountync.gov	On behalf of Mecklenburg County, we appreciate the House IVC and Public Safety Committee's leadership in reviewing House Bill 307, Iryna's Law, and examining ways to improve public safety and behavioral health outcomes. We strongly support the goals of House Bill 307. At the same time, we respectfully offer the following implementation considerations and recommendations to ensure the legislation can be effectively operationalized at the local level, particularly within high-volume county systems like Mecklenburg County. Access to Prior Involuntary Commitment Records Section (b1) requires judicial officials to determine whether a defendant has previously been subject to an involuntary commitment order. To implement this requirement: • A reliable, real-time mechanism must be established to allow magistrates to access and review relevant civil commitment records, including out of state records for the states that border North Carolina, etc. • This system must be available 24/7, given the volume of after-hours arrest processing. We understand that the North Carolina Administrative Office of the Courts is evaluating solutions. We encourage prioritization of a statewide, integrated system that is accessible at the point of initial appearance. Expansion of First-Level Commitment Examiner Capacity A critical bottleneck in implementation will be the availability of qualified First-Level Commitment Examiners. We respectfully request that the North Carolina Department of Health and Human Services develop a targeted plan to expand capacity, particularly for justice-involved populations. Potential strategies include: • Offering the certification curriculum in condensed in-person or virtual workshop formats • Waiving or subsidizing certification fees • Actively recruiting clinicians with criminal justice or

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					forensic experience • Partnering with counties and managed care entities to identify workforce and funding gaps, including addressing adequate compensation for IVC first exams and exams conducted overnight and weekends Without meaningful expansion, counties may face delays in required evaluations, particularly outside standard business hours. Improving Examiner Availability and Geographic Transparency Currently, DHHS maintains a directory of certified examiners organized by managed care organizations (MCO). However, this structure does not clearly identify where examiners are physically located, or which counties they actively serve. We recommend modifying the directory to include county or regional service coverage, enabling local officials to more efficiently identify available examiners. Role of Managed Care Organizations (MCOs) Managed care organizations already play a central role in maintaining networks of Capacity to Proceed evaluators. A similar model could be implemented for First-Level Commitment Examiners. We recommend: • Requiring MCOs to develop and maintain examiner networks sufficient to meet demand • Establishing response-time expectations for evaluations • Incorporating examiner availability into existing behavioral health infrastructure planning This approach would leverage existing systems and improve accountability. Clarification of Examination Location and Use of Technology We understand that where First Exams may occur is an important issue for the Committee. Mecklenburg County has programs currently in place that could assist in performing the First Exams, including psychologists and eligible clinicians within the Criminal Justice Services Forensic Evaluations Unit and First Exam eligible clinicians employed by the contract healthcare provider in the local detention center. We recommend that with consent of local judicial officials, sheriff’s offices and county personnel, First Exams

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					could occur at jails, arrest processing centers, and detention facilities. Given that all counties are not the same, we would not want it to be a mandate, but an option if all local officials agree that it can be performed effectively and safely. Further, the Committee should consider recommending permitting virtual evaluation, which would be particularly helpful in rural or resource-limited counties. A hybrid model could reduce unnecessary law enforcement transport, improve efficiency, and expand access in underserved areas. Outpatient IVC Enhancements While House Bill 307 primarily addresses inpatient IVC, we encourage consideration of complementary reforms to strengthen outpatient IVC, including: • Extending outpatient IVC periods to 180 days or longer • Expanding access to long-acting injectable medications, particularly for individuals with serious mental illness • Considering structured medication compliance requirements in appropriate cases These measures may reduce recidivism and improve long-term outcomes. Practical Challenges with Delayed Evaluations at Booking Requiring individuals to be transported at booking to hospitals or other facilities for IVC evaluations can create delays in returning them to custody and strain limited resources. In many cases, individuals are stabilized during a short hospital stay and then quickly returned to detention. However, medication compliance in detention is voluntary; and any stabilization achieved during a brief hospitalization is often short-lived. As a result, this cycle can be costly and operationally inefficient; and ineffective in achieving long-term behavioral health stability. A more effective approach would be to conduct IVC evaluations and hospitalizations closer to an individual's release from custody; and utilize outpatient IVC upon discharge to promote continuity of care and improve medication adherence. This approach better supports lasting clinical outcomes while also advancing public safety objectives. Conclusion

