NORTH CAROLINA
Psychiatric
Association

**House Select Committee on Involuntary Commitment and Public Safety**
**Public Comments**
**Approved by Executive Council March 23, 2026**

The North Carolina Psychiatric Association appreciates the opportunity to provide comments to the House Select Committee on Involuntary Commitment and Public Safety. The North Carolina Psychiatric Association (NCPA) is a professional medical organization representing nearly 1,000 psychiatrists statewide who provide care in hospitals, community clinics, private practices, emergency departments, jails, and state facilities.

Psychiatrists work daily at the intersection of behavioral health treatment, emergency services, and the criminal justice system. Recent events have highlighted gaps in the behavioral health system, but they also underscore the importance of thoughtful reforms that protect public safety while preserving clinical judgment and patient rights.

As policymakers consider implementation of Iryna's Law and other reforms, it is critical to recognize that increasing front-end demand for involuntary commitment evaluations—without parallel investment in treatment capacity and community services—will likely exacerbate existing system strain. Emergency departments are already experiencing significant psychiatric boarding, and additional demand may delay access to care, worsen patient outcomes, and ultimately undermine both patient safety and broader public safety goals.

We offer the following recommendations:

**Immediate Recommendations Related to Iryna's Law Implementation:**

1. **Reevaluate the Three-Year Lookback Period for Violent Offenses**
   Serious acts of violence are difficult to predict, and involuntary commitment in North Carolina is designed to assess current risk of harm based on recent behavior and clinical presentation. Iryna's Law includes a three-year lookback period for violent offenses when determining the need for involuntary commitment evaluations. This timeframe is overly broad and could lead to unnecessary evaluations that strain extremely limited emergency psychiatric resources.

   Research suggests that risk of violence is highest in the immediate period following psychiatric hospitalization or acute crisis, rather than years later. Policymakers may consider whether a one-year lookback period would better target individuals at highest risk while minimizing unnecessary evaluations for individuals who do not meet clinical or legal criteria for commitment at the time of assessment.

2. **Expand Telepsychiatry Options for Initial Evaluations**
   Currently, Iryna's Law requires that evaluations occur in emergency departments or crisis facilities. However, emergency departments across North Carolina are already experiencing significant psychiatric boarding. Allowing telepsychiatry evaluations will reduce unnecessary strain on emergency departments as well as the critical time gap between a court order and assessment, therefore reducing risk to the public. Telepsychiatry has already proven effective in other areas of forensic and competency evaluations within the state hospital system.

   IVC examiners should be assured they have all the relevant information to make assessments while still complying with confidentiality.

**Strengthening Behavioral Health Services in the Criminal Justice System**

1. **Establish Uniform Standards for Mental Health Screening and Treatment in Jails**
   North Carolina law already requires mental health screening for individuals entering jail, following passage of Session Law 2007-323 (HB1473). However, implementation varies across counties; some counties have robust behavioral health services, while others have limited resources. Standardization would help ensure that individuals with serious mental illness are identified early and connected to treatment, regardless of the county in which they are detained.

   NCPA recommends developing uniform statewide standards for:

   - Mental health screening upon jail intake
   - Access to psychiatric treatment
   - Coordination of care upon release

2. **Improved Coordination Between Jails and Community Mental Health Services**
   A frequent concern among psychiatrists is the "revolving door" between jails, hospitals, and the community, driven in part by gaps in coordination between the behavioral health and criminal justice systems. Strengthening these connections is essential to improving outcomes for justice-involved individuals with mental illness.

   NCPA recommends strengthening processes that ensure transfer of care to community services at the time of release, including connection to outpatient mental health providers, access to case management services, and coordination with community treatment teams when appropriate. Improved coordination can also support diversion efforts by connecting individuals to treatment earlier and reducing unnecessary involvement with the criminal justice system.

   Session Law 2007-323 (HB1473) specifically identified Local Management Entities (LMEs) as responsible for coordinating with county public health departments and county sheriffs to support individuals with mental health needs. However, it remains unclear to what degree these requirements have been consistently implemented across the state.

   NCPA recommends that lawmakers review the degree of implementation of Section 10.49.(f) of Session Law 2007-323 (HB1473) to assess compliance and, if needed, develop enforcement protocols to ensure consistent coordination between LMEs, local health departments, and law enforcement statewide.

