

NORTH CAROLINA GENERAL ASSEMBLY



HOUSE SELECT COMMITTEE ON INVOLUNTARY COMMITMENT AND PUBLIC SAFETY

REPORT TO THE 2026 SESSION of the 2025 GENERAL ASSEMBLY OF NORTH CAROLINA

APRIL 14, 2026

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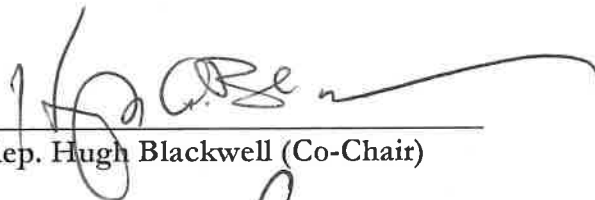
TRANSMITTAL LETTER

April 14, 2025


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TO THE MEMBERS OF THE 2026 REGULAR SESSION
OF THE 2025 GENERAL ASSEMBLY

The HOUSE SELECT COMMITTEE ON INVOLUNTARY COMMITMENT
AND PUBLIC SAFETY, respectfully submits the following report to the 2026
Regular Session of the 2025 General Assembly.



Rep. Hugh Blackwell (Co-Chair)



Rep. Timothy Reeder, MD (Co-Chair)

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COMMITTEE PROCEEDINGS

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The House Select Committee on Involuntary Commitment and Public Safety met five times after the 2025 Regular Session. The following is a summary of the Committee's proceedings. Detailed minutes and information from each Committee meeting are available in the Legislative Library.

November 13, 2025

Overview of the Involuntary Commitment (IVC) Process -

Mark Botts, JD, Associate Professor of Public Law and Government
UNC School of Government

Research on Mental Health and the Justice System -

Dr. Jeni Corn, PhD, Research Director-Social Sciences, NC Collaboratory

Impact of IVC on the Healthcare System and Emergency Providers -

Part I:

Nicholle Karim, Vice President of Policy, North Carolina Healthcare Association
Johana Troccoli, System Vice President, Behavioral Health, Duke University Health System

Part II:

Jeremiah Gaddy, MD, FACEP, NC College of Emergency Physicians

Magistrate Perspective on IVC -

Christopher Graves, Wake County Chief Magistrate, NC Administrative Office of the Courts

Mark Botts, associate professor of Public Law and Government at the UNC School of Government, presented an overview of the involuntary commitment process to the Committee. Professor Botts explained the criteria for inpatient, substance abuse, and outpatient commitment to help the Committee understand the involuntary commitment process. He explained that a person can enter the IVC process through civil proceedings, such as a layperson petition, clinician petition, and emergency procedure, or as part of a criminal proceeding, such as when a defendant is incapable to proceed or under Iryna's Law (S.L. 2025-93). Next, he described the two changes Iryna's Law made to the IVC process: (1) law enforcement is now required to share relevant information about an arrestee's potential to be dangerous to themselves or others with the judicial official who will determine the conditions of pretrial release, and (2) judicial officials will have a procedure to access a defendant's court records to search for prior orders of involuntary commitment that may have occurred within the last three years. Furthermore, he explained the role of judicial officials, law enforcement, commitment examiners, and hospitals throughout the IVC process, and discussed their respective responsibilities.

Professor Botts answered questions from the Committee.

Dr. Jeni Corn, Research Director of Social Sciences at the NC Collaboratory, provided an update to the Committee about the Collaboratory's research on mental health and the justice system as charged in S.L. 2025-93. The General Assembly has mandated the NC Collaboratory to study the following:

- The intersection of mental health in the justice system for both adults and juveniles in North Carolina includes initial response, mental health evaluation, inpatient and outpatient involuntary commitment, incarceration, post-release monitoring and treatment, and any other items the Collaboratory deems relevant.
- The availability of house arrest as a condition of pretrial release in each county or judicial district; and
- Methods of execution other than those currently authorized by state law.

Dr. Corn explained the challenge of conducting this research, the objectives listed, and the lack of accessibility to relevant data. She said there are disparate data collection systems across state agencies, mental health providers, and the judicial system, with no central repository for this information. The NC Collaboratory's research framework will be to

- Assess current policies and practices for people with severe mental illness.
- Compare models and policy reforms from other states that can potentially be adapted to North Carolina.
- Itemize the unmet and met needs of people with severe mental illness within the criminal justice system.
- Explore existing pilot initiatives related to severe mental illness.
- Identify potential impacts of the changes enacted in S.L. 2025-93 and formulate plans for state agencies to implement those changes.

Dr. Corn concluded with an explanation of the parameters of the research to be conducted. She said that \$1 million has been appropriated to the NC Collaboratory for study mandates related to Iryna's Law and research is to begin January 1, 2026, with a preliminary report due April 1, 2026. She stated that the anticipated goals are to collect new data, engage with stakeholders, and develop policy briefs for legislators.

Dr. Corn answered questions from the Committee.

Next, the Committee heard from Nicholle Karim, Vice President of Policy for the NC Healthcare Association (NCHA), and Johana Troccoli, System Vice President of Behavioral Health for Duke University Health System, to present on the impact of IVC on the healthcare system and emergency providers.

Ms. Karim spoke to the Committee about how the NCHA has been striving to reform and improve the IVC process after the passage of S.L. 2018-33. She said that that act modernized North Carolina's involuntary commitment law through collaborative efforts between law enforcement, behavioral health providers, and hospitals to help individuals receive the right care, at the right time, and in the right place. She stated that the legislation helped make it easier for individuals to access specialty facilities for care. Legislative reforms

included expanding the pool of healthcare professionals that can perform the first exam and allowing local management entity/managed care organization (LME/MCO) to (1) designate entities for the transportation of IVC individuals to specialty facilities and (2) designate qualified facilities as a crisis center or mental health care facility. Ms. Karim explained that emergency departments (EDs) continue to be the primary location for first exams and law enforcement continues to transport the majority of people in treatment through the IVC process (also known as respondents). Because EDs contain the most intensive lifesaving services and are designed to respond to medical emergencies, they must also provide additional resources, such as a sitter, to ensure the safety of respondents and to comply with government regulations. She further explained that the long wait times for proper placement at EDs can often frustrate respondents, and that stress due to their physical and/or mental condition increases the risk of danger to respondents and staff. Ms. Karim expressed that the NCHA plans to build on the previous reforms by (1) promoting non-ED sites as preferred locations for first examinations, (2) facilitating telehealth calls for defendants in detention under Iryna's Law, and (3) supporting DHHS Non-Law Enforcement Transportation pilot. Next, Ms. Karim introduced the Committee to Ms. Troccoli to provide more detail about the information already presented.

Ms. Troccoli is a member of the NCHA and was previously involved in reform for individuals under an IVC in the ED. She explained that telehealth has been a useful tool in EDs to promptly conduct first examinations. She said that after the first exam, the challenge is to locate a facility with the specialty care that meets the respondent's needs. She explained that all available psychiatric beds are not suitable for meeting the needs of all individuals in psychiatric care. Ms. Troccoli said that transporting individuals is also a challenge, as statute mandates placement within six hours but staffing shortages within law enforcement often results in longer placement times, and can inadvertently cause individuals to lose an in-patient bed.

Furthermore, she said that individuals who are evaluated in the ED, and do not qualify for IVC or require in-patient hospitalization, should be returned to their home under statute, but that this rarely occurs for those receiving care in a nursing home, mental health group home, or are in the custody of a local department of social services. She explained that in these care settings, due to an IVC evaluation, an individual may lose their placement at the home under special rules that allow for an emergency discharge, and that this results in the individual not having a place to go. Ms. Troccoli explained that these individuals are held in the ED for weeks and months, while EDs bear the responsibility of coordinating a new placement, and subsequently an individual's care may be delayed.

Ms. Troccoli explained that hospitals expect an increase in the number of IVC examinations of criminal defendants performed at hospitals due to Iryna's Law. She said that hospitals are not equipped as long-term care facilities and cannot offer a secure environment for defendants displaying violent behavior or who have recently committed a crime. She also said that community hospitals are unable to provide specialty forensic units to treat defendants. She explained that hospital police are planning measures to improve security, which may include sectioning off wings of the hospital to conduct commitment exams for defendants, which would also impact patient care. Increasingly, resources and staff are being diverted away from the EDs primary purpose of treating people in need of emergency care and are instead being used on people who no longer meet the IVC criteria, or don't require in-patient psychiatric treatment. Ms. Troccoli explained that the assessment of criminal defendants at hospitals

under Iryna's Law will be hard to manage, as children will experience extended wait times for placement, and staff will be subjected to physical violence.

Ms. Karim and Ms. Troccoli answered questions from Committee.

