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 civil commitment process in North Carolina. I began the practice of law in 1982 and in 1986 joined the Mecklenburg Public Defender's Office 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 civil commitment attorney full time in 2012 at the Mecklenburg Public Defender's Office until I retired. In that role I worked to protect my client's legal rights and to help them find pathways to treatment and recovery. I also advocated to improve the relevant health care and justice systems. 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 Involuntary Commitments if possible.

The work of your Committee is especially important to me because it involves questions about how best to improve the systems of justice and health care as well. I believe that at its core this was a strategic planning and management question. A quote that applies is "every system is perfectly designed for the results that it gets."

During the 1990s we in the criminal justice system received organizational and management training at the local and state level. One important lesson was the need to involve the various stakeholders and customers from all those involved and impacted in the system or process on a regular basis. When I look at the civil commitment process in North Carolina, it appears that the people responsible for designing and managing mental health and substance abuse treatment could do more to involve key stakeholders and customers on an ongoing basis.

While I was a part of efforts for reform of the criminal justice system in the 1990s, and knew of other such work for the civil courts, I've not seen a similar effort for strategic planning and management with the civil commitment system. Even with Mental Health Reform in the 2000s, the civil commitment process remained essentially the same that it was when I started in 1986. From time to time there may be a group that comes together on a particular issue for a particular topic, but nothing that resembles the kind of strategic policy and management that we saw with Structured Sentencing or with Treatment/Recovery Courts.

Having seen progress with Alternatives to Incarceration and Drug Treatment Courts, I hoped when started this assignment in 2012 that we in the system could identify those who experiencing the revolving door of frequent hospitalizations and arrests, and advocate for

resources to stop the revolving door. I also hoped we could also look at updating and reforming civil commitments. We were able to do so in the criminal justice system but not here.

Essentially our civil commitment system lacks a data reporting and management system, leadership, and institutional commitment towards developing and maintaining a meaningful systemic strategic plan. For example, there is no entity responsible for overseeing the civil commitment process that is charged with managing it the way there is the Sentencing Commission helps with understanding and managing the criminal justice incarceration process. Moreover, there is no data collected in such a way that would allow such a group to do its work. If Mecklenburg County wanted to find a way to find those "frequent flyers" in the civil commitment and justice system to target services to break the revolving door, it could not do it.

Another problem with the civil commitment process today is that it 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. The old saying, "you can lead a horse to water, but you can't make him drink", is particularly true if the place you lead them to has little to no water.

We don't have the services for the commitment process itself. The statute as written provides 10 days from the time a person is picked up on a custodial hold until the hearing. That works on paper but not the real world. We have inadequate psychiatric emergency and treatment facilities (as evidenced by extensive hospital boarding). People can be held in a regular emergency room or hospital for days, weeks, even months before a bed is found somewhere in the state. One of my clients was at Atrium Main Hospital (formerly Carolinas Healthcare CMC Main) for over four months. The law allows a doctor to hold someone for seven days at a time in perpetuity without getting access to a lawyer, judge, or treating psychiatrist. The only reason my client ended up on the docket was because a doctor became frustrated and figured out a way to get the matter before the court.

Another problem with the system is how it separates families from loved ones in distress. 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 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. It took some time for me to counsel them through that scenario before we could talk about their upcoming case. This practice causes great distrust of, and resentment towards, the medical and legal system. Imagine how that can discourage a patient from following through with treatment after leaving the hospital.

An ongoing problem with our commitment process is the continued dependence on families and lay people to initiate the commitment. 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. A nurse I worked with at another hospital, also from Pittsburgh, said the same thing. Both said that community services, especially supportive housing, were much greater in Pennsylvania and most likely accounted for the disparity between our systems.

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. 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 First Appearance Court 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 County's management service, MeckLink. Officials from the state said that it was 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. This is another example of why I say that tragedies with high profile cases locally and statewide are quite possibly a result of a breakdown from the legislature than from law

enforcement and local officials. If there were a system of strategic management that could accurately and honestly assess such tragedies or gaps, we'd know more. Either way, the lack of services or the lack of management, it's the Legislature's responsibility and it's up to the Legislature to provide the necessary reforms.

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 institutions 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. There may be other organizations or individuals with better plans, and I hope there are policies and practice that seek to 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.***

Here are some links to resources that help to offer solutions and further explain some of the issues I've described above:

Mental Health America Position Statement Supporting Recovery Based Systems:
https://mhanational.org/position-statements/in-support-of-recovery-based-systems-transformation/

Bazelon Center on Mental Health Law Position Statement on Involuntary Commitment:
https://mail.google.com/mail/u/0/#inbox/FMfcgzQgKvNpmDjLfMxDwCvkvZLcFzDr?projector=1&messagePartId=0.1

NAMI Position Statement on Involuntary Commitment:
https://mail.google.com/mail/u/0/#inbox/FMfcgzQgKvNpmDjLpHvLkNZkPxHtvTdB?projector=1&messagePartId=0.1

Mental Health America Position on Involuntary Commitment:
https://mhanational.org/position-statements/involuntary-mental-health-treatment/

Bazelon information regarding Psychiatric Advance Directives:
https://www.bazelon.org/our-work/mental-health-systems/advance-directives/

Mental Health America Position on Psychiatric Advance Directives
https://mhanational.org/position-statements/psychiatric-advance-directives/

NAMI Position on Psychiatric Advance Directives:
https://www.nami.org/advocacy-at-nami/policy-positions/responding-to-crises/psychiatric-advance-directives/

Charlotte Talks - *Understanding Involuntary Commitment in North Carolina*
https://www.wfae.org/show/charlotte-talks-with-mike-collins/2025-10-08/understanding-involuntary-commitment-in-north-carolina

WFAE – *Fractured* series on Mental Illness, Criminal Justice, and Hospitalization:
https://www.wfae.org/fractured

PBS Frontline - *Fractured*
https://www.pbs.org/wgbh/frontline/documentary/fractured/

Cherene Caraco - *This is My Brave*:
https://www.youtube.com/watch?v=A_d-v1qzDpI

NC Health News – Report by Disability Rights on Involuntary Commitment:
https://www.northcarolinahealthnews.org/2025/05/27/scathing-new-report-details-north-carolinas-involuntary-commitment-problem/

New York Times – Story about Crisis Navigation Project re Psychiatric Advance Directives:
https://www.nytimes.com/2018/12/03/health/psychiatric-advanced-directives.html

Mecklenburg County Justice Programs – Recovery Courts:
https://cjs.mecknc.gov/Services/STEP

SAMHSA Guidelines on Psychiatric Advance Directives:
https://www.samhsa.gov/resource/ebp/practical-guide-psychiatric-advance-directives

Mental Health America – Peer Support v. Involuntary Commitment Study
https://mhanational.org/wp-content/uploads/2025/02/Evidence-Peer-Support-May-2019.pdf

Psychiatric Services publication - *Psychiatric Advance Directives: A Call for Humanization*:
https://psychiatryonline.org/doi/10.1176/appi.ps.23074007