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					House Bill 307 represents an important step toward improving outcomes at the intersection of behavioral health and public safety. We stand ready to work with the Committee, DHHS, law enforcement, and the court system to ensure these reforms are implemented in a manner that is both effective and sustainable.
04/01/2026 11:42 AM	Mrs. Laurie Coker	2701 Stockton Street, Winston-Salem, North Carolina 27127		lauracamillecoker@gmail.com	A root problem with mental health care is the challenge of access because 1) stigma and fear and 2) the systems, especially publicly funded ones, are of consequence too complicated for individuals and families to access "upstream." However, with what is being learned about mental health and substance use response around the world, we know there are peer supported models that help people feel emotionally safer and more hopeful about getting help they need. One example are peer operated programs, of which we have several in our state, but which we need many more of. I believe if there were one in every county or two, we would see a decrease in crisis needs, and increase in people engaging in mental health care or substance use treatment, and even support for the neurodivergent who struggle with extreme anxiety and depression at times. Further, the focus of support is on social connection and the individual's recovery of mental health. Medical treatment focuses mainly on symptom management. Mental health challenges (includes substance use) are not merely biologically based so we need to ensure that we are using multiple lenses for support and treatment (a bio-psycho-social-spiritual approach) and not lean only on medication and crisis services and hospitalizations--all of which are extremely costly, industrialized now, and not truly 'person-centered', so to speak. In Winston-Salem we have a hospital diversion program called The Refuge. It is part of GreenTree Peer Support Program. We receive referrals from local hospital clinicians, public safety officers, and other first responder groups. We are able to give people up to three days to get support, rest, nourishment, and hygiene needs met. We also are able to determine, according the individual's wishes, what we can connect them with (often in person with that individual) to move them toward recovery. This may be substance use treatment, housing or shelter (yes, we have actually placed several in housing!), mental health assessment with a local provider, etc. Then they have the social backdrop of the Peer

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					Center to reinforce social connection and HOPE. As a retired psychiatric nurse and the retired director of GreenTree, I can attest that from the data we have kept, such centers are ESSENTIAL and I believe that as they become more embedded in communities, we will see people accessing help sooner because they simply feel safer having the support of someone else who has had similar experiences. This would reduce our overuse of E.D. visits and hospitalizations, saving the most critical treatment for those who need it most. Further, the funding of community based crisis intervention, such as Forsyth County's Behavioral Evaluation and Response ("BEAR") team, provides non-enforcement response yet the team is partnering with other agencies as may truly be needed. The team as well as our mental health E.M.S. team (county) do a bit of street engagement and evaluation. Communities need all these alternatives to purely clinical ones or mainly law enforcement/public safety responses. I am happy to share more about the function of peer operated organizations like GreenTree. I believe they are the critical fabric of support under our rather leaky safety net systems! Thank you for seeking public input.
04/01/2026 01:06 PM	Amanda Martin	1025 w.1st Street, Winston Salem, North Carolina 27101		amartin@greentreepeersupport.org	My name is Amanda Martin, and I am the Executive Director of GreenTree Peer Support Program in Winston-Salem, Forsyth County. I am writing to submit my public comment regarding the committee's ongoing discussions around our state’s mental health system, Iryna’s Law, and the proposed expansions of involuntary commitment (IVC) and psychiatric hospital beds. While I deeply share the committee’s urgency to address the tragic cycling of individuals through emergency departments, jails, and the streets, relying on more psychiatric hospital beds and forced treatment is a misguided approach that will ultimately cause more harm than good. Building more hospitals and expanding involuntary measures does not fix a broken mental health system; it merely creates more expensive, restrictive holding tanks for people who have been failed by a lack of community resources. Psychiatric hospitals are designed for short-term crisis containment and do not offer the long-term, continuous healing that individuals with severe mental health challenges

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					need. When we pour funding into brick-and-mortar institutions, we are investing in the most expensive and least effective part of the care continuum. People do not heal in isolation or under lock and key; they heal in communities where they are supported, housed, and treated with dignity. Furthermore, expanding IVC and forced treatment, whether inpatient or outpatient, strips individuals of their autonomy and often causes profound trauma. When the state forces care, it builds deep distrust in the medical and mental health systems, which deters individuals from voluntarily seeking help when they feel their mental health declining because they rightfully fear being locked up or losing their rights. We cannot "bed" our way out of a community crisis. Emergency rooms and jails are currently bottlenecked because people have nowhere else to go, but adding more psychiatric beds is a reactive bandage, not a proactive solution. If a person is discharged from a hospital only to return to homelessness, lack of food, or a community without peer support, they will inevitably end up back in crisis. Instead of tweaking Iryna's Law to funnel more people into an already overburdened involuntary system, the General Assembly must invest in the front-end of care. We need to divert funding away from building more hospitals and instead invest heavily in peer-run respites, recovery centers, voluntary community mental health clinics, supportive housing, and expanded Crisis Intervention Team (CIT) training. I urge this committee to listen to the voices of those with lived mental health experience. We cannot institutionalize our way out of this crisis. Please recommend investments in voluntary, community-based support infrastructures rather than expanding hospitals and involuntary commitments.
04/01/2026 01:17 PM	Ms. Jasmine Marshall	3521 Meadow Glen Dr, Clemmons, NC 27012	Forsyth	jsmnmrshll@gmail.com	What we currently call "mental illness" is actually the result of trauma in an overwhelming majority of cases. Involuntary commitment is traumatizing in & of itself. It is only logical to conclude that you can't heal people's trauma by repeatedly retraumatizing them. The data support this. In fact, studies have shown that forced hospitalization actually INCREASES the future risk of suicide & violent crime. Here is a link to an article on that: https://www.madinamerica.com/2025/08/forced-hospitalization-increases-suicide-and-violent-crime/ What we need instead are community alternatives led by those with lived experience. There needs to be more state support for peer respites and other forms of peer support -- NOT more hospitals and more psych wards. People heal through connection and compassion, NOT isolation and