Dr. Jeremiah Gaddy, a fellow of the American College of Emergency Physicians and a representative for the NC College of Emergency Physicians, presented on the impacts of IVC on emergency providers. In the context of the IVC process, Dr. Gaddy provided an overview of what emergency medicine is, what physicians are trained to do, and what emergency medicine is not. He said that emergency physicians are acute care specialists that care for a variety of individuals and are not trained to provide care for non-emergent psychiatric patients or to provide judicial assessment/capacity hearings. He explained that prolonged wait times for placement delays the provision of specialty care and proper treatment and increases the risk of workplace violence and the risks to vulnerable people seeking emergency care. Dr. Gaddy stated that the recommended boarding time for behavioral health patients is four hours, but North Carolina far surpasses that at 285 hours. He also said that, statistically, one in three healthcare workers will experience workplace violence. He explained that the IVC process has been described as a crisis driven model, meaning that care is prioritized only after a person is in crisis. He further explained that law enforcement is being diverted from patrolling communities to sit with justice-involved individuals who are waiting for first exams or placement. Dr. Gaddy stated that resources will be strained, and care delayed, if EDs take in more people who have been recently violent but are medically stable. Dr. Gaddy said that telepsychiatry bridges the legislative intent with clinical reality, and that it has been shown to decrease the amount of time individuals spend in hospitals, expedite care, and provide access to care in rural areas. He stated that the NC College of Emergency Physicians emphasizes using telehealth for criminal defendants. Other recommendations include a 24/7 call center, expansion of existing pilots/programs that offer telehealth services for people in crisis, increasing the number of crisis facilities, increasing data collection, and increasing efforts to mitigate workplace violence.

Dr. Gaddy answered questions from the Committee.

The Committee heard from Christopher Graves, Wake County Chief Magistrate under the North Carolina Administrative Office of the Courts, to provide a magistrate's perspective on involuntary commitments. Mr. Graves began his presentation to clarify that magistrates have the authority to issue the court order for examination of a respondent but not commitment itself, and that the decision to commit a respondent is up to the commitment examiner or judicial official. Mr. Graves highlighted statutes that are relevant to the IVC process, including those charging magistrates to issue an order to a designated person to take the respondent into custody for examination, after the magistrate finds reasonable grounds that the respondent is dangerous to themselves or others. Mr. Graves explained that after an order is issued, the magistrate then calls local law enforcement to transport the respondent to an area hospital or mental healthcare facility. Mr. Graves said that in instances where a medical professional petitions for an involuntary commitment, magistrates will either accept or reject the affidavit from the medical professional. He said if the affidavit is accepted, the magistrate would then issue a custody order to the facility, and coordinate with local law enforcement to serve the custody order on the respondent. Mr.

Graves said that magistrates are tasked with effectively communicating to law enforcement regarding the respondent's location, propensity for violence, and where law enforcement should transport the respondent for care. Mr. Graves explained how Iryna's Law may affect magistrates within the IVC process and highlighted the burden of transportation on local law enforcement. He said that the provision for magistrates to review past commitment records will need to be configured into the current, existing process.

Mr. Graves answered questions from the Committee.

December 17, 2025

Safekeeper Program -

Leslie Cooley Dismukes, Secretary, NC Department of Adult Corrections
Arthur L Campbell, III, MD, Chief Medical Officer & Chief of Health Services, NC Department of Adult Corrections

Law Enforcement Perspective on IVC; Medical Care in Jails -

Eddie Caldwell, Jr., Executive Vice President and General Counsel, North Carolina Sheriff's Association

North Carolina Statewide Telepsychiatry Program (NC-STeP) -

Sy Atezaz Saeed, MD, MS, *FACPsych*, Founder & Executive Director of NC-STeP, Founder & Director, East Carolina University (ECU) Center for Telepsychiatry; Professor & Chair Emeritus, Department of Psychiatry and Behavioral Medicine, Brody School of Medicine, ECU

Role of Telehealth in IVC Process -

Carrie Brown, MD, MPH, DFAPA, Chief Psychiatrist, NC Department of Health and Human Services (NC DHHS) and Chief Medical Officer, Division of State Operated Healthcare Facilities, NC DHHS

Overview of NCGA Behavioral Investments; Role of IVC in the Crisis System; IVC Facility Designation Process and State Operated Healthcare Facilities -

Kelly Crosbie, Director, Division of Mental Health, Developmental Disabilities, and Substance Use Services, NC DHHS

Carrie Brown, MD, MPH, DFAPA, Chief Psychiatrist, NC DHHS & Chief Medical Officer, Division of State Operated Healthcare Facilities, NC DHHS

Karen Burkes, Deputy Secretary for Facilities and Licensure, NC DHHS

Leslie Cooley Dismukes, Secretary of the NC Department of Adult Corrections (DAC), presented an overview of the Safekeeper Program and the context in which the program exists. Currently, DAC admits more people than it releases and has not been able to account for the increasing prison population, despite a slight increase in staffing

numbers. Additionally, nurse vacancies are at 48%. DAC is projected to have a \$63 million shortfall this fiscal year because of the increase in medical costs.

Individuals in the program must pose a security risk or require medical or mental health treatment. A medical/mental health safekeeper is someone who requires treatment that the county has decided can best be provided by DAC. However, DAC is not capable of providing all medical treatments in-house. There are 200 safekeepers in DAC facilities on average, which is the statutory limit. Persons held for medical or mental health treatment are initially held for a 30-day period. During this time, an individual will be assessed by DAC.

Dr. Arthur L. Campbell, MD, Chief Medical Officer and Chief of Health Services for DAC explained current statistical data on the status, capacity, and length of stay for mental and medical safekeepers program, as well as the challenges DAC has identified within the Safekeeper Program. One challenge is a lack of available medical data about incoming safekeepers, which can lead to a delay in treatment.

The second challenge is that mental and medical safekeepers are experiencing longer stays which impact program capacity while also decreasing available slots for other county inmates in need of medical and mental healthcare. DAC is seeing an increase in medical/mental health safekeepers. Safekeepers currently occupy 21% of all inpatient medical beds and 26% of DAC long-term care beds. Every bed occupied by a safekeeper is a bed not available to DAC convicted inmates.

Lastly, Dr. Arthur explains the indirect costs associated with medical and mental health safekeepers within the agency that are not accounted for in the statute that allows DAC to be reimbursed. In 2024, DAC spent \$8.2 million on long-term care for sentenced inmates in community care settings because there were no available beds. The current structure of the program does not support the most efficient and safe transfer of safekeepers. It is essential for the safekeeper program to have adequate resources to maintain public safety.

Ms. Dismukes and Dr. Arthur answered questions from the Committee.

Eddie Caldwell, Jr., Executive Vice President and General Counsel of the NC Sheriff's Association (NCSA) presented to the Committee the NCSA's perspective on mental health and substance abuse and explained the issues law enforcement faces involving IVC respondents.

The NCSA supports Medicaid expansion because additional funds would provide more care for people with mental health and substance abuse issues and prevent jails from being used as hospitals. The NCSA also supported Iryna's Law and believes that this is a step in the right direction to address the "catch and release" policies currently in place and to decrease the number of people in jails with mental health and substance abuse issues.

Mr. Caldwell explained the responsibility law enforcement has when transporting respondents for an IVC first examination to a 24-hour facility. Cities have a duty to provide all transportation of a respondent taken into custody within city limits. Counties have the same duty to those in custody outside the city limits, and cities and counties may contract with each other to provide transportation. All transportation between counties is provided by the sheriff's office of the county where the respondent is taken into custody.

Transportation by any other means may be authorized by a magistrate only if danger to the public, to family or friends of the respondent, to the health care provider, and to the respondent is not substantial. The statute does not allow IVC respondents to be detained in jail while awaiting the first examination, therefore the availability of telepsychiatry would not reduce the transportation costs incurred by the counties. The IVC process for sheriffs is dangerous, time-consuming, and can be a revolving door of IVC respondents who often cycle through the system. Law enforcement must ensure the respondent is under appropriate supervision and must stay with the respondent until a physician is available to conduct the first examination.

Insufficient 24-hour facility bed space is an issue that results in IVC respondents waiting long periods of time for a bed while law enforcement guards them. These 24-hour facilities are sparse throughout the state, and law enforcement officers often make multiple telephone calls over multiple hours or days to locate an available bed. NCSA believes an accessible directory of available beds, updated daily, can reduce the burden on law enforcement.

The NC Administrative Code requires each jail to develop a plan for medical care to include policies on handling routine medical care, administering medications, privacy during medical exams, etc. Medical plans become an issue for law enforcement when each medical plan is based on the resources available to that jail. Medical plans have already allowed for the use of telepsychiatry but because of lack of resources, some counties only have the capacity to use it for suicide watch. Defendants often decline participation in telepsychiatry due to distrust or the fear of being surveilled.

NCSA also spoke of the lack of safekeeper beds. There is no dedicated safekeeper unit for female inmates and sometimes an inmate cannot be accepted into the women's prison because there is not an available bed. When there is not an available bed, defendants will stay at the jail until a bed becomes available or their charges are disposed. This leaves defendants with only the resources the jail's medical plan can provide. It is not uncommon that a defendant who pleads guilty or whose case has been dismissed does not receive the treatment needed prior to being released because of the lack of timely resources the jails can provide.

DHHS has implemented the NC RISE (Restoring Individuals Safely and Effectively) program in Mecklenburg, Wake, and Pitt Counties to provide restoration services in jail to a defendant found ITP. The goal of this program is to reduce the need for transportation to state hospitals and reduce wait time between court-ordered capacity restoration and the conclusion of criminal cases.