3. **Continued Use of Diversion, Deflection and Capacity Restoration Programs**
   Strengthening diversion and deflection programs is critical to ensuring that individuals with serious mental illness receive timely treatment while also improving public safety and reducing strain on the state's emergency, hospital, and correctional systems. Improving access to behavioral health treatment and support services—including crisis response, case management, and ongoing treatment—can stabilize individuals earlier, reduce repeat crises, and decrease the likelihood that untreated mental illness will lead to interactions with law enforcement or incarceration.

   The state should continue expanding capacity restoration programs for individuals found incapable to proceed, building on the pilot programs in North Carolina. Historically, restoration services have been provided primarily in state hospitals, contributing to long wait times and significant system strain.

**Strengthening the Behavioral Health System**

1. **Increase Access to Psychiatric Beds**
   North Carolina continues to face significant shortages of staffed inpatient psychiatric beds and intensive community services, appropriate to serving this population, that reduce the need for psychiatric beds. Expanding access to psychiatric beds—while also addressing workforce, staffing and community services—remains a critical component of strengthening the state's mental health system. We support efforts outlined in Executive Order 33 to expand recruitment, implement programs to improve hiring and retention, and address shortages of state agency staff critical to behavioral health and public safety.

   NCPA supports meaningful investment in the state hospital workforce, including substantial increases in nursing compensation (at least 15%) to improve recruitment and retention. Without competitive salaries, hospitals cannot staff existing beds, limiting access to care and worsening system strain.

2. **Strengthen and Enforce Outpatient Commitment**
   North Carolina already has a statutory framework allowing courts to order involuntary outpatient commitment, applying preventative outpatient commitment criteria to prevent inpatient commitment, requiring certain individuals with serious mental illness to follow a structured treatment plan in the community, rather than remain hospitalized. However, despite existing authority, outpatient commitment is rarely used across the state, in part because accountability and responsibility for these orders became unclear in the wake of the transition to the LME/MCO system.

   While involuntary commitment is a tool for managing acute psychiatric dangerousness; outpatient commitment is a valuable tool for individuals with serious mental illness who have a history of treatment nonadherence, repeated relapse, hospitalization or deterioration when not engaged in care. However, experience in other states shows that it is only effective when carefully implemented, combined with appropriate, intensive community services and extended for 6 months or more.

   NCPA recommends that outpatient commitment is implemented in alignment with the American Psychiatric Association's Position Statement on Involuntary Outpatient Commitment:

   - 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.

3. **Expand Community Mental Health Services**
   Strengthening the community mental health system is essential to reducing crisis events and justice system involvement. Many affected individuals have co-occurring mental health and substance use disorders needing integrated service to address their conditions. These services help stabilize individuals with serious mental illness and prevent deterioration that leads to hospitalization or incarceration.

NCPA also supports the expansion of the behavioral health crisis continuum, including mobile crisis services, Behavioral Health Urgent Care, and 988-aligned services, to ensure that psychiatric crises are managed as health conditions rather than law enforcement events.

NCPA recommends continued expansion of:

- Assertive Community Treatment (ACT) teams
- Forensic Assertive Community Treatment (FACT) programs
- Formerly Incarcerated Transition (FIT) Program
- Case management services
- First episode psychosis programs
- Supportive housing and residential services
- Dual diagnosis services for persons with co-occurring mental health and substance use disorders
- A broader continuum of community-based care

4. **Ensure Continuity of Medicaid Coverage**
   Maintaining Medicaid Coverage is essential for individuals with serious mental illness to access treatment. Medicaid is the primary payer for many behavioral health services in North Carolina, including outpatient psychiatric care, therapy, case management, Assertive Community Treatment (ACT), substance use treatment and other community-based supports that help stabilize individuals and prevent crises.

   Ensuring continuity of Medicaid coverage can significantly improve treatment engagement and stability for individuals with serious mental illness. This will help reduce strain on emergency departments, hospitals, and correctional systems and help reduce preventable crises and improve outcomes.

Strengthening North Carolina's behavioral health system, including substance use treatment, requires a balanced approach that addresses public safety concerns while ensuring individuals with serious behavioral health disorders receive appropriate and timely treatment.

NCPA appreciates the Committee's attention to these issues and stands ready to serve as a clinical resource as policymakers continue this important work.