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					punishment. Additionally, a more robust peer support industry could help create jobs for formerly incarcerated and/or hospitalized individuals. This could benefit all of society, making the world a safer, kinder place for ALL of us.
04/01/2026 04:26 PM	Tina Gibson	4201 Peak Court, Apex, NC 27539	Wake	gibsontina@earthlink.net	I'd like to share a story of a young person who was very close to our family. He was smart, sweet, and an all-around great kid. In his early teens, he had a mental health crisis. We live in Apex, but there were no emergency beds to be found. The closest open bed was in Greensboro. Imagine that being the case with any other type of emergency, such as appendicitis or a car accident. Imagine the lost time searching for a place to take him. Imagine parents being required to drive an hour and a half each way to see their child every day. Imagine not being close by when another crisis occurred within the facility - a facility that was understaffed and not providing good care. The family made it through this first crisis, but things were never the same again. The struggles continue today - over 13 years later. I can't help but wonder if the outcome would have been much better if they had better access to care. If they were provided better care. Mental health needs should not be an afterthought. People should not be shuffled around and neglected. Treatment should be accessible, held to the same quality as other medical care, and followed through to a healthy outcome. Anything less is simply negligence.
04/01/2026 04:48 PM	Attorney Quisha Mallette	North Carolina Coalition Against Domestic Violence 3710 University Drive Suite 300, Durham, NC 27707	Durham	qmallette@nccadv.org	Please see below an excerpt of public comment submitted on behalf of Carianne Fisher, Executive Director of NC Coalition Against Domestic Violence. Full public comment provided via email to Jessica Boney: To Chairs Blackwell, Reeder and Members of House Select Committee on Involuntary Commitment: The North Carolina Coalition Against Domestic Violence is a statewide organization working to end domestic violence and strengthen the safety net for survivors. We support local programs across North Carolina with training, advocacy, and resources so they can provide lifesaving services like shelter, legal support, and crisis intervention. By advancing policy, raising awareness, and empowering communities, we’re building a safer North Carolina for everyone. We are submitting this public comment requesting that you consider the enclosed recommendations to ensure safeguards for domestic violence survivors impacted by North Carolina’s involuntary commitment system. North Carolina faces a

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					mounting behavioral health crisis, especially among domestic violence survivors experiencing trauma-related conditions. Millions of North Carolina residents live in mental health provider shortage areas, and a majority of survivors struggle to access trauma-informed, culturally responsive care. Simultaneously, DV and mental health professionals alike report a critical gap in cross-sector training and coordination. Involuntary commitment should be a last resort. However, in instances where a survivor is involuntarily committed, protocols are needed to ensure safety for that individual. Screening for intimate partner violence is necessary for evaluation and treatment planning. Survivors who are involuntarily committed should also have a clear discharge plan, including a warm handoff to vital community-based programs such as local domestic violence service providers and outpatient care. A survivor in crisis needs adequate safeguards to ensure a timely and effective response to their distress, including coordinated crisis response, well-trained system actors, adequate outpatient mental health services, and strengthened capacity for emergency shelter provided by domestic violence service providers. ---------- Full public comment submitted via email to Jessica Boney on behalf of Carianne Fisher, Executive Director NC Coalition Against Domestic Violence.
04/01/2026 05:00 PM	Ms. Tara Muller	801 Corporate Center Dr Ste 118, Raleigh, NC 27607	Wake	tara.muller@disabilityrightsnc.org	Disability Rights North Carolina respectfully submits the following on April 1, 2026: Dear Committee Members and Chairmen, Thank you for your work to address the intersection of public safety and mental health. We know you are grappling with many complex issues, and we hope that the below information about Olmstead is helpful: What is Olmstead? In Olmstead v. L.C., the US Supreme Court interpreted the Americans with Disabilities Act and held that unjustified segregation of people with disabilities is a form of discrimination. States must provide community-based services for people with disabilities when: 1. Integration in the community is deemed appropriate by treatment professionals; 2. The disabled person does not oppose living in the community; and 3. The provision of services in the community would be a