Lastly, Mr. Caldwell explained that NCSA is in support of Iryna's Law but are opposed to the requirement to conduct first examinations for criminal defendants via telepsychiatry. He stated that jails do not have adequate medical staff to conduct examinations, and the cost of the examinations would be shifted to the sheriff.

Mr. Caldwell answered questions from the Committee.

Dr. Sy Atezaz Saeed, founder and Executive Director of NC-STeP and professor and Chair Emeritus of the Department of Psychiatry and Behavioral Medicine at the Brody School of Medicine at ECU, presented to the Committee on the North Carolina Statewide Telepsychiatry Program (NC-STeP). Dr. Saeed acknowledged that mental disorders are

common and said that one in four Americans have a mental disorder, and in North Carolina, 54% of adults with mental illness receive no mental health treatment, 72% of children with a treatable mental health disorder did not receive needed treatment, and 93 counties are classified as Mental Health Professional Shortage Areas. He said that EDs across North Carolina are seeing an increase in mental health visits, and that people with mental health disorders were admitted to the hospital at twice the rate of those without mental health disorders.

Dr. Saeed explained that the General Assembly established a statewide telepsychiatry program (NC-STeP) with the mission to deliver timely, high-quality psychiatric care statewide, regardless of geography, and to focus on crisis stabilization to prevent unnecessary hospitalization. He stated that the NC-STeP program developed a proprietary web portal to coordinate scheduling, exchange clinical data, and make referrals across electronic health record systems to help streamline care. He said the goal of the program is to reduce lengths of stay for psychiatric patients in EDs, reduce unnecessary IVC's, improve transitions to community follow-up care, and reduce statewide behavioral-health costs.

Next, Dr. Saeed discussed the status of the NC-STeP Program. He said there are 28 hospitals in the network, 24 community-based sites, and that 68,150 total psychiatry assessments in ED's implicated a cumulative return on investment of \$64,513,800. He said the program has been impactful in improving access to specialized care in underserved areas, which has saved time and travel expenses, reduced hospital admissions and in-person consultations, and enhanced patient satisfaction.

To conclude, Dr. Saeed explained that mental disorders are common and the workforce is in short supply. He said that awards, articles, and data show that NC-STeP is an established model with proven results and is nationally known as an effective model to enhance access to mental health care. He said the program demonstrates a scalable, state-level model that provides underserved areas with access to care, and that further expansion of the program could shift IVC treatment from crisis-driven to preventive integrated behavioral health care. He stated that continued success will likely depend on sustained funding, technological infrastructure, workforce engagement, and expansion of telepsychiatry beyond emergency departments.

Dr. Saeed answered questions from the Committee.

The Committee next heard from Dr. Carrie Brown, Chief Psychiatrist of the NC Division of Health and Human Services (DHHS) and Chief Medical Officer of the Division of State Operated Healthcare Facilities, on the role of telehealth in the IVC process. Dr. Brown described the IVC process and stated that it consists of (1) the petition, (2) the custody order, (3) the first exam, (4) a search for a 24-hour mental health facility, and (5) the second exam. She stated that generally, telehealth is a well-established practice that is currently used for first and second exams. Dr. Brown said there are a variety of professionals that can be first examiners, but the second exam must be completed by a physician within 24-hours of admission to an inpatient psychiatric facility, and these exams cannot be completed by the same person. She said that currently there are 3,211 licensed psychiatrists practicing in North Carolina who can complete both first and second exams.

Dr. Brown answered questions from the Committee.

Kelly Crosbie, Director of the Division of Mental Health, Developmental Disabilities, and Substance Use Services under the North Carolina Department of Health and Human Services (DHHS), presented to the Committee an overview of the General Assembly's investments in behavioral health, the role of IVC in the crisis system, and the IVC facility designation process. Director Crosbie specifically addressed investments made by the General Assembly in the areas of crisis and justice. She said the vision for crisis investment is for people experiencing a crisis to have someone to contact (ex. 988, Peer Warmline), someone to respond (ex. mobile crisis response team), and a safe place for help (ex. Behavioral Health Urgent Care (BHUC) or Facility Based Crisis Center (FBC)). Director Crosbie said that DHHS has allocated \$80M for crisis system response and capacity, \$20M for non-law enforcement transport, and \$20M for related technology. She further explained that these crisis investments have increased capacity across North Carolina by adding 32 child beds, 80 adult beds at FBCs, 13 new BHUCs, two additional lines of support, and expanding Mobile Outreach Response Engagement Stabilization (MORES) to 20 counties. She stated that the Non-Law Enforcement Transportation (NLET) pilot is actively being pursued by DHHS to provide contract options for counties/hospitals without alternative transportation options. She said that statewide models for medical transportation have been challenging to produce for stakeholders, and DHHS is trying to address the shortages that exist in rural areas.

Director Crosbie stated that DHHS maintains BH SCAN as a centralized bed registry with a daily inventory of available beds. In February 2026, the system will include a pilot that tracks mobile crisis deployment and includes tracking software. Director Crosbie said that currently BH SCAN is tracking 76% of community inpatient psychiatric beds, and DHHS supports efficient placement of people in available beds to reduce long stays in emergency departments. Additionally, she said that less than 8% of beds are currently empty, but DHHS needs more acute beds.

Director Crosbie explained that approximately 43% of the \$99M appropriated for justice-involved programs had been allocated as follows: (1) to prevent people seeking mental health and substance abuse treatment from becoming involved with the justice system, (2) create access to mental health care for youth and adults involved with the justice system, and (3) support seamless re-entry and stabilization in the community for individuals involved with the justice system. She stated that investments have expanded (1) Law Enforcement Assisted Diversion (LEAD) to eleven counties, (2) helped launch Forensic Assertive Community Treatment (FACTS) in five regions, and (3) supported Treatment Accountability for Safer Community (TASC) substance abuse reentry in all counties, among other programs.

Director Crosbie then explained the duties of DHHS within the IVC process, which include the designation of facilities to accept involuntary commitment respondents and the creation of policies regarding safety, security, reporting, and program adequacy.

The Committee then heard from Karen Burkes, Deputy Secretary (DS) for Facilities and Licensure (DS), to explain in more detail how facilities around the state are designated. DS Burkes stated that across the state DHHS is tracking thirty-seven acute care hospitals and medical centers, ten psychiatric hospitals, fourteen facility-based crisis

centers, three combination FBC/NHMD centers, four Veterans Affairs Medical Centers, and five State facilities that have obtained IVC designation. Further, DS Burkes described how the Division of State Operated Healthcare Facilities (DSOHF) manages safety-net facilities that provide medical and behavioral treatment of adults and children, serving approximately 2,000 individuals daily. DS Burkes said that the three State Psychiatric Hospitals (SPHs) serve approximately 570 individuals daily and provide comprehensive inpatient mental health services to individuals who cannot be safely treated at a lower level of care. She further stated that SPHs function as a safety-net provider, and admission is available to anyone, regardless of their financial resources. Individuals are typically referred to the SPHs from emergency departments and jails, and DS Burkes further stated that the SPHs expect an increase in demand of services due to Iryna's law.

DS Burkes said that staffing limitations is one challenge associated with the expectation of serving more individuals. She said that one unit (typically 20-24 patients) requires 17 registered nurses, 42 health care techs (HCT), and two psychiatrists. Another challenge she described are individuals that have highly complex medical and mental health needs and who do not have appropriate care options in the community. DS Burkes said this can require additional staff support and can lead to longer lengths of stay for patients, limited numbers of patients in a unit, and limited discharge options, especially for those with a history of aggressive and sexualized behaviors.

DS Burkes explained that DHHS has made strides to address these challenges by soliciting employee feedback to inform policy changes that improve staff retention. DHHS has launched walk-in hiring events with same-day contingent offers that quicken the hiring process, enlisted nurse recruiters at each SPH, and implemented competitive salary scales for HCTs and RNs, funded by the elimination of 293 vacant positions. DS Burkes stated that DHHS is focused on expanding the workforce training pipeline through statewide partnerships with community colleges.

DS Burkes said that DHHS has established and is operating three detention-based capacity restoration pilots, called NC RISE. She said that Broughton Hospital's waitlist for incapable to proceed defendants has decreased by 60% after the pilot began in Mecklenburg County in 2022, and that the average time to restore capacity in the detention-based program is about 50 days, compared to more than 140 days at a SPH. DS Burkes said that DHHS launched a system-wide Electronic Health Record platform which has been essential for safe, quality coordinated care. She stated that DHHS will continue to improve retention, patient and staff workflows, and improve the system so respondents are properly discharged.

Dr. Brown, Director Crosbie, and DS Burkes answered questions from the Committee.

January 14, 2026

Overview and Effectiveness of Outpatient Commitment -

Dr. Marvin Swartz Professor, Duke University School of Medicine, Department of Psychiatry & Behavioral Sciences Director, Duke AHEC Program Faculty Member, Wilson Center for Science and Justice, Duke University School of Law

NC DHHS's Legislative Recommendations for Outpatient Commitment Treatment -
Carrie Brown, Chief Psychiatrist, NC DHHS Chief Medical Officer, Division of State
Operated Healthcare Facilities, NC DHHS

LME/MCO's Perspective of Involuntary Commitment Process -
Senitria Goodman, General Counsel, Chief Compliance Officer for Trillium Health
Resources

Comparative Analysis of Other States -
Stephen Eide, Senior Fellow, Manhattan Institute

Dr. Marvin Swartz, Professor of Duke School of Medicine and Department of Psychiatry and Behavioral Sciences, presented to the Committee on the origins and criteria of the involuntary outpatient commitment in North Carolina and other states. Dr. Swartz provided an overview of data on outpatient commitment effectiveness.