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					reasonable accommodation when balanced with available resources and other similarly situated individuals with disabilities. Olmstead says that when people need services because of a disability, they have the right to choose community services. This does not mean that individuals are forced to leave a facility or congregate care setting – it means that they should be able to live in the community if they want to, and if it is appropriate for their needs. To have a real choice, community services must be as available as facility-based services. Otherwise, it's not a real choice. Olmstead means that disabled people don't have to accept being segregated in facilities to get help. How Does a State Violate Olmstead? • When it keeps someone in an institution without medical necessity • When it only offers services in an institution that also could be offered in the community • When it makes the criteria to get institutional services lower than to get services in the community • When it invests in and expands institutional services at the expense of equally effective and less costly community-based services How Does Olmstead Relate to Title II and III of the ADA? Title II (public entities) • Title II applies to state and local governments (e.g., Medicaid programs, public facilities). • Olmstead directly governs here. • Olmstead requires governments to: o Provide services in the most integrated settings appropriate to an individual's needs, o Develop plans to transition people unnecessarily institutionalized from institutions to community-based care, and o Avoid unnecessary institutionalization. Title III (private facilities that are open to the public) • Generally, Title III applies to private businesses open to the public, like private hospitals. • For Title III, the focus is on accessibility and nondiscrimination in facilities and services. • Essentially, this application prevents the creation of "separate but equal" goods and services for people with disabilities in the community.

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					Where Does Olmstead Fit into NC's Mental Health System? Transitions to Community Living Initiative (TCL) TCL is designed to help people leave or avoid institutions and live independently when appropriate. Following a complaint by Disability Rights NC that NC was segregating people with mental health disabilities in adult care homes, the US DOJ sued the State of NC. The lawsuit settled in 2012 and led to the establishment of TCL, which provides the following supports to people with serious and persistent mental health disabilities who can live in the community: • Permanent supported housing • Community-based mental health services • Supported employment (job placement support) Crisis Intervention System The DOJ settlement with NC establishing the TCL program also required the state to compel each LME/MCO (Medicaid managed care agencies) to develop an adequate crisis intervention service system, including mobile crisis teams, walk-in crisis clinics, community hospital beds, and 24/7 crisis lines. Money Follows the Person (MFP) MFP is a federal program that helps states redirect Medicaid funds on an individual level from long term institutional services and supports into home and community-based services. The NC Medicaid program's participation in MFP provides flexibility where needed to help people transition from nursing facilities or other institutions into the community by covering costs of transition and ongoing community supports. Expansions of Home and Community-Based Services (HCBS) Shortly after the Olmstead ruling, the George W. Bush administration signaled its support for community-based services as well, issuing Executive Order 13217 providing Olmstead grants to states to assist in the transition from institutions to community. Many of those programs persist in the form of community services such as direct care workers, day programs, and supported employment implemented through Medicaid waivers and state funding. Olmstead Enforcement and Individual Transition Cases Individuals rely on Olmstead compliance to enforce their right to get help in their own community. Olmstead is more than a policy issue to be considered when designing new programs;

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					individuals can and do use it to enforce their own rights. Fact Checking Chris Sharp’s Claims on Olmstead At an NCGA committee meeting, Chris Sharp from Cicero Institute testified that DOJ consent decrees nationally are being “reversed en masse” and lawsuits are being dropped against states because DOJ relied on an incorrect interpretation of “integrated setting” under Title III instead of under Title II. Sharp then pivoted to discussing IVC, seemingly conflating and suggesting conflict between federal law and North Carolina’s forced treatment on individuals who are dangerous to themselves or others. In reality, these laws are properly read together to require that all treatment – whether voluntary or involuntary – be provided in the most integrated setting appropriate to the needs of a person with a disability. Sharp did not provide any details, and his claims about the current legal landscape are misleading at best. Contrary to his false paradigm, people generally do not leave institutional settings in order to refuse treatment; in fact, those who seek and receive appropriate community-based treatment generally fare better than those who are institutionalized. Olmstead remains the law of the land, and North Carolina’s DOJ settlement, and other Olmstead lawsuits in NC, are still alive and well. Sharp may have been referring to long-standing efforts to limit Olmstead from reaching people who are in danger of being institutionalized (as opposed to those already so confined), as the Fifth Circuit did in U.S. v. Mississippi, in 2023. However, the ruling did not address or touch on Olmstead’s central holding, which is that people who are already unnecessarily institutionalized have a right to transition to the most integrated setting appropriate to their needs. Also, it is binding only in the Fifth Circuit, not in Fourth Circuit, where NC is located. Sharp may also have been referring to a state-level Olmstead case in Pennsylvania that was recently dismissed for similar reasons, but again, that case has no bearing here in NC, where we value keeping families together in tightknit, loving communities where everyone can thrive and contribute. As a country and as a state, we have come a long way from the days of knee-jerk, forced institutionalization of children and adults with all types of disabilities. Now that we all have seen how fulfilling and productive the lives of disabled people can be, we do not believe our state or country should or will be going backward by re-instituting failed, costly, undesirable models.

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					Thank you for considering this information. In partnership, Corye Dunn Policy Director, Disability Rights North Carolina Tara Muller Policy Attorney, Disability Rights North Carolina
04/01/2026 05:00 PM	Rebecca Cerese	Chapel Hill, NC 27516	Orange	rcerese@gmail.com	I am submitting public comment based on personal experiences of a close friend of mine and her teenage child that should be considered in this important conversation about involuntary commitment (IVC) proceedings and policy. Much of the conversation revolves around adults or people already involved in the carceral system. We should also focus on minors and the use of IVC for prevention of a crime happening. A mother, my friend, went to a magistrate after witnessing extremely concerning behavior by her 15-year-old child, including graphic homicidal ideation. After reviewing her concerns, the magistrate ordered an IVC. My friend, having tried to get her child help before, asked the magistrate specifically whether law enforcement could bring her child to a hospital with psychiatric services—rather than the closest, and more limited emergency room, without psychiatric services. Unfortunately, despite reassurances from the magistrate, law enforcement did bring her child to the closest facility, and he was admitted. For 6 days, the minor child sat in an ED without treatment, seeing a psychiatrist through a tele-consult 20 minutes a day as they were trying to find placement in an inpatient facility, as assessments showed the minor child needed additional treatment. No facility was willing to take them, and then because they appeared calm and compliant, and their father was pushing to have the minor released into his care, they were released, with a minimal treatment plan that included pursuing outpatient mental health treatment and ensuring that all sharps in the home were secured, despite urgent homicidal and suicidal concerns. Meanwhile, the father did not follow up with any of the treatment plan, despite the mother's insistence. Finally a mandatory reporter got involved and reported the case to Child Protective Services. CPS opened an investigation,

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					exploring the idea that the father was not following up on recommended medical and safety care for the minor child. Unfortunately, the CPS case was closed within a month, after the child started seeing a therapist at their mother's insistence. The mother loudly objected to the case being closed because she feared the father would not follow through on treatment and safety recommendations. Unfortunately, sometime later, the minor child committed a violence crime that resulted in the death of a minor and impacted not just their immediate family, but their entire community. From this experience, I wanted to highlight areas I believe should be improved in the NC IVC process. 1. If an individual is IVC'ed, especially a minor, they should be required to be brought to a facility that has a psychiatric services. And if a minor is involved, the facility where the IVC-ed minor is brought should have appropriate psychiatric services and, in the case of minors, be equipped to treat young people. 2. If an individual's IVC is upheld, they should not be released until they have had a medication assessment and therapeutic treatment. Moreover, cases including homicidal ideation, should receive the utmost care and attention. 3. Given that none of the longer-term facilities for young people would accept this placement, and we were led to understand that it wasn't just a matter of not having beds available, but it may have been an acuity issue. So either, these facilities should not be allowed to turn away a patient if they have beds available, or the patient must be sent to another Emergency Department where they can be seen/assessed and treated before they are released, or there needs to be a facility that is funded and equipped to take minors who have violent tendencies and more serious mental health needs that are a danger to others. 4. The transition between IVC and release needs to have stronger oversight and enforcement measures to ensure that the patient is getting the continued care they need and that the parents/guardians are in compliance. Perhaps getting CPS involved at the time of discharge would be helpful, but the parent/guardian or patient themselves should also be able to appeal a discharge order if there is a disagreement.

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					5. Homicidal ideation should be taken seriously, as should the concerns of both or either parent. Repeatedly my friend's concerns were dismissed and minimized. 6. We also need research and funding for effective treatments for these issues, as well as investments in a facility that can handle patients with these more serious mental health issues that could pose a threat to the community, in a long terms setting if possible.
04/01/2026 05:24 PM	CEO Cherene Caraco	14226 Harvington Dr, Huntersville, NC 28078	Mecklenburg	ccaraco@promiseresourcenetwork.org	I am writing with immense concerns for the consideration to expand the use of involuntary commitment in NC. As noted in data, the use of the most restrictive, expensive, and least effective approach to serving people experiencing significant emotional distress has increased by over 100% in NC in a little over a decade, far outpacing population growth. At an average cost of $2,700/day for 1 person and no national or state data to demonstrate effectiveness in treatment engagement, recovery, well-being, or circumstances that lead to crisis, it is alarming that our state is following suit with others that have enacted policies rooted in fear with little to no truth to support their extreme positions. Locking people in psychiatric hospitals has a well known long standing history resulting in abuse, neglect, human rights violations and re-traumatization. To use the most restrictive and least humanizing approach to public health creates a false illusion of safety. I recognize the two recent tragedies that have occurred in NC and I'd like to highlight that in both instances, these individuals had been hospitalized multiple times and involved in multiple systems. If that was the solution, these deaths would have been prevented. Rather, these are systems failures where lack of coordination, engagement in on-going trusted relationships, and recovery opportunities in the community are prevalent. Despite this, alternative crisis prevention, diversion, and response models DO exist in NC, however are not replicated and scaled in robust ways. By supporting the use of forced treatment rather than reforming a broken community based mental health system, we are blaming "sick people" rather than community response. We know that post IVC, suicide rates increase by 100%. That is not safety, that is perpetuation of danger with individuals and families at the receiving end of the worst approach to "treatment." I am a suicide attempt survivor who falls into that statistic, attempting suicide in response to IVC. I am also the CEO of a peer-run organization that has had ZERO suicides across our 20 years of serving people with most complex combinations of mental illness, substance use disorder, being unhoused and formerly incarcerated. We