Dr. Swartz provided information about involuntary outpatient commitment (OPC), which involves a civil court order requiring the patient to comply with recommended treatment and to receive services. Non-compliance with the court order initiates law enforcement to transport the patient to a mental facility for evaluation and the patient may be involuntarily hospitalized if criteria is met. The court order cannot permit forced medication under involuntary outpatient commitment. The history of involuntary outpatient commitment began with North Carolina becoming one of the first states to pass a preventative form of OPC in 1984 when OPC was only available to persons who met the criteria for involuntary inpatient commitment. North Carolina is a national model for what is called "assisted outpatient treatment" by focusing on preventing deterioration of a mentally ill individual when court-ordered treatment is authorized at a lower threshold than inpatient commitment criteria. An individual does not need to be imminently dangerous to be committed to the hospital. Dr. Swartz explains that the criteria for OPC in North Carolina include:

- a) Presence of a serious mental illness.
- b) Capacity to survive in the community with available support.
- c) Clinical history indicating a need for treatment to prevent deterioration that would predictably result in dangerousness.
- d) Mental status that limits or negates the individual's ability to make informed decisions to seek or comply voluntarily with recommended treatments.

Outpatient commitment criteria are similar nationwide, Dr. Swartz noted that New York's criteria are more specific.

Dr. Swartz spoke about a study he conducted involving individuals who were released from inpatient treatment with the understanding from the courts that they would be part of an experiment to determine the effectiveness of outpatient commitment. Dr. Swartz concluded from this study that the longer an individual is participating in outpatient commitment, the less violent they become. He noted individuals with severe mental illnesses are most often victimized rather than perpetrators, and outpatient

treatment kept those individuals safe and away from violence. He explained that data is not accessible to determine how often outpatient commitment is used, but that use is variable throughout the counties. He noted mental health reform in 2000 and 2001 made the responsibility for outpatient commitment ambiguous, and counties were informed they could either manage care or provide care. Overall, the area programs decided to manage care. In a newly privatized system, payment for outpatient commitment went to the wayside and there became no financial incentive to use OPC and it fell to disuse. Dr. Swartz is unable to determine the effectiveness of these policies because of a lack of reporting and auditing.

Dr. Swartz remarked New York's assisted outpatient treatment (AOT) programs are based on the understanding that individuals with serious mental illness require supervision to live in the community and to prevent relapse. In New York, a petition for AOT must include the following: (i) two documented hospitalizations in the prior three years and (ii) one act of violence or threat of serious harm to self or others within the prior four years. There was opposition to the program because it required annual spending of \$32 million dollars. New York conducted an evaluation study, and it found that an individual's improvement is more likely to be sustained when they were in AOT for six months or longer. New York also found that the AOT court order and subsequent monitoring offer additional benefits in improving outcomes.

Dr. Swartz explained data available from North Carolina and New York indicate that OPC can reduce minor acts of violence and that acts of serious violence are far too infrequent to study accurately. Dr. Swartz concluded that improving treatment compliance may reduce serious violence. He explained that OPC law should be considered on the merits of improving treatment compliance and reducing relapse not as violence prevention per se.

The Committee heard from Dr. Carrie Brown, Chief Psychiatrist and Chief Medical Officer of the Division of State Operated Healthcare Facilities under NC Department of Health and Human Services (NC DHHS). Her remarks focused on outpatient commitment in North Carolina, she explained how individuals with serious mental illness cycle in and out of hospitals and jails because of non-compliance with treatment. She added that when treatment breaks down, there are limited mechanisms to use to reengage individuals for treatment.

Dr. Brown explained OPC is a court-ordered treatment requiring the individual to engage in mental health treatment while living in the community. She explained that OPC is for a limited number of adults who lack insight into their illness, decline treatment, and demonstrate repeated violence, arrests, or hospitalizations. She noted it is not appropriate for most people with mental illness. Dr. Brown identified the following for OPC:

- a) Outpatient orders lack specificity, resulting in implementation difficulties and unclear expectations.
- b) There are limited accountability and enforcement mechanisms to ensure treatment compliance.
- c) OPC is underutilized in practice because orders are complex, unclear, and difficult for individuals with serious mental illness to navigate.

- d) There is insufficient support to help individuals successfully comply with treatment requirements.
- e) There is a shortage of specialized providers, which limit access even when an order is in place.

Dr. Brown elaborated that an effective outpatient commitment starts with clearly defined and limited eligibility to focus on individuals with serious mental illness and documented patterns of violence, incarcerations, or hospitalization due to noncompliance. She noted how important it was that the response to noncompliance be efficient and that the capacity to adequately treat individuals be in place. To accurately measure efficiency, it is also important to centralize responsibility and accountability, and for there to be consistent training and ongoing evaluation. She explained OPC must work in concert with the justice system, healthcare system, and community to best assist people with severe mental illness. Dr. Brown suggested the following measures to improve outpatient commitment:

- a) List outpatient commitment as the most appropriate option on the petition.
- b) Require an initial treatment plan from the examining clinician, which includes expectations for adherence, services, medications, and identifies an outpatient provider who has agreed to accept the patient.
- c) Ensure every individual has a navigator with ongoing care management and monitoring.
- d) Extend the maximum commitment from 90 to 180 days to allow adequate time for stabilization.
- e) Expand capacity and accountability by engaging with Forensic Assertive Community Treatment programs and utilizing Treatment Accountability for Safer Communities.
- f) Ensure non-compliance with an outpatient IVC order results in inpatient admission.

Dr. Brown answered questions from the Committee.

Ms. Senitria Goodman, General Counsel and Chief Officer of Trillium Health Resources, presented to the Committee about the role of local management entities/managed care organizations (LME/MCOs) in crisis response for North Carolina. She noted county jails and hospital emergency departments are increasingly housing individuals with untreated behavioral health issues and are not designed to respond to behavior crisis.

Ms. Goodman explained the role of the LME/MCOs within the involuntary commitment (IVC) process are (i) to reimburse treatment providers for care to members, (ii) to link members to ongoing treatment after a crisis episode, and (iii) to manage member access to behavioral health crisis services through its provider network. The objective of IVC is to provide an evaluation by a qualified professional, stabilize the mental crisis, and protect the individual and the community with the least restrictive means possible. She noted the system breaks down when there is inaccessibility to qualified clinicians, unnecessary visits to jail or emergency departments, and long wait times in those respective locations. Trillium Health Resource meets these challenges with

wraparound services after an IVC. The flexible funding that the LME/MCOs receive help to provide community transition services, occupational therapy, and peer support.

Ms. Goodman explained that mobile crisis services need the following structure: (i) an immediate, on-scene response by licensed mental health professionals, (ii) a real-time risk assessment and de-escalation, and (iii) a clinical determination of next steps, instead of carceral custody and transportation or release into the community without stabilization. Mobile crisis services ease system burdens by reducing the number of individuals booked in jail due to mental illness. Mobile crisis services also reduce contact with the emergency department, reduce wait times, and improve safety outcome for the public and first responders. Ms. Goodman suggested that legislators support sustained funding for mobile crisis services, which would allow these services to be available in all counties. She also suggested making mobile crisis services the default front door for IVC determinations, assessment and treatment planning. She noted the willingness of the LME/MCOs to collaborate with stakeholders and develop IVC-specific mobile crisis response protocols.

Ms. Goodman explained to the Committee that individuals in behavioral health crisis need immediate clinician stabilization, instead of being in a waiting room, jail cell, or transport vehicle. She concluded mobile crisis services deliver the right response at the right time, and that the LME/MCOs are committed to increased utilization of mobile crisis services with proper infrastructure funding.

Ms. Goodman answered questions from the Committee.

The Committee heard from Stephen Eide, Senior Fellow of the Manhattan Institute. Mr. Eide presented on the discharge process, specifically when individuals are moved from hospital or psychiatric facilities to outpatient community psychiatric care. Mr. Eide focused his remarks on care coordination, medication adherence, follow-up, judicial involvement and outpatient commitment involving the severely mentally ill.

Mr. Eide explained the approach to discharging individuals is a step-down process. He noted the goal is continuity of care and to avoid the revolving door of mentally ill individuals in and out of jails and hospitals. Care coordination includes a robust program of family education because family engagement is key to strengthening prognosis. Families are best suited to help hospitals understand what works best for their loved ones and treatment team members can advise the family on diagnosis and resources. Simple changes can make an impact, such as creating a checklist to ensure that an individual who has been discharged gets to their follow-up appointment within seven days. Mr. Eide noted medication adherence is also important in the discharge process and begins with getting the individual off the wrong medications and on the right ones. He mentioned a key part of medication management focuses on making sure the individual is checking in regularly with their clinician, who can monitor symptoms and address side effects. Clinician shortages may be a challenge to medication adherence. He said offering housing is another beneficial solution as a follow-up measure after being discharged from involuntary commitment. Assertive outpatient treatment (AOT) must be funded to monitor individuals with serious mental illness. When it comes to judicial involvement, there must be a structure to formally integrate mental health program into jails, prisons

and community resources to reduce the number of seriously mentally ill involved in the criminal justice system. He pointed out that outpatient commitment is underutilized and should be considered at the point of discharge, and that timely placement is the key to AOT and should be a part of the treatment plan.

Mr. Eide discussed his recommendations to the Committee. He recommended (i) investing in psychiatric hospitals to open more hospital beds and (ii) investing in community mental healthcare.

Mr. Eide answered questions from the Committee.

February 10, 2026

Judicial Perspective on Commitments, Legal Standards, and Order Specificity

Lisa Coltrain, North Carolina Conference of District Attorneys, NC AOC

Explanation of New York Outpatient Commitment Statutes and Comparison to North Carolina

Robert Ryan, Staff Attorney, Legislative Analysis Division of the NC General Assembly

Lisa Coltrain, NC Conference of District Attorneys, presented on the legal process governing defendants who are found incapable to proceed (ITP) in criminal proceedings. Ms. Coltrain explained that the criminal justice and mental health systems work well independently but gaps may form where these systems intersect. G.S. 15A-1001 provides the criteria under which a person with mental illness or defect may be tried, convicted, sentenced, or punished. Ms. Coltrain clarified that even if a person has a mental illness or defect, it does not automatically mean that the person cannot be held accountable in criminal court. Rather, the defendant will only be found ITP if the defendant cannot 1) understand the nature and object of the proceedings against him, 2) comprehend his own situation in reference to the proceeding, or 3) assist in his defense in a rational and reasonable manner.

The question of capacity can be raised at any time by the judge, prosecutor, or defense attorney. G.S. 15A-1002. Once the issue is raised, there must be a capacity hearing and a determination by the judge. It is within the judge's discretion to order a forensic evaluation to assist in making this determination. At the judge's discretion, a defendant charged with a felony may be directed to Central Regional Hospital as a more appropriate venue for evaluation. However, local evaluators act as a default option and are required for defendants charged with a misdemeanor. Local forensic evaluators receive six hours of forensic evaluation training annually and perform most of the 2,000 evaluations that are conducted every year. Local evaluators have the authority to recommend to the judge that a case be referred to Central Regional when appropriate.

If parties cannot agree on capacity, the case moves into a contested capacity hearing. In a contested capacity hearing, the defendant has the burden to show by a preponderance of evidence that the defendant lacks capacity to proceed. Upon the judge's determination of ITP, the judge will initiate the involuntary commitment (IVC) proceeding. G.S. 15A-1003. The IVC determination is based on the defendants' dangerousness to self or others, as provided in G.S. 122C-3(11). A defendant who is found ITP, a danger to self/others, and is charged with a violent crime, will be committed to a state psychiatric hospital. Defendants are committed to the state hospital until capacity is restored and a trial or guilty plea can occur, or until charges are dismissed and the defendant is no longer a danger to self or others. If a defendant is found ITP, is a danger to self or others, but isn't charged with a violent crime, the judge will order a commitment examination.

Ms. Coltrain explained that the purpose behind a capacity evaluation is to determine whether the defendant understands what is occurring in court, while a commitment examination seeks to determine if the defendant is a danger to self or others. An examiner for the commitment examination may determine whether inpatient or outpatient treatment is necessary, or that no further treatment is necessary.

The criminal charge will remain pending following the finding of ITP. Around 75% of people who are determined ITP can gain or do regain capacity to proceed. G.S. 15A-1008 provides that charges must be dismissed when the defendant (i) will not gain capacity to proceed, (ii) has been incarcerated or committed longer than the maximum term of imprisonment, or (iii) has been incarcerated five years after an ITP determination for a misdemeanor or ten years after an ITP determination for a felony. Iryna's law requires that prior to dismissal of criminal charges for any reason pursuant to 15A-1008, a judge must make findings as to whether the defendant is a danger to self or others and should be involuntarily committed.

Ms. Coltrain expressed various areas of concern for district attorneys. The first concern is that local evaluators are often inadequate because they do not have court experience and receive little training. Another concern is that once a defendant is found ITP, there are not sufficient safeguards in place to prevent reoffending, and there are no adequate means of regaining capacity. In misdemeanor cases, prosecutors notice quick turnarounds for these defendants. Defendants are often released and reoffend shortly after. Because most people who have a mental illness are not violent nor found to be a danger to self or others, defendants are often released without resources to prevent that individual from reoffending. Lastly, Ms. Coltrain noted that once a defendant is determined to be ITP and non-restorable, charges are dismissed and prosecutors lose agency in the case. The defendant will be sent to a state psychiatric hospital until the defendant regains capacity or the case is dismissed, or until the defendant is no longer a danger to self or others.

Ms. Coltrain answered questions from the Committee.

The Committee then heard from Robert Ryan, Staff Attorney for the Legislative Analysis Division of the NC General Assembly, on New York's assisted outpatient commitment (AOC) statutes as they compare to North Carolina's outpatient commitment

statutes. AOT is a mandated mental health treatment plan that is provided to a recipient while the recipient resides in the community. The recipient receives the same medical treatment as a person who is committed voluntarily, except the recipient is receiving treatment under court order because a court has determined that the recipient would not receive treatment on a voluntary basis.

AOT was introduced in legislation titled Kendra's Law (1999), which was introduced as a result of an incident in NY where a woman was pushed in front of a train by a person with a history of mental illness. Kendra's Law established new mechanisms for identifying individuals who, due to treatment history and circumstances, would likely have difficulty living safely in the community without close supervision and mandatory treatment. Violation of an AOT order is not a criminal offense.

To be eligible for AOT, a person must be at least 18 years old, have a mental illness, and be incapable to live in the community safely and without supervision. The person must have a history of treatment noncompliance that has been a factor in (i) two or more hospitalizations in the last 36 months, (ii) acts of serious violent behavior in the last 48 months, or (iii) a court order for AOT that expired within the last six months after which the person's symptoms worsened and impacted major life activities. The person must be unlikely to participate in voluntary outpatient treatment, need AOT to prevent relapses, and be likely to benefit from AOT. The AOT criteria required by New York is narrower than the requirements of outpatient commitment in North Carolina.

The AOT process begins when recipients of services are referred by the community (family and friends) or by institutions to a Local Government Unit (LGU's) for an AOT investigation. If the criteria are met, the LGU files a petition for AOT with the court and a physician develops a plan approved by the court. The recipient is then connected with a care management provider. The care management provider conducts the daily monitoring of the recipient, including arranging medical care, and through frequent check-ins, has the ability to document and report issues with compliance. Violation of the order is not a criminal matter, but it does allow for the recipient to be considered for "involuntary removal." LGUs work closely with recipients to ensure the recipient's compliance.

New York's criteria for involuntary commitment were amended recently and now more closely aligns with North Carolina's involuntary commitment statutes. The new statute provides that a person who is at substantial risk of physical harm due to the inability or refusal, as a result of mental illness, to provide for the person's essential needs is eligible for involuntarily commitment. New York AOT orders can be in place for up to a year while North Carolina's OPC orders may only be in place for up to 90 days.

Mr. Ryan answered questions from the Committee.

March 18, 2026

Data Support at the NCDIT Enterprise Data Office -

Sam Thompson, MSW, Executive Director, N.C. Health Information Exchange Authority, N.C. Department of Information Technology

Trip Stallings, Executive Director, N.C. Longitudinal Data System, N.C. Department of Information Technology

LME/MCO's Perspectives on Mobile Crisis Teams -

Sean Schreiber, Executive Vice President and Chief Innovation and Strategy Officer Alliance Health

Allison Gosda, Chief of Clinical Services Partners Health Management

The Intersection of Guardianship, Involuntary Commitment, and Capacity to Proceed -

Meredith Smith, JD, Associate Professor UNC School of Government

Mark Botts, JD, Associate Professor, UNC School of Government

Shea Denning, JD, James E. Holshouser Distinguished Professor, Director, North Carolina Judicial College, UNC School of Government

Involuntary Commitment in North Carolina -

Dr. Christopher Sharp, Senior Fellow, Cicero Institute

Sam Thompson, Executive Director of North Carolina Health Information Exchange Authority of the North Carolina Department of Information Technology (DIT), spoke to the Committee about the functions and capabilities of the Enterprise Data Office (EDO). Trip Stallings, Executive Director of the N.C. Longitudinal Data System under DIT accompanied Mr. Thompson's presentation. EDO enables a data driven government by collecting information through NC Center for Geographic Information and Analysis (CGIA), NC Health Exchange Authority (NC HIEA), NC Longitudinal Data System (NCLDS), and Government Data Analytics Center (GDAC).

Mr. Thompson explained EDO supports the needs of the State by meeting with stakeholders to try and define the need. Defining the need helps EDO understand what role it should play when gathering certain datasets or building systems to meet the need. EDO seeks to identify the data owners because federal law governs permission and agreements that need to be in place to access certain levels of data.