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					serve as a safety net in our community and if these types of services were readily available, at scale, these deaths return on investment financially and regarding health and safety pays for itself. I implore you to engage people that live this, in neighborhoods and communities, with people everyday, not simply employees of hospitals, MCO's, or at Universities. There is an expertise and unmatched wisdom that people with mental health conditions possess that could truly create healing communities
04/01/2026 06:19 PM	Mr. Wes Rider	114 Silver Creek Dr, Swansboro, NC 28584	Carteret		We need more mental health recovery education and supports in our communities. All clinicians and administrators of our public system should be trained in recovery principles and values. Please consider funding the recently defunded Healthy Opportunities Pilot and take this program state wide. Stop sending people with mental health issues to religious programs based on AA. Stop coercing people to attend AA. Greatly increase funding for drop in centers. Focus on social determinants of health like housing, employment, access to education and healthcare. Stop treating addiction like a punishable moral failure and start treating it like a personal and public health issue.
04/01/2026 06:56 PM	Director of Programs Jeff Walker	240 Jefferson St., North Wilkesboro, North Carolina 28659	Wilkes	jwalker@wilkesrecoveryrevolution.com	Peer-run organizations and respite houses offer a powerful, community-based alternative to the current cycle between emergency departments, jails, and hospitals. These models center trust, dignity, and connection—often helping individuals stabilize earlier and avoid crisis escalation altogether. Because they're led or informed by people with lived experience, they can meet needs in ways traditional systems sometimes miss. As lawmakers work toward solutions, it's critical that people with mental health and lived experience are at the table—not just as participants, but as decision-makers. Their insight is essential to building a system that is more humane, effective, and truly responsive to the people it serves.
04/03/2026 03:15 AM	Leora Wimmer	Valenciennes, CENTRE 59300	Columbus	leorawimmer696@gmail.com	{ {I have|I've} been {surfing|browsing} online more than {three|3|2|4} hours today, yet I never found any interesting article like yours. {It's|It is} pretty worth enough for me. {In my opinion|Personally|In my view}, if all {webmasters|site owners|website owners|web owners} and bloggers made good content as you did, the {internet|net|web} will be {much more|a lot more} useful than

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					ever before.| I {couldn't|could not} {resist|refrain from} commenting. {Very well|Perfectly|Well|Exceptionally well} written!| {I will|I'll} {right away|immediately} {take hold of|grab|clutch| grasp|seize|snatch} your {rss|rss feed} as I {can not|can't} {in finding|find|to find} your {email|e-mail} subscription {link| hyperlink} or {newsletter|e-newsletter} service. Do {you have|you've} any? {Please|Kindly} {allow|permit|let} me {realize|recognize| understand|recognise|know} {so that|in order that} I {may just|may|could} subscribe. Thanks.| {It is|It's} {appropriate|perfect|the best} time to make some plans for the future and {it is|it's} time to be happy. {I have|I've} read this post and if I could I {want {relating to|referring to|regarding} this article. I {want to|wish to|desire to} {read|learn} {more|even more} {things|issues} {approximately|about} it!| {I have|I've} been {surfing|browsing} {online|on-line} {more than|greater than} {three|3} hours {these days|nowadays|today|lately|as of late}, {yet|but} I {never|by no means} {found|discovered} any {interesting| fascinating|attention-grabbing} article like yours. {It's|It is} {lovely|pretty|beautiful} {worth|value|price} {enough| sufficient} for me. {In my opinion|Personally|In my view}, if all {webmasters|site owners|website owners|web owners} and bloggers made {just right|good|excellent} {content|content material} as {you did|you probably did}, the {internet|net|web} {will be|shall be|might be|will probably be|can be|will likely be} {much more|a lot more} {useful|helpful} than ever before.| Ahaa, its {nice|pleasant|good|fastidious} {discussion|conversation|dialogue} {regarding|concerning| about|on the topic of} this {article|post|piece of writing| paragraph} {here|at this place} at this {blog|weblog|webpage| website|web site}, I have read all that, so {now|at this time} me also commenting {here|at this place}.| I am sure this {article|post|piece of writing|paragraph} has touched all the internet {users|people|viewers|visitors}, its really really {nice|pleasant|good|fastidious} {article|post| piece of writing|paragraph} on building up new {blog|weblog| webpage|website|web site}.| Wow, this {article|post|piece of writing|paragraph} is {nice| pleasant|good|fastidious}, my {sister|younger sister} is analyzing {such|these|these kinds of} things, {so|thus|therefore} I am going to {tell|inform|let know|

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					convey} her.| {Saved as a favorite|bookmarked!!}, {I really like|I like|I love} {your blog|your site|your web site|your website}!| Way cool! Some {very|extremely} valid points! I appreciate you {writing this|penning this} {article|post|write-up} {and the|and also the|plus the} rest of the {site is|website is} {also very|extremely|very|also really|really} good.| Hi, {I do believe|I do think} {this is an excellent|this is a great} {blog|website|web site|site}. I stumbledupon it ;) {I will|I am going to|I'm going to|I may} {come back|return|revisit} {once again|yet again} {since I|since i have} {bookmarked|book marked|book-marked|saved as a favorite} it. Money and freedom {is the best|is the greatest} way to change, may you be rich and continue to {help|guide} {other people|others}.| Woah! I'm really {loving|enjoying|digging} the template/theme of this {site|website|blog}. It's simple, yet effective. A lot of times it's {very hard|very difficult|challenging|tough|difficult|hard} to get that "perfect balance" between {superb usability|user friendliness|usability} and {visual appearance|visual appeal|appearance}. I must say {that you've|you have|you've} done a {awesome|amazing|very good|superb|fantastic|excellent|great} job with this. {In addition|Additionally|Also}, the blog loads {very|extremely|super} {fast|quick} for me on {Safari|Internet explorer|Chrome|Opera|Firefox}. {Superb|Exceptional|Outstanding|Excellent} Blog!| These are {really|actually|in fact|truly|genuinely} {great|enormous|impressive|wonderful|fantastic} ideas in {regarding|concerning|about|on the topic of} blogging. You have touched some {nice|pleasant|good|fastidious} {points|factors|things} here. Any way keep up wrinting.| {I love|I really like|I enjoy|I like|Everyone loves} what you guys {are|are usually|tend to be} up too. {This sort of|This type of|Such|This kind of} clever work and {exposure|coverage|reporting}! Keep up the {superb|terrific|very good|great|good|awesome|fantastic|excellent|amazing|wonderful} works guys I've {incorporated||added|included} you guys to {|my|our||my personal|my own} blogroll.|

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					{Howdy|Hi there|Hey there|Hi|Hello|Hey}! Someone in my {Myspace|Facebook} group shared this {site|website} with us so I came to {give it a look|look it over|take a look|check it out}. I'm definitely {enjoying|loving} the information. I'm {book-marking|bookmarking} and will be tweeting this to my followers! {Terrific|Wonderful|Great|Fantastic|Outstanding|Exceptional|Superb|Excellent} blog and {wonderful|terrific|brilliant|amazing|great|excellent|fantastic|outstanding|superb} {style and design|design and style|design}.| {I love|I really like|I enjoy|I like|Everyone loves} what you guys {are|are usually|tend to be} up too. {This sort of|This type of|Such|This kind of} clever work and {exposure|coverage|reporting}! Keep up the {superb|terrific|very good|great|good|awesome|fantastic|excellent|amazing|wonderful} works guys I've {incorporated|added|included} you guys to {|my|our|my personal|my own} blogroll.| {Howdy|Hi there|Hey there|Hi|Hello|Hey} would you mind {stating|sharing} which blog platform you're {working with|using}? I'm {looking|planning|going} to start my own blog {in the near future|soon} but I'm having a {tough|difficult|hard} time {making a decision|selecting|choosing|deciding} between BlogEngine/Wordpress/B2evolution and Drupal. The reason I ask is because your {design and style|design|layout} seems different then most blogs and I'm looking for something {completely unique|unique}. P.S {My apologies|Apologies|Sorry} for {getting|being} off-topic but I had to ask!| {Howdy|Hi there|Hi|Hey there|Hello|Hey} would you mind letting me know which {webhost|hosting company|web host} you're {utilizing|working with|using}? I've loaded your blog in 3 {completely different|different} {internet browsers|web browsers|browsers} and I must say this blog loads a lot {quicker|faster} then most. Can you {suggest|recommend} a good {internet hosting|web hosting|hosting} provider at a {honest|reasonable|fair} price? {Thanks a lot|Kudos|Cheers|Thank you|Many thanks|Thanks}, I appreciate it!|