Mr. Thompson discussed a flow chart displaying the involuntary commitment process to highlight where he has identified imbalanced information, as it also pertains to implementing Iryna's Law. For example, magistrates that review petitions have access to the criminal record of a defendant and no access to their clinical record while Iryna's Law instructs a magistrate to also consider previous commitments. Another example is that clinicians may access clinical records through NC HIEA, but do not have access to a patient's criminal record. Clinicians have stated that having the criminal record would

have been helpful in making decisions. Mr. Thompson also explained that the lack of standardized evaluations and documentation throughout the process is not systematically routed correctly, so EDO can help to improve that function.

Mr. Thompson explained that EDO is not attempting to engineer a solution but to think of ways to improve the system. Within the IVC process, he suggests that the NC HIEA provides close to real-time clinical data to inform IVC decisions; provide historical healthcare data to monitor and evaluate IVC; and route petition and examination data throughout the process. The Criminal Justice Law Enforcement Automated Data Services (CJLEADS) under GDAC provides close-to-real time criminal justice data to inform IVC decisions and provide historical data to monitor and evaluate IVC. Lastly, NCLDS is a system that links data across time and data sources and could join cross-sector data to support analysis of and improvements to the IVC process. Issues arise when statutory regulations inhibit using this data to inform the IVC process. For example, HIPAA-protected information can only be accessed by a covered entities and business associates. Likewise, only authorized law enforcement can access criminal record information. The statutes limit NCLDS access to education and workforce data, statutory changes would be necessary to grant authority to access other data.

Mr. Thompson and Mr. Stallings answered questions from the Committee.

The Committee heard from Sean Schreiber, Executive Director and Chief Innovation Strategy Office for Alliance Health, and Allison Gosda, Chief of Clinical Services for Partners Health Management, about the LME/MCO's perspective on mobile crisis teams and what role they play. Mr. Schreiber explains that LME/MCOs are responsible for managing the Medicaid services for complex individuals in the Medicaid system. To be managed by an LME/MCO means that a person has experienced a series of persistent mental illness, significant substance abuse disorder, or intellectual developmental disability. Funds allocated to the organization are used to provide services to the uninsured and underinsured. Alliance Health has diverted more people away from jails and emergency departments and linked them to crisis services. Mr. Schreiber then explained the design and constraints in implementing mobile crisis teams.

The goal of mobile crisis teams is to be a 24/7 response to behavioral health crisis in the community. The response can involve conducting assessments to determine their need for care or sitting with the member of the community and deescalate the crisis to ensure safety. Mobile crisis teams help link individuals to the care they need and to divert them from higher costs and more crowded systems. To be referred to mobile crisis, a person can call the 988 behavioral health line or any crisis line. One constraint for services provided by the mobile crisis teams is funding and that commercial insurance and Medicare do not cover the costs incurred by mobile crisis teams. Ideally, mobile crisis teams refer to at least a two-man team and in practice crisis teams consist of one person to responding to the member of the community experiencing crisis. The person responding does not have the credentials to administer a first examination, that is statutorily required to begin the IVC process. Mr. Schreiber believes there to be

adaptations that can be made in the context of Iryna's Law. Allison Gosda spoke to the Committee next, to provide additional context on outpatient commitment.

Ms. Gosda stated that mobile crisis teams are not a practical solution to conduct first exams because of limited licensed clinicians in tandem with secure locations for the safety of the individual and staff. She added that the support needed to better utilize mobile crisis teams are a coordinated system that establishes dedicated timelines on when to expect an individual to be evaluated or how soon an individual is to be evaluated which could prevent backlogs of individuals in hospitals and jails. A coordinated system would allow for certified examiners to conduct evaluations in safe locations, administer evaluations in a timely manner, and to efficiently follow-up with patient care. Mobile crisis teams are not a stand-alone solution and typically serve by conducting well-being checks as opposed to using law enforcement. Mobile crisis teams are also called when an individual on outpatient commitment has not shown up to their provider. They are not designed to provide ongoing monitoring or that long-term care and support that is often needed for individuals on an outpatient commitment order. It's been recognized that outpatient commitment has its own operational challenges and lacks the infrastructure and coordination of resources that are needed to function consistently and effectively across the continuum of care.

Lastly, Ms. Gosda, explained the differences between New York's Assisted Outpatient Treatment (AOT) program and how North Carolina conducts outpatient commitment. She said that AOT functions by combining judicial oversight along with outpatient treatment with an added intensive care management component. New York has a structured and dedicated care management team to ensure a response to missing appointments, frequent follows-up with consistent reporting. The other difference mentioned was the length of time in outpatient commitment varies greatly. While in North Carolina a person be subjected to a 90-day order and in New York the order can be in place for up to a year.

Mr. Schreiber and Ms. Gosda answered questions from the Committee.

Meredith Smith, JD and Associate Professor, Mark Botts, JD and Associate Professor, and Shea Denning, JD and James E. Holshouser Distinguished Professor, Director of North Carolina Judicial College with the UNC School of Government spoke to the Committee on the intersection of guardianship, involuntary commitment and the capacity to proceed proceedings. This presentation walked through a hypothetical scenario where a woman, named Paula, is demonstrated to have gone through each type of proceeding as it concerns her mental health and a criminal proceeding.

Ms. Smith explained that guardianship in North Carolina follows a substituted decision-making model which effectively takes away a person's authority to make decisions for themselves and gives that authority to someone else when that person has

been adjudicated as incompetent. Incompetency is determined when a court finds an adult lacks sufficient capacity to manage their own affairs, make or communicate important decisions concerning their person, family, or property. The standard used for determining incompetency is that the evidence must be clear, cogent, and convincing. Guardianship is determined by a court unless capacity can be sufficiently met through a less restrictive alternative, following the "best interest" standard. The powers and duties of a guardian of the person include: a) an entitlement to care while having custody and control of a ward, b) must provide the ward's training, education, employment, or rehabilitation, c) must establish the ward's place of abode with preference given to community-based treatment facilities, d) give any consent or approval necessary to enable to a ward to receive legal, psychological, or other professional care, and e) give any other consent or approval on the ward's behalf in their best interest (G.S. 35A-1241(1), (2), and (3)). Guardianship does not by itself authorize confinement or forced treatment. Instead, guardianship is a conduit for services, treatment, support, and assistance. Courts may exercise oversight by responding to a motion or other information to establish a guardian plan or program, order status reports and hold hearings, or remove and appoint a new guardian. After discussing Paula's circumstances involving guardianship, the presentation moved on to discuss the hypothetical scenario within the voluntary and involuntary commitment process.

Professor Botts explained the ways an adult can be voluntarily admitted to an inpatient facility for psychiatric or substance abuse treatment as Paula's guardian wishes to admit her to an inpatient facility without using the IVC process. One way is that an adult presumed capable and competent can be admitted with patient consent. Another way is that an adult deemed "incapable" can be admitted with patient consent in an advance instruction or the consent of health care agent. The third way is that an adult adjudicated "incompetent" can be admitted with consent of the guardian. Practically speaking, when a guardian has the authority to admit the ward, it does not mean the ward will be compliant. This is where IVC is different in that law enforcement has the means and authority to safely transport these individuals to the facility. Another difference between voluntary and involuntary commitment is the standard for admission and voluntary commitment does not require a finding of dangerousness. Mr. Botts concluded that each proceeding - guardianship, involuntary commitment, and capacity to proceed - asks different legal questions and consider different legal standards. It is usual that individuals with Paula's circumstances are involved in two, if not, all three types of proceedings discussed.

Lastly, Ms. Denning spoke to the Committee about the capacity to proceed in the scenario where Paula is facing charges of drug possession. She clarified that Paula's adjudication for incompetency, and the appointment of a guardian is relevant but not dispositive toward her criminal case. Adjudication of incompetency does not excuse criminal behavior. The capacity to proceed is based on constitutional constraints that prohibit trial and punishment of an individual whose mental illness or defect prevents

them from assisting in their defense. Commonly, courts will order a mental health evaluation and use that to determine whether the standard for “incapable to proceed” has been met. If the court determines an individual is incapable to proceed, then there must be a hearing on whether they meet the criteria for involuntary commitment. This hearing functions the same as any other IVC hearing except that with the prior determination of incapacity to proceed, the individual would be treated at a state facility where they can receive capacity restoration. There is a pilot program (NC RISE) in some counties where capacity restoration is being conducted in jails. One major frustration that is echoed by courts and law enforcement is that the system cannot keep up with the number of “incapable to proceed” defendants. Defendants are being held in jails for 4-56 months waiting on a bed at a state hospital and those facing misdemeanors, likely, don’t make it to the state hospital. Ms. Denning explains that within criminal proceedings the guardian has very limited authority to speak on behalf of the ward, to include entering a guilty plea or preventing a guilty plea from being entered.

Ms. Smith, Professor. Botts, and Ms. Denning answered questions from the Committee.

Dr. Christopher Sharp, a Senior Fellow from the Cicero Institute, spoke to the Committee on involuntary commitment in North Carolina. Dr. Sharp explained that North Carolina has all the elements for a robust civil commitment program but as noted by other presenters, the challenge is that systems with the information do not talk to each other.

Dr. Sharp explained the research and statistical data to conclude that North Carolina has available beds that are not being used. He found that state licensure requirements are more stringent than what Centers for Medicaid/Medicare Services (CMS) provide. Dr. Sharp suggested adding a property damage standard. Many individuals with mental illness are prone to escalation and adding a property damage standard would show the continuum of a person’s behavior. The connection between violence and mental illness are evident. For example, 15% of domestic violence perpetrators had present mental illness; also, chronic addiction and substance abuse are present in 61% of domestic violence perpetrator.

Dr. Sharp explained his research about building capacity in hospitals for individuals with severe mental illness to receive mental health treatment. The Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act, provided oversight protection for mentally ill individuals and is authorized to investigate and advocate on issues of abuse and neglect against mentally ill individuals. The scope of this act has expanded to move people from institutions to the community shown by a reduction of psychiatric beds. Dr. Sharp suggested that attorney generals can petition the federal government to refocus PAIMI’s to protect the civil rights of a person, rather than using an individual’s right to refuse treatment as a reason to move people from institutions into the community. He suggested to carve out severe mental illness to specifically focus on schizophrenia, bipolar disorder, and major depression because their propensity for violence is high and

should be the focus of IVC. Qualified health centers do handle these cases as they also juggle conditions like minor depression or anxiety that are treatable and can go away while the severe mental illnesses are long-term conditions. Building capacity in prisons involve creating special housing units for sexual predators and specialty housing units for known serious mental illness that will be released by the Department of Adult Corrections (DAC). Assisted outpatient treatment, assertive community treatment and forensic assertive community treatment provide the intensive supervision needed for these individuals to stay on their treatment plan. Dr. Sharp stated there are multiple vacant buildings in North Carolina that can serve as residential facilities. He suggested some cost-saving measures within courts and jails that can aid in funding these projects.

Law enforcement assisted diversion is the future of crisis intervention. Mobile crisis teams are limited in resources and availability, especially outside of normal business hours and weekend nights. Dr. Sharp supports a co-response model, which emphasizes a partnership between law enforcement and mental health professionals. Dr. Sharp stated that the Conference of Chief Justices and the Conference of State Court Administrators recommend combining specialty courts to streamline documentation for decision making.

April 14, 2026

Approval of Committee Minutes

Rep. Reeder, Presiding Co-chair

Overview of Committee Report

Jessica Boney, Staff Attorney for the Legislative Analysis Division, NCGA

Approval of Committee Report

Rep. Reeder, Presiding, Co-Chair

Rep. Reeder, presiding Committee Co-chair, called for a motion to vote on approving the Committee Minutes. With no objections the vote was passed to approve the minutes. Next, the committee heard from Jessica Boney, Staff Attorney for the Legislative Analysis Division, NCGA, who provided an overview of the Committee Report. She reviewed the findings and recommendations on behalf of the Committee and afterwards, a discussion ensued among various members of the committee. Rep. Reeder called for a motion to vote to approve the committee report. With no objections the vote was passed to approve the committee report. Members of the committee expressed their sentiments on moving forward and gratitude for staff and stakeholders who presented to the committee.

Committee documents such as the agendas and presentations discussed during committee meetings can be found, [here](#). Please email the Legislative Library at library@ncleg.gov for an audio recording of this meeting.

FINDINGS AND RECOMMENDATIONS

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Use of Telehealth in Jails to Complete the First Examination

The Committee finds that using telehealth to complete the first examination of the involuntary commitment process (IVC) in jails would address several issues facing the State, its custodial institutions, and the overall efficiency of its mental health systems. These issues include long wait times to see providers, transportation issues, logistical issues, and safety concerns. The Committee finds that the use of telehealth to complete first examinations of people in custody of county jails would help address the listed issues, as well as address the demand on hospitals and other institutions to complete the first examinations of people in custody.

The Committee encourages the General Assembly to help provide telehealth capability to all county jails by making an appropriation that would enable counties to obtain the required equipment, space, and contracts for a telehealth program.

The Committee recommends that the General Assembly direct the North Carolina Sheriff's Association, the North Carolina Department of Health and Human Services, and other stakeholders to explore the following: (i) a funding amount for the provision of telehealth services in all county jails within the State, (ii) a model for a telehealth program and its technical components, and (iii) a Request for Proposal for companies to contract with the North Carolina Sheriff's Association to provide telehealth services for the county jails.

Use of Mobile Crisis Units to Complete the First Examination

The Committee finds that Mobile Crisis is a valuable tool to address mental health concerns and crises in the State. The Committee commends Mobile Crisis teams and associates for their dedication and work to stabilize, assess, and de-escalate individuals in a variety of settings, divert people away from hospitals, inpatient facilities, and jails, and connect people to essential healthcare. The Committee recognizes that despite these efforts, a general lack of resources and points of disconnection throughout the State's mental health system has strained the system as a whole. Additionally, licensed clinicians are typically not among the members of Mobile Crisis who respond to crises.

The Committee recommends that the Local Management Entities/Managed Care Organizations consider and implement ways to use Mobile Crisis units to enhance the efficiency of the IVC process and ongoing treatment, including the retention of licensed clinicians as part of Mobile Crisis units to provide first examinations, with the goal of optimizing efficiency and use of resources.

Increase the Number of Providers Who Can Complete IVC Evaluations

The Committee finds that there is increased demand for providers who are authorized to perform commitment examinations. Expanding the number of providers who can complete commitment examinations could decrease the demand for State psychiatric beds, hospital beds and services, lower wait times, improve efficiency, and lead to other positive changes.

The Committee recommends amending General Statute 122C-263.1 to allow more qualified people to become certified in the performance of first examinations.

The Committee recommends that NC DHHS evaluate its current training program for commitment examiners and provide additional training that may be necessary for providers who conduct first examinations of individuals in jail.

Address Staffing and Bed Shortages in State Operated Facilities

The Committee finds there is an ongoing shortage of available beds in State operated facilities for individuals in crisis and that insufficient staffing significantly limits the ability to utilize existing bed capacity. The Committee finds that it is imperative to recruit additional staff, retain existing staff, and strategically plan for future workforce needs in order to effectively address the behavioral health needs of the State.

The Committee recommends NC DHHS to develop a specific plan to increase capacity that includes the review of (i) staffing models, (ii) hiring practices, (iii) retention, and (iv) incentive pools.

The Committee recommends NC DHHS explore all possible methods to address staffing shortages, including (i) a review of staffing requirements mandated by State statute and Joint Commission standards to identify potential reforms to staffing models, and (ii) consideration of grant opportunities and funding mechanisms to support beds and nongovernmental facilities.

Improved Data Collection and Further Study

The Committee finds there is a longstanding lack of data related to involuntary commitments. The Committee finds there are opportunities to collect data at various points in the involuntary commitment process, as highlighted in the presentation by Trip Stallings, Executive Director, N.C. Longitudinal Data System, NC DIT. The Committee finds that expanding the collection of deidentified data related to involuntary commitments will enhance the system through more effective, data-driven decision-making. Improved data collection will assist in identifying systemic deficiencies and in ensuring that individuals in crisis receive appropriate and timely support. The Committee recognizes the complexity of federal and State laws governing access to such data given its sensitive nature and that further study by NC DHHS, NC DIT and AOC is necessary. The Committee finds that additional training for judicial officers, together with updates to various involuntary commitment forms, would be beneficial in supporting and complementing expanded data collection efforts.

The Committee recommends the General Assembly enact legislation requiring NC DHHS, NC DIT, and AOC to study relevant State statutes, judicial and clinical practices, and available technological resources and recommend systematic improvements. The Committee recommends the stakeholders make recommendations to (i) develop additional training for judicial officers on involuntary commitment; (ii) update the required involuntary commitment examination forms, affidavits and petitions to ensure the State is collecting the most helpful information for judges to make IVC determinations; (iii) increasing data collection and sharing between DHHS and the Judicial Branch Case Management System of IVC exams and court proceedings; (iv) explore the feasibility of a public facing dashboard; and (v) allow longitudinal data for additional uses. The proposed legislation is attached as [Appendix C].

Lack of Use of Outpatient Commitment

The Committee finds that there is a lack of use and awareness of outpatient commitment and that oversight of the system could be improved. Discussions regarding the use of outpatient commitment by other states demonstrate how it may be more effectively used in North Carolina. The Committee strongly encourages the use of outpatient commitment.

The Committee recommends that the House of Representatives review relevant State statutes and identify revisions necessary to align with best practices adopted in other states.

The Committee also recommends that the House of Representatives ensure that there is a payment method and funding in place to support the expansion of outpatient commitment services.

Provide Law Enforcement Access to BH SCAN

The Committee finds that law enforcement officers face significant challenges in identifying and securing available beds for individuals subject to involuntary commitment. These challenges include (i) a lack of access to real-time data on bed availability, (ii) transportation issues, and (iii) inefficiencies that often result in officers driving several hours to a hospital without the assurance of an available bed. The Committee acknowledges that centralized, real-time data accessible to relevant stakeholders could increase efficiency and reduce strain on law enforcement resources.

The Committee recommends that the House of Representatives require the Department of Health and Human Services to implement real-time data availability for BH SCAN, give law enforcement access to BH SCAN, and create the ability to reserve an open bed.