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					{I love|I really like|I like|Everyone loves} it {when people|when individuals|when folks|whenever people} {come together|get together} and share {opinions|thoughts|views|ideas}. Great {blog|website|site}, {keep it up|continue the good work|stick with it}!| Thank you for the {auspicious|good} writeup. It in fact was a amusement account it. Look advanced to {far|more} added agreeable from you! {By the way|However}, how {can|could} we communicate?| {Howdy|Hi there|Hey there|Hello|Hey} just wanted to give you a quick heads up. The {text|words} in your {content|post|article} seem to be running off the screen in {Ie|Internet explorer|Chrome|Firefox|Safari|Opera}. I'm not sure if this is a {format|formatting} issue or something to do with {web browser|internet browser|browser} compatibility but I {thought|figured} I'd post to let you know. The {style and design|design and style|layout|design} look great though! Hope you get the {problem|issue} {
04/04/2026 11:54 AM	Dr. Joseph Blackwell	4232 Shannamara Drive, Matthews, North Carolina 28104	Union	Blackwelljh54@gmail.com	Violent criminals need to be off the streets. The emergency department is not the place for these people to be evaluated. It puts too much strain on an already strained system. Our healthcare workers are already at the forefront of violence, we do not need additional violent offenders in the emergency department. While the infrastructure may not be in place now, my hope is that these people will get the care they need while also not being allowed to return to society until there are safeguards in place to ensure that they are getting appropriate evaluation, monitoring, and medication administration they need to be functional members of society. Until this happens, innocent people will continue to suffer the consequences of violent, mentally unwell patients being allowed to roam the streets.
04/06/2026 01:52 AM	Nonprofit CEO Melissa Hales	8101 Stonebrook Terraxe 302, Raleigh, Nc 27617	Wake	Melhalesdev@gmail.con	Request to Address the Committee — Real-World Case Study on Guardianship/IVC Intersection Failure Resulting in Death Dear Representative Reeder, Representative Blackwell, and Members of the House Select Committee on Involuntary Commitment and Public Safety, My name is Melissa Hales. I am the founder and CEO of the Neurodiversity Advocacy Network of the SE Inc., based in Raleigh, NC. I am writing to respectfully request the

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					opportunity to address the Committee at your April 14 meeting — or to submit formal testimony for the record — regarding a real-world case that illustrates exactly the guardianship and IVC intersection your Committee has been studying. At your March 18 meeting, UNC School of Government faculty presented the case of "Paula" — a hypothetical woman adjudicated incompetent, cycling through involuntary commitments without improvement. I can offer the Committee something the hypothetical cannot: an outcome. April Crowe was a real person. A Durham native. She grew up down the street from me. We attended the same schools from elementary through NC State. We worked together after college. April had a husband who loved her, who saw her declining, and who petitioned the Orange County Clerk of Superior Court for guardianship — specifically so he could invoke involuntary commitment and compel treatment. The Clerk denied the petition. Without guardianship authority, April's husband had no legal mechanism to force treatment. No IVC authority. No ability to intervene. April's condition deteriorated until she weighed below 80 pounds. She died. The case was dismissed. A timesheet was submitted and accepted. No investigation. No review. This is not a policy abstraction. This is what happens when the guardianship system and the IVC system fail to connect — when a Clerk of Court can deny a family member the one tool that could save a life, with no accountability and no appeal that moves fast enough to matter. I am now advocating in a second case before the same Clerk — the guardianship of Lisa Faith Hamill, an elderly woman with advanced dementia and a $1.45 million estate in Orange County (File No. 23E000403-670). The parallels to April's case are alarming, and I have filed an Emergency Ex Parte Motion detailing systemic failures including financial exploitation, neglect, retaliation against advocates, and undisclosed conflicts of interest by court-appointed fiduciaries. What I would ask the Committee to consider: 1. When a Clerk denies a guardianship petition that would

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					enable IVC, and the person dies, what accountability mechanism exists? Currently, none. 2. Should family members have an expedited pathway to obtain guardianship authority specifically for the purpose of invoking IVC when a loved one is in medical decline? The current system is too slow to save lives. 3. Should there be mandatory reporting requirements when a ward or potential ward dies after a guardianship petition or IVC petition is denied? 4. Should Clerks of Court be subject to the same oversight mechanisms as judges when exercising quasi-judicial authority over guardianship and competency proceedings? The Judicial Standards Commission currently has no jurisdiction over clerks. I am available to testify in person on April 14, provide written testimony, or meet with committee members or staff at your convenience. I have extensive documentation including court filings, the accounting records, and a timeline of events in both the Crowe and Hamill matters. April Crowe's story is the real-world answer to the question your Committee has been asking. I respectfully ask that her story — and the ongoing danger to Lisa Faith Hamill — be part of the record. Respectfully, Melissa Ellen Hales CEO, Neurodiversity Advocacy Network of the SE Inc. Raleigh, NC (919) 451-4717 melhalesdev@gmail.com