Evaluate Legal Standards for Involuntary Commitment, Incapable to Proceed, and Guardianship/Incompetency

The Committee finds that there are different legal standards for involuntary commitment, incapacity to proceed, and incompetency, as outlined in the UNC School of Government presentation. Understanding the distinction among these standards is essential in addressing inefficiencies.

The Committee recommends that the House of Representatives require a comprehensive review of the legal standards governing each system to identify statutory revisions that would enhance system effectiveness and advance public safety for all individuals involved.

Mental Health and Criminal Justice Systems Operate as a "Revolving Door"

The Committee finds that the same individuals are repeatedly arrested or involuntarily committed, only to be released into the community and be arrested or committed again. This is referred to as the "revolving door" problem. This issue was discussed throughout the committee meetings, and was highlighted as a problem by Lisa Coltrain, who presented on behalf of the North Carolina Conference of District Attorneys. This issue is especially prevalent within the context of non-violent misdemeanors, where individuals do not receive necessary treatment for their underlying issues and therefore the individual will offend again. The major risk associated with this endless cycle is that eventually the offenses may become more serious.

The Committee recommends that the House of Representatives direct the North Carolina Department of Health and Human Services to establish a working group with interested stakeholders to address this revolving door problem and report quarterly to the General Assembly.

Study the Provision of Medical and Behavioral Health Care in Jails

The Committee heard from presenters about the necessary medical and behavioral health issues that individuals must be treated for while in jails. These issues require significant staffing, financial, transportation, and logistical resources. The Committee acknowledges the complex medical and behavioral health needs of individuals in jail, and the difficulties the NC Safekeeper's program faces, as explained by Leslie Cooley Dismukes, Secretary for NC Department of Adult Corrections.

The Committee recommends that the House of Representatives expand the NC Safekeeper's program.

The Committee recommends that the House of Representatives survey how medical and behavioral health care is currently being provided in jails and examine the details of these arrangements, including in-house services, contracted services, hybrid models, or other approaches.

Continue the Study of Involuntary Commitment and Public Safety

The Committee finds that it received valuable feedback, engaged in productive discussions, and completed meaningful work. However, the issues surrounding involuntary commitment and public safety are complex and require continued study.

The Committee recommends the General Assembly authorize the Committee to continue its work through the 2026 session and be reestablished to continue its work for the 2027-2028 biennium.

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COMMITTEE MEMBERSHIP

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2025-2026

Speaker of the House of Representatives

Appointments:

Rep. Hugh Blackwell (Co-Chair)
Rep. Timothy Reeder, MD (Co-Chair)
Rep. Terry M. Brown Jr.
Rep. Laura Budd
Rep. Grant L. Campbell, MD
Rep. Tracy Clark
Rep. Carla D. Cunningham
Rep. Dudley Greene
Rep. Donny Lambeth
Rep. Ya Liu
Rep. Charles W. Miller
Rep. Marcia Morey
Rep. Larry W. Potts
Rep. A. Reece Pyrtle, Jr.
Rep. Robert T. Reives, II
Rep. Heather H. Rhyne
Rep. Carson Smith
Rep. Charles Smith
Rep. John A. Torbett
Rep. Diane Wheatley
Rep. Donna McDowell White
Rep. Shelly Willingham

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COMMITTEE CHARGE/STATUTORY AUTHORITY

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Office of the Speaker
North Carolina House of Representatives

DESTIN HALL
SPEAKER OF THE HOUSE

HOUSE SELECT COMMITTEE ON INVOLUNTARY COMMITMENT AND PUBLIC SAFETY TO THE NORTH CAROLINA HOUSE OF REPRESENTATIVES

Section 1. The House Select Committee on Involuntary Commitment and Public Safety (hereinafter "Committee") is established by the Speaker of the House of Representatives pursuant to Rule 26(a) of the Rules of the House of Representatives of the 2025 General Assembly.

Section 2. The Committee consists of eighteen members appointed by the Speaker of the House of Representatives. The membership of the Committee shall include legislators as specified below. Members serve at the pleasure of the Speaker of the House of Representatives. The Speaker of the House of Representatives may dissolve the Committee at any time. Vacancies are filled by the Speaker of the House of Representatives. A Chair, Vice Chair, or other member of the Committee continues to serve until a successor is appointed.

Co-Chair Hugh Blackwell	Representative Terry Brown
Co-Chair Timothy Recder, MD	Representative Tracy Clark
Representative Grant Campbell, MD	Representative Carlo Cunningham
Representative Dudley Greene	Representative Ya Liu
Representative Donny Lambeth	Representative Charles Smith
Representative Charles Miller	Representative Shelly Willingham
Representative Larry Potts	
Representative Reece Pyrtle	
Representative Heather Rhync	
Representative Carson Smith	
Representative Diane Wheatley	
Representative Donna White	

Section 3. The House Select Committee on Mental Health and Involuntary Commitment will study and make recommendations regarding the intersection of mental health services, involuntary commitment processes, and the safety of the general public. Members of the committee will review current laws, policies, and practices governing involuntary commitment in North Carolina and consider measures to ensure both public safety and the appropriate treatment of individuals with severe mental illness. The committee will recommend legislative, administrative, and policy changes to strengthen North

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Carolina's mental health and involuntary commitment systems while supporting law enforcement's role in protecting communities.

Section 4. The Committee shall meet upon the call of the Chair. A quorum of the Committee shall be a majority of its members. No action may be taken except by majority vote at a meeting at which a quorum is present.

Section 5. The Committee, while in the discharge of its official duties, may exercise all powers provided for under G.S. 120-19 and Article 5A of Chapter 120 of the General Statutes. The Committee may contract for professional, clerical, or consultant services, as provided by G.S. 120-32.02.

Section 6. Members of the Committee shall receive per diem, subsistence, and travel allowance as provided in G.S. 120-3.1

Section 7. The expenses of the Committee including per diem, subsistence, travel allowances for Committee members, and contracts for professional or consultant services shall be paid upon the written approval of the Speaker of the House of Representatives pursuant to G.S. 120-32.02(c) and G.S. 120-35 from funds available to the House of Representatives for its operations.

Section 8. The Legislative Services Officer shall assign professional and clerical staff to assist the Committee in its work. The Director of Legislative Assistants of the House of Representatives shall assign clerical support staff to the Committee.

Section 9. The Committee may submit reports on the results of its evaluations and investigations, including any proposed legislation, to the members of the House of Representatives at any time. The Committee may submit a final report on the results of its work, including any proposed legislation, to the members of the House of Representatives by May 1, 2026. Reports shall be submitted by filing a copy of any report with the Office of the Speaker of the House of Representatives, the House Principal Clerk, and the Legislative library. The Committee terminates upon the convening of the 2026 General Assembly, upon the filing of its final report, or by dissolution by the Speaker of the House of Representatives, whichever occurs first.

Effective on this 2nd day of October 2025.



Destin Hall
Speaker

LEGISLATIVE PROPOSALS

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GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2025

H

D

BILL DRAFT 2025-1Iz-171A [v.2]

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)

Short Title: IVC and Public Safety Committee.

(Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, THE NORTH CAROLINA DEPARTMENT OF INFORMATION TECHNOLOGY, AND THE ADMINISTRATIVE OFFICE OF THE COURTS TO STUDY AND RECOMMEND SYSTEMIC IMPROVEMENTS TO THE INVOLUNTARY COMMITMENT PROCESS, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON INVOLUNTARY COMMITMENT AND PUBLIC SAFETY.

The General Assembly of North Carolina enacts:

SECTION 1. The North Carolina Department of Health and Human Services (DHHS), the North Carolina Department of Information Technology (DIT), and the Administrative Office of the Courts (AOC) shall study relevant statutes, judicial and clinical practices, and available technological resources to identify areas for systemic improvement in the involuntary commitment (IVC) process in the State. This study shall identify existing gaps in the State's current IVC process and shall provide specific recommendations to address or eliminate those gaps and ensure that individuals subject to involuntary commitment receive timely, data-driven, and accessible support. On or before February 1, 2027, DHHS, DIT, and AOC shall report to the Joint Legislative Committee

on Health and Human Services on the results of the study, which shall include, at a minimum, all of the following:

- (1) A comprehensive evaluation of the legal and operational frameworks governing involuntary commitment in the State to provide formal recommendations for systemic improvement. This evaluation shall focus on (i) ensuring that judicial officers receive timely clinical data from examiners to make informed, legally sound decisions regarding an individual's safety and treatment needs and (ii) establishing a foundation for more effective legal and clinical outcomes, including:
 - a. Parameters for training judges and magistrates on community-based services, such as Treatment Accountability for Safer Communities (TASC), "Community Treatment" teams, and Forensic Assertive Community Treatment (FACT) teams, to bolster treatment compliance and reduce recidivism.
 - b. Collaborating with the University of North Carolina School of Government to develop clinical workflows, transport guidance, and bench cards that ensure successful referrals across all agencies.
 - c. The update of electronic examination forms, affidavits, and petitions to capture consistent, high-quality data statewide.
 - d. Strategies to increase data sharing between DHHS and the E-Courts system regarding IVC exams and court proceedings, including the feasibility of a public-facing dashboard.
- (2) Any additional information deemed relevant by DHHS, DIT, and AOC to ensure high-quality data collection and data-driven decision making across the involuntary commitment system.

SECTION 2. This act is effective when it becomes law.